Music Therapy Treatment of Depressive Symptoms in Adolescents in Short-Term Inpatient Psychiatric Settings: A Survey Study

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DEDICATIONS

To the adolescents with whom I’ve worked over the past years, and to those with whom I will work in the future: Thank you for motivating me to delve deeper into this work.

To the music therapists and other creative arts therapists who have inspired me with your honesty in approaching your work, and who’ve strengthened the field with deep consideration of the implications of music therapy with adolescents.

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# TABLE OF CONTENTS

LIST OF TABLES ........................................................................................................... vii

LIST OF FIGURES........................................................................................................ viii

ABSTRACT..................................................................................................................... ix

I. INTRODUCTION ....................................................................................................... 1

II. LITERATURE REVIEW ............................................................................................ 8

   Adolescence .............................................................................................................. 8
   Adolescent Depression ............................................................................................. 11
   Experiences of Adolescent Depression ................................................................. 15
   Trends in Adolescent Psychotherapy ..................................................................... 19
   Creative Arts Therapies with Adolescents: Selected Literature .......................... 29
   Adolescents and Music ............................................................................................ 33

III. METHODS ............................................................................................................. 48

   Design of the Study ................................................................................................. 48
   Location of the Study ............................................................................................... 48
   Time Period for Study ............................................................................................. 48
   Enrollment Information ........................................................................................... 49
   Subject Type ............................................................................................................ 49
   Participant Source .................................................................................................. 49
   Recruitment ............................................................................................................. 49
   Subject Inclusion Criteria ....................................................................................... 50
   Subject Exclusion Criteria ..................................................................................... 50
   Investigational Methods and Procedures ............................................................ 51
Operational Definitions ................................................................. 53
Possible Risks and Discomforts to Subjects ..................................... 54
Special Precautions to Minimize Risks or Hazards ............................ 55

IV. RESULTS ..................................................................................... 56
Survey Respondents’ Characteristics ............................................... 72
The Influence of Goals on Methods and Most Important Factors ........... 81

V. DISCUSSION ................................................................................ 84
Overview ........................................................................................ 84
Major Findings ............................................................................... 84
Clinical Applications ..................................................................... 93
Limitations of the Study .................................................................. 95
Recommendation for Future Research ............................................. 97

VI. SUMMARY AND CONCLUSIONS ........................................... 101

REFERENCES .................................................................................. 104
Appendix A: Email Invitation to Participate in Survey ....................... 113
Appendix B: Authorization for Use of CBMT Email Addresses .......... 115
Appendix C: Reminder Email for Participation in Survey .................. 116
Appendix D: Survey ......................................................................... 117
Appendix E: Responses to Question 6 of Those Who Chose “Other (please specify):” ................................................................. 130
Appendix F: Responses to Question 8 of Those Who Chose “Other (please specify):” ................................................................. 131
Appendix G: Responses to Question 10 of Those Who Chose “Other (please specify):” ................................................................. 132
Appendix H: Responses to Question 11 of Those Who Chose
“Other (please specify):” ................................................................. 133

Appendix I: Responses to Question 15 of Those Who Chose “Other (please specify):” ................................................................. 134

Appendix J: Responses to Question 18 of Those Who Chose “Other (please specify):” ................................................................. 135

Appendix K: Open-Ended Responses to Question 19 “Please explain:” ................................................................. 136

Appendix L: Open-Ended Responses to Question 20 “Please explain:” ................................................................. 137

Appendix M: Open-Ended Responses to Question 22 “Please explain:” ................................................................. 138

Appendix N: Responses to Question 25 of Those Who Chose “Other (please specify):” ................................................................. 139

Appendix O: Responses to Question 26 of Those Who Chose “Other (please specify):” ................................................................. 140

Appendix P: Responses to Question 27 of Those Who Chose “Other (please specify):” ................................................................. 141

Appendix Q: Responses to Question 28 of Those Who Chose “Other (please specify):” ................................................................. 142

Appendix R: Responses to Question 31 of Those Who Chose “Other Techniques/Additional Comments:” ................................................................. 143

Appendix S: Responses to Question 32 of Those Who Chose “Other (please specify):” ................................................................. 145

Appendix T: Open-Ended Responses to Question 34 ................................................................. 146

Appendix U: Open-Ended Responses to Question 35 ................................................................. 148

Appendix V: Permission for Reprinting of AMTA 2011 Workforce Profile Data ....... 151
LIST OF TABLES

4.1. Most Important Factors Contributing to Successful Treatment: by General Theme ................................................................. 71

4.2. Aspects of Treatment Focused Upon in “Most Important Factors” Question .......... 72

4.3. Themes of Agency in “Most Important Factors” Question ........................................ 73
LIST OF FIGURES

4.1. Years of Experience Working As a Music Therapist ........................................ 58

4.2. Respondents’ Experience Working with Adolescents in Short-Term Inpatient Psychiatric Settings ................................................................. 58

4.3. Average Length of Hospitalization for Adolescents ...................................... 61

4.4. Treatment Team Members Collaborated with to Develop Treatment Goals .... 62

4.5. Treatment Team Members Collaborated with to Provide Treatment ............. 62

4.6. Diagnoses of Adolescent Patients Treated for Depressive Symptoms .......... 64

4.7. Top Goals When Treating Adolescents With Depressive Symptoms in Music Therapy ................................................................. 65

4.8. Methods Frequently Used When Treating Adolescents With Depressive Symptoms ................................................................. 66

4.9. Methods Chosen As Effective In Alleviating Depressive Symptoms in Adolescents ................................................................. 68
Music therapists work with adolescents in inpatient psychiatric settings. While diagnoses of adolescents admitted to inpatient psychiatric settings range from psychoses to mood disorders, depressive symptoms are a prevalent problem. Some of the adolescents are admitted to inpatient psychiatric settings with Major Depressive Disorder, while others have symptoms of depression along with other diagnoses. There is a lack of current data about the music therapy treatment of depressive symptoms in these situations. Thus, this study sought to determine the goals and methods of music therapists working to treat depressive symptoms in adolescents in short-term inpatient psychiatric settings, as well as music therapists’ perceptions of the most important factors that influence successful treatment of depressive symptoms in adolescents. A survey completed by 36 board-certified music therapists yielded information about the practices of music therapists working in the milieu of the short-term inpatient setting. Results show that the top goals of music therapists are to increase ability to cope with negative feelings/mood states, increase positive social interaction, and increase self-esteem. Responding music therapists reported most frequently using the methods of lyric analysis, rhythmic improvisation, and music listening. They found lyric analysis, rhythmic improvisation, and songwriting to be the most effective methods to treat depressive symptoms in adolescents in short-term inpatient psychiatric settings.
CHAPTER I: INTRODUCTION

Music therapy is currently used to treat adolescents with depressive symptoms in short-term inpatient psychiatric settings. This study focused on acquiring more detailed information about the current practices of music therapists for treating adolescents with depressive symptoms in short-term inpatient psychiatric settings. Specifically, this study sought to identify the methods that board-certified music therapists currently use to treat depressive symptoms in adolescents in short-term inpatient psychiatric hospitals and to learn their goals for treatment. The study also sought to identify music therapists’ perceptions of the most important factors that contribute to successful treatment of depressive symptoms in adolescents within this setting.

The researcher designed a web-based descriptive survey utilizing SurveyMonkey. After thoroughly reviewing current literature concerning music therapy treatment of depression in adolescents, and literature regarding adolescent inpatient psychiatry, the researcher created the survey items. The survey included both closed-ended and open-ended questions, including the demographics of music therapists and information about the treatment settings. Survey questions addressed the goals and methods used in treating depressive symptoms in adolescents in short-term inpatient psychiatry, as well as barriers to treatment. The survey also inquired about music therapists’ perceptions regarding the most important factors contributing to successful treatment of depressive symptoms in adolescents in short-term inpatient psychiatric settings. Thirty-six board-certified music therapists completed the survey.

Although music therapists are treating adolescents with depressive symptoms in inpatient psychiatric settings, limited data exists regarding best practice. Therefore, this
study was developed to address the limited published material addressing current
to practices of music therapists in treating adolescents with depressive symptoms in short-
term inpatient psychiatric settings. Information from this study can assist music
therapists working in inpatient psychiatric settings in designing effective treatments for
their adolescent patients that experience depressive symptoms. This study can guide
future research that will investigate the efficacy of particular methods in treating
depressive symptoms in adolescents in short-term inpatient psychiatric settings.

For the purposes of this study, depressive symptoms included hopelessness, lack
of energy, low self-esteem, inability to experience pleasure, excessive sadness not due to
bereavement, consistent feelings of emptiness, and excessive irritability when combined
with other symptoms. Patients did not need to have diagnoses of Major Depressive
Disorder in order to be included in this survey, but rather respondents were encouraged to
include data on patients whose treatment in music therapy focused on depressive
symptoms. Short-term inpatient psychiatric settings were defined as any setting where
patients remain in the facility 24 hours per day, are treated primarily for psychological
illnesses, and stay, on average, two to three weeks. Method was defined as the general
category of music therapy intervention that was performed with patients. Goal was
defined as the desired outcome of treatment. Adolescent was considered any individual
between and including ages 12 and 18. Adolescence was considered the period of time
between and including ages 12 and 18. Music therapy was defined in accordance with
the American Music Therapy Association as “the clinical and evidence-based use of
music interventions to accomplish individualized goals within a therapeutic relationship
by a credentialed professional who has completed an approved music therapy program” (AMTA, 2011b).

The period of adolescence is a psychological and physiological period of transition during which the body undergoes the changes of puberty and the mind begins to be capable of abstract thought. Adolescents struggle to find independence while navigating the waters of social and parental expectations (Emunah, 1990; Hamer, 1984; Newman & Newman, 2009). This time of life contains more rapid and pervasive developmental changes than any other period of development besides infancy (Oetzel & Scherer, 2003).

According to recent research, the lifetime prevalence of Major Depressive Disorder or dysthymia of any severity in adolescents is 11.7%, with 8.7% classified as having severe impairment (Merikangas et al., 2010). In 2006, 8.2% of adolescents experienced a Major Depressive Episode, though only 38.9% of adolescents with at least one Major Depressive Episode in that year received treatment for depression (National Institute for Health Care Management [NIHCM], 2010). Depressive symptoms are also prominent components of other diagnoses such as Bipolar Disorder, and thus, more adolescents experience depressive symptoms each year than are reflected in the above statistics (Volkmar & Martin, 2011). Additionally, 35.8% of female and 21.2% of male high school students reported sadness or hopelessness that prevented usual activity in 2007 (NIHCM, 2010), indicating a notably high prevalence of depressive symptoms beyond those diagnosed with depression.

Depression during adolescence can often impair adolescents’ ability to participate in social activities and forge social connections (Hamer, 1984; PintoFoltz, HinesMartin,
Adolescents often perceive a negative stigma attached to feelings or diagnosis of depression (Pinto-Foltz et al., 2010; Rose, Joe, & Lindsey, 2011). Additionally, experiencing depression increases adolescents’ likelihood of attempting suicide (NIHCM, 2010).

In 2006, 67,404 adolescent inpatient hospital stays were due to affective disorders (NIHCM, 2010). Though it is difficult to find up-to-date statistics on lengths of stay in psychiatric facilities for adolescents, in 1997 the average length for any adolescent receiving inpatient psychiatric care was 7 days (Geller & Biebel, 2006). Treatment periods in inpatient psychiatry are thus quite short for adolescents. In order to be admitted to an inpatient psychiatric facility, an adolescent must display signs of severe mental illness and functional impairment, such as risks of self-harm, inability to meet basic self-care needs, or emotional disturbances that inhibit participation in family or social activities (Gosselin & DeMaso, 2009). During inpatient psychiatric treatment, adolescents often have little choice in their activities, must abide by stringent rules, and are surrounded by strangers (Moses, 2010). Adolescents report feeling constricted and isolated during their stays in inpatient care (Haynes, Eivors, & Crossley, 2011; Moses, 2010). They also may witness acts of aggression, violence, or self-harm, which can in turn evoke confusion and restlessness in adolescent psychiatric inpatients (Haynes et al., 2011).

According to the American Music Therapy Association's 2011 Workforce Profile, 20% of music therapists work with mental health populations, including adolescent mental health populations. Additionally, 13% of music therapists reported working in a mental health setting, including inpatient psychiatric facilities (American Music Therapy
The short treatment period and other inherent characteristics of inpatient psychiatric hospitalizations, as well as the psychological effects of the hospitalization itself on the adolescent patient, pose unique challenges for the music therapist (Geller & Biebel, 2006). Since music therapists are employed in inpatient psychiatric hospitals, music therapists must find effective ways to treat depressive symptoms in adolescents given the unique characteristics of the short-term inpatient psychiatric setting.

Studies have found preliminary evidence that music and music therapy can be effective in reducing depressive symptoms in adolescents (Albornoz, 2011; Bittman, Dickson, and Coddington, 2009; Plenar, Sukale, Ludolph, and Stegemann, 2010; Rio & Tenney, 2002), and in normalizing EEG activation and lowering cortisol levels in adolescents with depression (Field et al., 1998; Jones & Field, 1999). Additionally, adolescents in short-term psychiatric settings have identified music listening as a method of calming down and regulating their behavior and mood (Tyson & Baffour, 2004).

However, only three studies addressed music therapy treatment of depression in adolescent inpatients (Bittman, Dickson, and Coddington, 2009; Hamer, 1984; Kuntz, 2012). McFerran’s (2010) book, Adolescents, Music, and Music Therapy: Methods and Techniques for Clinicians, Educators, and Students, also shows preliminary anecdotal evidence of the effectiveness of music therapy in addressing the needs of inpatient adolescents and adolescents with depression, though it does not provide explicit examples of music therapy in inpatient psychiatric settings with adolescents with depression.

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Additionally, many of these studies were carried out during a time when inpatient stays for adolescents were much longer, often lasting for months.

Although Kuntz’s (2012) thesis explored the general goal areas and methods music therapists use when treating a variety of diagnoses in adolescents in inpatient and outpatient psychiatric settings, including those of Major Depressive Disorder, the information was more general than that which was sought in the current study, and was dependent on diagnoses. Thus the current study provided more specific inquiry into music therapy practices specifically aimed at treating depressive symptoms in adolescents in inpatient psychiatric setting regardless of the adolescents’ diagnoses.

This study sought to answer the following question: what are music therapists’ goals and methods when treating adolescents with depressive symptoms in short-term inpatient psychiatric settings, and what do music therapists perceive as the most important factors in successfully treating adolescents with depressive symptoms? The objective of the study was to discover the current treatment practices of board-certified music therapists in their treatment of adolescents with depressive symptoms in inpatient psychiatric settings in order to better understand how music therapy can be effective in treating depressive symptoms in adolescents in inpatient psychiatric populations.

The results of the study indicate that the primary goal of most sampled music therapists was to increase adolescents’ ability to cope with negative feelings and mood states. Other prominent goals of the sampled music therapists in short-term psychiatric settings were to increase adolescents’ self-esteem and increase their positive social interactions. Methods most often used to treat adolescents with depressive symptoms in inpatient psychiatric settings were lyric analysis, rhythmic improvisation, and music
listening. The sampled music therapists perceived lyric analysis, rhythmic improvisation, and songwriting as the most effective methods. Finally, participating music therapists identified group cohesion, the therapeutic alliance, therapist-initiated support of the patient, and patient dedication as primary factors that contributed to successful treatment of depressive symptoms in adolescent in short-term inpatient psychiatric settings.

The study was delimited to board-certified music therapists who have worked in short-term inpatient psychiatric settings with adolescents age 12 to 18 for at least one year. Additional delimitations included that participants must have been able to read and write in English, and must have had Internet access, in order to complete the survey.

Limitations included the small sample size of respondents (n=36), and thus, responses cannot be generalized to all music therapists that work with this population. The results may not be applicable to rural settings. Additionally, most survey questions were multiple-choice closed-ended questions, which may have limited the depth of information provided by respondents. The questions may have been worded in ways that were not clear to readers, and thus responses may have been compromised by misunderstandings or confusion of the questions. The definition of short-term inpatient psychiatric setting, as written above, includes a statement that the average length of stay in such a setting is 2 to 3 weeks, which was not corroborated by survey data—which indicated that average treatment lengths were closer to one week. This definition was included in the email invitation to participate in the survey, and may have inhibited participation by those respondents who worked in settings in which the average treatment time was less than 2 to 3 weeks.
CHAPTER II. LITERATURE REVIEW

Adolescence

Adolescence is described as a time of transition between childhood and adulthood, starting at puberty. Adolescents transition physiologically, psychologically, and socially. Social development includes establishing supportive relationships outside of one’s family, affiliating with a peer group, and exploring intimate relationships (Newman & Newman, 2012; Volkmar & Martin, 2007). Psychological development during adolescence is largely related to increasing one’s independence from parental guidance, increased decision-making, and the acquisition of Piaget’s formal operations, which includes abstract reasoning and being able to envision alternate possibilities. The acquisition of abstract reasoning is heavily dependent upon the physiological development of the brain during adolescence, which includes increased visuoauditory, visuospacial, and somatic systems of the brain in addition to an increase in executive functioning due to growth in the frontal region of the brain (Newman & Newman, 2012, p. 354).

Physiological changes can have a profound effect on social development during this stage. Although puberty is considered the start of adolescence, puberty is a process that lasts many years and includes dramatic increases in the secretion of estrogen in girls and testosterone in boys. These increased hormones trigger physical growth—in height and body mass—and initiate the maturation of sex organs in males and females, resulting in female menarche and male fertility, which is the most clear physical marker that puberty has occurred (Volkmar & Martin, 2007). Females tend to experience puberty earlier than males. The average age of onset for female menarche is 12 to 13 years old,
while the average age of onset of fertility in males is 15 to 16 years old. Additionally, earlier-than-average onset of puberty has quite different impacts on females compared to males. Males who experience early puberty tend to become more popular, have high self-esteem, and greater school success. However, females who experience early puberty tend to have lower self-esteem, more negative body image, and have a higher risk for eating disorders and anxiety and mood disorders (Newman & Newman, 2012; Volkmar & Martin, 2007). The development of self-concept that integrates one’s body image into one’s identity is critical during adolescence, and thus, changes in physical appearance may be the source of psychological turmoil (Volkmar & Martin, 2007).

Many difficulties, both psychological and social, tend to occur during adolescence for most individuals. Adolescents’ changing hormones and physical maturation can lead to sexual impulses that may feel difficult to control, and which may cause tension between adolescents and their parents. Adolescents may wish to explore and express these sexual desires while parents may wish that the adolescents inhibit sexual expression. Indeed, the maturation of the adolescent physically, psychologically, and socially while remaining in a home run by their parents and not being financially independent often leads to conflicted feelings of desires for independence, feeling restricted by parents, and feelings of dependency on parents (Brunstetter, 1998; Volkmar & Martin, 2007).

Adolescence is the time in which parental and societal values are often tested, rejected, and then perhaps integrated into the identity of the adolescent (Brunstetter, 1998; Newman & Newman, 2012). Peer relationships become of utmost importance, with the opinions and recommendations of peers often seen as more important and more
accurate that that of parents. Peer approval or criticism may deeply impact adolescents’ self-concept and self-esteem. Additionally, peer groups provide an opportunity to test new behaviors, physical appearances, and ways of presenting oneself that can serve to clarify adolescents’ identities and social roles (Brunstetter, 1998; Newman & Newman, 2012; Volkmar & Martin, 2007).

Although cognitive abilities continue to develop, increasing the likelihood of adolescents being able to view situations from multiple perspectives, solve abstract problems and envision consequences, these skills develop at different speeds for all adolescents. Additionally, the increase in desires for independence and increase in emotions and sexual desire may make it difficult for adolescents to fully utilize their cognitive capacities (Newman & Newman, 2012; Volkmar & Martin, 2007). The presence of any psychological disorder, such as depression, may make coping with the demands of this period of life quite difficult and may negatively impact peer socialization and the solidification of identity (Brunstetter, 1998).

Although there is a relatively concrete signifier of the start of adolescence, there is a less clear definition of the close of adolescence. In most respects, individuals are considered legally adults at age 18. However, many psychological and social developments that are typically attributed to adolescence may have not been completed by this age. In fact, Newman and Newman (2012) propose an additional developmental stage of late adolescence, ranging from age 18 to 24, during which individuals continue to strive for financial and housing independence from parents and work on solidifying their individual identity. Despite current recognition that full development of adulthood may not be reached by age 18, legal requirements often require individuals who are 18
years or older to be placed in adult units of psychiatric settings. However, some adolescent inpatient psychiatric settings do include individuals who are 18 years old. Thus, for the purposes of this study, adolescence will be defined as ages 12 to 18 years inclusive.

**Adolescent Depression**

**Prevalence and incidence of adolescent depression.** Adolescent depression is recognized as a formidable presence in the United States. Merikangas et al. (2010) found in their National Comorbidity Survey Replication-Adolescent Supplement—a face-to-face survey of 10,123 adolescents—an 11.7% lifetime prevalence of Major Depressive Disorder or dysthymia of any severity, with 8.7% classified as having severe impairment. Females had a significantly higher lifetime prevalence of depression, with 15.9% lifetime prevalence compared to 7.7% in males. Additionally, the study found high rates of overall comorbidity in adolescent mental health disorder, though no specific statistics were reported on the comorbidity of depression with other mental health disorders. This observational study was administered to a nationally representative sample of individuals ages 13 to 18 and was sponsored by the National Institute of Mental Health. It assessed adolescents through a World Health Organization Composite International Diagnostic Interview, modified for language use with adolescents, and a survey mailed to parents to gain more information on symptoms, demographics, and sociocultural characteristics of their adolescent children (Merikangas et al., 2010). This study represents the most current knowledge about lifetime prevalence of depression in adolescents.

**Etiology of adolescent depression.** Genetic factors are known risk factors to the development of adolescent depression, with adolescents whose parents have a history of
depression or anxiety at a higher risk for developing depression than the overall population (J. S. Sadock & Sadock, 2007, pp. 532-533; Volkmar & Martin, 2007). Additionally, the presence of depression in other family members seems to be an environmental risk factor, providing a model for internalizing behaviors and lessening the likelihood that the adolescent will receive strong emotional support from a family member with depression (Volkmar & Martin, 2007).

Lewinsohn, Gotlib, and Seeley (1995) used a longitudinal observational study to determine risk factors for major depressive disorder in randomly selected urban and rural high school students age 14 to 18 years old. The sample appeared to be nationally representative of United States adolescents. Participants, n=1,507, were interviewed using the Schedule for Affective Disorders and Schizophrenia for School-Age Children and an abbreviated version of the Hamilton Depression Rating Scale at T1 and one year later at T2. Patients were also interviewed at T2 using the Longitudinal Interval Follow-Up Evaluation to ascertain information about the course of psychiatric symptoms and disorders that might have been experienced since T1. Participants were retrospectively divided into three groups—not mentally ill (n=1,189), substance abuse group (n=42), and major depression group (n=90). The substance abuse and major depression groups both had no disorder at T1 but had experienced an episode of substance abuse or major depression, respectively, between T1 and T2. Relevant to this thesis, females were significantly overrepresented in the depressed group. Results of the study indicated that the major psychosocial risk factors for having an episode of Major Depression include stress related to “negative daily hassles,” defined in the study as unpleasant social and nonsocial events. Other psychosocial risk factors include past suicide attempts, poor
physical health, internalizing behavior problems, and the presence of a negative major
life event in the participant or the participant’s family or friends (Lewinsohn et al., 1995).

Milne and Lancaster’s (2001) observational study explored the correlation
between depressive symptoms, as measured by the Self-Rating Depression Scale (SDS),
and various life factors in 59 nonclinical adolescent females between the ages of 14 and
16 years old. The factors studied were separation-individuation, interpersonal concerns,
self-critical concerns, attachment styles, and parental representations—how participants
perceived the care and protection they received from parents during their childhoods. All
factors were measured using self-report measures administered to groups of 20 subjects
in schools and completed in one data collection session. The researchers found a strong
positive correlation between depressive symptoms and poor parental attachment and poor
individuation. They also found a correlation between self-critical concerns and
depressive symptoms. Additionally, high levels of perceived maternal care were
negatively correlated with depressive symptoms (Milne & Lancaster, 2001). This study
provides insight into factors that may be most important to work on during therapy with
female adolescents with depression or to lower risk of depression in female adolescents,
namely self-criticism and poor individuation. The study also illuminates possible risk
factors for adolescent depression in females—poor parental attachment. It also shows a
possible preventative developmental experience—high-perceived maternal care.

Kaltiala-Heino and Fröjd (2011) reviewed relevant literature and found a
correlation between involvement in bullying and presence of depression in adolescents.
They found that both victims of bullying and bullies themselves had higher rates of
depression than the overall adolescent population (Kaltiala-Heino & Fröjd, 2011). This
was not a meta-analysis, but does provide some evidence that bullying may be a risk factor for depression in adolescents.

Conway, Rancourt, Adelman, Burk, and Prinstein (2011) explored the phenomenon of depression socialization. Through a longitudinal observational study, Conway et al. explored the influence of friend groups on the presence of depressive symptoms of individuals ages 10 to 14 years old (n=648) using self-report and peer-report data collection. Depression presence was measured by the Children’s Depression Inventory (CDI), a self-report measure. Participants also identified their own close friends and nominated peers who seemed sad most of the time. The authors calculated individuals’ friend groups, their positions within these groups based on the peer identifications, and the overall depression and sadness of the groups based on peer nomination and the group members’ CDI scores. All measurements were taken twice, with T1 and T2 being one year apart. Results found that higher average friend group depression levels at T1 were correlated to higher individual depression levels at T2 (Conway et al., 2011). This study implies that levels of depression may be more likely to increase in adolescents whose friends are depressed.

Au, Lau, and Lee (2009) used a descriptive observational study of 6,340 students from intact classes in schools in Hong Kong to determine how family cohesion and social self-concept—how well an individual feels they relate to and are regarded by peers—mediated the correlation between depression and suicidal ideation in these young adolescents. Participants in the secondary school group had a mean age of 13 years old. Participants completed questionnaires during class time, including the Suicide Probability Scale (SPS), Child Depression Inventory (CDI), Reynolds Adolescent Depression Scale
(RADS), the social self-concept domain of the Multi-domain Multi-perspective Self-concept Inventory (MMSI), and the family cohesion dimension of the Family Environment Scale (FES). The authors found a high correlation between suicide ideation and depression for the secondary school group, $r = .50$. They found a negative correlation between family cohesion and suicide ideation, $r = -.27$, and family cohesion and depression, $r = -.51$. They additionally found a negative correlation between social self-concept and suicidal ideation, $r = -.16$, and social self-concept and depression, $r = -.46$.

Higher family cohesion scores and higher social self-concept scores seemed to lower the likelihood that individuals with depression would have suicidal ideation, although social self-concept’s impact was lower than that of family cohesion. Additionally, the study found that females had higher mean depression and suicidal ideation scores (Au et al., 2009). The study in general supports the importance of both family and peer social groups in lowering the risk for depression and mediating negative effects of depression among adolescents.

Steingard et al. (2002) found in a prospective neuroimaging observational study of adolescents with depression ($n=19$) and non-depressed adolescents ($n=38$), that depressed adolescents had smaller white matter volume when compared with the control group, as calculated from the neuroimaging and statistically controlled for age. White matter volume and frontal lobe irregularities had previously been implicated in adolescent depression, and this study provides data confirming this hypothesis, though the small sample size is problematic (Steingard et al., 2002).

**Experiences of Adolescent Depression**

PintoFoltz, HinesMartin, and Logsdon (2010) undertook a qualitative grounded
theory study of twenty-one ninth graders, with a mean age of 14.33 years old, in a public high school in a southern urban area of the United States. Researchers collected data on adolescents’ thoughts, feelings, and reported behaviors regarding depression and peer relationships during two audiotaped one-hour focus groups. Field notes were also taken during the focus groups, and the same researchers who conducted the interviews coded the data. These adolescents’ main concerns related to depression were related to social interaction and status—being dissimilar to peers, risks to reputation, and risks to relationships. Adolescents additionally expressed concern that peers with depression may harm themselves (PintoFoltz et al., 2010). This study provides insight into the concerns that adolescents have regarding diagnoses and experiences of depression. They worry about how depression may impact their social functioning and also are concerned about the safety of individuals with depression.

**Stigma related to adolescent depression.** Clear et al. (2011) and Rose et al. (2011) studied adolescents’ perceptions of stigma related to depression. Both studies’ results show that adolescents perceive stigma surrounding depression. Clear et al. (2011) used an observational study of extant data from a recent randomized controlled trial to examine levels of personal stigma—how much stigma one’s self assigns to a characteristic of others or self—and perceived stigma—what one thinks others think about a characteristic—about depression in 1,375 Australian adolescents ranging from asymptomatic to subclinical to clinical in their range of depression and anxiety. Measured by the Depression Stigma Scale, and controlling for and correlating with sociodemographic variables and illness symptoms, they found that mean perceived stigma scores were 20.53 out of a possible 36, while personal depression stigma had a
mean of 14.48 out of 36, creating a statistically significant difference in personal versus perceived stigma, indicating that participants consistently thought others would think worse of mental illness than they personally did (Calear et al., 2011).

Rose et al. (2011) similarly studied, in a cross-sectional correlation study, how perceptions of stigma, as measured by the Attitudes Towards Psychological Help scale, correlate to severity of depression, as measured by the Reynolds Adolescent Depression Scale 2nd edition (RADS-2), in 108 African American adolescents receiving outpatient treatment for depression. Chi-square analysis of results found a significant positive correlation between severity of depression and perceptions of stigma ($x^2=7.86; p<0.01$). Thus, adolescents with more severe symptoms of depression felt more stigma surrounding their diagnosis. Interestingly, 77% of participants measured as having mild to severe depression responded in interviews that they had needed an emotional counselor, psychiatrist, or both, as did 51% of participants classified as normal (Rose et al., 2011). These studies reflect both adolescents’ felt pressure to be normal as well as adolescents’ awareness of their need for assistance in dealing with their mental health problems.

Perceived barriers to treatment for depression in adolescents. Meredith et al.’s (2009) longitudinal observational study assessed what adolescents with depression perceived as barriers to treatment and how those perceptions affected what care patients received in the next six months. This study interviewed, at baseline and six months later, 368 individuals, half of whom were experiencing depression and the other half of whom had no experience of depression within the past six months. It found that teens classified as depressed perceived more barriers to treatment than did adolescents without
depression. Additionally, it found that on average depressed adolescents rated family stigma as the most prominent barrier to treatment, with problems and responsibilities related to school, home, or work as the second most perceived barrier to treatment. Lack of access to care, not wanting treatment, and feeling that the cost would be too high were other highly perceived barriers to treatment. Finally, this study found that only 56% of participants with depression received any treatment in the next six months (Meredith et al., 2009).

In addition to stigma and other barriers to treatment, parents may not recognize adolescents’ behaviors as symptomatic of depression, and rather may attribute them to typical adolescent development. Irritability may particularly be overlooked as a potential symptom of depression, with parents viewing it more as adolescent resistance to authority than a sign of psychopathology (Volkmar & Martin, 2007).

**Experiences of inpatient hospitalization by adolescents.** Moses’s (2010) simple descriptive observational study interviewed 80 adolescents between the ages of 13 and 18 years old who had been voluntarily hospitalized in an inpatient psychiatric facility for the first time. The face-to-face semi-structured interviews were conducted within seven days of discharge from the hospitalization and sought to discover what aspects of hospitalization were the most helpful to adolescents. The interviews also focused on discovering any perceived negative aspects of the hospitalization. It found that the most positive aspects of hospitalization were support and normalization from peers and staff, in addition to learning cognitive and behavioral coping methods. Negative experiences repeatedly expressed were excessive time in rooms, confinement, excessive restrictions, and excessive repeated need to share intimate details of one’s self (Moses, 2010).
Trends in Adolescent Psychotherapy

Some authors and practitioners recommend working with parents and families when treating adolescents (Brunstetter, 1998; Gosselin & DeMaso, 2009; Shapiro, 1994). Family relations often impact the development of depression and other mental illnesses and affect the adolescent’s ability to cope with depression and recover from it (Au et al., 2009; Brunstetter, 1998). Thus, gaining an accurate picture of the configuration of the family and the quality of the relationships between family members is important (Brunstetter, 1998).

Authors have written about the difficulties of working with adolescent patients (Brunstetter, 1998; Oetzel & Scherer, 2003; Rubenstein, 1996). Adolescents may have difficulty clearly expressing themselves verbally, blame others for their problems, believe that suffering will always continue, and may not trust adults. However, adolescents’ heightened emotions may also increase their investment in desiring change (Brunstetter, 1998; Rubenstein, 1996).

Rubenstein (1996) and Brunstetter (1998) both recommend listening intently to adolescent patients with respect, as adolescents often think that adults don’t listen to them. Rubenstein (1996) recommends supportive advocacy for the issues that adolescent patients find most salient to them—such as needing a quieter place to study. This would require a therapist to sit in on a meeting between the patient and school where the patient advocates for him/herself, or for the therapist to facilitate the patient calling up local community resources (Rubenstein, 1996). Brunstetter (1998) similarly recommends extensive support for the adolescent patient, through interspersing discussion of the core
issues of the patient with supportive statements and validations of the experience, process, and identity of the adolescent patient.

Oetzel and Scherer (2003) provide recommendations for working with adolescents based on pertinent literature and their experience working with adolescents in psychotherapy. They highlight the idea that adolescents usually enter therapy in the precontemplative stage of therapeutic change, and thus, the therapist must attempt to move the adolescent into greater investment in the change process by emphasizing nonjudgmental acceptance and respect for the perspectives of the adolescent patient, in addition to showing empathy (Oetzel & Scherer, 2003, p. 217). Additionally, therapists should be genuine in their interactions with adolescent patients, since adolescents seem to quickly notice and respond poorly to insincerity. Cognitive ability may also factor into the therapeutic relationship with adolescents, as some adolescents cannot yet self-reflect or bear in mind the future consequences of behavior in the same ways that adult patients may be able to, yet adolescents are highly sensitive to “being talked down to,” making it important to understand and relate to the adolescent at their cognitive functioning level. Adolescents’ attachment history and ability to tolerate intense emotions may also affect how they relate their striving for autonomy with their experience of trusting a therapist. Adolescents entering therapy may be more likely to exhibit anxious attachments, which may result in manipulation or dismissal of the therapist. Adolescents may find intense emotions overstimulating, requiring the therapist to react in muted ways to emotions expressed during the early parts of therapy, until greater coping skills can be developed. Finally, adolescents are often involuntarily attending therapy and may be confused about what the process entails, which can feel detrimental to their search for autonomy. A
A therapist that is able to integrate choices into the treatment and can explain the purposes and processes of therapy may be more successful at engaging these adolescents (Oetzel & Scherer, 2003).

**Most common treatment types for adolescent depression.** Adolescents who experience depression may be prescribed antidepressant medications, typically selective serotonin reuptake inhibitors or SSRIs, although tricyclic antidepressants are also sometimes prescribed. Adolescents may attend individual, group, or family psychotherapy in order to treat their depression, alone or in conjunction with antidepressants (Volkmar & Martin, 2007).

In 2011, the Centers for Disease Control and Prevention (CDC) released statistics that indicated that 3.7% of adolescents ages 12 to 17 years old in the United States were taking antidepressants (Pratt, Brody, & Gu, 2011). This is less than the percentage of adolescents who are likely to have depression, but is congruent with studies showing that not all adolescents with depression seek or receive treatment, as shown in Meredith et al. (2009). In comparing the CDC statistics with depression prevalence statistics from Merikangas et al. (2010), it seems about one-third of adolescents with depression currently take antidepressants, although some percentage of individuals in the CDC study may have been taking antidepressants for anxiety.

Wagner (2005) reviewed all double-blind placebo-controlled trials with antidepressants in children and adolescents. The review found that only two antidepressants, fluoxetine and sertraline, were supported by more than one study finding a positive and statistically significant treatment outcome of these pharmaceuticals compared with placebo (Wagner, 2005).
March and Vitiello (2009) discuss the outcomes of the Treatment of Adolescent Depression Study (TADS), one of the largest studies of fluoxetine effectiveness. TADS evaluated the comparative effectiveness of fluoxetine only, fluoxetine combined with cognitive behavioral therapy (CBT), cognitive behavioral therapy only, and placebo through a randomized controlled trial involving 327 adolescents, ages 12 to 17, who were diagnosed with Major Depressive Disorder. Cognitive behavioral therapy is a short-term, structured therapy that focuses on current problems and their resolutions (J. S. Sadock & Sadock, 2007). The sample included wide socioeconomic variability and minority representation, and appears generalizable to the national adolescent population. TADS evaluated effectiveness at weeks 12, 36, and 52. The study found that although the fluoxetine-only treatment was more effective than CBT at week twelve, combining CBT with fluoxetine treatment was the most effective treatment option overall, with 71% of subjects in this condition showing clinically significant improvement at week twelve of treatment, with an effect size of 0.98. Additionally, the article reports that CBT combined with fluoxetine provided the quickest relief from symptoms, with maximum medical effectiveness reached three months before either fluoxetine or CBT alone (March & Vitiello, 2009).

Diamond et al. (2010) explored the effectiveness of Attachment-Based Family Therapy (ABFT) in lowering suicidal ideation and depressive symptoms among 66 mostly African American female adolescents identified as suicidal, according to the Suicidal Ideation Questionnaire, and moderately depressed, as measured by the Beck Depression Inventory. The study used a randomized controlled trial comparing ABFT to Enhanced Usual Care (EUC), which consisted of referring patients to other mental health
care providers such as other therapists. ABFT is a manualized family therapy that targets family processes associated with depression and suicide, focusing on improving family problem solving, organization, and affect regulation, with the overall goal of strengthening family cohesion. This study found that the rate of improvement in lowering suicidal ideation in the ABFT group was significantly greater than that of the EUC during the twelve weeks of treatment, as was the amount of change from baseline to post-treatment and baseline to follow-up twelve weeks after treatment end, with 70% of ABFT and 34.6% of EUC participants reporting suicidal ideation in the normative range at follow-up. However, there were not statistically significant changes in depression scores for either the ABFT or EUC groups, though there was some clinically meaningful change in depression scores in the ABFT group throughout the course of the study, with 54.8% of ABFT participants no longer having clinical range depression by the end of the treatment period (Diamond et al., 2010). Results of the study are inconclusive regarding the efficacy of ABFT specifically on depression in adolescents but, because suicidal ideation can accompany depression, it shows that ABFT may be useful in treating the suicidal subsection of depressed adolescents.

Michael and Crowley’s (2002) meta-analysis of 38 empirical studies from 1980 to 1999 on the treatment of child and adolescent depression comparing effect sizes of psychosocial treatment or pharmacotherapy, found that, combined, psychosocial treatments had a larger mean effect size on depression in adolescents—ES=0.93 for controlled trials and ES=1.35 for pre-test/post-test design—than the mean effect size of pharmacotherapy, ES=0.28 in treating adolescent depression (Michael & Crowley, 2002). No studies included in this thesis were included in Michael and Crowley's (2002) meta-
analysis, since most studies did not directly relate to adolescents in inpatient psychiatric settings. The studies included in this meta-analysis may have included antidepressants that are no longer considered the most effective for use in adolescents, and thus the results may not be fully accurate considering the advances that may have been made in the efficacy of antidepressants in treating adolescents since the meta-analysis was carried out.

Mark’s (2008) article reviews data from MarketScan Commercial Claims and Encounters, which collects data on private insurance claims, and from Medicaid Databases, from the year 2004 to 2006 in order to assess what percentage of adolescents receiving antidepressant medications also received psychotherapy in the six months following initial prescription. It found that less than one-third of adolescents filing with Medicaid and less than half of those filing with private insurance received psychotherapy that they reported to insurance. The author notes that some individuals may have paid for psychotherapy out of pocket, in which no data would be available from these databases (Mark, 2008). This indicates that the majority of adolescents receiving antidepressant medication do not receive additional psychotherapy, despite recent research that supports the efficacy of adding psychotherapy to pharmaceutical treatment of depression and adolescent preference for psychotherapy over pharmacological treatment (March & Vitiello, 2009).

Wu et al. (1999) analyzed data of 1,285 child—ages 9 to 17—and parent/guardian pairs from the National Institutes of Mental Health Methods for the Epidemiology of Child and Adolescent Mental Disorders Study, which gathered data from subjects in Connecticut, Georgia, New York and Puerto Rico, to determine factors related to mental
health utilization in individuals with depressive and disruptive disorders. This data, collected through in-person structured interviews conducted separately with parents and children in their homes, included individuals with no disorders and was analyzed to control for specific socioeconomic factors. The study reported more females meet the criteria for depressive disorder than disruptive disorder. Lifetime mental health service use was higher for individuals with disruptive disorders, with 56.3% of the sample receiving services, than for those with depressive disorders, in which 38.6% received services. The study additionally found that parents’ perceptions of the need for mental health services were greater if their children had disruptive disorders than if their children had depressive disorders. Interestingly, in children and adolescents, they found more correlation between having depressive disorders and desiring mental health treatment, indicating that parents and their children differ in their perceptions of the need to treat depressive disorders (Wu et al., 1999).

Bradley, McGrath, Brannen, and Bagnell (2010) surveyed 156 Nova Scotian adolescents to ascertain preference for treatment method and willingness to seek treatment for depression, and which side effects would most deter adolescents from taking antidepressants. Results showed that 92% of males and 94.9% of females rated preference of talk therapy higher than antidepressants, with a statistically significant and clinically meaningful difference in preference rating between talk therapy and antidepressant use. Results may be inaccurate due to the lack of prior testing of the scales used and the presence of the list of antidepressant side effects, which may have affected the preference rating of using antidepressants (Bradley et al., 2010). However,
the study provides preliminary evidence that adolescents value non-pharmacological treatments for depression.

**Inpatient psychiatry with adolescents.** The current goal of inpatient hospitalization is to rapidly stabilize individuals so that patients can safely transition to less intensive mental health care settings. Admission of an adolescent to an inpatient psychiatric setting requires that individuals have signs of highly severe mental illness and some functional impairment, including risks of self-harm, inability to meet basic self-care needs, or emotional disturbances to such a level that participation in family or social activities is inhibited (Gosselin & DeMaso, 2009, p. 55). Admission may be voluntary or involuntary, but parents and adolescents usually must consent to the hospitalization. Adolescents are evaluated with a battery of psychological assessments including the Children’s Depression Inventory, the CRAFT Substance Abuse Screening Test for adolescents, and other brief rating scales. Patients are also evaluated for aggression risk at the start of admission and supported in developing preventative measures and coping skills throughout their hospitalization. Assessment information is also gathered from the patient, parent, and, when possible, from schools, outpatient mental health-service providers, and other family members (Brunstetter, 1998; Gosselin & DeMaso, 2009).

Treatment goals are focused on attainable steps that restore health and safety in the individual patient, and are ideally formulated with collaboration between the patient, psychiatrist, community-based mental health care providers, and parents. Treatment is based on these goals and carried out through multimodal interventions, including psychopharmacology, psychoeducation, psychotherapy, active therapy, therapeutic recreation, and case management. Because adolescent inpatient psychiatric
hospitalizations are usually short, medications may not reach their full effectiveness or show their side effects during the course of the hospitalization. Psychotherapies are usually administered in individual and group settings, where participants may attend only one session due to short stays (Gosselin & DeMaso, 2009).

Due to the severity of symptoms of adolescents admitted to inpatient care, unit routines are highly structured, materials are screened and restricted for physical safety, and media may be censored to avoid violent or profane language. Units may also adhere to points-based behavior modification token economy programs. Community meetings, which include the patients of a unit as well as one or two staff members, are often held each morning or once per week to address the needs of the unit and formulate solutions to unit-wide problems that have arisen (Brunstetter, 1998; Gosselin & DeMaso, 2009).

Some difficulties specific to the adolescent inpatient psychiatric unit include difficulty in forming alliances with adolescent patients who may have been involuntarily committed, and who may be difficult to connect to regardless of admission type. Additionally, patient and staff stress and even trauma may result from episodes of restraint necessitated by unmanageable violence or aggression in a patient (Brunstetter, 1998; Gosselin & DeMaso, 2009).

Family may represent a specific difficulty, as delicately balancing patient privacy and parental interest in knowing all health information about their child, especially in regards to substance abuse and sexual health may be quite challenging (Gosselin & DeMaso, 2009, p. 57). Providing as much information as possible about the illness and hospitalization to both patients and family, with efforts to collaborate with family members and patients in creating treatment plans, may lesson anxiety and increase
investment in the adolescent’s treatment. Forming alliances with the patient and family in order to ensure the patient’s continued therapy and care after the course of the hospitalization is of key importance (Brunstetter, 1998; Gosselin & DeMaso, 2009). Integrating the family into treatment may be difficult within the short time frame of inpatient hospitalization, and thus family meetings—a standard element of adolescent inpatient hospitalization—may serve as one of the only spaces for working with parents. In these meetings, family experiences may be normalized and increased understanding of the adolescent problems may be possible. Additionally, specific patterns of interaction may be pointed out and worked on with therapist encouragement of change for the good of the adolescent patient (Brunstetter, 1998). Patients may be discharged to their homes or to step down services such as partial hospitalizations or residential settings. Patients are required to attend school during their psychiatric hospitalization, and meetings between staff, patients, and school officials are often needed to facilitate a patient’s re-entry into the school setting (Gosselin & DeMaso, 2009).

Geller and Biebel’s (2006) article provides an overview of the trend over the past twenty years of declining numbers of inpatient psychiatric facilities and residential treatment facilities specified for children and adolescents. According to the authors, private psychiatric facilities have increased in number as state-run psychiatric facilities have declined significantly—Pennsylvania no longer has any state-run adolescent psychiatric units. In 2003, the readmission rate for adolescents who received inpatient psychiatric care in state facilities was 6.6%. The average length of stay in a psychiatric inpatient facility for individuals under 18 years old decreased from 41 days in 1970 to 7 days in 1997. However, child and adolescent occupancy rates in psychiatric hospitals
rose 34% between 1997 and 2001. The authors report that in 55% of states in 2003, mental health authorities believed that there was a shortage of beds for adolescent patients that needed treatment in inpatient facilities (Geller & Biebel, 2006).

Arnold et al. (2003) studied rehospitalization rates in 180 adolescents ages 12 to 19 years old over a ten-year period following participants’ first inpatient psychiatric hospitalization. This prospective observational study followed participants for up to 10.3 years after the initial hospitalization and found that 44% of participants were re-admitted to a psychiatric hospital at least once during the study period. Of those re-admitted, 18.9% were within the first six months after the initial hospitalization. The study additionally found that diagnoses of affective disorders, including Major Depressive Disorder, were the largest predictor of re-hospitalization (Arnold et al., 2003).

**Creative Arts Therapies with Adolescents: Selected Literature**

Emunah (1990), a drama therapist who had worked in the field for fifteen years at the time of writing her article, explores the developmental challenges that confront individuals during adolescence from a psychodynamic perspective and proposes that the creative arts therapies are particularly suited to assist adolescents in processing and working through this stage of life. The author points out that adolescence involves dramatic changes in physical characteristics, as well as cognitive and emotional challenges and changes. She proposes a four-pronged concept of adolescence—*explosion, expression, containment, and expansion*—and suggests ways that the creative arts therapies can assist in each of these aspects of adolescent development. In working with *explosion*, creative arts therapies can draw on the confusion and energy that often results from adolescents exploring greater independence from their parents, directing this
intense energy into the arts. The author suggests that adolescence is a time of heightened creativity, thus resulting in a greater need for creative expression as a cathartic release of the chaos and emotionality that often accompanies adolescence. However, adolescents then need to feel how to have mastery over these emotions, and the creative arts can encourage active containment through holding expression within the media of the art. Finally, creative arts therapies can help adolescents explore their hopes, new possibilities for their present and future, and generally encourage expansion by helping the adolescent to explore various aspects of the artistic material and processes and use those to embody hopes, aspirations, and alternatives. This article provides a theoretical basis for effective use of creative arts therapies with adolescents.

Dance/Movement therapy literature suggests that the movement of one’s body is an important form of communication and connection, (Chase, as cited in Chaiklin & Schmais, 1993). Dancing or moving with others provides individuals with new ways of interacting with their environment and those around them (Chase, as cited in Chaiklin & Schmais, 1993; Nemetz, 1995). Patients engaged in shared rhythm draw from “the common pool of energy” and experience greater strength and security than they could if moving alone, and thus, rhythm brings into focus the shared actions of individuals, leading to communication between group members and body awareness in the individual (Chase, as cited in Chaiklin & Schmais, 1993, pp. 80-81). Indeed, moving one’s body may lead to new ways of experiencing one’s body in action, and thereby may increase one’s feelings of empowerment, as an agent of action (Nemetz, 1995). This literature is relevant to music therapy with adolescents in that rhythmic improvisation incorporates movement and synchrony in the sharing of rhythms.
Creative arts therapies with adolescents with depressive symptoms. Pifalo (2011) used a pre-test/post-test nonrandomized quasi-experimental design to study the effects of an eight week combined art therapy and cognitive behavioral therapy (CBT) group treatment in reducing trauma symptoms associated with childhood sexual abuse in 41 subjects age 8 to 16 years old. Treatment was one hour per week and combined the “clear-cut goals” (p. 181) of CBT with the ability of art therapy to allow for expression of traumatic events and feelings without needing to know how to verbalize them. The Trauma Symptom Checklist for Children (TSCC), which includes a depression subscale, was used to evaluate the participants before and after treatment. Relevant to this thesis, the study found a statistically significant decrease in depression subscale scores from pre- to post-test with a p value of .01 and a moderate effect size (Pifalo, 2011).

Jeong et al., (2005) used an experimental study of Korean students (n=40) with mild depression with a mean age of 16 years old to determine the effects of dance/movement therapy on psychological distress and neurohormones. The treatment protocol for the experimental group (n=20) was 45-minute dance/movement therapy sessions three times per week for three weeks, and included sessions designed around the themes of body and group awareness, movement expressions, movement and images, and differentiation and integration of feelings. The participants in the control group (n=20) received no treatment during the course of the study but were invited to participate in a similar treatment protocol after the study ended. All participants completed the Symptom Check List-90-Revision, a self-report inventory of emotional distress before and after the treatment period. The researchers additionally measured participants’ plasma serotonin and dopamine concentrations—the neurohormones most associated with depression—
before and after the treatment period. Results showed a statistically significant decrease in depression and anxiety in the experimental group but not the control group, as well as significant increases in serotonin in the experimental group (Jeong et al., 2005). This study provides evidence that dance/movement therapy can be an effective treatment for depression in adolescents.

**Arts-based interventions with adolescents in inpatient psychiatric settings.**

Tyson and Baffour’s (2004) cross-sectional observational study integrated solution-focused therapy with the arts-based interventions. The study focused on discovering arts-based strengths—coping skills as well as points of mastery or pride in the adolescents’ life—in adolescents in acute-care inpatient psychiatric settings. Consistent with the solution-focused therapy model, these strengths needed to be self-identified. Thus, one hundred adolescents were asked to think about positive strengths they had used in the past to stop problems from “pushing them around” (p. 219). Participants then wrote narrative reports about these self-identified strengths. Listening to music was mentioned most often as the most frequently used arts-based strength. Rap music was most often the type of music listened to, followed by rock. Writing, including writing poetry, stories, and lyrics, was the second most-mentioned strength, followed by artwork and singing/playing an instrument. Additionally, 58.3% of the subjects had diagnoses of Major Depressive Disorder or Dysthymia, indicating that these results may particularly apply to the scope of this thesis (Tyson & Baffour, 2004). This indicates that adolescents already find creative arts expression to be a useful coping tool.
Adolescents and Music

Multiple studies confirm that listening to music is an important and frequent activity for adolescents (Nippold, Duthie, & Larsen, 2005; North, Hargreaves, and O’Neill, 2000; Tarrant, North, & Hargreaves, 2000), and that music can serve to assist adolescents in coping with difficulties in their lives (North et al., 2000; Tarrant et al., 2000). Additionally, music may allow adolescents a modality through which to connect to others or separate themselves from others (Laiho, 2004). The connection to others may relate to shared listening experiences, where adolescents listening to music together experience similar emotions resulting from the music. Shared listening experiences to a particular preferred type of music may also strengthen membership in a particular social group. Music may connect adolescents psychologically with others who are not present physically, or to past events and figures in adolescents’ lives (Laiho, 2004). In this way, music’s role during adolescence is inherently social, and can serve to assist in adolescent developmental tasks of discovering an identity within a peer group—a peer group that may be physically or psychologically present in the adolescent’s life.

Tarrant et al. (2000) used a survey design to determine the reasons adolescents listen to music and discover how much music they listen to each day. The study included 245 adolescents in the United Kingdom and United States with a mean age of 15.27 years old. The study found that adolescents in the United States listened to an average of 2.52 hours of music per day, with the most prevalent reasons for listening to music being to relieve tension or stress, to relieve boredom, and to help get through difficult times (Tarrant, North, & Hargreaves, 2000).
North et al.’s (2000) survey sought information about the importance of music in adolescents’ lives, time spent listening or performing music, and reasons for listening and performing music. The study, involving 2,465 adolescents age 13 to 14 in England, acquired data from voluntarily completed surveys distributed to 22 schools. Their results found a mean of 2.45 hours of music listening per day (SD=1.64), with 17% of the responders currently playing instruments and an additional 51.7% who had played instruments at some point but had stopped. These figures indicate a high level of engagement with music in adolescents. Additional data showed that this sample preferred listening to music over all other indoor activities, with only a slight advantage over watching television. Finally, top reasons for personally listening to music were to get through difficult times, to relieve tension or stress, and to express emotions (North et al., 2000). These studies provide an indication that music is an important part of adolescent life and that music therapy may be complementary to the ways that many adolescents already use music in their personal lives.

A more recent school-based survey study exploring the leisure activities of older children and adolescents (Nippold et al., 2005) confirmed music listening, along with attending music concerts, as the top-rated leisure activity of adolescents and older children. The study included 100 older children, on average almost 12 years old, and 100 young adolescents with an average age of 14 to 15 years old. In the young adolescent group, 82% reported that they liked to spend their free time listening to music or going to concerts, with females reported this preference more than males—90% of female respondents and 74% of male respondents. The second-most popular leisure activity was
watching TV or videos, with 72% of young adolescents choosing this option (Nippold et al., 2005).

Field et al., (1998) and Jones and Field (1999) used randomized controlled trials to study the effects of music listening on decreasing asymmetrical right frontal electroencephalogram (EEG) activation, associated with increased negative affect in depressed adolescents (Field et al., 1998). These studies compared music listening to massage (Field et al., 1998) or to sitting and relaxing (Jones and Field, 1999). These studies found that listening to popular upbeat music—chosen by focus groups of adolescents prior to the studies—was as effective as massage and more effective than sitting and relaxing at attenuating asymmetrical right frontal EEG activation, as measured by EEG. Additionally, Field et al. (1998) subjects—28 chronically dysthymic African American and Hispanic female adolescents—were administered the Depression Adjective Checklist before and after music listening. No change was found in these scores, indicating that physiological changes do not effect immediate experienced psychological change. Jones and Field (1999), who studied 30 African American and Hispanic adolescents of both genders who were diagnosed with dysthymia or major depression and who had baseline EEG indicating greater relative right frontal activation, measured only EEG (Jones and Field, 1999). These studies provide some hope that frontal lobe abnormalities in adolescent depression, mentioned here and in Steingard et al.'s (2002) study, may be partially remedied through music listening, supporting the positive neurological impact of music.

**Music therapy with adolescents.** In his essay, Tervo (2001), a music therapist from Finland with 20 years of experience in adolescent inpatient psychiatry, presents his
thoughts on the value of music therapy with adolescents from a psychoanalytic perspective. The author posits three stages of music therapy, including introduction, learning, and improvisation. The author identifies learning as an important stage in which the patient is becoming familiar with instruments, the music therapist, and the music therapy process itself. In this stage, the adolescent may feel amateur and may learn to trust the music therapist based on the therapist’s ability to assist the patient in gaining feelings of mastery. Once trust and comfort in the environment and with new instruments are established, the adolescent can enter the improvisation stage, in which they can freely experiment with the music with support from the music therapist. The author suggests that during the improvisational stage, after trust has been established, musical instruments and the music made with them can act as transitional objects for adolescents, wherein they project their desires for omnipotence, closeness, sexual identity, etc., onto the music they make. Thus, music therapy can foster the healthy ability of adolescents to use symbols—in the form of musical interactions—to represent real feelings and experiences of the psyche. This in turn assists in healthy development (Tervo, 2001).

McFerran’s (2010) book includes a systematic review of music therapy literature regarding music therapy with adolescents, including works published up to 2008, and analyzed to show various characteristics of music therapy with adolescents. The analysis showed that only 3% of adolescent music therapy literature was written about work done in mental health institutions (McFerran, 2010, p. 29). The author further analyzed literature to establish broad categories of methods that were used with adolescents. The author found that 35% of literature included “live songs,” 34% included methods of
“improvisation,” 25% used “pre-recorded music,” and 6% used “musical games.”

Additionally, the author found that 59% of the literature focused on individual music therapy while 38% focused on group music therapy with adolescents, and 3% focused on both individual and group sessions, or family music therapy (McFerran, 2010, p. 37). This analysis of the literature provides an overview of current music therapy practice with adolescents.

Gold, Wigram, and Voracek (2007) used a pre-test post-test design observational study in Austria to determine the effect of various therapeutic variables on the outcome of music therapy with children and adolescents between the ages of 3.5 and 19 years old, n=75. Participants had primary diagnoses of developmental disorders, adjustment or emotional disorders, or behavioral disorders, and received one individual 45-minute session of music therapy each week from music therapists. Total treatment time varied and was allowed to last past the study period. Pre-tests were given at the beginning of treatment, with post-tests given after 25 sessions or when therapy was terminated, whichever came first. Music therapists documented the therapeutic techniques used in each session, most frequently reporting use of improvisation—including free and structured improvisation—and non-music media use, which included role play, movement, games and other creative media. Additionally, songs, receptive musical techniques, and verbal discourse were also used during this study. Each patient was assessed pre- and post-test using the Child Behavior Checklist (CBCL) to identify behavior problems and the burdens scale of the Hertlingshausen Satisfaction Questionnaire (HZFB) to assess the burden that the patient’s behaviors pose on their environment. Parents completed both measures, in addition to a post-test satisfaction
rating of the music therapy experience for their child. Therapists used visual analogue scales to retrospectively rate improvement or worsening of symptoms, quality of life, and resources of patients. Combining these assessments with the music therapists’ reports of techniques used and technique success ratings, the study tested the influence of specific therapy techniques on final treatment outcomes. They found, when controlling for therapist and participant variables—such as age, sex, therapist experience level, and patient diagnosis—that the use of non-music media had the most significant impact on symptom level and burdens. When non-music media were used in therapeutic methods, they negatively impacted therapeutic outcomes. Use of non-music media explained 16% of variance in symptom change level and 10% of variance in burden change level.

Music-based techniques, such as improvisation and song use, and verbal discourse were positively correlated with clinical improvement in symptoms, as reported by the music therapist. However, the use of non-music media, such as role-play and puppet play, was correlated with insignificant therapeutic change as measured by the CBCL and HZFB (Gold, Wigram, & Voracek, 2007). Thus, this study suggests that music therapy with children and adolescents with a variety of diagnoses is most effective when therapeutic sessions focus on music-based methods. As the study points out, this may be due to inherent therapeutic properties of music or to music therapists’ increased expertise in working within music (Gold, Wigram, & Voracek, 2007).

Daveson & Skewes (2002) discuss the theoretical reasons that rhythm seems to be an integral part of music therapy interventions, sharing case examples from their work with adolescents. The authors note that rhythm often serves to organize individuals’ understanding of musical expression. The authors highlight that when multiple rhythms
that fit together occur simultaneously, individuals can experience their own reality—their rhythm—as well as a shared reality with others—how their rhythm fits together with those of other group members. This duality of experienced realities then allows individuals to feel connection with others while maintaining a sense of self.

**Music therapy with adolescents with depressive symptoms.** Albornoz (2011) used a pre-test post-test randomized controlled trial of 24 male Venezuelan adolescents and adults with at least mild depression, who were being treated at an outpatient facility for substance abuse to study the impact of group improvisational music therapy on depression. The control group received standard care, which included individual and group psychotherapy, cognitive behavioral therapy, couples therapy, pharmacotherapy, and group meetings and recreation. The experimental group received standard care plus twelve, two-hour group improvisational music therapy sessions once per week, which included exploration of instruments, group music improvisation, and discussion, with flexibility in the ratio of each of these aspects. Pre- and post-tests using the Beck Depression Inventory, a self-report measure, and the Hamilton Rating Scale, which was observer rated by a psychologist not involved in treatment and blind to the groups, were compared at the end of the treatment cycle. The study found that although both groups’ depression scores had a statistically significant decrease between pre- and post-test, it found no statistically significant difference in the amount of depression decrease between the control and experimental group as rated by the Beck Depression Inventory. However, comparing Hamilton Rating Scale scores, statistically significant difference was found between post-test scores of the experimental compared to control group, with greater decrease in scores in the experimental group, with a large effect size (Albornoz, 2011).
Although Hamilton Rating Scale scores provide indicators that music therapy is a valuable addition to other types of care, lack of difference between control and experimental Beck Depression Inventory, with both groups’ scores decreasing, imply that adding music therapy may not provide clinically significant change. Additionally, the inclusion of other modalities in treatment makes it difficult to determine the effects of music therapy itself. Finally, the small sample size of only males, which included some adults, makes it less generalizable as a treatment for adolescent depression, indicating that more research needs to be done on this topic. However, the study’s music therapy treatment was a true reflection of music therapy as clinically implemented and therefore is a valuable insight into the possibility of a specific intervention having clinical relevance for treatment of adolescent depression.

Rio and Tenney (2002) discussed their work with adolescents in a juvenile detention center, where the adolescents had primary diagnoses of Oppositional Defiant Disorder or Conduct Disorder, but often also experienced depressive symptoms. Music therapy goals during group treatment included developing empathy, controlling impulses, improving relationships, increasing attention, improving communication and self-expression, and promoting self-esteem. Depressive symptoms were particularly present in the authors’ female music therapy group, but were evident in the authors’ two male groups as well. Methods used in music therapy groups included music listening, singing, movement to music, and rhythmic improvisation, and participants were encouraged to bring their preferred music into music therapy sessions. The authors presented case excerpts that supported the efficacy of these methods in increasing self-esteem, providing
opportunities for relating to others in a healthy manner, and developing group cohesion (Rio & Tenney, 2002).

Plenar, Sukale, Ludolph, and Stegemann’s (2010) pilot study in Germany, n=6, used a multiple-iteration single subject design to assess the effects of group music therapy, in the form of a band project, combined with individual dialectic behavior therapy for adolescents (DBT-A), in reducing non-suicidal self-injury and depressive symptoms in their small female sample who were recruited from the author’s practice and the community. The five subjects participated in twelve two-hour group music therapy sessions led by a licensed music therapist, focusing on relaxation, sharing preferred music, and performing preferred music as a group, with each participant exploring different instruments. Within each group music therapy session, each subject left the group to attend individual DBT-A, which focused on exploring emotional connections to desires to self-injure, relationships, and alternatives to self-injury. Mean sum scores of depression as measured by the Beck Depression Interview were lowered from 35.4 prior to treatment to 28.4 after treatment (Plenar et al., 2010). This study is not generalizable but shows the possible effectiveness of music therapy, in conjunction with DBT-A, as a viable treatment for depression in adolescents, though the authors discussed the increased feasibility with mild to moderate depressed rather than severely depressed adolescents, due to inability to effect change in one severely depressed subject.

Robb and Ebberts (2003) used a descriptive case study design with quantitative measures to study how music therapy affected anxiety and depression in adolescents undergoing bone marrow transplantation. The music therapy treatment focused on songwriting and video production. Anxiety was measured by the State-Trait Anxiety
Inventory for Children, and depression was measured by the Children’s Depression Inventory. Three subjects in music therapy sessions, and three in a control condition of playing simple games with a research investigator, participated in six, one-hour sessions over three weeks. Pre- and post-tests of anxiety and daily measures of depression were acquired and analyzed to find no conclusive results of the effects of music therapy on depression, though 2 music and 1 control participant showed consistently lowered anxiety post-session compared to pre-test (Robb & Ebberts, 2003).

**Music therapy with adolescents in inpatient psychiatric settings.** Frisch, a music therapist working primarily from a psychodynamic orientation, discusses the elements of music—namely, symbol and structure—that make music particularly useful in working with adolescents in inpatient psychiatric settings (Frisch, 1990). She specifically addresses the use of songwriting with adolescents in inpatient psychiatric settings, stating:

> A song is a vehicle that carries in it a person’s elements—one’s rhythms, melodies, feelings, thoughts, the deepest parts of the soul—and expressed these elements in a creatively encapsulated form that is integrated and unique. (p. 28)

She points out that songwriting creates a bridge between non-verbal and verbal communication, and therefore may particularly be useful in assisting gradual development of verbal communication of difficult emotions and experiences. She finally identifies cases in which individual patients and groups of patients have written songs to address difficult transitions in their lives and assist them in coping with stressful life events.
Register’s (2002) survey of board-certified music therapists found that 87.5% of music therapists collaborate with families and other professionals during the treatment of their patients—most frequently with family members, occupational and speech therapists, and medical professionals. Although the majority of respondents reported working with individuals with developmental disabilities and only 16.5% reported working in a psychiatric facility, this survey shows that music therapists are likely to be collaborating with other professionals during their treatment of adolescents in inpatient settings (Register, 2002).

Wooten (1992) used a pre-post-test experimental crossover design with a baseline condition and two experimental groups to study the effects of heavy metal music versus mainstream rock music in a sample of adolescents, n=35, in an inpatient psychiatric facility. Most diagnoses were of major affective disorder (comparable with today’s major depressive disorder), conduct disorder or oppositional defiant disorder, or substance abuse. At the time of the study, heavy metal music represented a new and rebellious type of music, and mainstream rock was comparable with today’s pop music in its popularity with adolescents. The study measured short term changes in positive and negative affect using the Positive and Negative Affect Schedule (PANAS), before and after subjects either read something of their choice—the baseline condition—or listened to rock music or heavy metal for twenty minutes. Both groups experienced the baseline condition and both experimental conditions, with one condition presented each day for the three-day span of the study. Results found no statistically significant difference in the amount of change in positive or negative affect when comparing either experimental group or the baseline condition. However, they did find that when subject data were
divided based on subjects’ musical preferences, those who preferred heavy metal music had a statistically significant increase in positive affect after listening to heavy metal music. This increase in positive affect was significantly higher than this group’s change in affect when listening to rock music. It was also higher than the change in affect, under any condition, of subjects who preferred rock music (Wooten, 1992). This study was completed with a small sample size, but does support the use of patient-preferred music with adolescents in inpatient psychiatric facilities, particularly with adolescents whose musical preferences are not those of the mainstream.

**Music-based interventions with depressed adolescents in inpatient psychiatric settings.** Hamer’s (1984) Master’s thesis was a single study design with ten iterations studying the effects of eight twice-weekly individual songwriting sessions on depression and anxiety scores as measured in pre- and post-tests by the Children’s Depression Inventory and the Children’s Manifest Anxiety Scale. Participants were ages 12 to 15. The author discusses songwriting as a method that can lower patients’ defenses, provide an alternate form of verbal expression, and provide opportunities for success. She described four stages of her music therapy treatment and a procedure for songwriting in individual sessions. Her songwriting procedure began with a patient and therapist piano improvisation, followed by the patient creating melody lines that could go with the improvisation, and finally, the patient created lyrics. The therapist was available to help with each step of songwriting, as was needed on a patient-by-patient basis. Additionally, some patients wrote lyrics first and then adapted them for use in a melody sung over guitar chords played by the therapist. Results of the study show that eight depression scores decreased after this intervention, one depression score increased, and one
remained the same (Hamer, 1984). Although the length of treatment utilized for this study would likely not be possible in current inpatient psychiatric treatment, this study provides preliminary evidence that the specific method of songwriting is an effective intervention for reduction of depression in adolescents in inpatient psychiatric care for depression.

Bittman, Dickson, and Coddington’s (2009) randomized controlled trial crossover study measured the effects of a standardized drumming protocol on quality of life, including overall depression and anhedonia as measured by the Reynolds Adolescent Depression Scale (RADS), in 52 adolescents—including African American, Puerto Rican, Asian, and Caucasian subjects—living in a court-referred residential treatment program with a variety of diagnoses. Subjects were measured prior to treatment, after the six-week treatment period, and at a six-week follow-up. Treatment consisted of six, weekly, one-hour sessions focused on non-verbal expression through drumming. Sessions included rhythmic exercises in which participants could participate freely, as well as structured rhythmic exercises focused on answering questions about problem solving and self-identity through drumming. Sessions also included group discussion following the music making. Results found significant decreases in overall depression, with 6.1% change (p=0.004), as well as decreases in anhedonia comparing pre- and post-tests. Follow-up measures found that six weeks later anhedonia remained improved, but decreases in overall depression were not maintained (Bittman et al., 2009). While this study was not implemented by a music therapist, it does provide insight into the effectiveness of group music making in decreasing depressive symptoms in adolescents (Bittman et al., 2009). All elements of the intervention, described in depth in the
published study, would be appropriate for use in music therapy sessions. This study provides valuable insight into one specific intervention of drumming that has been found useful in treating adolescent depression in a group long-term residential setting.

Kuntz’s (2012) thesis addressed a similar but broader topic as compared to the one this thesis seeks to address. Kuntz surveyed 39 board-certified music therapists to determine current trends in music therapy for adolescents in both inpatient and outpatient settings, focusing on diagnoses of Anxiety Disorders, Conduct Disorder, Oppositional Defiant Disorder, Bipolar Disorders, Major Depressive Disorder, Attention Deficit/Hyperactivity Disorder, and Substance Abuse. She found that approximately 82% of respondents worked with adolescents with Depressive Disorders, and 41% of respondents worked with adolescents in inpatient psychiatric or inpatient behavioral health settings. The most prominent goal areas for music therapists working with adolescents with Major Depressive Disorder were self-esteem, mood, expressivity, coping mechanisms, and creativity, with self-esteem chosen almost twice as often as any other goal area (Kuntz, 2012). Interestingly, when comparing methods chosen to best meet needs of adolescents with Major Depressive Disorder and methods chosen to address the goal of self-esteem—the most prominent goal area chosen by respondents for working with adolescents with Major Depressive Disorder—the methods change quite drastically. For working on self-esteem the highest rated method was “skills training on musical instruments,” with 14 respondents choosing this option (p. 62). However, only 2 individuals rated this as the best method to meet the needs of adolescents with Major Depressive Disorder. There was some coherence in ratings between these two questions, with the top two methods to meet the needs of adolescents with Major Depressive
Disorder—personal song (client selected) and lyric analysis (therapist selected)—representing the second and third most-chosen methods for working on self-esteem. The author’s overall conclusion was that methods and goals did not differ significantly between Major Depressive Disorder, Bipolar Disorder, Conduct Disorder, and Substance Abuse. However, because of the small sample size and inclusion of both inpatient and outpatient populations, and because depressive symptoms may be present in a wider variety of diagnoses than just Major Depressive Disorder, it seems appropriate to further investigate the needs of adolescents with depressive symptoms. Although Kuntz collected data on the goal areas of music therapists working with Major Depressive Disorder, as well as the methods used to address each goal area, the resulting data is less specific than that which is sought in this current thesis. Thus, the current thesis represents a narrowing in focus from Kuntz’s thesis in order to gain further insight specifically into depressive symptoms in adolescents within the inpatient setting. Additionally, the current thesis includes a narrower age range than that of Kuntz’s, classifying adolescents as age 12 to 18 rather than 10 to 17 as Kuntz did. This is more in line with current literature and practice and further narrows the focus of the current thesis.
CHAPTER III: METHODS

Design of the Study

The study was a descriptive survey study. The purpose of a descriptive survey design is to obtain information from a group of individuals at one point in time (Mertens, 2010). A descriptive survey, then, was most appropriate for this study because the researcher sought information regarding current practices at a moment in time. Additionally, a survey best allowed for a larger number of music therapists to contribute to the study. The objective of the study was to identify the methods board-certified music therapists currently use to treat depressive symptoms in adolescents hospitalized in short-term inpatient psychiatric facilities, and to know their goals for treatment. Additionally, the survey sought music therapists’ perceptions of the most important factors that contribute to successful treatment of depressive symptoms in adolescents within this setting, in order to better understand how music therapy can be effective in treating depressive symptoms in adolescents in inpatient psychiatric populations.

Location of the Study

Participants completed a web-based survey. An invitation to participate in this survey was distributed to members of the Certification Board for Music Therapists (CBMT) through an email message that included a link to the online survey.

Time Period for Study

The study took place from January 15th, 2013, to June 14th, 2013. The survey period was from January 28th, 2013, to February 11th, 2013.
Enrollment Information

The study’s potential participants included 348 members of the CBMT who identified themselves as working with adolescents and in psychiatric settings. The participants were estimated to be ages 21 to 90 years old. The minimum age was established at 21 years old because it was necessary for participants to have completed at least a bachelor’s degree in order to have earned board certification (MT-BC) as a music therapist. The upper age criterion was based on the expectation that the oldest practicing music therapists would fall under age 90. Participants were expected to come from a variety of geographic regions of the United States. The sample was expected to include more female than male participants, as would be representative of the overall demographics of music therapists practicing in the United States.

Subject Type

Participants in this study were recruited from the nonclinical population of practicing board-certified music therapists (MT-BC) working in the United States who had at least one year of experience working with adolescents in inpatient psychiatric settings.

Participant Source

Professional members of the CBMT who identified themselves as working with adolescents and in inpatient psychiatric settings composed the pool of potential participants for this study.

Recruitment

Upon Drexel IRB approval of the study, the researcher sent an email study invitation (Appendix A) to 348 members of CBMT who identified themselves as working
in psychiatric settings and with adolescents. The researcher obtained all contact information from the CBMT (see Appendix B). The email invitation provided basic study information and study participation criteria, as well as a link to the web-based survey. The announcement was sent once and was followed by a reminder email one week later (Appendix C). After reading the email invitation, individuals willing to participate accessed the survey via a secure online link. Participants then completed the survey during a single online session. No names were recorded of those who accessed the link. Therefore, neither the researcher nor other participants knew who participated in the survey, with the exception of two participants who emailed the researcher to inquire about receiving the results of the study. Email addresses were not re-used or disclosed to any outside individuals or groups. There was no material incentive or remuneration for participating in the survey.

Subject Inclusion Criteria

Participants were included in the study if they reported being board-certified music therapists (MT-BC) over age 21 and under age 90 who worked with adolescents in inpatient psychiatric settings for more than one year. Participants must have been able to speak, read, and write in English in order to participate, since the survey was in English with no translation available.

Subject Exclusion Criteria

Music therapists working in residential programs that exclusively treated patients for longer than three months were excluded, as the study sought to find more information on short-term hospitalization. Music therapists who were not board-certified or who had less than one year of experience were not included in the survey. Additionally, music
therapists without access to the Internet or email were excluded, since the study collected data only via an online survey.

**Investigational Methods and Procedures**

**Instrumentation.** After reading the email invitation, individuals who decided to participate followed a link to the online survey (Appendix D). The survey included both closed-ended and open-ended questions that addressed the demographics of music therapists and inquired about aspects of the treatment of adolescents with depressive symptoms in short-term inpatient psychiatric facilities. Questions specifically inquired about music therapists’ use of patient-preferred music, their collaboration with other treatment team members or families, and their goals and methods used during treatment of depressive symptoms in adolescents in inpatient psychiatric settings. The survey also inquired about how music therapists addressed patient perceptions of stigma surrounding their diagnoses or hospitalization. Finally, respondents were asked what they believed were the most important factors contributing to successful treatment of depressive symptoms in adolescents within short-term inpatient settings. The survey items were based on existing literature regarding treatment of adolescents with depression and adolescent inpatient psychiatry.

**Informed consent.** The email invitation that music therapists received specified that by completing the online survey, the individual consented to participate in the study. No signature was required in order to avoid the signature compromising the anonymity of the survey data. The survey was created on SurveyMonkey, a secure, password-protected site that also stored the data. The first page of the survey re-stated the objectives of the study and reminded participants that they could choose to exit the survey at any time, and
that by continuing on to the next page of the survey they gave their informed consent to participate in the study.

**Data collection.** The survey took approximately 15 to 25 minutes to complete, not including time to read the invitation email. It began with demographic information about the participating music therapist. The participant then answered questions about their work settings and the adolescents they treated, including questions inquiring about how many adolescents with depression or depressive symptoms that each participant treated each week. The remainder of the survey focused on specific information regarding treatment, including barriers to treatment. The survey inquired about the types of goals and methods the music therapists found effective in treating depressive symptoms in adolescent patients, as well as their perceptions about the most important factors that contribute to successful treatment of depressive symptoms in adolescents. The survey included open-ended questions as well as free comment space after many of the multiple-choice closed-ended questions.

**Data analysis.** After completion, the data was stored on SurveyMonkey’s website. Closed-ended items were analyzed using descriptive statistics available from SurveyMonkey. Items were analyzed based on response frequency. Additionally, responses were filtered to group responses by therapists’ levels of experience and theoretical orientations, in order to determine if these characteristics correlated with changes in goals or methods used. Responses were also filtered by top goal chosen, to ascertain the possible effects of goals on the methods used by participating music therapists. Open-ended items were analyzed through content analysis. During content analysis the researcher identified the most frequently cited words and themes described
by subjects and coded each response based on which themes were included. The researcher then analyzed these codes and distilled from them the most common and prominent themes.

**Operational Definitions**

For the purposes of this study:

1. **Depressive symptoms**: Hopelessness, lack of energy, low self-esteem, inability to experience pleasure, excessive sadness not due to bereavement, consistent feelings of emptiness, or excessive irritability when combined with other symptoms.

2. **Depression**: Diagnoses of Major Depressive Disorder, Single Episode or Recurrent (*DSM-IV-TR* code 296.2x or 296.3x), Dysthymic Disorder (*DSM-IV-TR* code 300.4), Depressive Disorder NOS (*DSM-IV-TR* code 311), Adjustment Disorder with Depressed Mood (*DSM-IV-TR* code 309.0), Bipolar I (*DSM-IV-TR* code 296.xx), Bipolar II (*DSM-IV-TR* code 296.89), and Cyclothymic Disorder (*DSM-IV-TR* code 301.13), if the current predominant manifestations are of depressive symptoms, as judged by the treating music therapist. Additionally, individuals without the above diagnoses but whose clinical profiles are dominated by depressive symptoms.

3. **Adolescence**: The period of time between and including ages 12 and 18.

4. **Adolescent**: Any individual between age 12 and 18.

5. **Music Therapy**: In accordance with the American Music Therapy Association, “The clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a
credentialed professional who has completed an approved music therapy program,” (AMTA, 2011b).

6. **Hopelessness**: The inability to expect good things to happen or for situations to improve.

7. **Irritability**: Having excessive reactions to stimuli, often resulting in anger or annoyance.

8. **Short-term inpatient psychiatric settings**: Any setting where patients remain in the facility 24 hours per day, are treated primarily for psychological illnesses, and stay, on average, two to three weeks.

9. **Method**: The general category of music therapy intervention that is performed with patients, such as songwriting.


**Possible Risks and Discomforts to Subjects**

Since this study was anonymous, and involved only professional music therapists discussing their work, there were minimal risks associated with the study. No discomforts or risks were anticipated. Very minor discomfort may have resulted from the 15 to 25 minutes required of the participants to complete this survey. Since this was an online survey, participants could have withdrawn or taken a break at any time. Additionally, although SurveyMonkey maintained the anonymity of participants, there remained a chance that the site could have been illegally entered, and unauthorized individuals could have accessed email addresses of recruits or data of subjects—which would not be connected to participants in any way. However, to the knowledge of this
researcher, no breaches of security to SurveyMonkey’s website occurred during the course of this study.

**Special Precautions to Minimize Risks or Hazards**

Participants were notified in both the email invitation and on the first page of the survey of the estimated time frame required to complete the survey, thereby minimizing discomfort by preparing the participants for this time commitment. Email addresses of recruits were destroyed immediately after the reminder email was sent out. The survey was created on SurveyMonkey, which is a secure, password-protected site that also stored the data. Special precautions were taken to ensure the security of the survey and collected data by only the researcher and her advisor Florence Ierardi having access to the password to this online account. However, because it was an online survey there remained a mild risk that the site could be entered illegally, thereby compromising the security of the data. If this had occurred, the Office of Regulatory Research Compliance and recruits would have been notified immediately of this breach of security. However, to the knowledge of this researcher, no breaches of security to SurveyMonkey’s website occurred during the course of this study.
CHAPTER IV: RESULTS

The survey was sent to 348 Board-Certified Music Therapists that had registered with the Certification Board for Music Therapists as working with adolescents and in psychiatric settings. Out of these 348 prospective participants, 47 individuals started the survey. Of these, 7 were ineligible to complete the survey due to their lack of having worked as a music therapist with adolescents in a short-term inpatient psychiatric setting for at least one year. Additionally, two participants only answered basic demographic questions. This left 36 individuals who completed the survey. The 36 individuals who completed the survey represent an overall response rate of 10.3%.

These respondents represented six regions of the United States, divided by American Music Therapy Association regional designations, including the Midwest, Great Lakes, Mid-Atlantic, Southeastern, Southwestern, and Western regions. The most respondents of any region came from the Mid-Atlantic Region, with ten respondents, followed by the Great Lakes and Western Regions, in which eight and seven respondents, respectively, reported practicing. Additionally, one respondent reported practicing outside of the United States. No respondents came from the New England Region.

Overall experience as a board-certified music therapist ranged from one year to over 20 years, with half of respondents having worked as music therapists for between 4 and 10 years (Figure 4.1). Approximately 58% of respondents had been working with adolescents in inpatient psychiatric settings for one to three years (Figure 4.2).
Figure 4.1. Years of Experience Working As A Music Therapist

Figure 4.2. Respondents' Experience Working with Adolescents in Short-Term Inpatient Psychiatric Settings
When asked for their highest level of education in music therapy, the majority of respondents, 58.3%, reported completing their Bachelor’s degree. Thirteen respondents, 36.1%, completed their Master’s degree, while two respondents completed their Doctoral degree. In addition to their degrees, 7 respondents reported receiving certifications in Neurologic Music Therapy. Four respondents reported being Licensed Professional Counselors. Other additional certifications, each reported once, included Licensed Creative Arts Therapist, Licensed Mental Health Counselor, National Certified Counselor, National Master Social Worker, Fellow of the Association for Music and Imagery, Licensed School Counselor, and Chemical Dependency Professional. The majority of respondents, 61.1%, practice in a city or urban community, while 27.8% practice in a suburban community and three respondents (8.3%) work in a rural community. One respondent additionally reported working in a suburban facility that served urban, rural, and suburban patients. Only three respondents identified as male, while the rest identified as female. Twenty-five respondents, 69.4%, reported working full time. Seven respondents (19.4%) reported working part-time, with 2 additional respondents working per diem, one working PRN—as needed by the facility—and the final respondent reporting currently being unemployed, although this respondent reported having one to three years of experience working with adolescents in inpatient psychiatric settings, so her responses were included.

When asked about the type of psychiatric setting in which they work, 44% reported working in adolescent psychiatric units while 41% reported working in combined adolescent and child psychiatric units. Only four respondents reported working in combined adolescent and adult psychiatric units. The majority, 61%, reported
working in private psychiatric hospitals regardless of unit type. Additionally, ten respondents reported working in a psychiatric unit in a medical hospital, with only three respondents reporting working in a state-run psychiatric hospital.

One-third of respondents (12 respondents) reported that their treatment team or facility had a specific clinical theoretical orientation. Almost half of respondents reported that there was no specific theoretical orientation, while the remainder did not know. Of those who reported that the setting has a specific theoretical orientation, the most common theoretical orientations were Cognitive Behavioral and Dialectical Behavior Therapy, with four responses each. Additionally, one respondent reported a Medical orientation with Cognitive Behavioral and Dialectical Behavior Therapy strategies. One respondent each reported that their treatment team or facility’s orientation was Humanistic/Person-Centered, Psychodynamic, and Patient and Family Centered Care. Of the respondents who reported that their facility has a specific theoretical orientation, 83% (10) reported reflecting this orientation in their music therapy practice, while one additionally reported utilizing a clinical theoretical orientation that deferred from that of her facility.

The overall average length of hospitalization for the adolescents with which respondents work was one to two weeks—64% of responses—while an additional 5 respondents reported average lengths of hospitalization of less than one week and 8 reported average lengths of hospitalization of over three weeks, as shown in Figure 4.3.
The majority of respondents, 77.8%, reported collaborating with other members of the treatment team in developing treatment goals, with 69.4% reporting collaborating with other members of the treatment team in providing treatment to patients, as shown in Figures 4.4 and 4.5. Over 60% of survey participants work with recreation therapists, social workers, and psychiatrists in developing treatment goals. Fourteen respondents reported collaborating with other creative arts or expressive arts therapists in developing treatment goals, with most of these collaborating with other music therapists. Of those participants who collaborate to provide treatment to patients, more than 50% of survey participants reported collaborating with recreation therapists and social workers. Thirteen respondents reported collaborating with other creative arts or expressive arts therapists in providing treatment, with the majority of these, once again, collaborating with other music therapists.
Figure 4.4. Treatment Team Members Collaborated with to Develop Treatment Goals

Figure 4.5. Treatment Team Members Collaborated with to Provide Treatment
Only three respondents, or 8.7% of the sample, reported collaborating with or including family members in music therapy treatment. Of these three respondents, two said that they educate the family about music therapy’s goals and methods as well as providing family members with suggestions of ways to connect with the patient through music. The other respondent explained that she provides “weekly family group sessions that include music, art, and/or rec [sic] therapy with all patients and their family.”

The average age of adolescents seen in music therapy is 14 to 15 years old, with 86% of respondents choosing this response. The great majority of respondents, 80%, treat more than 6 adolescent patients for depressive symptoms each week, with 25% of respondents treating over 10 patients per week. Almost all respondents, 91.7%, provide only group music therapy for adolescents with depressive symptoms, with no individual music therapy. Three respondents provide both group and individual music therapy sessions.

When asked to identify all diagnoses that apply for the adolescent patients that respondents treat for depressive symptoms, over half of respondents (58%) identified 5 or more diagnoses. The most commonly identified diagnoses were Major Depressive Disorder, Single Episode or Recurrent, Depressive Disorder NOS, and Bipolar I Disorder—each of which was chosen by over 78% of respondents, as shown in Figure 4.6. Over 50% of respondents identified Bipolar II Disorder and Adjustment Disorder with Depressed Mood, and 44% of respondents identified Schizoaffective Disorder. An additional six respondents chose Dysthymic Disorder and three chose Cyclothymic Disorder. Participants additionally identified Conduct Disorder, Eating Disorders, Mood Disorder NOS, and Paranoid Personality Disorder in their written comments as diagnoses.
for which they treat adolescents for depressive symptoms. One respondent additionally commented that she treats adolescents with suicidal ideation or suicide attempts.

**Figure 4.6. Diagnoses of Adolescent Patients Treated for Depressive Symptoms**

Participants identified their top goals of music therapy when treating adolescents with depressive symptoms, shown in Figure 4.7. The majority of respondents, 52.8%, identified *increase ability to cope with negative feelings/mood states* as their number one goal of treatment. There was less agreement about the number two goal of treatment, with 36% of participants choosing *increase self-esteem*. Even less agreement existed for the third goal of treatment, with 30% choosing *increase positive social interaction*, and 25% choosing *increase experiences of pleasure*. When looking at the aggregate totals of goals that were chosen as within the top three goals of treatment, the top rated were *increase ability to cope with negative feelings/mood states, increase positive social interaction, and increase self-esteem*. Three-fourths of participants chose *increase ability to cope with negative feelings/mood states*. Almost two-thirds (61%) of respondents
chose *increase positive social interaction*, and 58% identified *increase self-esteem* as one of their top three goals of treatment. *Increase experiences of pleasure, increase hopefulness*, and *improve self-efficacy* were chosen as within the top three goals by 10, 7, and 6 respondents, respectively. Three individuals added additional goals, which were “to create an aesthetic musical/arts experience,” “increase feelings of validation or universality,” and “identifying potential triggers that contribute to depression.” One respondent additionally stated, “This is a question that can’t really be answered in such a general way unless one is a therapist who provides intervention [sic] according to a protocol, which is not client-responsive therapy.”

**Figure 4.7. Top Goals When Treating Adolescents With Depressive Symptoms in Music Therapy**

![Graph showing the number of respondents identifying each goal.](image-url)
Respondents were asked how frequently they use specific music therapy methods in treating adolescents with depression. Over half of respondents reported frequently using the methods of *lyric analysis* (80%), *rhythmic improvisation* (71.4%) and *music listening (without lyric analysis)* (57.1%), as shown in Figure 4.8. Almost half of the respondents (47%) frequently use *ensemble-style live music making*, and 41.7% frequently use *singing*. Additionally, over 28% of respondents frequently use *songwriting, music-assisted relaxation, and non-referential improvisation* when treating adolescents with depressive symptoms. Four respondents added comments to indicate that they frequently use music combined with visual arts, with two of these respondents indicating that they also combine music with other art forms such as acting and writing. Finally, two respondents’ comments indicated that they frequently use music and imagery, and one reported using music-based cognitive games such as “Name that Tune.”
Participants were asked to then rate which methods they felt were the most effective, second most effective, and third most effective in alleviating depressive symptoms when treating adolescents in inpatient psychiatric settings. The most effective method was identified by 25% of respondents as rhythmic improvisation, representing the highest rated method in this category (see Figure 4.9). Approximately 19% of participants thought that lyric analysis was the most effective method, while 16.6% thought that music listening (without lyric analysis) was the most effective method. The second most effective method was identified by 22% of respondents as songwriting. The third most effective method was identified by 19.4% of participants as lyric analysis, while 16.7% thought that songwriting was the third most effective method. Overall, participants think that lyric analysis, rhythmic improvisation, songwriting, music listening, and ensemble-style live music making are effective, all being chosen by over 27% of participants as within the top-three most effective methods. Over half of participants think that lyric analysis is effective, with 55% identifying it as within the top-three most effective methods. Almost half (47%) of participants put songwriting and rhythmic improvisation within the top-three most effective methods, while 33% and 27%, respectively, identified music listening and ensemble-style live music making within the top-three most effective methods. Additionally, two individuals commented that combining art with music was an effective method. Finally, one individual reported that “most experiences are effective during group experiences,” while another said that she could not chose a most-effective method because “the most effective methods are those that speak specifically to the needs of each client, and therefore are different for each.”
Approximately 72% of respondents (n=26) reported basing over 50% of each music therapy session on patient-preferred music. Additionally, four respondents identified the use of patient-preferred music as one of the most important factors contributing to successful treatment of depressive symptoms in adolescents with inpatient psychiatric settings.

All but one respondent reported that they suggest musical experiences for the patients to use at home after discharge. The most common at-home technique was *listening to specific songs to achieve a goal (such as relaxation)* although *singing* and *songwriting* were also suggested as techniques by over 60% of participants. Additionally, 9 respondents reported that they suggest that patients take music lessons or continue to learn an instrument at home, while 7 respondents recommend that patients
participate in music with others in the community after discharge. Five respondents recommend that patients use music to document, match, or change their mood. Finally, two respondents recommend that patients make art along with their music listening after discharge.

_Resistance to sharing thoughts and feelings about self and unwillingness to participate verbally in sessions_ were the most commonly identified patient barriers that respondents encountered when treating adolescents with depressive symptoms in music therapy. One respondent reported depressive symptoms to be the biggest barriers to treatment, “many feel unmotivated, fatigued, anhedonic, etc.” One respondent additionally commented that the choices given in the multiple-choice format of this question could all be seen as symptoms of depression, and are therefore “indicators of treatment needs” rather than barriers. Similarly, another respondent reported not experiencing patient barriers to treatment:

> I would not say I encounter “barriers” persay [sic]. Even the adolescents with the most depressive symptoms, and especially these adolescents, love and crave their music. They appear to feel cared about and understood to have a place to listen to something that resonates with them. Whether it’s playing an instrument, listening to music, or even music video games (Guitar Hero, SingStar), the majority of patients find something that moves them.

Additionally, two-thirds of respondents reported that they observed patient perceptions of stigma surrounding their diagnosis and/or experiences of inpatient hospitalization during music therapy sessions.
When asked in an open-ended question about how they address patient perceptions of stigma, many themes emerged in respondents’ answers. Five respondents reported initiating musical interventions to specifically address feelings of stigma. Seven respondents stated that they typically educate patients about mental illness, with one respondent giving this quote, “everyone gets sick, and many people take medications…some need physical issue check-up, others need mental issue check-ups…if you want to live a healthy life, we’ve got to manage this illness.” Seven respondents explored themes of group support, with patients or therapists initiating discussions about stigma and coping:

If a patient mentions stigma, the other patients will often initiate a group conversation about their varying perceptions and offer support to one another. This seems to be very effective for adolescents, as they typically highly regard the opinions and views of their peers.

Finally, nine participants reported providing verbal support to patients: “…I validate their feelings and let them know that the public does not have a true understanding of mental illness and it’s causes.”

At the end of the survey, patients were asked, in an open-ended question, to describe the most important factors contributing to successful treatment of depressive symptoms in adolescents within short-term inpatient settings. Responses were categorized by theme, as shown in Table 4.1. Most responses included multiple themes, such as this quote that included themes of therapeutic relationship and individualized treatment/flexibility:
Being flexible. Listening to what they want. Observing and knowing when they [are] ready to ‘work’ on their issues verses [sic] pushing for too much, too soon. You must build a repoire [sic] with them before asking them to disclose and open up.

Table 4.1

*Most Important Factors Contributing to Successful Treatment: by General Theme*

<table>
<thead>
<tr>
<th>Theme</th>
<th># of respondents</th>
<th>Example Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic relationship</td>
<td>9</td>
<td>“My ability to ‘connect’ with each adolescent”</td>
</tr>
<tr>
<td>Group properties</td>
<td>6</td>
<td>“Use the group dynamics and peer support for positive change…”</td>
</tr>
<tr>
<td>Individualized Treatment/Flexibility</td>
<td>6</td>
<td>“A variety of activities ready to go if one thing doesn’t work for that particular group”</td>
</tr>
<tr>
<td>Preparing for the future</td>
<td>4</td>
<td>“Education for family members to promote supportive environment upon discharge, comprehensive outpatient discharge plan”</td>
</tr>
<tr>
<td>Patient Dedication</td>
<td>4</td>
<td>“Patients being aware that they need to change in some way in order to maintain safety.”</td>
</tr>
<tr>
<td>Patient-Preferred Music</td>
<td>4</td>
<td>“Willingness to try ‘their’ music and go from there”</td>
</tr>
<tr>
<td>Self of the therapist</td>
<td>4</td>
<td>“Openness and presence as a therapist”</td>
</tr>
<tr>
<td>Safe Environment</td>
<td>4</td>
<td>“Providing a safe, supportive environment”</td>
</tr>
</tbody>
</table>

The comments could additionally be categorized by which overall aspects of the treatment context they focus on—the music intervention, interpersonal aspects, or qualities of the therapist or patient, as shown in Table 4.2. Some of the above themes directly fit into the treatment context categories, while other themes bridge multiple treatment context categories.
Table 4.2

*Aspects of Treatment Focused Upon in “Most Important Factors” Question*

<table>
<thead>
<tr>
<th>Aspect of treatment</th>
<th># of respondents</th>
<th>Theme/ Example Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal aspects during music therapy</td>
<td>15</td>
<td>Group properties/ “building rapport and trust fast through empathetic listening and non-judgment.”</td>
</tr>
<tr>
<td>sessions</td>
<td></td>
<td>Patient-Preferred music/ “Working with the client for them to find a role in music that they are comfortable with.”</td>
</tr>
<tr>
<td>Music interventions</td>
<td>8</td>
<td>Patient Dedication/ “The Patient’s [sic] willingness to overcome their symptoms.”</td>
</tr>
<tr>
<td>Qualities of the therapists</td>
<td>7</td>
<td>Self of the Therapist/ “willingness to try their music.”</td>
</tr>
<tr>
<td>Interpersonal aspects at facility</td>
<td>7</td>
<td>“Effective, empathetic support from staff.”</td>
</tr>
<tr>
<td>Qualities of the patient</td>
<td>5</td>
<td>Patient Dedication/ “The Patient’s [sic] willingness to overcome their symptoms.”</td>
</tr>
</tbody>
</table>

These responses could finally be organized based on who the respondents thought had agency or responsibility in initiating the desired actions or outcomes as shown in Table 4.3. Responses indicated that the treatment success depended on one or more of the following: therapist, patient, group, or community/external environment. Many times respondents gave multiple people agency during their comments, for instance, “1. Building Feelings of Mastery and Self-Esteem  2. Self-Validation  3. External Validation 4. Providing appropriate outlets to express emotions  5. Feelings of camaraderie [sic] and belonging in the group.” In this quote, #1 and 2 seem to be the agent of the patient, #3 could be therapist or group, #4 seems to be therapist, while #5 is group. Additionally, four responses did not indicate who had agency. In these responses that did not indicate agency, respondents rather defined qualities of the patient or aspects of treatment, but did not specify whose responsibility it might be to carry out these actions or assist in creating their specified results.
Table 4.3

*Themes of Agency in “Most Important Factors” Question*

<table>
<thead>
<tr>
<th>Who has the agency</th>
<th># of respondents</th>
<th>Example Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Therapist</td>
<td>21</td>
<td>“Encourage them, believe in them.”</td>
</tr>
<tr>
<td>The Patient</td>
<td>10</td>
<td>“The patient’s willingness to overcome their symptoms.”</td>
</tr>
<tr>
<td>The Group</td>
<td>3</td>
<td>“If the group does not work together, patients are less willing to participate and share.”</td>
</tr>
<tr>
<td>The Community/External Environment</td>
<td>5</td>
<td>“Good support network in and outside of the hospital, appropriate social experiences outside of the hospital and positive recreational activities outside of the hospital.”</td>
</tr>
<tr>
<td>Agency not distinguished</td>
<td>4</td>
<td>“Healthy emotional expression &amp; coping skills.”</td>
</tr>
</tbody>
</table>

Survey Respondents’ Characteristics

**Level of education.** Responses were divided between those respondents who had acquired a Master’s degree or Doctoral degree (PhD) in music therapy compared to those respondents whose highest level of education was a Bachelor’s degree in music therapy. Top goals of treatment were very similar between these two groups. Methods used most frequently were also similar, choosing *lyric analysis*, *rhythmic improvisation*, and *music listening*, although respondents with a Bachelor’s degree used *lyric analysis* more than *rhythmic improvisation* and respondents with a Master’s or PhD used *rhythmic improvisation* more than *lyric analysis*. Perceptions of efficacy in methods were also similar between the two groups, with fewer individuals with a Master’s degree or PhD perceiving songwriting as effective than those with a Bachelor’s degree (33% compared to 57% found *songwriting* effective).
Experience working with adolescents in inpatient psychiatric settings. Ten respondents reported having 8 years or more of experience working with adolescents in inpatient psychiatric settings. Their responses were analyzed to determine any differences in their goals and methods compared to respondents who had less than 8 years of experience in this setting (n=26). Both groups frequently chose increase ability to cope with negative feelings/mood states and increase positive social interaction as top goals of treatment. However, respondents with 8 years or more of experience working with adolescents in inpatient psychiatric settings focused on increasing self-esteem much less than those with less than 8 years of experience. Of those with 8 years or more of experience, 30% chose increase self-esteem as one of their top goals of therapy, compared to 69% of those with less than 8 years of experience. In fact, increase self-esteem was chosen more often than increase positive social interaction as a top goal of therapy among those with less than 8 years of experience.

The two groups’ methods differed in terms of frequency of use and perception of efficacy. The most frequently used methods by those with less than 8 years of experience, in order of frequency, were lyric analysis (used frequently by 80%), rhythmic improvisation (61%), and music listening (50%). The most frequently used methods by those with over 8 years of experience were rhythmic improvisation (used frequently by 90%), lyric analysis and music listening (70% each), and music-assisted relaxation and non-referential improvisation (60% each). This displays that respondents with 8 years or more of experience use a greater variety of methods. Half of respondents with 8 years or
more of experience thought that rhythmic improvisation was the most effective method in alleviating depressive symptoms in adolescents. There was less agreement about the most effective method among those who had less than 8 years of experience, with the top choice of lyric analysis chosen by 23% of this sub-sample as the most effective method. Overall—combining choices of the top three most effective methods—these two groups differed in their perception of the most effective methods. In those with over 8 years of experience, rhythmic improvisation (chosen overall by 80%) and lyric analysis (40%) were perceived most often as effective methods. In those with less than 8 years of experience, lyric analysis (chosen by 61%) and songwriting (53%) were chosen most often as effective methods. Thus, respondents with 8 years or more of experience perceive the non-verbal method of rhythmic improvisation as more effective than lyric analysis as compared to respondents less than 8 years of experience working with adolescents in inpatient psychiatric settings, who perceive the verbally-based methods of lyric analysis and songwriting as most effective.

Additional differences that seemed to coincide with years of experience working with adolescents in inpatient psychiatric settings included amount of collaboration and perceptions of the most important factors that contribute to successful treatment of depressive symptoms in adolescents within short-term inpatient settings. Respondents with 8 years or more of experience were more likely to collaborate with other treatment team members in providing treatment, with 90% of this sub-sample collaborating compared to 61.5% of respondents with less than 8 years of experience. Over one-third (36%) of respondents with less than 8 years of experience focused on factors relating to the agency of the patient—as illustrated by such comments as “the patient’s willingness
to overcome their symptoms”—while no respondents with over 8 years of experience focused on these factors as important in contributing to successful treatment of depressive symptoms.

**Clinical orientation.** Results were filtered based on the clinical theoretical orientation of the facility or treatment team. Twelve respondents reported that their treatment team or facility had a specific clinical theoretical orientation, with ten reporting that they reflected the clinical theoretical orientation in their practice. Dialectical Behavior Therapy and Cognitive Behavior Therapy were the two most commonly identified clinical theoretical orientations of facilities or treatment teams, with 4 respondents choosing each of these. Additionally, two individuals identified reflecting a Humanistic/Person Centered orientation, and one each identified reflecting a Psychodynamic or Patient and Family Centered Care.

**Dialectical Behavior Therapy.** All four respondents that identified Dialectical Behavior Therapy (DBT) as the clinical theoretical orientation of the facility or treatment team reported reflecting this clinical orientation in their music therapy practice. Goals of treatment were generally consistent with that of the overall survey sample. The methods used by this sample varied slightly from that of the overall sample. All respondents in the DBT sample frequently used *lyric analysis*, compared to 80% of the overall sample, and 75% frequently used *songwriting*, compared to 36% of the overall sample. Two out of three DBT respondents also reported frequent use of *ensemble-style live music making* and *rhythmic improvisation*. Additionally, three out of four DBT respondents identified *lyric analysis* as the method they have found to be most effective in alleviating depressive symptoms in adolescents, compared to 19.4% of the overall sample. The fourth DBT
respondent thought that \textit{rhythmic improvisation} was the most effective method. When looking at all methods identified as within the top three most effective methods, \textit{lyric analysis} and \textit{songwriting}, chosen by three respondents each, and \textit{rhythmic improvisation}, chosen by two respondents, were the top rated methods. This reflects the choices of the overall survey sample.

This DBT sample was slightly more likely to collaborate with members of the treatment team in developing treatment goals than the overall sample—all DBT respondents compared to 77.8%, respectively—and less likely than the overall sample to collaborate in providing treatment—half of DBT respondents compared to 69%, respectively. Additionally, \textit{songwriting} was recommended by all four of the DBT sample as a technique they suggest to patients for their at-home use, compared to 63.8% of the overall sample.

\textit{Cognitive Behavior Therapy.} Of the four individuals who identified their facility as having a clinical theoretical orientation of Cognitive Behavior Therapy, three respondents reported reflecting Cognitive Behavior Therapy in their music therapy treatment. The three individuals in this sample did not agree on their top goal of treatment, with one respondent each choosing \textit{increase ability to cope with negative feelings/mood states}, \textit{increase positive social interaction} and \textit{increase self-efficacy}. The first two goals coincide with the top goals of the overall sample. However, the respondent who chose \textit{increase self-efficacy} is the only respondent in the overall sample that chose this as the top goal of treatment. Regarding methods used, 75% of these individuals who reflect CBT in their practice reported frequently using \textit{songwriting}, as compared to 36% of the overall sample. The CBT sample also uses \textit{ensemble-style music}
making more frequently than the overall sample, with 3 out of 4 respondents in the CBT sample reporting frequent use compared to 47% of the overall sample. There was less agreement about what the most effective method was than the overall sample, with songwriting, ensemble-style live music making and rhythmic improvisation being chosen by one respondent each in the CBT sample. The fact that one individual chose songwriting was notable, since only two other respondents in the overall survey sample identified this as the most effective method.

The CBT sample reported collaborating in developing treatment goals less than the overall sample, with two-thirds collaborating with other members of the treatment team in developing treatment goals, compared to 77.8% of the overall sample. However, the percentage that collaborated in providing treatment was similar to that of the overall sample, with about two-thirds of the sample and overall sample collaborating to provide treatment. Goals and methods did not notably change in the CBT sample. However, out of the three music therapists who reported reflecting CBT in their music therapy practice, one reported basing less than 10% of the session on patient-preferred music, and this respondent was the only respondent in the entire survey sample to base less than 10% of their sessions on patient-preferred music. One reported basing 10% to 25% of the session on patient-preferred music, compared to only three respondents total in the overall survey sample. The third respondent reporting basing 76% to 100% of the session on patient-preferred music, while 41.7% of the overall sample reported this same percentage.

Additionally, in the CBT sample, lack of confidence in effectiveness of treatment options was the most commonly identified barrier to treatment, with all three respondents identifying this, compared to 31.4% of the overall sample.
One individual reported that their facility had a Humanistic/Person Centered clinical theoretical orientation and that she reflects this in her music therapy practice. She chose as her top goals of treatment increase ability to cope with negative feelings/mood states, increase patient involvement in milieu activities, and increase positive social interaction. Her frequently used methods mostly coincided with that of the overall sample, although she reported frequently using movement to music, which only 13% of the overall sample reported using frequently. This respondent identified rhythmic improvisation as the most effective method, which was also the most frequently chosen most-effective method in the overall sample. Her second most effective method was non-referential improvisation, which only one other respondent identified as within the top three most effective methods among the overall sample. Her third most-effective method was movement to music, which was also only identified by one other respondent as within the top three most effective methods. This humanistic/person-centered respondent identified themes of focusing on the therapeutic relationship, the influence of the group, interpersonal factors, the qualities of the therapist, and the agency of the therapist as the most important factors in treating adolescents with depressive symptoms in short-term inpatient psychiatric settings. She stated,

Make a connection. Listen to them. Let them lead whenever possible. Use the group dynamics and peer support for positive change and redirect negative/destructive behaviors. Understand that they may feel stigma outside of the hospital, but in the hospital they may recognize that they are among the least mentally ill patients on the floor. Recognize that they are often creative.
Encourage them. Believe in them. Don’t take negative behaviors towards you as a therapist personally.

Another respondent reported practicing from a humanistic/person-centered orientation although her facility practiced from a medical orientation with CBT and DBT strategies introduced in treatment. This respondent reported that her top goal of treatment was “to create an aesthetic musical/arts experience,” with her second and third goals as increase self-esteem and increase social interaction. This respondent reported frequent use of the method of non-referential improvisation and “receptive musical experiences including-Music and visual arts, music and story, music and imagery.” This respondent reported that “most music experiences are effective during the group experiences,” and identified “someone attempting to help them” as the most important factor contributing to successful treatment of depressive symptoms in adolescents within short-term inpatient settings.

**Psychodynamic.** One respondent reported reflecting a psychodynamic clinical theoretical perspective in her music therapy practice. She identified increase ability to cope with negative feelings/mood states, increase feelings of mastery, and increase positive social interaction as her top goals of treatment, coinciding with two of the top three goals of the overall sample. However, only two other respondents in the overall sample identified increase feelings of mastery as within their top three goals of treatment. Her frequently used methods mostly agreed with that of the overall sample, although she reported frequently using movement to music, which only 13% of the overall sample reported using frequently. The methods this respondent perceived as most effective were rhythmic improvisation, music-assisted relaxation, and lyric analysis. Although rhythmic
improvisation and lyric analysis coincide with the overall sample’s perceptions of the most effective methods, this psychodynamic respondent was only one of six respondents in the overall sample to choose music-assisted relaxation as within the top three most effective methods. She was also the only respondent to identify verbal therapy as the most important factor contributing to successful treatment of depressive symptoms in adolescents within short-term inpatient settings.

*Patient and family centered care.* One respondent reported reflecting Patient and Family Centered Care in her music therapy practice. Her top goal of treatment was increase ability to cope with negative feelings/mood states, agreeing with the majority of respondents in the overall sample. Her second and third goals of treatment were increase experiences of pleasure, which was the fourth most-chosen goal of therapy in the overall sample, and increase hopefulness, which was chosen as a goal by 19% of the overall sample. This respondent reported frequently using only three methods: music listening (without lyric analysis), therapeutic music lessons, and singing. Although music listening and singing were frequently used by over 40% of the overall sample, only 13.8% of the overall sample frequently used therapeutic music lessons. She identified music listening (without lyric analysis) as the most effective method and therapeutic music lessons as the second most effective method. She identified movement to music as the third most effective method, although she only reported using this method occasionally. When compared to all other individuals who reflected a theoretical orientation in their music therapy practice, this participant’s responses reflect a more limited variety of methods used, and appear to be the most varied from the overall sample.
The Influence of Goals on Methods and Most Important Factors

**Increase ability to cope with negative feelings/mood states.** Answers were filtered to include only those of respondents who chose *increase ability to cope with negative feelings/mood states* as their top goal of treatment (n=19). Methods most frequently used by these individuals were *lyric analysis* (chosen by 84% of this subsample), *music listening (without lyric analysis)* (68%), and *rhythmic improvisation* (68%). These respondents most chose *rhythmic improvisation* as the most effective method—chosen by 36.8% of these individuals. Overall, this group chose *lyric analysis* and *rhythmic improvisation* most often as top effective methods, chosen by 63% and 57.9% respectively, reflecting the top choices of the overall sample. About one-third of these respondents (36.8%) also thought that *songwriting* and *music listening (without lyric analysis)* were effective methods.

**Increase self-esteem.** Four respondents chose *increase self-esteem* as their top goal of treatment. The second most-frequently chosen goal of treatment in this subsample was *increase experiences of pleasure*. These respondents all reported using *ensemble-style live music making* and *singing* frequently, with three additionally identifying frequent use of *rhythmic improvisation*. Two individuals each reported frequently using *songwriting, referential improvisation, music-assisted relaxation, lyric analysis, music listening (without lyric analysis)*, and *therapeutic music lessons*. Regarding their perceptions of the effectiveness of methods, three out of four of these respondents reported *ensemble-style live music making* as the most effective in alleviating depression, while the fourth respondent thought that *therapeutic music lessons* were most effective. Of the overall sample, only five respondents thought that *ensemble-style live*
music making was the most effective method, indicating that a much greater proportion of individuals who focused on increasing self-esteem think that ensemble-style live music making is effective compared to the overall sample. The percentage of respondents in this sub-sample who chose rhythmic improvisation as an effective method was comparable to that of the overall sample, with half of this sub-sample and 47% of the overall sample finding it effective. However, it is notable that both individuals who identified rhythmic improvisation as within the top three most effective methods identified it as third most effective method. All respondents who identified increase self-esteem as their top goal of treatment indicated that they recommend that adolescents learn an instrument or take music lessons at home after discharge.

**Increase positive social interaction.** Three individuals chose increase positive social interaction as their top goal of treatment. These respondents reported frequently using the methods of rhythmic improvisation and ensemble-style live music making. The percentage of individuals in the overall sample who frequently used either of these methods was 69% for rhythmic improvisation, and 47% for ensemble-style live music making. Two of these three respondents thought that ensemble-style live music making was the most effective method in alleviating depressive symptoms in adolescents, compared to 13.4% of the overall sample, while the other thought that rhythmic improvisation was the most effective method, compared to 25% of the overall sample. Only one respondent identified music listening within the top three most effective methods in this sub-sample. The goals of treatment, then, seemed to impact the methods used by music therapists to treat adolescents with depressive symptoms in inpatient psychiatric settings.
In summary, results showed that top goals of treatment overall are increase ability to cope with negative feelings/mood states, increase self esteem, and increase positive social interactions. Most frequently used methods are lyric analysis, rhythmic improvisation, and music listening (without lyric analysis), while respondents thought that lyric analysis, rhythmic improvisation, and songwriting were the methods most effective in alleviating depressive symptoms in adolescents in short-term inpatient psychiatric settings.
CHAPTER V: DISCUSSION

Overview

The current lack of research that specifically investigates the efficacy of music therapy methods in treating adolescents with depressive symptoms in short-term inpatient psychiatric settings necessitated the current study. The results of this survey provide preliminary insights into the current practices of music therapists who work in short-term inpatient psychiatric settings with adolescents experiencing depressive symptoms. These results will be discussed within the context of existing literature to guide the clinical practice of music therapists working with adolescents with depressive symptoms in short-term inpatient psychiatric settings. The author will make recommendations for future research.

Major Findings

The primary focus of the survey was to gain understanding of the goals and methods of music therapists working with adolescents with depressive symptoms in short-term inpatient psychiatric settings and to learn music therapists’ perceptions of the most important factors contributing to successful treatment of adolescents in this setting. The results of this study generally support the trends in adolescent psychotherapy reviewed above, and reflect similar themes as the above literature on experiences of adolescent depression.

Results of this survey suggest that current average treatment times for adolescents in inpatient psychiatric settings is similar to the average length of 7 days as reported by Geller and Biebel (2006), with slightly over half of respondents in this study reporting that their patients have an average length of hospitalization of one week or less.
However, other respondents identified average treatment times ranging to over 1 month, indicating that some adolescents experience somewhat longer-term hospitalizations.

Congruent with Rubenstein’s (1996) and Brunstetter’s (1998) recommendations to be non-judgmental and listen to adolescent patients with respect for their experiences and ideas, 8 respondents specifically mentioned listening to the adolescent patients and/or validating patient experiences as the most important factors in successfully treating depressive symptoms in this population. Oetzel and Scherer’s recommendations that adolescent patients should be given opportunities for choice within treatment is reflected in the results of this study, where almost three-quarters of respondents based over 50% of their sessions on patient-preferred music. Additionally, survey respondents’ comments regarding the most important factors in successful treatment of depressive symptoms in adolescents further suggest that respondents encourage patients’ decision-making within the sessions, through a “willingness to try ‘their’ music” or “allowing the client space to reach out/express him/herself at his/her own pace.”

Indeed, methods such as rhythmic improvisation include consistent opportunities for patients to make decisions regarding their moment-to-moment actions within the music, within a musical structure that may enable adolescents to feel safe to experiment with new ways of playing (Daveson & Skewes, 2002). This exploration of musical expression, when supported by the therapist who listens and participates in music making with the adolescent, may then ease the establishment of a therapeutic alliance, which was identified as a difficulty of working with adolescents in inpatient psychiatric settings (Brunstetter, 1998; Gosselin & DeMaso, 2009) and which was identified as a key factor
in successfully treating depressive symptoms in adolescents in inpatient psychiatric settings by respondents in the current study.

Results of the study, in which two-thirds of respondents report observing patient perceptions of stigma surrounding their diagnosis and/or experiences of inpatient hospitalization, corroborate the findings of Calear et al. (2011) and Rose et al. (2011). Additionally, barriers to treatment reported in the current study—most frequently *resistance to sharing thoughts and feelings about self* and *unwillingness to participate verbally in sessions*—reflect common difficulties of working with adolescents as expressed by Brunstetter (1998), Oetzel and Scherer (2003), and Rubenstein (1996).

The current study showed that the majority of respondents collaborate with a wide variety of professionals, both in developing treatment goals and in providing treatment, confirming and clarifying Register’s (2002) findings that music therapists generally collaborate with other professionals. It is interesting to note that some respondents reported that they only collaborate in providing treatment and do not collaborate in developing treatment goals because the overall treatment goals are decided by the psychologist or psychiatrist. Additionally, some respondents reported that goals are decided during treatment team meetings that music therapists are not able to attend. Other respondents reported developing independent goals for their music therapy treatment. This shows that there exist a variety of ways in which collaboration occurs in inpatient psychiatric settings.

The most common clinical theoretical orientations of facilities as reported by respondents were Cognitive Behavior Therapy (CBT) and Dialectical Behavior Therapy (DBT), and these were also the two clinical theoretical orientations reflected most in
music therapists’ practice, out of those respondents who reported their facility having a clinical theoretical orientation. The combining of CBT with music therapy, reflected in this study’s results, as well as the findings of Pifalo (2011), which found that combining CBT with art therapy was effective in reducing depressive symptoms in adolescents and children, indicate that CBT may be appropriate to integrate with creative arts therapies in the treatment of adolescent depression. Similarly, DBT may also be appropriate to integrate with creative arts therapies in the treatment of adolescent depression, as supported by this study’s respondents reporting combining DBT with music therapy and Plenar et al.’s (2010) report of the successful use of individual DBT combined with group music therapy in reducing depression in adolescents.

Contrary to recommendations from the above literature, this study found that collaboration with family members does not frequently occur during music therapy treatment of adolescents with depressive symptoms in inpatient psychiatric settings. Since Au et al. (2009) found that increased family cohesion negatively correlates with development of depression, and Milne and Lancaster (2001) found that poor parental attachment was correlated with increased depressive symptoms, the lack of collaboration with family members may be due to decreased cohesion and support in the families of adolescents with depressive symptoms hospitalized in inpatient psychiatric settings. However, Au et al.’s (2009) findings, as well as developmental literature and inpatient psychiatry best practice literature, imply that finding ways to collaborate with family members can greatly impact positive change in adolescents. This belief in the importance of collaboration with family members is supported by two respondents who identified education of family and support from family as important factors in successfully treating
adolescents with depression. However, collaborating with family members may be outside of the professional responsibilities of music therapists in inpatient psychiatric settings.

Goals of treatment seemed to have an effect on the methods most commonly used. The top goal of treatment was increase ability to cope with negative feelings/mood states. This goal is congruent with results from Moses’s (2010) interviews with formerly hospitalized adolescents, who reported that learning coping methods was a positive aspect of hospitalization. The goal of increase ability to cope with negative feelings/mood states fits with the overall goal of inpatient hospitalization as outlined by Gosselin & DeMaso (2009), namely, to rapidly stabilize adolescent patients in order to safely transition them to less intensive mental health care settings, and satisfies Gosselin and DeMaso’s recommendations that goals of therapy be focused on attainable steps that restore health and safety in the individual patient. The frequent use of lyric analysis and music listening by individuals whose top goal was increase ability to cope with negative feelings/mood states is congruent with Tarrant et al.’s (2000) and North et al.’s (2000) findings that adolescents tend to use music listening as a way to get themselves through difficult times.

Since lyric analysis involves listening to music and then discussing the lyrics of that music, the method of lyric analysis seems to draw on an already-existing preference of adolescents while adding an additional social aspect of discussion. The use of music listening and lyric analysis in a group context adds greater social aspects to these methods, whereby patients may experience connections with group members based on the music experienced together and, in the case of lyric analysis, discussed with peers.
This then may provide assistance in the adolescents’ psychosocial developmental task of developing group identity, one of the functions that music can play in adolescence according to Laiho (2004).

When the second-most frequently chosen goal of *increase self-esteem* was focused upon, respondents reported more use of the methods of singing and ensemble-style live music making than the overall survey sample, and used rhythmic improvisation similarly to the overall survey sample. Since Sadock and Sadock (2007) define self-esteem as “a measure of one’s sense of self-worth based on perceived success and achievements, as well as a perception of how much one is valued by peers, family members, teachers, and society in general,” (p. 40), it follows that methods used to achieve this goal would be those that attempted to provide structured experiences of success or achievement.

The third most-frequently identified goal of treatment, *increase positive social interaction*, directly relates to the importance of peers in the adolescent developmental task of identification with a group, as outlined by Newman and Newman (2012) and Volkmar and Martin (2007). Respondents who reported a top goal of either *increasing self-esteem* or *increase positive social interaction* reported using ensemble-style live music making more often than the overall survey sample, and also use rhythmic improvisation frequently. Their use of lyric analysis and music listening was less than that of the overall sample. The methods of *ensemble-style live music making* and *rhythmic improvisation* create social interaction without requiring the use of words, which may facilitate ease of interaction. Indeed, patients working together towards a common goal, by using their bodies to make music, may lead to non-verbal attunement.
and feelings of connection to other group members, as suggested by dance/movement therapy literature above (Behrends et al., 2012; Chase, as cited in Chaiklin & Schmais, 1993; Nemetz, 1995). Creating social interaction without the use of words may be particularly important with adolescents in inpatient psychiatric settings, as the two most commonly perceived barriers to treatment were *resistance to sharing thoughts and feelings about self* and *unwillingness to participate verbally in sessions*.

Clinical theoretical orientation seemed to most impact goals that participating music therapists chose. Similar to the overall survey sample, respondents who reflected a Dialectical Behavior Therapy orientation, Psychodynamic orientation, or Patient and Family Centered Care orientation, chose *increase ability to cope with negative feelings/mood states* as a top goal of treatment, as did one out of two respondents with Humanistic orientation, and one out of three Cognitive Behavior Therapy oriented respondents. However, the respondent whose orientation was Patient and Family Centered Care focused additionally on the infrequently chosen goals of *increase experiences of pleasure* and *increase hopefulness*. Respondents of Humanistic orientation chose infrequently chosen goals—“create an aesthetic musical/arts experience” and *increase patient involvement in milieu*. The Cognitive Behavior Therapy oriented respondents showed the most variability in their top goals chosen, although they generally reflected top goals of the overall sample, with one choosing *increase ability to cope with negative feelings/mood states*—as stated above—one choosing *increase positive social interaction*, and one choosing *increase self-efficacy*.

The overall sample reported prominent use of *rhythmic improvisation*, and perceived it as an effective method. This method was also reported as a successful
method in treating depressive symptoms in adolescents by Rio and Tenney (2002), and is similar to the drumming protocol used by Bittman et al. (2009). Interestingly, Tervo (2001) suggested that improvisational methods would be most effective after trust has been established between the therapist and patient, and in his model improvisation is used during the second of his phases of music therapy. However, the results of this study indicate that improvisation, specifically rhythmic improvisation, can be successfully used at a very early stage of therapy—since treatment times were usually less than two weeks. Rhythmic improvisation specifically, rather than other types of improvisation, may be appropriate for use in short-term inpatient psychiatric settings due to rhythm’s ability to organize individuals and provide structure in movements of the group, increasing the sense of security and predictability in the music and promoting trust within the group, (Chase, as cited in Chaiklin & Schmais, 1993; Daveson & Skewes, 2002). Two comments regarding the most important factors that contribute to successful treatment of depressive symptoms specifically identified establishing trust as an important factor, with one respondent stating, “building rapport and trust fast through empathetic listening and non-judgement [sic].” This comment indicates that music therapists in inpatient psychiatric settings may be intentionally focusing on increasing trust quickly, perhaps by using the predictable and structured nature of rhythmic improvisation, so that patients feel free to explore and express during music therapy.

The music therapists included in this study thought that songwriting was the second most effective method in alleviating depressive symptoms in adolescents, although it was only the fifth most-frequently used method among all respondents. Their perceptions of songwriting as effective supports that songwriting continues to be valuable
in treating depressive symptoms in adolescents in inpatient psychiatric settings, as supported by Frisch’s (1990) discussion and case examples, and Hamer’s (1984) thesis, which found songwriting to be effective in reducing depression scores in 8 out of 10 adolescents in her study.

The amount of experience working with adolescents in inpatient psychiatric settings appeared to be the therapist characteristic that most impacted methods used, methods perceived as effective, and other aspects of treatment. Individuals with less than 8 years of experience in inpatient psychiatric settings focused more on self-esteem as a goal of treatment, and had a slightly higher preference for verbally-based music therapy methods such as lyric analysis. Respondents with less than 8 years of experience also focused more on patient agency in treatment than respondents who had 8 years or more or experience.

Those with 8 years or more of experience working with adolescents in inpatient psychiatric settings used a greater variety of music therapy methods frequently, and showed a greater degree of agreement in identifying effective methods—with 80% of these respondents identifying rhythmic improvisation as an effective method. Those with 8 years or more of experience were also more likely to collaborate in providing treatment than those with less than 8 years of experience. These results imply that as music therapists gain experience in working with adolescents in inpatient psychiatric settings, they use a wider variety of methods, including more rhythmic improvisation and active music therapy methods—such as ensemble-style live music making, collaborate more with other treatment team members in providing treatment, and focus more on their own agency rather than that of the patient or group.
The increased focus on their own agency rather than on the agency of the patient when identifying the most important factors for successfully treating depressive symptoms, may indicate that individuals with 8 years or more of experience feel increased comfort in using the self of the therapist as an agent of therapeutic change. This increased use of self may increase comfort with and efficacy of improvisatory methods. They may be more confident in their ability to authentically present themselves in sessions, and thus are more willing to create music in the moment with the adolescents with whom they work, as opposed to engaging in more structured and verbally-based interventions such as songwriting.

Clinical Applications

This survey provides valuable information for clinical practice. Responding music therapists in this survey report using group music therapy almost exclusively when treating adolescents with depressive symptoms, with only three respondents reporting use of individual music therapy. This greater use of group rather than individual treatment may be due to structural limitations of inpatient psychiatric settings, rather than the preference of music therapists, but it indicates that music therapists new to working in inpatient settings should prepare themselves to practice mostly group music therapy.

Almost one-third (29%) of the respondents who reported that they observe patient perceptions of stigma surrounding their diagnoses or experiences of inpatient hospitalization reported that group experiences and discussions were used to address these perceptions of stigma. In their open-ended responses, 16.7% of the overall sample identified properties of the group as one of the most important factors in treating adolescents in inpatient psychiatric setting. When combined with developmental
literature that stresses the role of peers in adolescent psychosocial development (Brunstetter, 1998), these results suggest that group music therapy may be more effective than individual music therapy in treating adolescents with depressive symptoms in inpatient psychiatric settings. Additionally, the findings of Au et al. (2009) indicate that the higher one’s social self-concept, the less likely they are to become depressed.

PintoFoltz et al. (2010), found that adolescents’ most prominent concerns regarding depression were that it would make them dissimilar from peers and negatively impact their relationships. Thus, group validation and participation, and patient identification with the group, may be quite valuable for the recovery of those individuals experiencing depressive symptoms, and may prevent worsening of symptoms.

Also clinically relevant may be the differing trends of music therapists with less than 8 years of experience working with adolescents in inpatient psychiatric settings compared to music therapists with 8 or more years of experience in this setting. Music therapists with more experience tended to frequently use a greater variety of methods than those with less experience with adolescents in inpatient psychiatric settings. Perhaps less experienced therapists would benefit from this increased method use. However, less experienced therapists may be slightly younger and therefore more aware of musical preferences of adolescents—leading to a greater ability to use recorded music that is relevant to the adolescent patients. Differences may also be the result of changes in music therapy education models. Additionally, there is no evidence within this study that the treatment models of more experienced music therapists are more effective than the treatment models of less experienced music therapists who work in inpatient psychiatric settings with adolescents.
Additionally, one comment about techniques recommended for at-home use bears mentioning here. A respondent stated, “…I also suggest that patients gain awareness of songs that are “triggers” for self-injurious behaviors (i.e., cutting, burning, drug use, etc.).” This comment indicates that there may be types of music or particular songs that are triggers for undesired behaviors, and furthermore indicates that some songs or possibly genres might be contraindicated for certain adolescents due to the likelihood that these songs may trigger an unwanted response in the patient. The comment appears to suggest that these contraindications would be particular to each patient, and thus, no generalized statements can be made as to which types of music might be contraindicated. However, the practicing music therapist would do well to maintain awareness of each patient’s response to songs and genres used in music therapy sessions. Discussions with patients to discover any potential triggering music may also be of great value.

Limitations of the Study

This survey study included a small sample (n=36). Thus, the responses may not be fully representative of the current practices of music therapists who work in inpatient psychiatric settings. Additionally, the potential respondents were recruited from an email list from the Certification Board for Music Therapists, limited to those music therapists who identified themselves as working with adolescents and in psychiatric settings. Thus, the survey may not have reached all eligible music therapists, since some music therapists may not have accurately identified their work setting with the Certification Board for Music Therapists, and thus may not have been invited to participate in the survey despite working with adolescents in inpatient psychiatric settings.
The survey inquired specifically about short-term inpatient psychiatric settings, and thus results do not indicate current practices of music therapists in outpatient or residential treatment settings. The results may not be accurately representative of music therapists who practice in rural settings, since only three individuals (8% of the sample) reported practicing in a rural community. It also may not apply to music therapists practicing outside of the United States, since all but one respondent reported practicing in the United States.

The way that some questions were asked may have limited the study. When asked “Do you collaborate with other members of the treatment team in providing treatment?” 69% responded yes. However, in analyzing the open-ended comments that accompanied this question in a free comment space labeled “please explain,” it became evident that respondents interpreted this question in a variety of ways. Some respondents answered yes because they co-treated (provided treatment together during a session) while others answered yes because they discussed treatment methods or patient characteristics with other professionals. Additionally, at least one respondent reported that nursing staff sometimes assisted patients in using music outside of music therapy, and that this displayed collaboration with other members of the treatment team in providing treatment.

Information omitted from the study also may have limited the study’s accuracy. Respondents did not receive definitions of the goals or methods included in the survey. Although these goals and methods are based on current literature regarding depression and music therapy practices, and thus are likely to be generally understood by most music therapists, it is possible that responding music therapists interpreted these goals and
methods in a variety of ways. In practice, *non-referential improvisation* could include *rhythmic improvisation*. Thus, *rhythmic improvisation* and/or *non-referential improvisation* may have been under-represented in the interpretation of the results. Additionally, when asking about frequency of methods used, this researcher included the method of *singing*, while in asking about respondents/ perceptions of the most effective methods, this researcher inadvertently changed the method from *singing* to *singing/vocal improvisation*. The lack of definitions of music therapy methods made it impossible to accurately determine which methods were active or receptive music therapy methods, and thus no conclusions can be drawn about whether active methods or receptive methods, in general, are most effective. Therefore, while this study provides more specific information on the goals and methods of music therapists working with adolescents in inpatient psychiatric settings, there may be variations in what these goals and methods look like clinically—for example, lyric analysis could involve recorded music or live music.

Finally, the definition of *short-term inpatient psychiatric setting* that was included in the email invitation to participate in the survey includes a statement that the average length of stay in such a setting is 2 to 3 weeks. This length of time was not corroborated by survey data—which indicated that average treatment lengths were closer to one week. This definition may have inhibited participation by those perspective respondents who worked in settings in which the average treatment time was less than 2 to 3 weeks.

**Recommendations for Future Research**

In order to gain a deeper understanding of the complexities of clinical decision-making by music therapists working with adolescents experiencing depressive symptoms
in short-term inpatient psychiatric settings, future research on this topic should utilize interviews and focus groups. Focus groups and interviews would allow for music therapists to explain their practices more fully. Results of this study indicate that music therapists are interested in more fully explaining their practice—some respondents in the current study appeared to feel limited by the multiple-choice format of the majority of the questions in the survey, despite there being a space to add additional comments in most of the questions. One respondent reported, in response to a question about techniques recommended for at-home use that “the complexity of the clinical situation is hard to reflect in forced choice questions.” Focus groups of music therapists may be particularly useful in understanding more fully how music therapists evaluate the effectiveness of the methods that they use. These qualitative formats would allow the researcher to gain more insight into music therapists’ conceptions of what specific methods and goals look like in clinical practice, and how they determine which methods are most preferable for treating adolescents with depressive symptoms in inpatient psychiatric settings. Other areas for exploration in focus groups and/or interviews would be to explore details of how music therapists collaborate with other treatment team members, and how they decide when and with whom to collaborate. Exploration of reasons for collaboration may illuminate why music therapists with more experience working with adolescents in inpatient psychiatric settings tended to collaborate more in providing treatment.

Results of this study indicate that future music therapy research with this population should aim to explore the efficacy of the methods of songwriting, rhythmic improvisation, and lyric analysis for treating adolescents with depressive symptoms in inpatient psychiatric settings. These methods should be studied in the context of group
music therapy, since that is the context in which most music therapy occurs with adolescents in short-term inpatient psychiatric settings. In comparing the prevalent use of group music therapy in the results of this study to the available literature and to McFerran’s (2010) analysis of adolescent music therapy literature, it seems that more music therapists write about their experiences with individual adolescents, even when stating that their work often occurs in groups—such as in Frisch’s (1990) article. This may be due to the relative ease of writing case examples compared to the difficult logistics involved in writing about or studying group responses. However, the results of this study indicate that more qualitative and quantitative writing about group music therapy with adolescents is needed in order to more fully reflect current practices in the music therapy field.

Future research with this population should explore if and how the gender of patients treated for depressive symptoms in music therapy influences the goals of therapy and methods used in music therapy. It should examine if females with depression in inpatient psychiatric settings have different needs than adolescent males with depression in this setting. Additionally, because there is a much higher rate of depression in adolescent females than in adolescent males, research should determine if the ratio of adolescents in inpatient psychiatric settings with depressive symptoms reflected the same gender ratio as the overall adolescent population with depression.

Future research should also explore what it means to create a “safe space” within music therapy. Four respondents reported that a safe space was one of the most important factors in successfully treating adolescents with depressive symptoms in inpatient psychiatric settings, but none of them explained what this might look like.
Future research should explore the at-home use of music therapy techniques by adolescents. Since 35 out of 36 respondents reported suggesting musical experiences for the patients to use at home after discharge, it will be important to research how often adolescents actually use these methods at home. Research in this domain should also explore how effective these at-home methods are in continuing to reduce depressive symptoms in adolescents, through longitudinal studies. Additionally, the at-home methods of *listening to specific songs to achieve a goal, singing, songwriting, making music with others*, and *learning an instrument*—either on one’s own or through music lessons—should be explored individually to determine if one method tends to be more effective or is used more often by adolescents. This research might also explore the less-mentioned recommendations of adolescents listening to music to document, match, or change their moods, as well as the recommendation of making art to music at home.
CHAPTER VI: SUMMARY AND CONCLUSIONS

The objective of this study was to gain information regarding the current practices of music therapists working with adolescents with depressive symptoms in short-term inpatient psychiatric settings. Specifically, it aimed to discover the goals and methods currently used by music therapists in this setting, as well as music therapists’ perceptions of the most important factors that contribute to successful treatment of depressive symptoms in adolescents in inpatient psychiatric settings, and any barrier to treatment.

A review of the literature indicated a lack of research regarding music therapy treatment of depressive symptoms in adolescents in inpatient psychiatric settings. The review indicated that adolescents tend to perceive stigma surrounding depression, but that adolescents support seeking treatment for depression. Literature also indicated that music is an important part of daily life for most adolescents, and that some adolescents use music as a coping strategy.

This information led the researcher to develop an online descriptive survey to explore music therapists’ treatment of depressive symptoms in adolescents in inpatient psychiatric settings. The survey was constructed to gather information about demographics of the participating music therapists, information about the facilities in which they work, and details of their music therapy practice with adolescents with depressive symptoms. The survey inquired about music therapists’ goals and methods when working with adolescents with depressive symptoms, about any barriers to treatment they observe, and about the factors they consider most important in successfully treating depressive symptoms in adolescents in short-term inpatient psychiatric settings.
Results showed that overall, participating music therapists provide music therapy in a group format rather than in individual sessions to adolescents with depressive symptoms in short-term inpatient psychiatric settings. Music therapists focus on goals of increase ability to cope with negative feelings/mood states, increase self-esteem, and increase positive socialization. Clinical orientation most impacted goals that participating music therapists chose. Methods most frequently used included lyric analysis, rhythmic improvisation, music listening (without lyric analysis), and ensemble-style live music making. Methods perceived as most effective were lyric analysis, songwriting, and rhythmic improvisation. These goals and methods were somewhat mediated by years of experience of music therapists working with adolescents in short-term inpatient psychiatric settings—those with more experience used a wider range of methods.

Almost all participating music therapists reported recommending music therapy techniques for at-home use, including techniques such as listening to a specific song to achieve a goal, singing, songwriting, and taking music lessons or learning an instrument. Most music therapists reported observing stigma and addressing it in music therapy through discussion, group processing, or musical interventions such as songwriting. Respondents believed that the most important factors relating to successful treatment of adolescents were most often related to interpersonal aspects of treatment, with the most emphasis on the qualities of the therapist that made them better able to connect with the adolescents. Other important factors were related to qualities of the group, other staff, and to the patients themselves.

The study provides more detailed information than was previously available regarding the current practices of music therapists in short-term inpatient psychiatric
settings who work with adolescents with depressive symptoms. The author recommends that future research utilize interviews and focus groups to gain more qualitative information about music therapists’ work with adolescents with depressive symptoms in inpatient psychiatric settings, including how music therapists determine which methods are most effective in working with this population. Research should also aim to study the effectiveness of the specific music therapy methods of *lyric analysis*, *songwriting*, and *rhythmic improvisation*, since these were chosen as most effective by participating music therapists.
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Appendix A: Email Invitation to Participate in Survey

Dear Music Therapy Colleague,

You are invited to participate in a research study entitled “Music Therapy Treatment of Depressive Symptoms in Adolescents in Short-Term Inpatient Psychiatric Settings: A Survey Study.” This study specifically focuses on current uses of music therapy with adolescents in short-term inpatient psychiatric settings to treat adolescents with depressive symptoms. This email is being sent to all Board Certified Music Therapists who work with adolescents and in psychiatric settings according to data from the Certification Board for Music Therapists.

My name is Emily Sheehan. I am currently a second year music therapy student in the Department of Creative Arts Therapies Masters’ Program at Drexel University. I am the student Co-Investigator for this study designed to gather information, through an online survey of music therapists, about their work with adolescents with depressive symptoms in inpatient psychiatric facilities. This study is being advised by Principal Investigator Florence Ierardi, a faculty member in the Department of Creative Arts Therapies at Drexel University. We are interested in learning the goals and methods of music therapy currently being used in clinical practice with adolescents in this inpatient psychiatric setting. Basic demographic information will also be collected.

In order to participate in this study, you must:

- Hold the credential of Board Certified Music Therapist (MT-BC)
- Have at least one year of experience working with adolescents in short-term inpatient psychiatric settings
- Have the ability to read and respond in English.

For the current study, adolescent refers to any individual between the ages of 12 and 18. Short-term inpatient psychiatric facilities are considered settings where patients remain in the facility 24 hours per day, are treated primarily for psychological illnesses, and stay, on average, two to three weeks. Depression will refer to 1) having a primary diagnosis involving depression, such as Major Depressive Disorder, or 2) to situations in which the symptoms that primarily addressed during treatment are those of depression, including lack of energy, low self-esteem, inability to experience pleasure, and other symptoms.

If you meet the participation criteria and are interested in participating in this study, please access the online survey through this secure online link: https://www.surveymonkey.com/s/DJWCZ8H. The survey will include questions about your professional background and clinical experience with adolescents with depression in inpatient psychiatric settings. The survey should take no longer than 25 minutes to complete. The survey will remain open for 2 weeks from this notification.
The information that you provide will remain completely anonymous. The website being utilized for this online survey does not track or store your email address, and the researcher will not be able to identify the email addresses of those who choose to participate or those who choose not to participate. Your confidentiality will be protected to the extent that is allowed by law. This survey is entirely voluntary and you have the option to withdraw at any time.

Your consent to participate in this research study is implicit when you complete and submit your survey. There are no risks associated with participation in this research study and there will be no compensation for participation. However, by completing this survey you will assist the researcher in completing her thesis and may benefit the music therapy profession through the sharing of your clinical experiences with this population. Results of this study may be submitted for publication in a professional journal, a book chapter, and/or presented at a conference.

If you have any questions regarding this research study, please contact Emily M. Sheehan or Professor Florence Ierardi at the phone numbers and email addresses below. Additionally, you may contact the Drexel University Office of Regulatory Compliance at (215) 255-7857 for more information regarding your rights as a research participant.

To proceed with this survey please click the link https://www.surveymonkey.com/s/DJWCZ8H.

Thank you in advance for your time and consideration.

Sincerely,

Emily M. Sheehan, Co-Investigator
Music Therapy Graduate Student
ems348@drexel.edu
(406) 539-3044

Florence Ierardi, MM, MT-BC, LPC
Principal Investigator
fmi22@drexel.edu
(215) 762-1178
Appendix B: Authorization for Use of CBMT Email Addresses

January 3, 2013

Ms. Emily M. Sheehan
Thesis Student
Drexel University
Philadelphia, PA 19104

Dear Emily:

This letter will serve as confirmation that the Certification Board for Music Therapists (CBMT) provided you with the email addresses of board certified music therapists for your research study entitled “Music Therapy Treatment of Depressive Symptoms in Adolescents in Short-Term Inpatient Psychiatry Settings.”

The Certification Board for Music Therapists is an independent body that establishes policies, procedures and standards for board certification in music therapy. The CBMT board certification program is accredited by the National Commission for Certification Agencies (NCCA). The CBMT is also a charter member of the Institute for Credentialing Excellence (ICE). Granting of the Board Certification credential to music therapists (MT-BC) recognizes professional competence in the knowledge and skills required for current practice. Please contact me if further information is needed.

Sincerely,

Karen Howat
CBMT Certificate Services
Phone: (800) 765-2268 ext. 24
Email: KH@cbmt.org
Appendix C: Reminder Email for Participation in Survey

Dear Music Therapy Colleague,

One week ago I invited you to participate in a survey about the goals and methods used during music therapy with adolescents suffering from depressive symptoms in inpatient psychiatric settings. This survey will provide data for a research study entitled, “Music Therapy Treatment of Depressive Symptoms in Adolescents in Short-Term Inpatient Psychiatric Settings: A Survey Study.”

Thank you to all of you who have already completed this survey. I would like to extend an invitation to those of you who have not yet found the time to consider completing the survey in the next week, as the deadline for completing it is (Date 2 weeks from initial invitation sent).

The survey can be accessed by clicking on this link: https://www.surveymonkey.com/s/DJWCZ8H.

Additionally, you can find the original email invitation at the end of this email.

Thank you in advance for your time and contribution.

Sincerely,

Emily M. Sheehan, Co-Investigator
Music Therapy Graduate Student
ems348@drexel.edu
(406) 539-3044

Florence Ierardi, MM, MT-BC, LPC
Principal Investigator
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(215) 762-1178
Appendix D: Survey

Music Therapy Treatment of Depressive Symptoms in Adolescents in Short-term Inpatient Psychiatric Setting

Thank you for your interest in contributing to this study.

The purpose of this research is to gather information about the goals and methods used by music therapists who work with adolescents with depressive symptoms in short-term inpatient psychiatric settings.

When answering questions about your patients, please answer based on your work with adolescents who have official diagnoses involving depression as well as those who present with depressive symptoms but may have alternate diagnoses.

Thank you in advance for your participation in this survey!

1. By continuing to the next page of this survey, you are providing consent to participate in this study. All answers are voluntary and you may exit the survey at any time. The survey will take approximately 15 to 25 minutes to complete. You will not be asked for your name, and your email address will not be connected in any way with your answers to this survey. Answers will remain completely confidential and anonymous. Results of this study may be submitted for publication in a professional journal, a book chapter, and/or presented at a conference.

   - Continue
   - Exit Survey

2. Have you worked as a music therapist with adolescents in a short-term inpatient psychiatric setting for at least one year? ("Short-term inpatient psychiatric setting" refers to a setting in which patients remain in the facility 24 hours per day, are treated primarily for psychological illnesses, and stay on average two to three weeks.)

   - Yes
   - No
Music Therapy Treatment of Depressive Symptoms in Adolescents in Short-

3. How long have you been working as a music therapist?
   - Less than 1 year
   - 1-3 years
   - 4-7 years
   - 8-10 years
   - 11-15 years
   - 16-20 years
   - over 20 years

4. How long have you been working with adolescents in short-term inpatient psychiatric settings?
   - Less than 1 year
   - 1-3 years
   - 4-7 years
   - 8-10 years
   - 11-15 years
   - 16-20 years
   - over 20 years

5. What is the highest level of education that you have completed in Music Therapy? (please check only one).
   - Bachelor's degree
   - Master's degree
   - Doctoral degree
Music Therapy Treatment of Depressive Symptoms in Adolescents in Short-

6. Please select all additional degrees or certifications you have received:
- Neurologic Music Therapy (NMT)
- Licensed Creative Arts Therapist (LCAT)
- Licensed Mental Health Counselor (LMHC)
- Licensed Professional Counselor (LPC)
- National Certified Counselor (NCC)
- Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP)
- Doctorate in Psychology (PsyD)
- Other (please specify):

7. What AMTA region of the United States are you practicing in?
- Midwest Region
- Great Lakes Region
- Mid-Atlantic Region
- New England Region
- Southeastern Region
- Southwestern Region
- Western Region
- I'm practicing outside of the United States

8. In what type of community are you currently practicing?
- City or urban community
- Suburban community
- Rural community
- Other (please specify):
Music Therapy Treatment of Depressive Symptoms in Adolescents in Short-

9. What is your gender identity?
   - Female
   - Male
   - Genderqueer
   - Gender non-conforming
   - Prefer not to answer
   - Other (please specify):

10. What is your employment status:
    - Full-time
    - Part-time
    - Half-time
    - Per Diem
    - Other (please specify):
11. In which type of inpatient psychiatric setting do you work with adolescents with depressive symptoms?
- Adolescent Psychiatric Unit in a Medical Hospital
- Adolescent Psychiatric Unit in a State-Run Psychiatric Hospital
- Adolescent Psychiatric Unit in a Private Psychiatric Hospital
- Combined Adolescent and Adult Psychiatric Unit in a Medical Hospital
- Combined Adolescent and Adult Psychiatric Unit in a State-Run Psychiatric Hospital
- Combined Adolescent and Adult Psychiatric Unit in a Private Psychiatric Hospital
- Combined Child and Adolescent Psychiatric Unit in a Medical Hospital
- Combined Child and Adolescent Psychiatric Unit in a State-Run Psychiatric Hospital
- Combined Child and Adolescent Psychiatric Unit in a Private Psychiatric Hospital
- Other (please specify):

12. What is the average length of hospitalization for the adolescents you work with?
- Less than 1 week
- 1 week
- 2 weeks
- 3 weeks
- 1 month
- over 1 month

13. What is the average age of adolescents you see in music therapy?
- 12-13 years old
- 14-15 years old
- 16-18 years old
Music Therapy Treatment of Depressive Symptoms in Adolescents in Short-

14. How many adolescent patients do you treat for depressive symptoms? (This can include primary diagnoses involving depression, or that you are focusing on depressive symptoms in a client without diagnosed depression.)

- Less than 1 per month
- 1-2 per month
- 1-2 per week
- 3-4 per week
- 5-6 per week
- 7-8 per week
- 9-10 per week
- Over ten patients per week

15. Please check all diagnoses that apply for the adolescent patients you treat for depressive symptoms:

- Major Depressive Disorder, Single Episode
- Major Depressive Disorder, Recurrent
- Depressive Disorder, Not Otherwise Specified
- Bipolar I Disorder
- Bipolar II Disorder
- Schizoaffective Disorder
- Dysthymic Disorder
- Cyclothymic Disorder
- Adjustment Disorder with Depressed Mood
- Other (please specify):

16. In what context do you most often provide music therapy for adolescents with depressive symptoms?

- Individual therapy
- Group therapy
- Both individual and group therapy
- Other (please specify)
17. Does the treatment team or facility have a specific clinical theoretical orientation?
- Yes
- No
- Don't Know

18. What is the clinical theoretical orientation of the facility or treatment team?
- Cognitive Behavioral
- Humanistic/Person-Centered
- Psychodynamic
- Systems Theory
- Neurodevelopmental Theory
- Dialectical Behavior Therapy
- Other (please specify):

19. Does your music therapy practice at the facility reflect this clinical orientation?
- Yes
- No

Please explain:

20. Do you collaborate with other members of the treatment team in developing treatment goals?
- Yes
- No

Please explain:
21. Which treatment team members do you collaborate with most often to develop treatment goals?

- [ ] Psychologist
- [ ] Psychiatrist
- [ ] Social Worker
- [ ] Behavior Specialist
- [ ] Occupational Therapist
- [ ] Physical Therapist
- [ ] Recreational Therapist
- [ ] Speech Therapist
- [ ] Art Therapist
- [ ] Dance-Movement Therapist
- [ ] Expressive Arts Therapist
- [ ] Play Therapist
- [ ] other Music Therapist
- [ ] Administration

22. Do you collaborate with other members of the treatment team in providing treatment?

- [ ] Yes
- [ ] No

Please explain:
Music Therapy Treatment of Depressive Symptoms in Adolescents in Short-

23. Which treatment team members do you collaborate with most often to provide treatment?
- Psychologist
- Psychiatrist
- Social Worker
- Behavior Specialist
- Occupational Therapist
- Physical Therapist
- Recreational Therapist
- Speech Therapist
- Art Therapist
- Dance-Movement Therapist
- Expressive Arts Therapist
- Play Therapist
- other Music Therapist
- Administration

24. Do you collaborate with or include family members in music therapy treatment?
- Yes
- No

25. How do you collaborate with or include family members in music therapy treatment?
(Please select all that apply.)
- Educate family about music therapy's goals and methods
- Include family members in music therapy sessions
- Provide family members with suggestions of ways to connect with the patient through music
- Other (please specify):
### Music Therapy Treatment of Depressive Symptoms in Adolescents in Short- 

26. When treating adolescents with depressive symptoms during music therapy, what are your top three goals of treatment?

<table>
<thead>
<tr>
<th>Goal #1</th>
<th>Goal #2</th>
<th>Goal #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase ability to cope with negative</td>
<td></td>
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<tr>
<td>feelings/mood states</td>
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<tr>
<td>Expand range of affect</td>
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<tr>
<td>Increase hopefulness</td>
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<tr>
<td>Increase patient initiation of activities</td>
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<tr>
<td>Increase feelings of mastery</td>
<td></td>
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<tr>
<td>Increase self-esteem</td>
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<tr>
<td>Increase patient involvement in milieu activities</td>
<td></td>
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<tr>
<td>Improve self-efficacy</td>
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<tr>
<td>Increase positive social interaction</td>
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<tr>
<td>Increase experiences of pleasure</td>
<td></td>
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<tr>
<td>Other (please specify):</td>
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</tbody>
</table>

### Music Therapy Treatment of Depressive Symptoms in Adolescents in Short- 

27. Music therapy literature indicates that the following methods are used with adolescents with depression. Please indicate how often, if at all, you use these methods in treating adolescents with depressive symptoms.

<table>
<thead>
<tr>
<th>Method</th>
<th>Frequently</th>
<th>Occasionally</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Songwriting</td>
<td></td>
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<tr>
<td>Composition</td>
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<tr>
<td>Ensemble-style live music making</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Rock band approach (performance-oriented)</td>
<td></td>
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<tr>
<td>Non-referential improvisation</td>
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</tr>
<tr>
<td>Referential improvisation</td>
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<td></td>
</tr>
<tr>
<td>Rhythmic improvisation</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Movement to music</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Music-assisted relaxation</td>
<td></td>
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</tr>
<tr>
<td>Lyric analysis</td>
<td></td>
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</tr>
<tr>
<td>Music listening (without lyric analysis)</td>
<td></td>
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</tr>
<tr>
<td>Therapeutic music lessons</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Singing</td>
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<td></td>
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<tr>
<td>Other (please specify):</td>
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</tr>
</tbody>
</table>
**Music Therapy Treatment of Depressive Symptoms in Adolescents in Short**

### 28. Which of these methods have you found to be most effective in alleviating depressive symptoms in adolescents?

<table>
<thead>
<tr>
<th>Method</th>
<th>Most Effective</th>
<th>Second Most Effective</th>
<th>Third Most Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Songwriting</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Ensemble-style live music making</td>
<td></td>
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<tr>
<td>Rock band approach (performance-oriented)</td>
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<tr>
<td>Referential improvisation</td>
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<tr>
<td>Non-referential improvisation</td>
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<tr>
<td>Rhythmic Improvisation</td>
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<tr>
<td>Composition</td>
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<td></td>
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<tr>
<td>Music-assisted relaxation</td>
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<td></td>
</tr>
<tr>
<td>Singing/Vocal Improvisation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lyric analysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Music listening (without lyric analysis)</td>
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<td>Movement to music</td>
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<tr>
<td>Other (please specify):</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 29. On average, what percentage of each session is based upon patient-preferred music?

- None
- less than 10%
- 10-25%
- 26-50%
- 51-75%
- 76-100%

### 30. Do you suggest musical experiences for the patients to use at home after discharge?

- Yes
- No
31. Which techniques do you suggest for patients’ at-home use?

- Listening to specific songs to achieve a goal (such as relaxation)
- Singing
- Songwriting
- Other Techniques/Additional Comments:

32. When working with adolescents with depressive symptoms, what are the most prominent patient barriers you encounter? (Please select all that apply)

- Discomfort with playing instruments or singing
- Unwillingness to participate verbally in sessions
- Resistance to sharing thoughts and feelings about self
- Discomfort in facility
- Distrust in care providers
- Lack of confidence in effectiveness of treatment options
- Other (please specify):

33. Literature has indicated that adolescents experiencing depression perceive stigma surrounding their diagnosis and/or experiences of inpatient hospitalization. Have you observed this perception of stigma during music therapy sessions?

- Yes
- No

34. How have you addressed patient perceptions of stigma?
Music Therapy Treatment of Depressive Symptoms in Adolescents in Short-Term Inpatient Settings

35. What are the most important factors contributing to successful treatment of depressive symptoms in adolescents within short-term inpatient settings?

Thank you!

Thank you for your time and consideration in completing this survey. Your answers are valued contributions to this research.

Any questions or concerns regarding this survey may be directed to:

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Co-Investigator
ems52@drexel.edu
(406) 536-3044

Florence Leardi, MM, MT-BC, LPC
Principal Investigator
fnc22@drexel.edu
(212) 780-1178
Appendix E: Responses to Question 6 of Those Who Chose “Other (please specify):”

Please select all additional degrees or certifications you have received:

LMSW

Chemical Dependency Professional

Fellow of the Association for Music and Imagery

Please note [sic] that NMT is an approach, not any type of official certification

Licensed school counselor
Appendix F: Responses to Question 8 of Those Who Chose “Other (please specify):”

In what type of community are you currently practicing?

A mix of everything. The hospital that I work in is in a suburban setting but we have patients who come from all communities. The majority of patients are from mostly urban/suburban areas.
Appendix G: Responses to Question 10 of Those Who Chose “Other (please specify):”

What is your employment status:

I work PRN as a mental health technician, though I was hired specifically because of my MT-BC status. Mental health techs are required to lead groups for patients, and all of the groups I lead are music therapy groups. The facility where I work does not offer a music therapist position.

Currently unemployed
Appendix H: Responses to Question 11 of Those Who Chose “Other (please specify):”

In which type of inpatient psychiatric setting do you work with adolescents with depressive symptoms?

Adolescent Psychiatric Unit in a City Hospital
Appendix I: Responses to Question 15 of Those Who Chose “Other (please specify):”

Please check all diagnoses that apply for the adolescent patients you treat for depressive symptoms:

- Eating disorder, conduct disorder, PPD
- Mood Disorder, Not Otherwise Specified
- Conduct Disorder
- Suicidal ideation, Suicide attempt
Appendix J: Responses to Question 18 of Those Who Chose “Other (please specify):”

*What is the clinical theoretical orientation of the facility or treatment team?*

Patient and Family Centered Care

Medical with Cognitive Behavioral & DBT strategies introduced within group and individual treatment
Appendix K: Open-Ended Responses to Question 19 “Please explain:”

Does your music therapy practice at the facility reflect this clinical orientation?

We provide opportunities for our patients to cope through music. This has the potential to benefit them and their family.

I utilize different forms of therapy. Although it is mostly cognitive behavior, DBT is also practiced. The facility is currently exploring trauma based care and will be piloting this on 2 of our 8 units.

I practice from a humanistic/person-centered orientation and find myself adapting my practice to the facility.

I believe in highly individualized treatment in music therapy, and therefore do not operate from the assumptions of only one perspective.
Appendix L: Open-Ended Responses to Question 20 “Please explain:”

Do you collaborate with other members of the treatment team in developing treatment goals?

The facility has specific themes per day of the week. For example, all groups on Wednesdays might be focused around depression while all groups on Thursdays may be focused around anxiety. However, group topics may be somewhat altered depending on the needs of the patients. I regularly consult my colleagues (i.e., nurses and other mental health techs) on the needs of the patients and specific group topics.

I work alternately with another music therapist, occupational therapist, and recreational therapist. We are able to view each others [sic] notes, and consult, if necessary.

Team meetings each morning with CTC, doctors, rehab team, and nurses

We identify treatment needs as a team and develop goals accordingly.

I currently do not collaborate on goals for the adolescents that I serve. I work within the treatment plan that is developed by the larger team.

I am the only music therapist for a 5 unit hospital, so I am doing groups while treatment team is conviening [sic].

I make an effort to participate in team meetings, and determine what rehabilitation services would best serve the patient.

Weekly collaboration with attending psychiatrist

Treatment goals are established by the psychiatrist. Music therapy supports and supplements.

Just with nursing staff right before the group…I get a census and run down of any outstanding behaviors.

Treatment team meets every morning to discuss patients’ progress and needs. Team includes Doctor, Nurse, Care Coordinator, and at least 1 therapist. I am the main therapist on the unit, so the therapist at the meeting is a music therapist.
Appendix M: Open-Ended Responses to Question 22 “Please explain:”

Do you collaborate with other members of the treatment team in providing treatment?

Yes, i [sic] collaborated…however, i [sic] haven’t worked with this population in 5 years so i [sic] don’t know if that skews your results. I currently work in the state hospital adult psychiatric setting, but am answering questions regarding the adolescent pop. [sic] based on my past experiences.

Occassional [sic] discussion of patients [sic] needs, my suggested interventions and any additional needs specific to a patient. I also collaborate with the other music and recreation therapists in our department to determine the best approach to meeting the groups [sic] needs at the time there is a difficult situation or need to discuss.

I collaborate with the nurses and other mental health technicians.

I work independently with the patients when they are in my groups.

We share ideas about things that have worked and ways we can use this knowledge to reach goals

The nursing staff will sometimes follow through on assisting patients with using music outside of MT.

I collaborate/ co-treat with unit staff including nurses, mental health techs [sic], and behavior specialists. I also work along side several other Creative Arts Therapists (Dance Movement Therapists) on the unit in question.

Treatment planning and execution are provided using a team approach

I do have consistent conversations with the staff that are working with the adolescents to gain an understanding of what the patient’s [sic] need.

I identify what services would be best for the patient according to the treatment goals.

I work as primary case manager and therapist for each client, provide music therapy in groups.

We report general group topics and try to tie consistent themes if necessary.

But only for specific things, such as general relaxation groups

We don’t often co-treat, but at times we can depending on the census and the needs of the floor.
Appendix N: Responses to Question 25 of Those Who Chose “Other (please specify):”

*How do you collaborate with or include family members in music therapy treatment? (Please select all that apply.)*

Weekly family group sessions that include music, art, and/or rec [sic] therapy with all patients and their family
Appendix O: Responses to Question 26 of Those Who Chose “Other (please specify):”

When treating adolescents with depressive symptoms during music therapy, what are your top three goals of treatment?

This is a question that can’t really be answered in such a general way unless one is a therapist who provides intervention according to a protocol, which is not client-responsive therapy.

The primary goal or intention that I set for groups is, to create an aesthetic musical/arts experience.

3. Increase feelings of validation or universality

Identifying potential triggers that contribute to depression
Appendix P: Responses to Question 27 of Those Who Chose “Other (please specify):”

*Music therapy literature indicates that the following methods are used with adolescents with depression. Please indicate how often, if at all, you use these methods in treating adolescents with depressive symptoms.*

Music games

Music listening without lyric analysis……what does this mean? I use receptive music with other creative arts and music with imagery…?

Receptive music experiences including – Music and visual arts, music and story, music and imagery

Music in combination with other creative forms (art/drawing, acting, writing); cognitive games (song title Charades, “Name that Tune,” etc.)

Mandala or art while listening to specific music
Appendix Q: Responses to Question 28 of Those Who Chose “Other (please specify):”

Which of these methods have you found to be most effective in alleviating depressive symptoms in adolescents?

Expressive therapy through activities like drawing to music, imagery and music/drawing, and CD covers are big hits, usually as well.

Again, there isn’t a correct or “most often” answer for those of us who engage in client-responsive therapy. The most effective methods are those that speak specifically to the needs of each client, and therefore are different for each. Additionally, I don’t remember the last time I used only one method with any client or client group, so again, I can’t really answer this question.

I can say most music experiences are effective during the group experiences.

Third most effective: drawing to music
Appendix R: Responses to Question 31 of Those Who Chose “Other Techniques/Additional Comments:"

Which techniques do you suggest for patients’ at-home use?

Relaxation, instrument playing, joining a musical group/organization

Playing music with friends/peers

Creating mixes to “document” moods, happy, sad, hopeful, encouraging.

Journaling about songs or musical experiences, art with music and using music interests to connect in the community for healthy social support environments.

Music for emotional expression

The techniques I suggest are often patient-specific. For example, if a patient communicates that he enjoys playing guitar, I will suggest improvising on the guitar or finding songs he can play that express how he is feeling. I also suggest that patients gain awareness of songs that are “triggers” for self-injurious behaviors (i.e., cutting, burning, drug use, etc.).

Drawing to Music

Learning/developing musically on an instrument that they show preference for and/or have exhibited receptivity towards in a session

Music lessons

Resources to further lessons given during treatment. Suggested sites for chord charts etc

Continued music lessons or group ensembles

Continuing instrument lessons in drums, guitar or piano

Joining a band/choir, music group if they responded to that in the hospital

Things I have encouraged range from music-assisted relaxation techniques that we develop in treatment to continuation in formal music training, with numerous other recommendations in between.

Participation in ensembles such as a Church choir
This is typically based on the situation and the patient(s). Discussions have led to the use of music in a person’s life after discharge. The complexity of the clinical situation is hard to reflect in forced choice questions.

Studying instruments

Participation in outside musical groups and activities to increase social interactions

Making art inspired my [sic] music listening

Music for emotional awareness – identifying what songs make the patient feel a certain way; demonstrating how music can change mood both negatively and positively

Writing, journaling of music and or lyrics

Create an emergency playlist using the iso principle where the music matches the mood and then with each song shifts client mood to a better state

Learning an instrument
Appendix S: Responses to Question 32 of Those Who Chose “Other (please specify):”

*When working with adolescents with depressive symptoms, what are the most prominent patient barriers you encounter? (Please select all that apply)*

I would not say I encounter “barriers” persay [sic]. Even the adolescents with the most depressive symptoms, and especially these adolescents, love and crave their music. They appear to feel cared about and understood to have a place to listen to something that resonates with them. Whether it’s playing an instrument, listening to music, or even music video games (Guitar Hero, SingStar), the majority of patients find something that moves them.

Getting to group

All of the above can be symptoms of depression and/or being an adolescent. I don’t consider these barriers. They are indicators of treatment needs.

Depressive symptoms: many feel unmotivated, fatigued, anhedonic, etc.

At times resistance in writing down feelings/emotions. Lack in motivation overall.

Relational conflicts between group members
Appendix T: Open-Ended Responses to Question 34

How have you addressed patient perceptions of stigma?

Refer to shared group experiences/support. Validate that they are doing the right thing by getting tx [sic].

“Everyone gets sick, and many people take medications…some need physical issue check ups, others need mental issue check ups…if you want to live a healthy life, we’ve got to manage this illness.

Talk with them. Education.

If a patient mentions stigma, the other patients with often initiate a group conversation about their varying perceptions and offer support to one another. This seems to be very effective for adolescents, as they typically highly regard the opinions and views of their peers. If this does not happen, staff will speak individually with the patient about his or her perceptions and concerns.

Encouraged expression of feelings and group discussions

Used this very topic to spark songwriting sessions.

Listen, discuss a particular song, talk about it.

Normalize; explicitly separate brain chemistry from the person; help clients to figure out what to tell friends about where they’ve been.

Often we will work on expanding the sense of self through increasing self-awareness, defining positive characteristics, identifying active means of improving aspects of self that are less developed, and when appropriate, exploring successes of others who have had similar life experiences.

Discussing their feelings and explaining positive ways to cope with stigma.

I have not be [sic] aware of this appearing while I was servicing the child/adolescent unit.

I encourage the patients to see that mental illness is not any different than any other illness such as pneumonia [sic]. It’s just the brain is the body part that is not functioning correctly.

Education on mental illness
I explain that we all have different reactions to things in our life. I validate their feelings and let them know that the public does not have a true understanding of mental illness and it’s causes.

Addressed it directly, verbally and musically immediately in treatment

Reassuring them that their hospitalization is private and need not be shared with others unless a patient wants to.

Discussed ways to explain hospitalization to peers when returning to school settings

Often, I do not directly need to address it. Usually during group discussion, the patients begin to realize that several of their peers go through similar situations. Also, for lyric analysis, I may choose songs that were written by people who may have had similar experiences (i.e. Demi Lovato), again emphasizing the fact that other people (even famous people) have had similar situations.

Normalizing experiences, validation, and self disclosure

Adolescents are sometimes able to form bonds through their similar struggles. Feeling like someone else understands them is helpful.

Talked about it as a group. Often, some members of the group have been here before or have more experience with a depressive diagnosis and can offer insight into dealing with the stigma.

Discussing that mental illness is a sickness not just being “crazy”. Thoughts of others cannot be controlled but education of mental illness is helpful.

I think that group sessions help adolescents to see that they are not alone. We frequently to do a lyric analysis of the song by saosin called “You’re Not Alone” to talk about this topic.

Validate emotions, encourage other group members to share own perceptions, brainstorm ways to cope with stigma

Verbal processing, CBT techniques
Appendix U: Open-Ended Responses to Question 35

What are the most important factors contributing to successful treatment of depressive symptoms in adolescents within short-term inpatient settings?

Good therapeutic rapport.

Openness and presence as a therapist; creating a safe environment; working with the client for them to find a role in music that they are comfortable with.

Safe space, rapport with therapist, willingness to try “their” music and go from there.

Understanding and listening to the patients to best understand their individual needs and to find a way to apply the music and session to reach them. Helping the adolescents understand that they are not alone and others feel the same as them, and in part their emotional development may play a role in their depression. Also, to take into account any physical, environmental, family or social factors that are contributing to their depression to best address the whole person and the adolescents needs.

Healthy emotional expression & coping skills

Achieving group cohesion is the most important factor contributing to successful treatment. If the group does not work together, patients are less willing to participate and share.

Acceptance & validation of the patient's feelings and experiences first before challenging them to expand or improve their depressive symptoms.

Building rapport and trust fast through empathic listening and non-judgement [sic]

Finding something they value, that they are good at and can continue. Supportive family/guardians.

The patient's willingness to overcome their symptoms

1. Building Feelings of Mastery and Self-Esteem
2. Self-Validation
3. External Validation
4. Providing appropriate outlets to express emotions
5. Feelings of comradarie [sic] and belonging in the group

Being flexible. Listening to what they want. Observing and knowing when they ready to "work" on their issues verses pushing for too much, too soon. You must build a repoire [sic] with them before asking them to disclose and open up.
Building a therapeutic report [sic] with the patient - providing a safe, supportive environment.

Supportive milieu, allowing the client space to reach out/expess [sic] him/herself at his/her own pace, validation of feelings related to life experiences, pointing out client strengths and abilities

Instilling hope, developing coping skills, learning new ways to think, developing interests

Make a connection. Listen to them. Let them lead whenever possible. Use the group dynamics and peer support for positive change and redirect negative/destructive behaviors. Understand that they may feel stigma outside of the hospital, but in the hospital they may recognize that they are among least mentally ill patients on the floor. Recognize that they are often creative. Encourage them. Believe in them. Don't take negative behaviors towards you as a therapist personally.

1.) Strong and appropriate therapeutic relationship; 2.) Highly flexible and reflexive music engagement based specifically on the needs of the clients as he or she presents them from moment to moment.

Safety, building trust, validation, and providing a lot of encouragement.

Someone attempting to help them.

Rapport with staff

Willingness to engage in tx [sic] and admit illness

An open mind and lack of judgement [sic] on any harmful activities they engage in. Focusing on what would make them personally happy and helping them find a way there.

Combined with verbal therapy interventions

Encouraging appropriate prosocial group activities and supporting them in discussing their issues.

My ability to "connect" with each adolescent: having/knowing the music that they relate to, being able to have meaningful social interactions, maintain rapport, etc.

Patients being aware that they need to change in some way in order to maintain safety. Patients being motivated to change. Effective, empathetic support from staff. Finding ways to help the patients express themselves comfortably, perhaps nonverbally.

Finding the music the patient connects with
Developing self efficacy, education for family members to promote supportive environment upon discharge, comprehensive outpatient discharge plan

Establishing connections to others.

Patient preferred music and activities and a variety of activities ready to go if one thing doesn't work for that particular group.

Discussing the importance of continued treatment and compliance with doctors' advice after leaving facility.

I think for them to see that they are not alone and have success oriented experiences with peers and with creating or discussing music

Patient willingness to participate in treatment, patient ability to establish sense of hope/future goals

Effective coping skills, good support network in and outside of the hospital, appropriate social experiences outside of the hospital and positive recreational activities outside of the hospital

Client buy in and willingness to make changes in his/her life.
Appendix V: Permission for Reprinting of AMTA 2011 Workforce Profile Data

American Music Therapy Association
8455 Colesville Rd., Ste. 1009 • Silver Spring, Maryland 20910
Tel. (301) 589-3300 • Fax (301) 589-5175 • www.musictherapy.org

May 7, 2013

Emily M. Sheehan
1935 Mt. Vernon St. Apt. 3R
Philadelphia, PA 19130

Dear Emily:

With the appropriate citation*, the American Music Therapy Association is pleased to grant you permission to post the following text from the AMTA’s 2011 Workforce Profile in your introduction:

"According to the American Music Therapy Association’s 2011 Workforce Profile, 20% of music therapists work with mental health populations, including adolescent mental health populations. Additionally, when asked about what setting they work in, 13% of music therapists reported working in a mental health setting, including inpatient psychiatric facilities (American Music Therapy Association [AMTA], 2011)."

We understand that you are in the process of writing your thesis on how music therapists treat adolescents with depressive symptoms in inpatient psychiatric settings.

Thank you for assisting the American Music Therapy Association in furthering its mission of advancing public knowledge of music therapy benefits and increasing access to quality music therapy services.

Best wishes to you in all your future endeavors.

Sincerely,

Andrea H. Farbman

Andrea H. Farbman, EdD
Executive Director

**“Printed with the permission of the American Music Therapy Association”**