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A model for music therapy with students with emotional and behavioral disorders

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Abstract

Music therapy has been used in a variety of ways to benefit students with emotional and behavioral disorders (EBD), even though little information on the specifics involved in applying music therapy to this population has been written. With proper planning of musical activities and sessions, students can benefit from a music therapy program structured for the success of each individual. The purpose of this paper is to review how music therapy has been used with students with EBD and to propose a model of music therapy for students with EBD in a pyschoeducational setting. With caseloads increasing for music therapists, organization and planning of the music therapy program is an effective way to optimize services. The model presented is designed to combine the music therapy process with the 9-week grading period of the school setting and provides suggestions for music therapy and other therapeutic modalities to work collaboratively with students with EBD.

Keywords: Disability; Emotional and behavioral disorders; Interdisciplinary team; Music; Music therapy

Students with emotional and behavioral disorders (EBD) have a wide variety of problems and diagnoses. Many students with EBD have short attention spans, difficulty relating to people, low self-esteem, and family problems and are easily frustrated. These students have difficulty learning due to behavioral and emotional disturbances that interfere with the learning process and may suffer from a variety and degree of mental disorders. Students with EBD receive a variety of diagnoses, including schizophrenia, depression, anxiety disorders, attention-deficit hyperactivity disorders, autism, or other sustained disturbances

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in conduct (Zionts, 1996). However, students who are socially maladjusted (i.e., have a conduct disorder) are not considered to have an EBD due to the theoretical lack of an emotional component.

The Individuals with Disabilities Education Act (IDEA, 1997) defined a child with a serious emotional disturbance as having these characteristics: (a) an inability to learn that cannot be explained by intellectual, sensory, or health factors; (b) an inability to build or maintain satisfactory interpersonal relationships; (c) inappropriate types of behavior or feelings under normal circumstances; (d) a general, pervasive mood of unhappiness or depression, and/or (e) a tendency to develop physical symptoms or fears associated with school problems. One or more of these characteristics must be exhibited over a long period of time to a marked degree and must adversely affect educational performance (Breen & Fielder, 1996).

The U.S. federal definition of a "serious emotional disturbance" has been widely criticized as inappropriate and inadequate (Kauffman, 2001). It lacks concrete guidelines for an educational or a clinical setting (Zionts, 1996), but provides vague terminology for assessing students and the severity of their disability. Also, according to the definition, a student must be failing academically to qualify for special education services; therefore, a large number of students can be denied special services if they are on grade level (Kaufman).

Despite these weaknesses, the definition of EBD provides a helpful framework for educators to construct appropriate interventions and strategies for teaching students identified with this disability even though the U.S. federal definition is vague in terms of measuring behavior (Kauffman, 2001). In general, students with EBD are difficult to teach due to their inability to learn, general depressive state, and inability to form relationships. For example, consider the challenges to effective teaching of a student if a school phobia is present, somatic complaints exist, and behavior problems constantly interfere with instructional methods.

Advances in understanding EBD have made major strides possible in the areas of identification and assessment of the disorder within the past 30 years, but many challenges still exist to effective service delivery that require prompt attention and resolution (Lane, Gresham, & O'Shaughnessy, 2002). Lane and co-workers have identified four key challenges to serving students with EBD. One of these challenges, and the primary focus of this paper, is the necessity of better designing the curricula and instructional methods used to educate students with EBD.

Due to the many interfering stimuli involved in teaching students with EBD, there is a need to use hands-on learning experiences to motivate these children. Music is a motivating medium to use with students with EBD and music therapy services can provide an outlet for a variety of positive outcomes including nonverbal communication, structure for socialization, and school experiences in which a student can be successful. According to the American Music Therapy Association (AMTA), music therapy is "the prescribed use of music by a qualified person to effect positive changes in the psychological, physical, cognitive, or social functioning of individuals with health or educational problems" (AMTA, 2003). Music therapy is specified as a related service under IDEA and can assist students in meeting the educational and behavioral goals addressed in their individualized education plan (IEP).

Kessler (1967) described the goals of music therapists working with exceptional children. Music therapists use music to increase the child's awareness of himself or herself and others,

improve communication skills, and help improve the child's self-concept by teaching him or her a skill that is significant to others. Music therapy goals for students with EBD should be based on the special needs of the children, and music activities should promote concentration, teamwork, self-control, discipline, and an appropriately channeled release of energy and tension (Bennis, 1969). The purpose of this paper is to explore the use of music therapy for students with EBD and to present a model music therapy program that has been used with students with severe EBD in a psychoeducational setting.

Review of literature

Early literature involving music therapy research specific to emotional and behavioral disorders relied heavily upon narrative information, but still provided relevant information to the practice today. Cooke (1969) noted the lack of systematic research aimed at understanding how music affects behavior, and contributed this to the complexity of measuring musical stimuli such as rhythm, tempo, and pitch. Hussey, Laing, and Layman (2002) reviewed the literature and found several categories of perceived benefits of music therapy, such as improvements in: (a) affective functioning; (b) communication social dysfunction; (c) cognitive dysfunction; and (d) musical responses.

Music therapy

Benefits of music therapy

As a student achieves musical success, his or her self-esteem and self-worth may increase. A study of 13 hospitalized patients diagnosed with "adjustment reaction to adolescence" reported a significant increase in mood recognition, group cohesion, and improved self-esteem with the use of a music therapy program (Henderson, 1983). In this study, music groups used recorded musical compositions to discuss moods and emotions, composition of stories to background music, and drawing to music. Several studies include the use of music therapy as a medium for self-expression. For example, Anshel and Kipper (1988) investigated the effects of group singing on trust and cooperation. Ninety-six adult males were tested and results indicated group singing stimulated, perhaps even promoted, trust and cooperativeness. Standley (1996) found that music activities acted as a reinforcer and could be beneficial to overall academic and social behaviors. More recently, Robb (2000) studied the effect of music therapy on the behavior of hospitalized children and found that music elicited significantly more social engaging behaviors than other hospital activities.

Music therapy for students with EBD

Music therapy interventions combined with effective behavior management techniques may provide a structured and creative outlet for professionals to teach students with EBD. Within the special education setting, music therapy interventions can facilitate

development in cognitive, behavioral, physical, emotional, and social skills (AMTA, 2003). Many researchers and therapists have reported success in pairing behavioral techniques with music therapy to elicit positive changes in social skills (e.g., Hanser, 1974; Steele, 1977 as cited in Eidson, 1989).

Students with EBD often have deficits in affective functioning and need instruction, support, guidance, structure, and motivation in expressing themselves. Music therapy can be a valuable service to promote self-expression and self-worth in children with EBD. Gewirtz (1964) used music therapy as a form a supportive psychotherapy with children by using music as a medium to establish positive peer relationships and provide a release of emotion. Gewirtz' music therapy goals were divided into three categories: short-term goals, such as using music to produce an immediate positive behavioral result and using the educational value of music, long-term goals, such as socialization, group interaction, and cooperation, and achievement goals, such as promoting positive growth and self-esteem with opportunities to have successful social experiences.

Music therapy and communication

There is a small but growing body of research investigating the effects of music on EBD, including a study by Coons and Montello (1998) that investigated the effects of active versus passive group music therapy on preadolescents with EBD and learning disorders. Their results suggested that group music therapy activities could help facilitate the process of self-expression, and creativity and provide an avenue to appropriately display the emotions of anger and frustration. Other studies discussed the effects of music therapy on communication skills on children with EBD. North (1966) used music with children with autism and schizophrenia, both of which qualify a student for the label of EBD under the U.S. federal definition, to facilitate forming interpersonal relationships and increase communication skills. More contemporary research investigated the effects of a Nordoff and Robbins approach to music therapy on eleven children with autism. This approach emphasizes improvisational, creative music making. Results suggested that improvisational music therapy was effective in eliciting and increasing communicative behaviors such as verbalizing, vocalizing, gesturing, and other instrumental responses to musical stimuli (Edgerton, 1994).

Music therapy and behavior

Music therapy studies have also reported a positive change in behavior with students with EBD. Hanser (1974) studied the use of contingent music listening with emotionally disturbed boys and found a significant decrease in inappropriate verbal and motor behavior when the contingency – ongoing background music – was applied. Another study measured inappropriate behaviors (fighting and out-of-seat) on three school buses and found that these behaviors decreased with the use of contingent background music (McCarty, McElfresh, Rice, & Wilson, 1978). These researchers also found that overall group cohesion increased with the students on the bus during the study period.

A three-year study of a music therapy program in a residential treatment center for emotionally disturbed children found that music therapy services increased on-task behavior and influenced an overall positive behavioral change (Steele, 1975). Cripe (1986) investigated

the effect of rock music on children with attention-deficit disorder. This study, involving eight males, aged 6–8, indicated a statistically significant reduction in the number of motor activities during music periods. Eidson (1989) examined the effect of a behavioral music therapy treatment program on 25 emotionally handicapped students aged 11–16. The results demonstrated that students improved interpersonal behaviors and transferred social skill improvements across classrooms. This same year, Burleson, Center, and Reeves evaluated the effects of background music on on-task performance with four male children, aged 5–9, in a psychoeducational center. Results supported their stated hypothesis that music reduced off-task responses and increased on-task behaviors. Finally, Hilliard (2001) studied the effects of music therapy groups and the grieving process in children. Results indicated that music therapy groups reduced grief symptoms among research participants.

Music therapy programs in school and residential settings

Music therapists working in schools or residential settings with children with EBD find a lack of research to guide their work (Hussey et al., 2002). No literature currently available describes a specific music therapy program for working with students with EBD. Some literature does describe the music therapy process within the public school setting. Coleman (2002) described the music therapy process for learners with severe disabilities within the public school and residential settings. The school-based model Coleman described reportedly assists students in attaining educational goals and teachers in using music therapy strategies. The frequency of sessions is based on the educational needs specified in a student's IEP and duration of sessions range from a one-time consult to weekly or bi-weekly sessions for one or more years. Gladfelter (2002) described music therapy for students with learning disabilities in private day school. Students attended weekly 45-min sessions for the entire school year and participated in activities such as playing instruments, singing, listening to music, creating music, improvising, writing lyrics, producing music videos, and drama exercises. Specific goals for each child were only developed for students receiving individual music therapy services. The music therapy program focused on the following goals: (a) building self-esteem through successful musical experiences; (b) developing and refining auditory processing skills; (c) encouraging attention to task; (d) enhancing speech and language skills; (e) improving fine and gross motor skills; (f) promoting academic concepts; (g) developing appropriate social skills; (h) expanding leisure-time activities; and (i) encouraging self-expression.

Music therapy program for students with EBD

The Rutland Psychoeducational Center in Athens, Georgia, serves elementary, middle, and high school students diagnosed with severe EBD. Currently, one board-certified full-time music therapist supervises the program. The music therapist is a member of the interdisciplinary treatment team consisting of teachers, social workers, psychologists, administrators, and an art therapist. The music therapist attends weekly treatment team debriefings on students, facilitates daily group and individual music therapy sessions,

Table 1

Music therapy program goals for elementary, middle, and high school group sessions:

(1) Create structured, safe musical experiences for students to achieve success and increase self-esteem.
(2) Establish group cohesion and cooperation using a check-in method incorporating drumming and chanting.
(3) Provide organized and planned sessions focused on achieving a group goal, based on individual IEPs, group needs, and treatment team recommendations.
(4) Encourage on-task and appropriate behavior using immediate positive reinforcement, second chances, and music as a contingency for appropriate behavior.
(5) Provide musical experiences to encourage self-expression, communication skills, and socialization.
(6) Facilitate group movement to music activities enhancing motor coordination, fine and gross motor skills, overall physical fitness, and self-awareness.
(7) Provide musical experiences to reinforce cognitive skills and aid in the development of speech and language.
(8) Allow for students to explore personal musical interests and develop skills in becoming a musician.

and provides consultation to teachers on how to utilize music therapy strategies in the classroom.

The music therapist meets with each elementary class, consisting of five to eight students, weekly for a 45-min session for the duration of the school year. Middle school classes alternate music and art therapy sessions each 9-week grading period and, therefore, meet with the music therapist for two 9-week periods each year. High school students meet with the music therapist for individual and/or group sessions throughout the school year as recommended by the treatment team. Individual music therapy sessions take place with students in all grade levels and are referred to the therapist by the treatment team and address the goals listed in Table 1.

The program outline presented combines the music therapy process with the 9-week grading periods used at the Rutland Center. The outline is designed to be an effective, organized way to utilize music therapy services and provides a way for the therapist to plan specific goals and objectives for individuals and groups (see Appendix A).

The first week of the 9-week curriculum is dedicated to the referral and assessment processes. During this week, the music therapist takes referrals from the treatment team for individual sessions. The therapist reviews students' files to study pertinent information such as their social history, psychological evaluations, and other behavioral assessments. Students' IEPs are reviewed during this week to study individual behavioral and academic objectives. During each class' scheduled music therapy session time, the therapist observes the students in their classrooms and notes individual behaviors and classroom dynamics. The music therapist also uses this time with the class to establish rapport and to administer other assessment materials such as behavior rating scales and self-reporting measures. Individual music therapy assessments are also used, such as the Beech Brook Music Therapy Assessment for Severely Emotionally Disturbed Children (Hussey et al., 2002).

The therapist reviews all pertinent information regarding music therapy services for the class and meets with the treatment team to decide on long-term goals for the 9-week period. One long-term goal for all sessions is to increase on-task, appropriate behavior across classroom settings. At least one other long-term goal is chosen for each class with the guidance of the treatment team. These goals are developed to coincide with the character education program adopted by the Rutland Center, "Good Character," produced by Live Wire Media. Goals can include, but are not limited to, anger management skills, self-expression, coop-

eration, self-esteem, resolving conflicts, listening to others, and doing the right thing. Once the treatment focus is established for groups, the therapist writes a statement of clinical purpose, designs a music therapy curriculum specific to the class needs, and describes methods of measuring progress. Other therapeutic providers, such as the art therapist, social worker, and psychologist, also concentrate on the treatment focus to provide an interdisciplinary teaching of concepts.

Weeks two through eight focus on implementing the music therapy curriculum and ongoing evaluation. Each class that attends music therapy sessions has a different curriculum and activities planned. However, some aspects of treatment remain constant. Every session begins with a check-in activity that allows students to express how they feel at that moment. Students have the opportunity to express themselves and to practice being aware of their peers' feelings, and the therapist has a chance to assess the groups' dynamics. The therapist plays the djembe (African drum) and chants a hello song while the students clap and sing. The therapist sings "hello" to each student, and they are encouraged to give a check-in number from 1 to 10 to express how they feel. A score of 1 means the student feels "very bad" and a score of 10 means the student feels "excellent." Students are also encouraged to express *why* they are feeling a certain way. After the students respond, they are allowed to take a solo on the hand drum and then pass it to the next person. The short-term goals for this activity are to establish group cohesion and encourage self-expression and creativity.

Another constant for each music therapy session is the method of data collection for each class. A teacher or teacher assistant attends each music therapy session with the class in order to collect data. Before the process begins, the teacher is instructed on how to record data. The data collection procedure is intense, but data collection is considered paramount when determining progress towards established goals. The teacher or teacher assistant tracks each student for 60 s intervals and records their behavior. If the student is on-task, he receives a check, and if he is off-task he receives a dot. On-task behavior is defined by the nature of each activity and can include clapping, singing, stomping, playing instruments, and moving to music. At the end of 30 min, each student's participation score is calculated as determined by their on-task behavior and those students who have 90% of their points or better earn a musical reward. Students who earn a reward are allowed to choose any instrument in the music room to play for 30 s. They can choose to play an instrument independently or with the therapist's direction. The goals of data collection are to monitor individual progress, to promote on-task and appropriate participation, and to compare progress across classrooms to assess for skill generalization. Individual participation scores are calculated at the end of the 9-week period to provide teachers with a music therapy participation score for report cards.

Additionally, anecdotal observations are recorded for every student after the session is concluded. These observations have been helpful during debriefings with the treatment team, for interim progress notes, and for individual 9-week reports. Progress is also monitored for each class's treatment focus with the use of anecdotal observations and self-reporting measures.

The last week of the 9-week period focuses on reviewing the curriculum and treatment goals, generalizing the treatment focus outside of the music room, reviewing treatment data, and providing on-going consultation and follow-up. The therapist reviews activities administered throughout the 9-week period and encourages a discussion on how students can use the skills acquired during sessions. If self-reporting measures and/or other assessments were

used, they are re-administered at this time. Often, the class works on developing a group music project such as a musical drama, song, rap, or instrumental ensemble and presenting the performance to other classes of their choice or the entire school. The therapist provides on-going consultation with the teacher throughout the therapy process and provides ideas of how to use music therapy strategies in the classroom. Simple examples of this are commonly known, such as using songs to teach the letters of the alphabet or multiplication tables. An example of a specific technique that can be used in the classroom is *lyric analysis*, in which a teacher can pick a song that is age-appropriate and obtain the lyrics. The teacher has students take turns reading aloud, and a variety of educational objectives can be addressed including reading comprehension, phonetics, and meaning interpretation. With many popular songs, correcting grammar is another learning objective that can be undertaken. Finally, 9-week progress notes are written for each individual student and include their participation scores, anecdotal observations, successful behavior management strategies used, and future recommendations for music therapy services.

The music therapist structures sessions to provide a successful experience by giving prompts and positive reinforcement and breaking musical tasks down into manageable, achievable components. Rules are clearly displayed in the music room and students are given three verbal warnings before being asked to leave the session. If students are asked to leave, the therapist meets with the individual at a later time, consults with the individual about appropriate, acceptable behavior in the music room, administers appropriate consequences with the teacher's collaboration, and asks the student to rejoin the group for the following session. Some of the behavior management techniques used during music therapy are planned ignoring, proximity control, the use of clear and precise directions and expectations, structured activities provided at a regular pace, and verbal warnings, redirection, and prompts. Since many students with EBD have short attention spans, activities last approximately 3–5 min with short transitional activities to provide movement from one activity to the next. Students participate in an average of four activities per session not including the check-in, musical reward, or the good-bye chant that closes the session. Session activities include a variety of established techniques such as lyric analysis, song writing, instrumental improvisation, instrumental ensembles, group singing, group drumming, movement to music, and musical games. To provide closure for each session, the therapist plays a drum and chants each student's name as a prompt to line up.

Conclusion

Music is a non-invasive medium that enhances self-expression, self-esteem, motor skills, coordination, and socialization. It facilitates creativity, inventiveness, independence, and success. Music activities can be structured for positive responses, therefore it may be even more beneficial to students that have significant emotional needs. Specifically, active music therapy groups in which students participate in a hands-on manner encourage self-expression and may help channel frustrations in a positive and creative way. Musical spontaneity and instrument improvisation, skills actively encouraged in therapy, build self-confidence and offer opportunities for positive social interactions. Drumming activities enhance eye–hand coordination, gross motor skills, vestibular functions, and overall well

being. Furthermore, music therapy is a positive behavior support that can be utilized to promote individual strengths. Appropriate behavioral interventions such as proximity control, redirection, planned ignoring, pre-set consequences, giving choices, and positive reinforcement can be incorporated into the music therapy setting as readily as they can be implemented in classroom settings. With proper planning of activities and sessions, music therapy is a beneficial therapeutic medium for many students with EBD. Creating a music therapy program in accordance with individual and group needs is an effective, organized method of utilizing the music therapy process. The treatment focus is established with the help of the interdisciplinary treatment team, assessments are conducted, methods of measuring progress are used, and sessions are planned in advance. The organization of treatment in one specific goal area allows for teaching of the concept with other therapeutic modalities. Furthermore, the classroom teacher can easily access and implement character education units and lesson plans that correspond with the music therapy curriculum to reinforce concepts in the school classroom or home setting.

In conclusion, music therapy can provide many avenues of learning and development for students. Music can be structured in a non-threatening environment and facilitate each student achieving success. Music therapy is especially beneficial to children as they grow biosocially, cognitively, and psychosocially. Children with emotional and behavioral disorders have specialized needs and music can help facilitate meeting those needs in a fun and creative way. Music is a great reinforcer and motivator, and will always be an innate part of being human.

Appendix A. Music therapy curriculum outline 9-week process

Week 1

Referral, assessment, self-report, observation of class, target treatment focus, design music therapy curriculum.

Weeks 2–8

Begin curriculum, on-going evaluation (data on participation and treatment focus).

Week 9

Review of curriculum and treatment focus, generalization of treatment, on-going consultation, review treatment data, administer participation scores for report cards.

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