Family Music Therapy for Teenagers with Mental Illness:

A Systematic Review and Evidence-Based Program

by

Sophie N. Lott

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Graduate Supervisory Committee:

Melita Belgrave, Chair
Eugenia Hernandez Ruiz
Jennifer Pereira

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ABSTRACT

Adolescents experience a lot of stress from changes and difficulties in their physical appearance and their relationships—affecting their mental and emotional well-being as well as their family's relationships and functioning. Research has shown that family music therapy has been fairly successful in helping both children and adolescents and their families improve their communication and mutual attunement while encouraging self-expression in the child and teenager. However, the literature focuses mainly on families with children ages 10 and under, at-risk families, and non-clinical families. Little focus in the research literature is given to adolescents and their mental and emotional health concerns.

The purpose of this thesis was two-fold: 1) to perform a systematic review and collect information from articles that used music interventions or music programs to address the mental health needs of families and adolescents, and 2) to develop a family music therapy program for teenagers with mental health concerns based on the research literature used for the systematic review. Fourteen articles were included in the study. The main interventions and programs were improvisation (n = 6), songwriting (n = 3), lyric analysis or song discussions on client-selected music for introspective and expressive purposes (n = 3), therapeutic singing (n =1) and structured group music making (n = 1). Common outcomes included improvement in the adolescents' self-expression and communication, restoration of family relationships, increased awareness of covert family issues, and improved family communication and interactions. The proposed six-week

music therapy program is improvisation-based, considering the amount of improvisational interventions that were found in research. Session plans include interventions such as musical “icebreakers” and warm-ups, improvisation, lyric analysis, and a culminating songwriting experience.

Keywords: family therapy, music therapy, adolescents, mental illness

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INTRODUCTION

Adolescence is a period of transition, change, and uncertainty. Aside from the physiological changes, an adolescent begins to develop socially as “peer influence and acceptance [become] very important” to them (Stanford Children's Health, 2019). Adolescents' emotional health also shifts as they experience mood swings on a regular basis (Office of Adolescent Health, 2017). However, sometimes there may be a mental health disorder behind those emotions. According to the Office of Adolescent Health (2017), “one in five adolescents has had a serious mental health disorder,...at some point in their life.” A teenager's family is an essential part of their emotional well-being and overall feelings of connection (Jose & Pryor, 2010; Raising Children, 2018). However, an adolescent's issues can bring tension and stress into the family, and as a result, “[affect] multiple dimensions of family functioning,” which, in return, could also be a risk factor for the adolescent's disorder and/or problematic behaviors (Hoffman, Hinkle & Kress, 2010, p. 25). Family therapy has helped families and their adolescents to support each other during treatment of the adolescent's disorder all while improving healthy communication within the family (Blessit, Voulgari, & Eisler, 2015; Hoffman, Hinkle, & Kress, 2010; Keiley, 2002). Recently, a form of family therapy that has been shown to be beneficial is Family Music Therapy (FMT).

Some research suggest that music therapy is generally less intimidating and less invasive as compared to traditional talk therapy –allowing clients to express their thoughts and feelings without having to put it into words (Faulkner, 2017; Lord, 2015).

Therefore, clients are more open to discover insights, receive feedback, and resolve interpersonal conflicts, especially during musical improvisations (Faulkner, 2017; Jacobsen & McKinney, 2015; Lord, 2015; Nemesh, 2016; Nemesh, 2017; Oldfield, Bell, & Pool, 2012; Paisali, 2012b; Paisali, 2014; Sanchez, 2017). As a result, family members have an opportunity to restore their relationships (Faulkner, 2017; Paisali, 2012b; Paisali, 2014). Clients of FMT have self-reported increased positive emotions and fewer mood disturbances in their day-to-day lives (Faulkner, 2017; Jacobsen, McKinney, & Holck, 2014; Paisali 2014; Porter et al., 2017). FMT has been known for other benefits such as improvements in communication and mutual attunement between the parent and the child (Fairchild, Thompson, & McFerran, 2017; Jacobsen & McKinney, 2015; Nemesh, 2016; Nemesh, 2018; Oldfield, Bell, & Pool, 2012; Porter et al., 2017; Paisali, 2010; Paisali, 2012b; Paisali, 2014). As a natural by-product, parenting skills also improve including parental sensitivity, conflict resolution, and adaptive communication skills (Faulkner, 2017; Lord 2015, Paisali, 2010; Paisali, 2012a; Paisali, 2012b).

Most of the children included in FMT-related studies were 6 to 10 years old (Faulkner, 2017; Jacobsen & McKinney, 2015; Jacobsen, McKinney & Holck, 2014; Nemesh, 2018; Oldfield, Bell, & Pool, 2012; Paisali, 2012b; Paisali, 2013; Paisali, 2014; Porter et al., 2017; Sanchez, 2017), and the more common populations in the current research literature were at-risk families, families without a member with a specific diagnosis or disorder, emotionally neglected children, and children with trauma-related disorders (Fairchild, Thompson, & McFerran, 2017; Faulkner, 2017; Jacobsen &

McKinney, 2015; McKinney, & Holck, 2014; Lord, 2015; Nemesh, 2017; Nemesh, 2018; Paisali, 2010; Paisali, 2012a; Paisali, 2012b, Paisali, 2013; Paisali 2014; Sanchez, 2017). However, there is little research on FMT, teenagers, and mental health. Articles with teenagers and pre-adolescents are not as common in the literature (Fairchild, Thompson, & McFerran, 2017; Lord, 2015; Nemesh, 2017; Porter et al., 2017). There is also a small amount of literature on mental health and psychiatry in family music therapy (Oldfield, Bell, & Pool, 2012; Porter et al., 2017).

Purpose of Project

There were two purposes for this project. The first purpose was to complete a systematic review pertaining to Family Music Therapy, teenagers, and mental health. The aim of the systematic review was to provide music therapists a quick summary of how music therapy and music-based interventions worked with families and teenagers with mental illness. Four research questions were formulated to guide this research.

1. What populations are addressed in the literature about family music therapy, adolescents, and music interventions?
2. What kind of interventions are used in treatment?
3. What are common improvements and end results throughout the studies

The second purpose was to utilize the research findings from the systematic review to develop a Family Music Therapy (FMT) program for teenagers with mental health disorders.

METHOD

Design

Inclusion criteria. Articles included were limited to those published between 2008 and 2018 in order to use the most recent research for best practice. Peer reviewed articles, dissertations, case studies, qualitative, quantitative, and mixed methods studies were included as long as FMT interventions were conducted with participants. Articles written in English or that provided an English translation were included due to English being the author's first and most fluent language. Articles were included also if a full-text copy was available online without a membership requirement and/or an upfront fee.

Studies were required to have at least one teenage client ages 11-18 (with the mean age of multiple clients up to 18-20 years old) and one family member included or participating in the study in some way such as being in sessions, receiving parent consultation, witnessing or attending the culminating project for the adolescent's treatment/participation in study. Main symptoms or concerns addressed in accepted studies were to be related to mental health, psychosocial well-being, and/or maintaining or restoring relationships within the family. Lastly, studies also had to have a music-based intervention used in a therapeutic setting as a container of change.

Exclusion criteria. Articles were excluded if they were published before 2008 to avoid outdated research. Studies that did not include participants in the study or at least a case study or vignette were also excluded, particularly theological essays, editorial essays, systematic reviews, meta analyses, and others. This allowed for a clearer view of

how interventions worked with real versus hypothetical families and to allow a focus on one study at a time in full detail unlike in systematic reviews or meta analyses. Other reasons for exclusion were non-English articles and/or articles not available in full-text without membership requirements or costs.

Studies that did not include at least one teenage client and one family member in the study in some way were excluded. Examples of the latter exclusion criteria include family members only mentioned by the teenager in an interview or family members interviewed about their teens in certain programs without actually being involved in some way. Articles were also dismissed when mental health/psychosocial needs and/or family functioning were not addressed in the treatment or program. Lastly, any studies that did not use music in a therapeutic setting as an agent of change were excluded. Examples of that include participants listening to music outside of the study/treatment/program for personal use or participants merely mentioning how music has helped them outside of the study/program.

Search Strategy

The literature search was performed in October 2019. For the search, *Google Scholar* and five databases through a local university library website were used. Two of the databases were related to counseling and psychotherapy: *Medline Plus* and *Counseling and Psychotherapy Transcripts, Client Narratives and Reference Works*. Music-related articles were searched for in several databases including *JSTOR*, *Worldcat*, and *Academic Search Premier*. The main search Arizona State University Library website

using all resources was also utilized.

A combination of keywords were used including: “'Family therap*' AND adolescen* AND music*” and “ 'Family therap*' AND (music* OR music therap* OR “music therapy”) AND (adolescen* OR teen*).” References from studies excluded in the full-text screening phase were utilized and screened as well, especially articles mentioned in excluded systematic reviews.

Screening Process

Using the developed criteria, the author performed a title and abstract screening, excluding any article that was irrelevant to the topic and/or clearly did not meet one of the inclusion criteria. Articles were reviewed in full-text either when articles met the inclusion criteria so far or if more information was needed to decide on including or excluding it. Afterwards, the author analyzed each study and compared it with the inclusion criteria. Any article that did not meet all of the inclusion criteria were removed from the review.

Data Extraction

Next, the author created data-extraction sheets, one for each article, using the research questions as already mentioned. All included studies were read thoroughly to answer them. Once all of the articles were analyzed, the author coded the information—highlighting any common findings or themes. Afterwards, a table was created listing common answers for each research question.

RESULTS

The screening process began with 858 potential articles in which 778 were excluded at the title/abstract level. 80 full-text articles were reviewed, and 65 articles were excluded based on the inclusion/exclusion criteria. Originally, 15 articles were included but that number changed to 14 articles once a duplicate article was excluded. The most frequent reasons for excluding an article in the full-text screening were: articles did not include participants in the study (e.g., theological essays, systematic reviews) (n = 13), articles did not implement a music-based intervention (n = 10), and no family members were mentioned, included, and/or interacted with the adolescent(s) in the study (n = 9). Other reasons for exclusion included in order from most frequent to least frequent: majority of younger clients were either too old (n = 7) or too young (n = 6), teenagers were not mentioned or included and/or age was not specified (n = 7), article focused on one family member and/or the therapist rather than on the entire family (n = 5), article was written before 2008 (n = 4), full-text articles were not available without membership or monetary requirements (n = 3), and the available full-text was not written in English (n = 1).

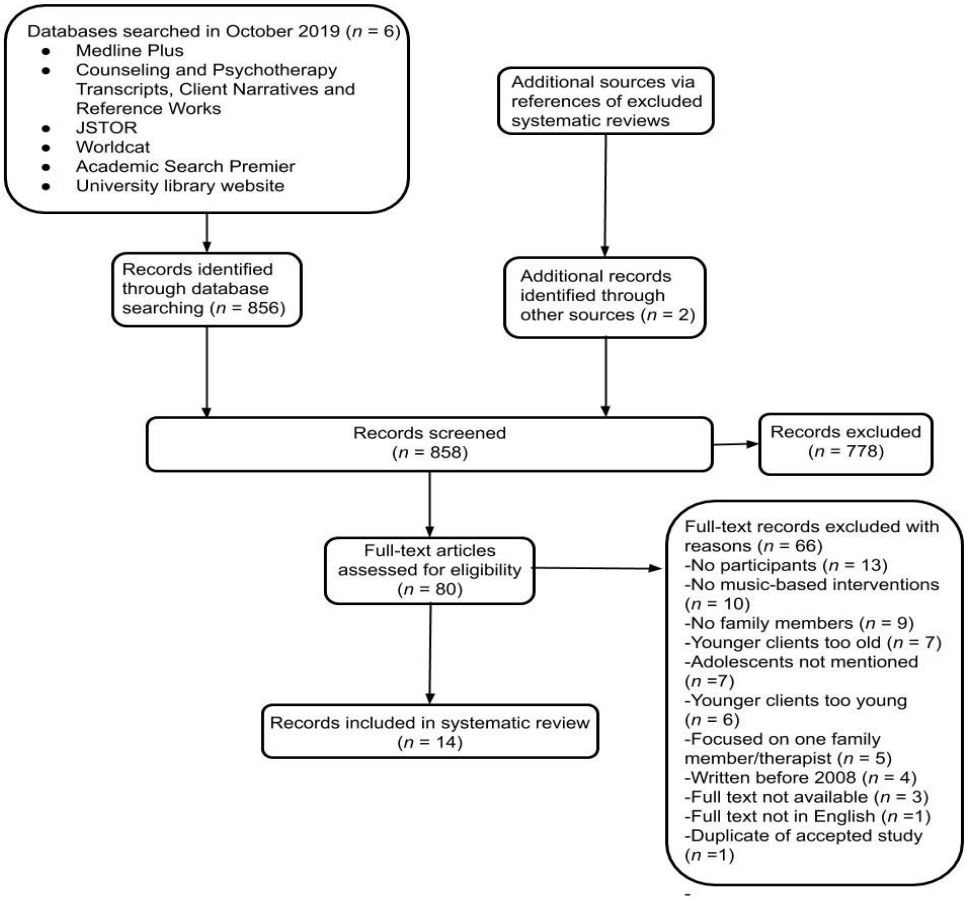

Figure 1: PRISMA Chart of Systematic Review and Results

Participants

A variety of populations were represented in the included studies. Most of the studies took place in mental health and psychiatric settings (*n* =5). In that setting alone, an array of mental health disorders were addressed including major depressive disorder (*n* = 3), emotional/mood or behavioral disorder (*n* = 3), anxiety (*n* = 2), trauma (*n* = 1),

and substance abuse (*n* = 1). It is noted that some articles addressed multiple diagnoses at once whether it was in one individual or a group of adolescent clients (Lenz, Del Conte, Lancaster, Bailey, & Vanderpool, 2014; McIntyre, 2009; Rayburn, Winek & Anderson 2016). Oncology was another major setting explored in the literature (*n* = 3) as well as at-risk teens (*n* = 2) in situations such as homelessness and incarceration. Articles featuring general population and typically functioning families and teenagers were also a part of the included literature (*n* = 2). Lastly, children and adolescents with disabilities—such as autism, physical disabilities, and intellectual disabilities—were in studies where music interventions addressed family functioning and the relationship between the teenager and the caregiver(s) or family member(s).

Family members were included in the study in different ways. While the majority of the studies conducted family therapy or included family members as part of the teenager's treatment (*n* = 10), some studies had family members be present for the presentation of the teenage client's culminating project for support (*n* = 3), and one study had families using music in a way to soothe their adolescent child in between sessions as "inspired by involvement with music therapists and other musical staff" *(n* = 1) (O'Callaghan, Baron & Barry, 2011, p. 782). For example, one parent sang to her child Bob Marley's "Don't worry, be happy" when the teen was first diagnosed with cancer (O'Callaghan, Baron & Barry, 2011, p. 782).

Many of the studies had families in groups of three or more (*n* = 12) whereas few included only parent-child dyads (*n* = 2) (Porter et al, 2017; Sorel, 2010). Sam Porter and

his colleagues (2017) included 251 parent-child dyads in their randomized controlled trial with children and adolescents with emotional and behavioral disorders using music therapy. Meanwhile, Suzanne Sorel's 2010 study is an in-depth qualitative case study focusing on the relationship between a mother and her pre-teenage son with autism using the Nordoff-Robbins method of music therapy.

Treatments and Programs

A little over half of the studies were led by music therapists as the primary investigators (n = 8). The remaining six came from other disciplines such as psychology (n = 2), Human and Health services (n = 2), Family and Child Services (n = 1), and music education (n = 1). Some studies had primary investigators that were certified in two fields such as Beth Nemesh who is both a music therapist and a family therapist (Nemesh 2017 & Nemesh 2018). A vast array of interventions were used in treatment. Improvisation was the most common intervention used with families and teenagers (n = 6), followed by songwriting (n = 3), and client-selected music for building coping skills, self-expression, processing grief and/or trauma, and other therapeutic purposes within treatment (n = 3). Other music interventions included therapeutic singing, structured music making, lyric analysis, and music skill building.

Client-selected music for talk therapy was especially used by professionals outside of the music therapy field (Fraenkel, Hameline, & Shannon, 2009; Hanchon, Phelps, Fernald, & Splett, 2017; Rayburn, Winek, & Anderson, 2016). In a study by Hanchon, Phelps, Fernald, and Splett (2017), the therapist had the sixteen-year old female

client begin filling a box full of items that would help her cope with daily stresses (p.22). This project began during her hospitalization and throughout her therapy sessions (p. 21-22). Another therapist worked with a teenage female client and had the client bring in music that represented various parts of her identity and also the various stages of her traumatic experience before, during, and after the event (Rayburn, Winek, & Anderson, 2016). In group sessions at a homeless center implementing narrative therapy, the therapist invited the clients to bring in music that has helped them feel better and share their music with the group (Fraenkel, Hameline, & Shannon, 2009, p. 337).

In those three studies, with therapists specializing in psychology and therapy, the client brought in their personal music to the session as directed by the therapist in which that music was used to process past events and express oneself. This contrasts to the music therapy field where the music therapists bring in the intervention for the clients, instead of the other way around. While including client-preferred music to best fit their "age, culture, and stylistic differences" is best practice (American Music Therapy Association, 2013, Professional Competencies, 13.12), the music therapist also carefully plans music interventions to help their clients reach their personalized goals based on their education and experience.

Some programs centered around a culminating project such as creating a music video, writing and producing musicals based on the clients' lives, and developing a physical box full of various coping methods (Burns, Robb, & Haase, 2009; Cohen & Palidofsky, 2013; Hanchon, Phelps, Fernald, & Splett, 2017; Robb et al., 2014). Two of

the studies centered around a music therapist leading teenage and young adult clients undergoing Hematopoietic Stem Cell Transplant for cancer treatment through the process of creating and filming a music video using original songs written by clients and the therapist (Burns, Robb, & Haase, 2009; Robb et al, 2014). The 2009 study included a smaller sample size from two hospitals while the 2014 study randomized clients from eight different hospitals and included more research questions and results such as social integration and family environment.

A collaboration between the Chicago Symphony Orchestra, the Storycatchers, and incarcerated teenage females guides the participants in writing, creating, producing, and performing a musical work based on their own life stories (Cohen & Palidofsky, 2013). Family members attended the final product and the post-show talk about the girls' experiences (p.177). A collection of coping skills was developed throughout sessions between a therapist and a teenage female client as previously mentioned (Hanchon, Phelps, Fernald, & Splett, 2017).

End Results of Treatment

Adolescents. Throughout the literature on adolescents in treatments and programs using music-based interventions and family member participation, the most common improvements were increased display of self-expression and improved communication skills. These two skills were developed especially in teenagers having difficult conversations with their family members, expressing their feelings, and/or resolving conflict within the family (Nemesh 2018). In Nemesh's 2018 study, during a family

improvisation centering around family roles, there were two moments when the younger clients communicated with their parents on specific issues. The first time it is mentioned, one daughter—while conducting the instrument play as suggested by the father—suggests "the parents should first play together with more coordination and harmony between them" meaning that the parents should attune their relationship first (Nemesh, 2018, p. 92) before focusing on their children and their problems. In the second moment, the older daughter directly shared with her mother that the parents do not "hear [her] enough" and that she feels non-existent in the family after her mother tells her she "always do what [she wants]" (p.92). Other outcomes for teenage clients included improvements in social skills, introspection, self-reports of confidence, relaxation skills, and symptom management. A brief summary of the adolescents' outcomes are summarized in Appendix A.

Family outcomes. A wide gamut of results for the family appeared throughout the studies. Refer to Appendix A for an overall summary of these findings. The most common outcome for families was the overall restoration and/or improvement of the relationship(s) within the family as observed and/or measured by the therapist or the primary investigator using appropriate the appropriate scales. This was followed by recognition of underlying issues or problematic behaviors, and improved communication and interactions between family members. In studies that recognized problem identification as an end result of the treatment or program, this was mainly achieved through improvisation-based interventions.

In a 2010 study, Suzanne Sorel presents some moments where the mother and her 11-year old son with autism have a difficult conversation about having him "share his mom" with his other siblings and his dad in an improvised blues-style song (p. 189-190). Later in the article, during the eighteenth session, the mother sings another improvised song teaching her son to let her have her "grown-up talk" and have her voice heard too. Difficult conversations between family members were more effective and successful when using music as a communication tool to support the words.

Empathy and support for one another, another effect found in the studies, were seen in a variety of situations such as grieving the death of a loved one, processing and coping with a traumatic event, and supporting the teenage client through cancer treatment (Hanchon, Phelps, Fernald, & Splett, 2017; O'Callaghan, Baron, & Barry, 2011; Rayburn, Winek, & Anderson, 2016). In a 2017 study, conducted by Hanchon, Phelps, Fernald, and Splett, they found that the teenage female client began to reconnect with her family as they processed their grief for the loss of her paternal grandparents that occurred around the onset of her depressive and anxiety symptoms and self-cutting (p. 21-22, 26). In another study, conducted by Rayburn, Winek, and Anderson (2016), the therapist addressed a traumatic event the teenager had experienced before treatment began and helped support her rebuild rapport between her and her parents over the experience while developing healthy coping mechanisms together (Rayburn, Winek, & Anderson, 2016).

Other results were increased understanding, improved functioning and quality of life, conflict resolution, and self-expression. However, two randomized controlled trials yielded no significant outcomes or improvements within the parent-teen dyads despite numerous benefits for the teenage clients (Porter et al, 2017). The study, taking place in Northern Ireland, randomly selected 251 parent-child dyads into two groups: an experimental music therapy group that also used usual care and a control group that proceeded with usual care (psychiatric counseling and/or medication) at their mental health care facility (Porter et al, 2017, p. 587). While many significant improvements were noted in the teenage clients in domains such as communication, self-esteem, and mood (with the decrease in depression scores), there were no significant outcomes for the guardian or for family functioning (Porter et al., 2017, p. 590-591).

However, while they did measure for family functioning in their study, it is not clear whether the music therapy interventions used were intended to treat both the young client and parent and address family functioning in the dyad or if they were used mainly for the benefit of the younger clients. It mainly states that improvisation was used to have the participant choose an instrument and express their emotions that day or the week before the session (p. 587). Therefore, the results on family functioning may not necessarily mean that the use of music intervention was entirely unsuccessful for the family considering the lack of details on how music was used for the parent-child dyad.

Limitations

While the results may suggest music therapy to be a viable option for families and adolescents, there are some limitations in this systematic review. First, the vast majority of articles included in the systematic review were qualitative studies such as phenomenological and case studies (n = 9) followed by randomized controlled trials (n = 3), and articles using mixed methodology (n = 2). While qualitative articles provide in-depth details of a program or treatment, the sample sizes are too small to generalize the results to the overall population. Considering one randomized controlled study indicated no significant improvements in family functioning, more quantitative studies on this topic are recommended to further analyze findings with a large sample size. For the other limitation, the author did not have additional reviewers for the systematic review due to time constraints. Therefore, the author recognizes some bias in that regard.

Discussion

Music interventions used with adolescent clients and their families included teenagers with various needs such as mental health symptoms, physical ailments, and developmental disabilities. Main interventions used were improvisation, songwriting, and using client-selected music to express oneself and to process difficult emotions such as grief and trauma. At the end of most programs, the adolescent clients experienced improvements in communication, self-expression, social skills, introspection, self-reported confidence, relaxation skills, and symptom management. For families, progress was made mainly on reconnecting with each other, identifying problem behaviors within

the family, communicating clearly with each other, and supporting each other through stressful life events. With this information and evidence collected from the included studies, a proposed Family Music Therapy program for adolescents with mental health needs can be created for music therapists to implement in their practice.

PROPOSED FAMILY MUSIC THERAPY PROGRAM FOR ADOLESCENTS

Purpose Statement

The purpose of the systematic review as described above was to provide a background and initial data for an evidence-based six-week Family Music Therapy program for teenagers with mental health needs. This program will mainly be improvisation-based, considering that improvisation was more commonly used in music interventions and programs with families and teenagers. Improvisation-based music therapy has been used with a wide variety of populations from people with Traumatic Brain Injury (TBI) to young teenagers with eating disorders (Taylor, 2010, pp. 134, 184-190). A study by Gilboa, Bodner, and Amir (2006), described musical improvisation as "an effective way to convey emotions," by allowing clients to "express deep feelings and hidden emotions" and "transform [their] communication patterns..." (pp. 199, 202-203). Other outcomes reported in the use of musical improvisation included clients "accessing self awareness," addressing "emotional difficulties...to achieve personal growth," and achieving a state of catharsis and self-expression (Taylor, 2010, pp. 134, 37, 190).

Improvisation, as mentioned by Gardstrom (2007), also creates an opportunity "for a client to make connections with others through music (p. 122). In a study conducted by Pavlicevic (1999), as described in the conclusion of the article, clients who participated in an improvisation music therapy group commented about group members "getting to know one another...listening to one another in a new way, deriving support from another, taking leads from, and depending on one another" (Conclusion section, para. 2). These intrapersonal and interpersonal benefits of improvisation demonstrate its potential for individual family members to both express themselves and to connect with each other as an unified group. Other music interventions will be implemented such as instrument play, lyric analysis, and a songwriting intervention that serves as the culmination of treatment during the sixth and final session.

Therapeutic Goals

The following therapeutic goals will be divided among two different categories. One will be for the teenager(s) and his/her/their own well-being. The other category will focus on goals for the family in general. In the case that one of the parents may have difficulties in one domain of functioning or more, therapeutic goals will be assigned for him/her as well.

For the teenager. As discovered during the systematic review, the typical therapeutic goals for adolescents are to increase use of self-expression, increase use of self-reflection, improve healthy and effective communication with the family, and manage mental health symptoms and mood. Improvisation interventions have helped

teenagers express themselves and communicate effectively with others (McIntyre, 2009; Nemesh, 2017 & 2018; Porter et al, 2017; Sorel, 2010). Other interventions such as songwriting, structured instrument play, and analyzing client-preferred music will supplement these goals as well (Burns, Robb, & Haase, 2009; Cohn & Palidofsky, 2013; Fraenkel, Hameline, & Shannon, 2009; McIntyre, 2009; Rayburn, Winek, & Anderson, 2016; Robb et al, 2014).

For the family. Based on the findings of the systematic review, the typical therapeutic goals for the family are to explore possible causes of discord between family members, increase use of healthy and effective communication with each other, and improve overall family functioning and well-being. Improvisational methods were especially shown in the literature to help families uncover underlying issues behind their surface-level disagreements and arguments and also to help navigate difficult conversations (Lenz, Del Conte, Lancaster, Bailey, & Vanderpool, 2014; Nemesh 2017 & 2018; Sorel, 2010). The use of improvisation for the majority of the program will assist in this process. Lastly, studies showed that many programs and treatments ended with families reconnecting with each other and improving their overall functioning (Fraenkel, Hameline, & Shannon, 2009; Hanchon, Phelps, Fernald, & Splett, 2017; Lenz, Del Conte, Lancaster, Bailey, & Vanderpool, 2014; McIntyre, 2009; O'Callaghan, Baron, & Barry, 2011; Rayburn, Winek, & Anderson, 2016).

Domains and Problem Areas Addressed

Communication. Communication has a large influence on family functioning, considering it is one of the seven dimensions assessed in the Family Assessment Device (FAD) based on the McMaster Model of Family Functioning (MMFF) along with affective involvement, affective responsiveness, behavioral control, problem solving, roles, and overall family functioning (Epstein, Baldwin, & Bishop, 1983). Jackson, Bijstra, Oostra, and Bosma (1998) describe "effective communication" as "a central feature of good family functioning. Teenager-parent interactions and communication patterns become essential in conflicts that arise from the adolescent's search for independence and the "different ways of looking at the same issue" clashing between the teenager and the parent(s) (Jackson, Bijstra, Oostra & Bosma, 1998, p. 305; Pickhardt, 2009, para. 11).

Therefore, the communication model used in the family "can make an enormous difference" in conflict resolution (Pickhardt, 2009, para. 16). Pickhardt (2009) suggests that a "collaborative parent" who uses "a 'discussing to understand' approach" may achieve a more satisfying resolution rather than an authoritarian parent who pursues victory and control over the issue through an "arguing to win" philosophy (para. 16-17). By addressing problems in communication and promoting self-expression through either verbal or non-verbal methods, this may aid family members to both express their views, thoughts, and emotions while—at the same time—understand and respect the perspectives of their loved ones.

Cognition. During improvisation interventions, many issues will come up for family members and the teenager. Many difficulties in cognition for the family may arise such as unawareness of problems within the family and/or self and difficulty with problem solving. The processing questions given by the therapist will help the teenager(s) and the family members to become self-cognizant of problematic behaviors and dynamics within the family and to come up with solutions for these problems together as a family. This will be especially helpful for the adolescents, as their frontal cortex—which helps with problem solving and decision making—is still developing at this point (American Academy of Children and Adolescent Psychiatry, 2016).

Social. The last domain addressed in the program will be social skills such as listening to the other person and their thoughts and emotions, and empathizing with the other person. Many of the problems that may arise in families often come from family members not fully listening to what the other is saying and empathizing with them and how they might be feeling, which is "an important part of communication" as stated by Peterson and Green (2009, Family Communication section, para. 1). Once issues are made aware and are explored by the family, processing questions led by the therapist can help assist family members listen to each other, try to understand how the other person may be feeling, and to provide emotional support for one another.

Participants

The first step in setting up the program will be to recruit families in groups of three-to-five family members which can be a combination of adult clients (parents, legal guardians, adoptive parents, other relatives, etc.) and teenage clients (children, grandchildren, niece/nephew, adopted child or foster child, etc.). Children clients younger or older than the adolescent age range may participate in the program with their family and teenage relative, as long as they are able to engage in music interventions without detracting away from the treatment of the family and the teenage client. Considering the mental illnesses mentioned in the literature, the program is best suited for adolescent clients with mainly emotional/mood disorders, behavioral disorders, anxiety disorder, trauma-related disorders, and substance abuse. Program adjustments for teenagers with other diagnoses are described in a later section.

Preparation

A variety of instruments will be needed for the sessions such as non-pitched percussion instruments (e.g., drums, maracas, tambourines, rainstick, triangle, djembe) and pitched percussion instruments (xylophones, piano/keyboard if available at the facility, metallophones, kalimba etc). This is to ensure that there is a variety of instruments for family members to choose from to express themselves that will be easy to learn how to play. If a family member plays an instrument outside of the program, they can bring that in as well (e.g., oboe, clarinet, guitar, violin, cello). A precaution to consider is to remove any heavy, blunt, or other potentially dangerous instruments out of

the material list if the teenage client demonstrates externalizing behaviors including throwing items or self-harm.

Program Adjustments for Exceptional Families

There may be certain times where six weeks of improvisation-based music therapy may not be enough time and/or may be too fast-paced to provide quality services for extremely dysfunctional families, teenagers with a mental illness not addressed in the typical program, and families and teenagers in other exceptional cases. The adjustments suggested are to extend the assessment period from two weeks to four weeks to allow time for the family, teenager, and the therapist to develop a trusting relationship and to create a safe container for in-depth therapy to be cultivated. Once the family and the teenager(s) decide that they feel safe to explore their issues, the treatment portion of the program may begin. If terminating the treatment after six-to-eight weeks may be harmful for the family and/or teenager in anyway, the therapist can choose to extend the treatment portion for another two-to-four weeks—making the program last up to 10 or 12 weeks. Individual music therapy sessions with the teenager may also be advised to address a serious mental illness or a concerning behavior, to forge a stronger rapport between the adolescent and the therapist, and/or for other appropriate purposes.

If the therapist becomes certain that a domestic violence situation is developing within the family, it is recommended to refer the family to a music therapist specializing in domestic violence and/or a domestic violence shelter unless the therapist has specific training in this area him-or-herself. The therapist may also involve authorities if he/she

believes at least one family member is in danger of serious harm from another person in the family. In another situation, the therapist is obligated to refer the teenager client to an in-patient mental health hospital or involve other appropriate services if he/he believes the teenager is likely to cause harm to him/herself and/or others.

Data Collection

At the beginning of the program, teenage clients will be led through some scales as appropriate depending on the referral given and their diagnosis or symptoms. A couple of possible scales that can be used to assess the teenage client are the Teen Anger Triggers Scale (Leutenberg & Liptak, 2011), the 6-item Kutcher Adolescent Depression Scale: KADS (Kutcher, 2008), Teen Functional Assessment (TeFA) (Kutcher, 2008), and the Youth Anxiety Measure for DSM-5 (YAM-5) (Murris, Simon, Lijphart, Bos, Hale, Schmeitz, & International Child and Adolescent Anxiety Assessment Expert Group, 2017). These assessments can be implemented over the first two sessions to save time for other assessment procedures. Music preferences of the adolescent and family members may also be assessed in an informal interview. Throughout the program one of the scales that is the most relevant to the adolescent's treatment plan will be used at the beginning of each session to track progress. For the family, a family functioning scale, such as the McMaster Family Functioning Scale, will be administered for each family member at the first session and at the last session (Epstein, Baldwin, & Bishop, 1983).

Interventions

Session plans and the interventions have been created to help ease the family into improvisation process first, then to help families explore and process problematic dynamics, attitudes, or behaviors within the family, to solve these problems, and regain connection with each other. Each session will be 50 - 60 minute long depending on the needs of the family and the adolescent client. The first three sessions will include an "ice breaker," an activity that will warm up and ease the family into music making and other interventions before going into the improvisation element. Assessments and check-ins will be completed at the beginning of the session, and a post-session mood scale will be implemented during the last 5-10 minutes of the session.

Session 1: Introduction

Assessment and warm up. The therapist will have the teenage client(s) fill out an assessment based on problematic areas addressed in the referral, and each member of the family will fill out a family functioning scale within the first ten minutes of the session. For the first warm up, the family will each have an instrument and sit in a circle with the therapist. Each person will play their instrument in order of the circle as indicated by the therapist. To have the person on their left play next, the client will say "zip." If they want to have the person on their right to play next, they will say "zap." This will engage the family in a communication-based intervention that may provide opportunities for humor, especially when two people in the group are in an ever-going exchange of "zips" and "zaps" between each other. In those situations, the therapist may direct one of the clients

to go the other direction to avoid frustration arising in the group.

Instrument introduction and structured music-making. The therapist will introduce the family to the available music instruments for the remainder of the program. Each person will have the opportunity to play and experiment with each instrument. The therapist may help guide clients with specific instruments as needed and as appropriate. After everyone has experimented with the instruments, the therapist will have each family member pick an instrument that they want to play. Then, the therapist will have a family member pick an appropriate song that most of the family and the therapist knows. The therapist will sing the song while playing the guitar and the family will play their instruments with each other.

Introduction to improvisation. The therapist will introduce the concept of improvising on an instrument as playing spontaneously without a specific plan. First, the family will improvise together without a specific theme while the therapist plays an accompaniment on the guitar and adapts it based on what is heard in the family's improvisation. Next, the therapist will lead a referential improvisation that asks each family member to pick an instrument and then improvise on the prompt “how are you feeling?” or “how was your day?” The therapist or assistant music therapist will record the improvisation. After 2-3 minutes of improvising, the therapist will lead the family through some processing questions about the improvisation by fist playing the recording and then asking each family member what they noticed while they were playing both about themselves and about the family members.

Closing. The therapist will end the session by having each family member come up with a goal for the family during the time before the next session to improve their functioning. Then, each person will fill out a Likert-type mood scale. The therapist will ask each family member to bring in lyrics to a song that they feel represents themselves.

Session 2: Lyric Analysis

Check-in and warm up. The therapist will lead a verbal check-in with the family about how their week has been and whether they were able to meet their self-assigned goal(s) or not and why. The adolescent client(s) will fill out a different assessment form depending on either the referral or what the therapist has noticed during the previous session. For the warm-up, the therapist will have each member select a non-pitched percussion instrument. Then, each person will drum out their names, one tap per syllable and the rest of the family repeats back the person's name and the associated rhythm. Other topics can be explored for this intervention such as drumming out one's favorite food or favorite singer/artist.

Lyric analysis. Next, the therapist will lead a lyric analysis on each song that each family member has brought in. First, the song will be played either through a multi-media player or live by the therapist on piano or guitar while singing. Afterwards, the therapist will lead the group in analyzing the song lyrics starting with having the person explain why they chose this song. Processing questions for the other family members may include “How does this song make you feel?”, “Did you know this about this person (the family member)?”, “What did you learn about (family member) from this song?”,

and other open-ended questions that may guide the family into knowing more about each other through their song lyrics. When disqualifying or judgmental attitudes from one or more family member(s) arise during the discussion, the therapist may take time to lead that family member through processing their thoughts and the reasoning behind them and eventually resolving those dismissive attitudes. The session will close with the typical mood scales to track progress and with the family picking a goal for the remainder of the week.

Session 3: Improvisation on Identity

Warm-up. After performing a verbal check-in with the family (functioning, mood, whether they met their previous goal, etc), each family member will select a djembe and sit in a circle. This intervention can also be done on a flat surface if there are no djembes available. Then, the family member will intertwine arms with each other (left arm over the other person's right arm and right arm under the other person's left arm. Starting with the first person, the family will spell and tap the first person's name by each successive hand, which adds a challenge since the clients' arms are intertwined. After the first person's name is spelled out, the last person that taps the last letter of the previous name will start with the first letter of their first name and continue from there. Eventually, this challenge may bring a sense of humor to the group as they laugh over the difficulty of keeping track of whose hands belongs to which person and if it is their turn or not.

Identity expression. Each person in the family will select an instrument that they feel represent themselves and will also play how they are feeling today. Afterwards, the family will be led through questions that guide them on what they heard from the other person and how that applies to how they perceive that person. The therapist may lead further discussions to explore a family member's perception of their relative and resolve any negative perceptions that may emerge during this intervention. This process is done for each family member. Then, the therapist will lead the group in an improvisation with their selected instrument based on the prompt "play out what a typical family dinner is like" or "play out an activity you frequently do together." Questions will be given to guide family members in exploring what they heard and why they played their instruments in a particular way. Discussions may also center around family dynamics, communication patterns, and other components of family functioning. The session will end with a post-session mood scale and the family setting a goal for the remainder of the week.

Sessions 4-5: Family Map

This intervention will span over one or two sessions depending on the size of the family. This was borrowed and adapted from an intervention in a research article for this population (Fansler, 2018) The session will begin with an improvisation on how their day went after a verbal check in with the family. Next, each family member will select one instrument that represents a specific member in the family (including themselves) and briefly improvise with that instrument symbolizing the person's overall personality, demeanor, and other characteristic traits. Afterward he/she will place them in an area as in-

dicated by the therapist. As more instruments are added to the area, the client is directed to place the instruments in a way that best resembles the individual relationships in the family and the overall dynamic.

Processing questions may include: “Why did you choose (instrument) for (family member)?”, “Why did you assemble the instruments in this way?”, “Why did you put your instrument at this location?”, and “What can your family do to help you feel more included and/or more of a part in the family?”. This process is repeated for each member of the family. With the clients' consent, the therapist may take a picture of each family map that is created by a family member. The session ends with a post-session mood scale and a set goal for the rest of the week.

Session 6: Songwriting

A verbal check-in and an improvisation based on the theme “How are you feeling?” will start the session. Then, as a culminating project, the family will brainstorm together lyrics for a song that represent each family member and the goals they'd like to continue after the program. The therapist will write the lyrics on either a whiteboard and/or a big sheet of paper taped to the wall. For each verse, the family comes up with lyrics that describe each member of the family with the help of the therapist. The individual that the verse is written about may not tell the family member what to write about them. The purpose of this is to have the other family members describe what they see in the other person and what they like about the other person. This may facilitate conversations where family members reconcile their differences, focus on the positive

traits of an individual relative, and encourage that individual through spoken and/or written affirmations.

For the chorus, the family will write lyrics about what kind of a family they are and/or what they would like to work on or what they would like to be in the next year. After the song is written, the therapist and the family work together to come up with a melody and simple chord progression that fits the lyrics of the song. The family will pick an instrument and the therapist will first sing the song with the guitar or piano while the family plays their instrument in a spontaneous manner. Next, the therapist will encourage the family members to sing along with the melody.

Closing. The therapist will have each family member fill out the family functioning scale once more, and the therapist will fill out one assessment that best matches their treatment plan throughout the program. Next, the family will be led one last dialogue on what they learned during the last six weeks and what they plan to do to continue the growth and further foster the family's functioning level.

DISCUSSION

The two aims of this project were to 1) Complete a systematic review on articles featuring families, teenagers, music, and mental illness to provide music therapists a brief summary of the literature that is available for this topic to apply in their own practice and 2) use the collective data from the systematic review to create a six-week Family Music Therapy program for teenagers with mental illnesses. Fourteen articles were included for

data extraction. They featured clients in mental health settings both inpatient and outpatient, community programs (e.g., groups for at-risk and/or homeless teenagers), and clinics for children and teenagers with disabilities. Most families were often in groups of three or more (n = 12), and family members were included in the study in various ways from being an additional client to witnessing the presentation of the teenager's culminating project with the program. Improvisations were the most commonly used music-based interventions in treatment ($n = 6$) followed by songwriting, lyric analysis, therapeutic singing, and structured group music making.

Results for the adolescent clients included improvements in self-expression, communication skills, social skills, introspection, confidence, relaxation and/or coping skills, and managing their individual mental health symptoms depending on their individual diagnosis (e.g., For someone with depression: fatigue, helpless or negative thinking, suicidal thoughts). Then, for families there were improvements in restoring relationships, awareness of issues within the family, communication and interaction patterns, empathy and/or emotional support, family functioning, quality of life, conflict resolution, and self-expression. One study found no significant improvements in family functioning (Porter et al., 2017).

The proposed improvisation-based program for this population will generally last up to six weeks long but can be extended to fit the needs of exceptional families and/or adolescents depending on the situation. Individual sessions for the adolescent may also be offered to allow more time for the teenager and therapist to build a healthy therapist-

client rapport. Therapeutic goals will mainly address skills and needs within the communication, cognition, and social domains of both the adolescent and the family. The program will begin with an assessment period that eases the family into improvisational music-making and end with a culminating songwriting intervention at the end of treatment. Other interventions used will include “ice-breakers” or warm-ups, instrument play and lyric analysis.

RECOMMENDATIONS AND IMPLICATIONS

In the future, this program could be implemented with a family with an adolescent client with a mental illness. This study was performed because of the author's interest to eventually work with adolescents both one-on-one and with their families as inspired by a clinical project that involved working with a teenage female client in individual sessions through problems about her family and other relationship issues through improvisation. This systematic review and program proposal are meant for current music therapists who work with this population to use and incorporate into their practice. Further research is required to assess how successful this program is with families and their adolescents in a therapeutic setting and to suggest any changes or additional research.

Music therapists should collaborate with family therapists, counselors, and/or psychologists when developing other programs for this population. This is especially the case since mental health concerns are addressed and music is used to uncover the subconscious thoughts of the individual and the family. With this collaboration, music

therapists can also advocate for their field and educate their clinical colleagues as they work together. Being trained in Analytical Music Therapy is another recommendation to consider as this will aid in the music therapist to be more effective with the use of improvisation and verbal processing to uncover and process unconscious material and issues with this population.

Teenagers go through many changes in their physical, emotional, mental, and social domains that may or may not cause some difficulties in their overall well-being. Considering the research that suggests that most families and their adolescents benefit from a form of Family Music Therapy, it is important to see this type of program implemented so that adolescents may connect closer with their families during a time of many difficult changes in their lives and as they navigate the complicated world of young adulthood.

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APPENDIX A

TREATMENT RESULTS FOR ADOLESCENTS AND THEIR FAMILIES

Study Citations	Population/Diagnosis	Teenager Results	Family Results
Burns, Robb, & Haase (2009)	Oncology	Increased self-report of hope, spirituality, and self-transcendence post intervention. "Favorable effect sizes" four months post-treatment in overall health, management of symptom distress, defensive coping, spirituality, and self-transcendence (E14).	No significant outcome reported
Cohen & Palidofsky (2013)	Incarcerated/at-risk teenagers	Increased use of self-expression, self-reflection, and confidence; improved social skills and skill-building; processing grief and trauma	Restoring relationships and re-connecting with family members
Fraenkel, Hameline, & Shannon (2009)	Homeless	Increased use of self-expression	Reconnecting with family members; strengthening sense of family; goal setting; increased use of self-expression
Hanchon, Phelps, Fernald, & Splett (2017)	Major Depressive Disorder	Improvements in mood; resuming past hobbies	Improvements in relationships and emotional support while grieving recently deceased loved ones
Lenz, Del Conte, Lancaster, Bailey, &	Psychiatry	Reduction of symptoms and	Recognizing behaviors of other

Vanderpool (2014)		somatic complaints; changes in hostility; increased self-expression and self-reflection	family members and how it effects them and how to best respond to them
McIntyre (2009)	Behavioral/mood disorder	Improved confidence, social interactions and family engagement; reduction in mood disturbances	Re-establishing connections and relationships
Nemesh (2017)	General Population	Increased use of self-expression and communication	Recognizing underlying issues both individually and collectively; decision making
Nemesh (2018)	General Population	Increased use of self-expression, leadership skills, and communication	Identifying dysfunctional behaviors and dynamics; restoring relationships; promoting healthy communication; conflict resolution
O'Callaghan, Baron, & Barry (2011)	Oncology	Increased use of healthy coping and relaxation skills, self-expression and creativity	Parents supporting and encouraging their teens during treatment
Porter et al. (2017)	Emotional/Behavioral disorders	Improvements in communication (especially for clients ages 13 and over) and self-esteem; decrease in depressive symptoms	No significant difference family/social functioning
Sorel (2010)	High functioning	Improvements in	Increased self-

	autism	communication and conflict resolution, recognizing needs of others, establishing individuality, and increasing use of listening and taking turns	expression, recognition of issues, self-reflection; improved relationships
Strensaeth (2013)	Developmental Delays and Physical Disabilities	Stimulation, improvements in social skills and interactions; “sense of agency” (p.10)	Improved interactions between adolescent and caregiver(s)