

ANGLIA RUSKIN UNIVERSITY

**MUSIC THERAPY FOR YOUTH AT RISK:
AN EXPLORATION OF CLINICAL PRACTICE
THROUGH RESEARCH**

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requirements of Anglia Ruskin University
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Music Therapy for Youth at Risk: An Exploration of Clinical Practice Through Research

Philippa Derrington

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ABSTRACT

This outcome study investigates whether music therapy can improve the emotional well-being of adolescents who are at risk of exclusion or underachievement. Specifically, it addresses music therapy's impact on students' self-esteem, anxiety, attitude towards learning, behaviour and relationships with peers.

The setting for the research was a mainstream secondary school and its federated special school for students with emotional and behavioural difficulties. Over nineteen months, a mixed methods design was used to observe change in students before and after music therapy. One group received twenty, weekly, individual sessions, and the other formed a wait-list group for comparison and then received the same treatment. At four different times during the project quantitative data were collected from students, teaching staff and school records, and qualitative data from semi-structured interviews with the students before and after their period of intervention.

The study found that music therapy made a positive difference. The high level of treatment adherence (95%) of all twenty-two students confirmed music therapy's appeal to this client group. The majority of teachers (58%) reported improvement in students' social development and attitude overall, and for some mainstream students (56%) recognition of self-concept increased. The conviction with which students conveyed their positive experiences of music therapy was striking.

The study supports the author's argument for therapeutic support to be made available at secondary schools and promotes a student-centred approach, as exemplified in the thesis. It concludes that music therapy can be effective for youth at risk but requires more participants in subsequent investigations for it to be proved statistically.

KEY WORDS:

Adolescents, music therapy, education, emotional and behavioural difficulties

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CHAPTER 1

INTRODUCTION

1.1 Introduction to the thesis

Adolescents¹ at risk of underachievement or exclusion often have emotional difficulties which, left ignored for whatever reason, can lead to disruptive and challenging behaviours, affecting all areas of school life including their ability to form relationships and access education. This pattern and my experience² of music therapy with young people with special needs and/ or complex emotional difficulties, in a mainstream and special secondary school, have led me to undertake this research. The study sets out to examine the effectiveness and value of music therapy as an intervention for these teenagers who have emotional and behavioural difficulties and can be at risk of exclusion from school. My hypothesis is that music therapy can effectively address students' emotional needs and therefore help them to be more motivated at school and engaged in learning.

Statistics show that young people are experiencing an 'increased amount of stress upon their social and emotional development which, in turn, is impacting on their behaviour and their mental well-being' (Carr and Wigram, 2009, p.3). The government recognised the need to improve the emotional and social well-being of children with the policies Every Child Matters (2003), the Children's Act (2004) and the Education Act (2005). In addition, the National Institute of Clinical Excellence highlighted the need for more research into the suitability and effectiveness of specialist interventions, recommending that schools need to take action by 'providing specific help for those children most at risk of social, emotional and behavioural problems' (NICE, 2008, p.6). There is therefore an urgent need for research into music therapy, as one such intervention, with this client group.

'Evidence-based Practice is increasingly applied in order to determine what

¹ Throughout this thesis, the words adolescent, teenager, pupil and student are interchanged however they always refer to the young people that the music therapist works with who are aged between 11 and 17.

² The thesis is written in the third person apart from when the researcher/therapist is talking specifically about her own work.

interventions should be funded, and can be understood as an approach to healthcare that promotes the collection, interpretation and integration of valid, important and applicable patient-reported, clinician-observed and research-derived evidence' (Wigram, Pedersen and Bonde, 2002, p.257).

The need to educate students with emotional and behavioural difficulties in mainstream schools has increased following lines of educational inclusion since the 1990s and the proposed 'right' to mainstream education, as set out in the report 'Inclusive schooling: children with special educational needs' (DfES, 2001b). Many children who might have attended special schools in the past are now being included in mainstream schools. This means that there may be students who have considerable difficulties and attend mainstream school but do not have access to specialist provision, which is otherwise commonplace in special schools. In particular this is true of music therapy. There continues to be a much greater percentage of music therapy work in special schools. However, the provision of music therapy for children with special needs within mainstream schools has not increased enough to meet the needs of these young people.

This research project investigates the efficacy of music therapy with secondary school-aged youth at risk. 'Music as a therapy provides patients of all ages with an effective means of exploring and communicating a wide range of emotions' (Bunt and Pavlicevic, 2001, p.181). Despite this claim, Carr and Wigram's (2009) systematic review of music therapy in mainstream schools³ showed that only ten of sixty studies were from the UK and none of these were outcome studies providing very little evidence to support the effectiveness and value of music therapy with adolescents.

This chapter introduces the study beginning with an overview of adolescence and some of the challenges which students face. It outlines how music therapy was set up at a Social Inclusion Centre and subsequently became established at a secondary school; ultimately the setting for this research.

³ Mainstream schools are UK state schools for all children between the ages of five to sixteen.

1.2 Adolescence and adolescent culture

Adolescence is the healthy age of rebellion, the argumentative or the 'I don't care' phase, often characterised by phrases such as 'whatever', 'yeah, right' and other monosyllabic utterances. Many books are written to help parents and carers cope with this period of change, destabilisation and upheaval, such as 'Get out of my life: but first take me and Alex into town' (Wolf and Franks, 2008) or 'Teenagers! What every parent has to know' (Parsons, 2009).

Winnicott (1984) referred to this time as a necessary stage of socialisation which ensures the growing young person can relate to peers, parent figures, society and themselves without fear of losing their own sense of identity or resorting to antisocial behaviour. This is a huge transition for the adolescent and therefore no surprise that there are many problems inherent in this period of development. Winnicott goes on to describe the unavoidable confusion and turbulence of adolescence which is universal and regardless of social situation. This stage is not necessarily easier for young people who have been brought up in a secure and loving environment.

Freud (1958) believed that adolescence was an interruption to peaceful growth. He considered it usual that the adolescent fluctuated between love and hate of parents, suffered conflict between excessive independence and dependence and experienced other extremes, such as intense suffering and ecstatic happiness. This view was endorsed by Boucher (1999) who further explains that 'maintaining even moderate psychological balance is particularly difficult if the previous stages of development have not been peaceful or smooth...For adolescents who are vulnerable, these struggles can be overwhelming and can adversely impact development' (p.232).

Adolescence is the stage of development when the young person must develop a sense of his or her own identity, which usually involves rejecting adult values. So, the adolescent seeks a role for themselves in society and importantly a role with, and acceptance by, their peers. At the same time as focussing on their individuality, adolescents usually have a strong drive to fit in and belong. This can lead to conflict because, at the same time as trying to effectively assert themselves as individuals, they need to conform to societal norms (Geldard and Geldard, 2004). Thus, around this time the peer group becomes more important and influential, and the adolescent

needs to follow its standards which can include everything from behaviour, fashion, beliefs, trends and certain kinds of music (Conger, 1979). Isolated personalities can group together because of common interests (Winnicott, 1984) and this need to belong is essentially what drives the gang culture which is typical of this age group (Blos, 1966).

Disorders of attachment at any age can cause difficulties (Bowlby, 1969) but, in adolescence, can lead to problem behaviours such as addiction, antisocial behaviour, eating disorders, psychosomatic illness and self-harm (Bailham and Harper, 2004). Bowlby goes on to suggest that adolescents can develop a sense of belonging and a degree of security by joining gangs. Nowadays, the fact that teenagers often wear hoods comes across as intimidating and threatening which is part of their appeal. As well as ensuring belonging to their social group, hoods offer them greater anonymity and therefore protection.

The behaviour of gang culture is often extremely antisocial and fosters a misguided sense of societal expectations and rules, leadership and values. Guy, the policy director at the Centre for Social Justice, explains that 'the kids most affected [by gangs] are those for whom it provides an explanation and an ennobling narrative to their life' (Rogers, 2011). The expectations of gang members influences and drives the culture of experimenting with, and abusing, drugs and alcohol which for the most vulnerable teenagers can easily lead to many of the problems mentioned previously. The growing attraction of gang culture and the sense of belonging it can provide is appealing to such teenagers as a means of coping with the pressures they face.

The riots in London, Birmingham and Manchester in the summer of 2011 involved over 1,700 people of whom more than half were adolescents. This caused a public outcry. Some people called for the return of corporal punishment, such as caning for minor offences and hanging for repeated convictions. Others preferred a three-strikes rule suggesting that, after three convictions, children from any age should be locked up forever doing hard labour to pay for their prison cell and food. The view was also expressed that in prisons solitary confinement, rather than being mixed with their contemporaries, would be the only way to decrease the strength of the gangs and hold they can have over individuals.

Comments on an article concerning these riots suggested that, until we get to grips with the underlying issues such as deprivation and marginalisation and tackle youth at risk, there may be more such summers of malcontent. It was recognised that youths who fail in the education system are left with fewer options than others and may have been affected by abuse, loss, or other trauma as well. The need to address such problems and help adolescents is reiterated by counsellors and therapists who work with them. For example, Geldard and Geldard (2004) describe proactive counselling, Ierardi, Bottos and O'Brien (2007) set up a community-based creative arts therapy programme for at-risk youth and Austin (2007) describes music therapy with inner city children who are in care.

Many music and other arts therapy projects are community-based and aim to reach the young people in their environment. The education setting however, where children and adolescents are legally bound to attend until the age of 16⁴, offers opportunity for consistent support for these vulnerable students. Therefore, this makes a school an obvious place to provide any kind of therapeutic intervention. This was key in my decision to set up music therapy in an educational setting for secondary-aged pupils.

1.3 Setting up music therapy at a Social Inclusion Centre

Social Inclusion Centres (SIC) were set up in the UK in the 1990s. They were formerly known as Pupil Referral Units (PRU) and this original name has since been reinstated, perhaps because the acronym PRU is preferable to SIC. They tend to be on the site of a mainstream school but not in all cases. These centres were set up for pupils who struggle in a mainstream school but, rather than be excluded, could be referred to these smaller specialist units for support. The units are specially organised to help students access education with learning support and, in some cases, provide carefully planned and monitored work placements for vocational training. PRUs are sometimes considered as reintegration centres where students go for brief periods of time for additional support before hopefully being able to return to mainstream classes. This is not always possible due to the students' needs, however links with mainstream classes are maintained where appropriate.

⁴ The compulsory leaving age is raised to 18 from 2013.

The music therapy pilot project which I set up within a Social Inclusion Centre aimed to provide students with a creative outlet and confidential space to express themselves. The work took place in the Social Inclusion Centre itself, which was a temporary mobile unit. This meant carrying the instruments across a school playing field from the music department in all weathers. Within the mobile unit a room was partitioned off but it was not sound-proofed which meant that both students who were trying to work were disturbed and those who were having music therapy knew they could be overheard. Despite this less than ideal set-up, music therapy quickly established itself. Lugging the drum kit across the field became a familiar sight on a Friday morning and I gradually enlisted helpers. One of these was a student who had music therapy, whose case illustrates the value of short-term work:

Vignette 1

When I met Mac⁵ he was 15 and had been frequently excluded at different times throughout his schooling. He was constantly underachieving, often refusing school and was at risk of permanent exclusion because of his aggressive behaviour. He was referred to music therapy for two reasons: his lack of self-belief - despite much support and encouragement from the dedicated team at the Social Inclusion Centre - and his withdrawal from social contact with others.

Mac spoke to me openly about the trouble he had been in and was likely to be in the future and he doubted that anything could ever improve. He could not create a positive self-image and he did not seem to care what impression he made. He told me that he couldn't possibly play the drums without an alcoholic drink first. He didn't smile, responded as minimally as possible to the idea of playing and fled the first couple of sessions after just a few minutes.

In our third session together, Mac was still reluctant to play but talked about a good drummer in his year group. We pursued the idea of asking this student along to show him some tricks on the drums. John joined us the following

⁵ As in all my examples throughout this thesis, I have changed the students' names for reasons of confidentiality.

week. He was quite happy to have the chance to practise the drums but I needed to structure the session so that the two of them could share the space and work together effectively. I began with games that involved turn-taking, anticipation and a lot of noise. The two boys, who otherwise did not hang out together, soon began to have a laugh, make up music, explore drum techniques and really have fun.

Even though sessions felt chaotic at times, there was a significant change in Mac. He became keen to play the drums and learn a riff which John could teach him, or even to show John something which he had worked out himself. Rather than playing truant, Mac was always waiting for me at eight o'clock in the morning, so that he could help carry the drum kit over to the centre. Although this was only on a Friday, his form teacher commented on his improved motivation at other times in the week as well and she felt he had a slightly brighter outlook on school generally.

A few sessions were videoed and in the tenth and final session together, the students organised the time themselves and gave me clear instructions about how to film them. They created an improvised piece on the drums which included elements from other sessions, such as turn-taking activities and sudden changes in volume. It was very interactive and playful. I could never have estimated how much and how quickly Mac's confidence and feeling of self-worth would develop. Sharing the music therapy space with a peer created a tangible experience of achievement and talking about the music together was also really important. Mac seemed happier in himself. He had found an outlet in music to express a part of himself which had remained largely untapped, and he had found common ground to forge a friendship which helped him to reintegrate into school.

The project was very successful in many ways. The teaching staff noticed changes in all the students who had attended regularly and there was general acknowledgement and approval of its benefits. The head of the Social Inclusion Unit and the school's head teacher were impressed by the students' level of commitment and their ability to feed back on how music therapy had helped them. One student said "I never thought I could play the drums but we played duets and it's given me confidence to try

something else now”. Another student, who had missed a lot of school due to chronic illness shared some video excerpts of his session with his mother and said “It was nice for her to see me doing something and not just being ill”.

Unfortunately, the school could not continue to fund music therapy as it was already running at a huge deficit and the provision, which could only benefit a few, was considered too expensive. The head teacher and other teaching staff did however share the value of the work to their colleagues in other schools in the area. Inspired by the work, I approached the head teacher of Cottenham Village College, which had a similar set-up for student support, with the evidence I had gathered and, as a result, set up music therapy there in 2003. This is the educational site for this research project⁶.

1.4 Youth at risk and disaffected adolescents at school

‘We don't need no education

We don't need no thought control

No dark sarcasm in the classroom

Teachers leave them kids alone’ (Pink Floyd, Another brick in the wall, part II, 1979)

The term disaffection can be interchanged with problem behaviour or emotional and /or behavioural difficulties which are, by definition, social phenomena. Disaffected students are often at risk of failing academically and reject education. They need to be identified as soon as possible by schools for support to be put in place as they might need different opportunities to succeed especially when the mainstream approach is not working. Cooper (1993) examined the major problem of disaffection in schools and how integrated and segregated settings both have something to offer in dealing effectively with students.

Literature before the 1990s usually referred to delinquent students, rather than today's term of disaffected. The etymological origin of the term ‘delinquent’ is from the same root as ‘relic’ which means ‘something left behind’ or ‘something left undone’

⁶ Permission was granted to name the college in this study and the letter of support to my application is included as appendix 1.3.

(Grimshaw, 1996). Although this term is no longer used, its origin implies that students with specific problems can often be left behind. In some cases students who do not meet certain criteria of children's services miss out on provision which is available.

There are many causes for disaffection (Vizard, 2009) and reasons why students turn up at school in a disrupted state, continuously bored and unwilling to give anything a try. The students may be from very troubled families, suffer from economic and material deprivation, or lack good parenting and can also be defined as students who are in danger of negative future events (McWhirter et al., 2006). Vizard lists stressful lifestyles, mental health issues, poor food and drink, crime, addictions and media as factors that can lead to disaffection. Cobbett (2009, p.15) writes: 'There is a high correlation between social deprivation and both underachievement (Croll, 2002) and exclusion from school (Ofsted, 2006)'.

'Barriers to learning' is the current term used to define the many difficulties which youngsters face which can inhibit learning and access to learning (Farrell, 2006). Such difficulties with learning, emotions and social development can prevent school being an enjoyable and sociable place. Disaffection may begin in primary school but students are often considered more challenging as they 'harden up' on their transfer to secondary school where behaviours can become much more difficult to manage.

'Educating Essex', a television documentary of life in a modern secondary school (2011), highlighted current thinking regarding the teacher's role in relation to pupils. The deputy head teacher, Drew, believes that exclusion is morally wrong, recognising the link between school exclusion, failure at school and criminal activity. As one half of male and one third of female sentenced prisoners were excluded from school, and one half of male and seven out of ten female prisoners have no qualifications (Berman, 2011), Drew argues that 'to lose them, is to know they'll drift'. He explained the need to provide very strong guidelines for young people: 'Today's boundaries between adults and children are not as secure, as strong as they were in the past' (episode 1). He suggested that allowing young people to always express their opinion and let them make decisions can actually be detrimental. Adolescents, by their nature, test out every possible boundary so, he argues, they need guidelines and rules to help them recognise when they have got it wrong.

When antisocial behaviour in the school environment becomes increasingly difficult to control, students are often excluded. Their subsequent educational input varies depending on the student's needs but units with smaller class sizes and more activity-based learning is one solution. One way of addressing the problem is The National Care Farming Initiative where commercial farms work together with health and social care agencies to provide farming activities for adolescents as an alternative to school. There are about 50 care farms in the UK which aim to improve the physical and mental health and well-being of young people with various educational and mental health needs (Davis, 2008). Students undertake a programme of activities, including mechanics, art, equestrian skills and cooking, which are designed to lead them to a qualification from The National Open College Network (NOCN)⁷.

Similarly, The Centre School in Cottenham, for students with emotional and behavioural difficulties who have all been excluded or been subject to a managed move from a mainstream school, provides such vocational training and qualifications. In chapter three, The Centre School and its federated mainstream college Cottenham Village College, as well as the specific needs of the students who are referred to music therapy, are explained in greater detail.

It is often considered that 'the troubled adolescent can do much for himself' (Oaklander, 1978, p.291) because they have accumulated resources from experiences, memories and feelings to cope well with difficult situations that arise, such as incidents of bullying or family separation. If the school gives pupils a positive sense of self by providing a structure which includes curriculum, pastoral support, discipline and good relations between the staff and pupils, coined by Cooper as 'the triumvirate of respite, relationships and opportunities' (1993, p.241), the adolescent in need has much more than his own bank of experience on which to rely. Although adolescents require opportunity for independence and autonomy, they also need direction for the future, solid teaching and regular affirmation from adults.

This last point in particular forms the central tenet of The Centre School: it is vital that staff show that not only each day is a new day but each new lesson can be a new

⁷ Through the Qualifications and Credit Framework (QCF), organized by National Open College Network (NOCN), students can achieve a qualification (a certificate or diploma) by amassing credits from the completion of small units.

start. However, school files which follow students from setting to setting do not necessarily allow this. In a semi-autobiographical account by a housefather in a home for maladjusted boys, Plass (1989) wrote:

‘You may recall that in our last meeting I suggested that our boys are, as it were, trapped in a hall of distorting mirrors. Each mirror – family, friends, school, staff – throws back a different reflection. The file is a dangerous mirror for disturbed children. They know it is there, but they are not allowed to see it. They fear it may be inaccurate, and sometimes because it tells the truth. Tom would dearly love to burn his file. I would like to lend him the matches, but I have my own responsibilities...’ (p.155).

1.4.1 Adolescents with emotional and behavioural difficulties

Since 2001, students with emotional and behavioural difficulties are recognised as having special needs (DfES, 2001b). According to the Special Educational Needs Code of Practice (DfES, 2001a) students with behavioural, emotional and social difficulties can be withdrawn or isolated, disruptive and disturbing, hyperactive, lack concentration, have immature social skills and present challenging behaviours. Sometimes the term challenging behaviour is used as a euphemism for social and emotional difficulties (Farrell, 2006). Typically, these students may demonstrate outbursts of temper, verbal and physical aggression, non-compliance, difficulties working with others, an inability to focus and cause damage to school property. There can be several reasons for emotional and behavioural difficulties. There may be causal factors, such as traumatic childhood experiences, a fractured or very insecure family background, poor models of behaviour such as family violence, or a family history of emotional and behavioural difficulties (Farrell, 2006).

The first report on children with emotional and behavioural difficulties⁸ commissioned by the UK government described the child as ‘one who is disturbed by or disturbs a normal situation’ (Underwood, 1955). In 1989 pupils with emotional

⁸ The children were defined as maladjusted.

and behavioural difficulties were defined in Circular 23/89, (DES, p.3) as exhibiting:

‘unusual problems of adaptation to a range of physical, social and personal situations. They may set up barriers between themselves and their learning environment through inappropriate, aggressive, bizarre or withdrawn behaviour. ...[They] have developed a range of strategies for dealing with day-to-day experience that are inappropriate and impede normal personal and social development, and make it difficult for them to learn’ (cited in Cooper, Smith and Upton, 1994, p.20).

Five years later, the government’s document ‘Pupils with problems’ (Circular 9/94) (DFE, 1994) proposes that:

‘their problems are clearer and greater than sporadic naughtiness or moodiness and yet not so great as to be classed as mental illness...EBD may show through withdrawn, depressive, aggressive or self-injurious tendencies. There may be one or many causes. Family environments or physical or sensory impairments may be associated’ (cited in Howarth and Fisher, 2005, p.2).

There is no precise definition of what constitutes emotional and behavioural difficulties (DFE, 1994, p.4) but there are contributing factors which recur. Students are likely to be emotionally unstable, have problems with self-esteem, poor social skills, be looked-after children, have one or more carers with mental health problems, live a chaotic life style, been witnesses to violence and abuse or been physically or sexually abused themselves.

‘The majority of these pupils are, in reality, very unhappy, hovering as they do on the fringes of society. They are disabled from functioning normally by a complex interaction of causes ranging from genetic factors, through family difficulties including being exposed to physical and/or sexual abuse, to the pressures of a changing society. They are emotionally volatile and lack those qualities of stability and robustness which enable other pupils to survive similar pressures intact’ (Howarth and Fisher, 2005, p.10).

When there is emotional distress, the student can become withdrawn, find concentration difficult and therefore lose the ability to stay on task and learn. The work of Laevers and Heylen (2003) demonstrates that children cannot learn successfully unless their emotional well-being is assured and Rutter et al. (1979) stressed the impact that schools and teachers make on a student's development and emotional well-being as well as achievement. Most students who have emotional difficulties have very low self-esteem which Oaklander (1978) explains is not unexpected, 'since how we perceive and value ourselves determines to a great extent how we behave, how we cope with life, how we manage ourselves' (ibid. p.281). Low self-esteem can lead to antisocial behaviour such as fighting, stealing and bullying, as well as being highly anxious, afraid or indecisive. Whether students are diagnosed with emotional and/or behavioural difficulties, are classed as disaffected or deemed 'naughty', they are all youth at risk of underachievement and potential exclusion, and are therefore in need of extra support.

1.4.2 Youth at risk and music therapy

Young people at risk of exclusion from school can benefit from a creative and safe outlet to express themselves, be themselves and work through difficult feelings and ideas in the way that they choose. Exploring self-expression through live music, using methods such as songwriting (Goldstein, 1990; McFerran, 2003; Robarts, 2003) and improvisation (Bruscia, 1987; Round 2001), is a relevant and effective means because most young people identify with music easily. They are already familiar with it and can relate to one another through it: 'Music is often the only tool that enhances communication with this population' (McIntyre, 2007, p.62). For students who find any verbal communication difficult, other than beyond a defensive and often aggressive language, communicating through music can be easier. Making music enables them to articulate their fluctuating moods and allows me to hear and respond to their voice.

'Music is a cultural material (as is language) that provides a kind of semiotic and affective 'power' which individuals use in the social construction of emotional feelings and displays' (Sloboda and O'Neill, 2001, p.415). This assertion helps to explain why adolescents can identify themselves through music. Social experiences,

which are critical to this age group, are heightened even more by the music which accompanies them and impacts on the emotions in the context in which it is heard. Music is an important escort through the turbulent time of adolescence and for students who are experiencing particular difficulties. Music therapy can be a way for them to explore their feelings and emotions, using a medium which they recognise, accredit and take seriously.

The goal of therapy is to promote health, encompassing the individual and the individual's relationship with the broader concepts of society, culture and environment (Bruscia, 1998). My aims for each student vary but my goal is to help them establish healthy emotional well-being: mood affects the ability to think independently and make good life choices. The need to focus and build on the here and now is crucial in each music therapy session. Whatever their past experience or cause of stress, having fun and being playful using music enables the young person to stay with the present and to work positively and creatively at that time. 'Sometimes [...] past traumas will fade and lose their importance in a present that offers the individual the possibility of free expression and above all the possibility of remaining in close touch with [...] present feelings and emotions' (Miller, 1997, p.145). For some, stress or trauma may have happened several years ago, for some the night before, and for others even in an altercation directly prior to their session. Students who have to tackle challenging home situations face enormous emotional difficulties and it is these students who can use music therapy to find an effective means of expressing their potentially conflicting thoughts and ideas. Most of the students referred to music therapy struggle with a lack of self-control and ability to manage very difficult feelings such as anger and unfairness, which in turn impedes their learning.

My work with teenagers was largely influenced by Alvin's model of interactive and free improvisational music therapy (Alvin, 1975) and Rogers' client-centred therapy (1951). Teenagers, who are often aware of their own internal standards, respond well to such an approach which encourages self-exploration and resolution of conflict on one's own terms (Kroger, 2000). The students' developing self-awareness and internal conflicts can be supported so they can find their own answers.

Psychodynamic theory, particularly in the work of Priestley (1975), also shapes the way I respond to teenagers when I consider the non-visible elements of transference

and counter-transference. In chapter four, set within a theoretical framework and illustrated with examples on DVD, characteristics of my approach are explored.

1.5 Outline of the research study

The fact that I established a permanent music therapy post at a secondary school is evidence in itself that music therapy is recognised locally as making a positive difference. There is an understanding within the senior leadership team at The Cottenham Academy (the combined name for the mainstream school Cottenham Village College and the special school called The Centre School) that music therapy is beneficial, but how exactly and to what extent?

One research project, 'Minority Voices' led by Young Minds (Street et al., 2005), provided rich evidence from verbally articulate adolescents about their access to and experience of mental health services. However, the material proposed in my project is unique in that it gives voice to vulnerable students who have not been involved in such a systematic study before.

My study of the role of music therapy in secondary education (Derrington, 2006) suggested that music therapy can be a successful intervention with teenagers who are excluded from school and with those at risk of exclusion. The study focused on one mainstream secondary school with a learning support unit and, through case studies, showed how music therapy sessions encouraged adolescents to express their feelings creatively and spontaneously and, in particular, how they were able to explore issues of identity through songwriting and play. Following on from this study I was interested to investigate more specifically how music therapy affects a student's self-esteem, anxiety, disruptive behaviour and levels of anger, and whether any effects of music therapy are sustained.

In June 2009 I obtained a three-year scholarship from The Music Therapy Charity to be the lead investigator of the 'Youth at Risk Project' (appendix 1.5). At this time, I was working three days a week at The Cottenham Academy which continued throughout the period of research alongside two days a week dedicated to this project. The charity has supported and fully funded this research investigation, which has

taken place in collaboration with the Institute of Education (University of London), The Cottenham Academy and Anglia Ruskin University.

1.5.1 The research questions

My main research question which came from my clinical practice and which this research study answers is:

Does music therapy help to improve the emotional well-being of adolescents who are at risk of underachievement or exclusion?

The sub-questions are:

Does music therapy increase self-esteem, improve integration with peers and motivate adolescents to learn?

Does music therapy make a noticeable impact on attendance and behaviour?

Does music therapy reduce anxiety?

Does any impact from music therapy have a lasting effect once the therapy sessions have finished?

The exploration of my clinical work and these specific questions were the main motivation for my investigation. The fact that students are motivated to attend voluntarily and engage in the sessions, when their instinctive reaction is to resist provides strong evidence for the effectiveness of music therapy. Vulnerable and ‘at-risk’ students often give up on most things before they even try them and being consistently non-compliant is typical of disaffected students who do not become involved in school, whether in classroom learning or through leisure activities. Why then do most of them commit to music therapy? I was particularly interested in the students’ views on music therapy given in the interviews, and to hear from them of their understanding and evaluation of the approach that is offered in music therapy.

1.5.2 Overview of methodology

In order to answer the research questions, the study used a mixed methods design. Students were put into two groups A and B, and received the same treatment but consecutively. Thus, group A received 20 weeks of individual music therapy sessions after which group B began their block of 20 weekly, individual sessions.

All of the students completed questionnaires, including categories which explored their self-esteem, anxiety levels, anger, attitude to school and perception of their behaviour. These were completed at four points in time over a period of 19 months. Such repeated data measures aimed to show any effect that music therapy made. As part of the quantitative data collection, teachers were also asked to complete questionnaires at the same points in time as the students. Their questions corresponded to the categories given to the students but also included others relating to the students' ability to organise themselves and accept discipline. Other data were retrieved from school attendance registers, and records of incidents of challenging behaviour including periods of exclusion.

For the qualitative data, students were interviewed before and after their block of music therapy in a semi-structured way to give students opportunity to chat in an informal way as well as answer a few questions. As many of the students have complex social, emotional and/or behavioural difficulties, such an approach was designed to be as easy as possible for them. A full description of the design and method is presented in chapter five.

1.6 Conclusion

This chapter has outlined how music therapy research originated from my clinical practice with adolescents at The Cottenham Academy. The next chapter reviews the literature that puts this research into context. Chapter three examines the two school settings in detail and looks at some of the challenges of working in an educational and target-based environment. Chapter four focuses on my approach and offers a detailed description, with DVD examples and vignettes, of the clinical work. This adheres to the design of the study which is explained in chapter five. The subsequent two

chapters look at the key findings: chapter six comprehensively covers the analysis of the quantitative data from the questionnaires and other sources; chapter seven reviews the qualitative data from the interviews and presents a compelling account of what music therapy has meant to them in their own words. Chapter eight consists of some individual case studies. Chapter nine summarises the main findings and reflects on the method, considering implications for further research.

This research aims to provide significant quantitative data, described within the context of school work and a specific approach, to show that music therapy contributes to the emotional well-being of adolescents who are at risk. This is the first study of its kind and will add to the literature on music therapy with adolescents. A number of articles and chapters have been written about this area of clinical work but there is less research-based evidence as the review in the following chapter confirms.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This review begins by looking at the literature on adolescence (2.2) and youth at risk (2.2.1) The general use of music and how adolescents respond to it, is the focus of section 2.2.2 because music can play an important part in helping them through this often difficult period of growing up. The role of music therapy is introduced in settings other than schools (2.3) before a review of arts therapies in other settings (2.4) and schools (2.5).

The review then concentrates on the music therapy literature in schools and is split into three parts. Part I: work with students with learning disabilities in special schools (2.6); II: work with students with emotional and behavioural difficulties in special schools and specialist support units (2.7); III: work with youth at risk and disaffected adolescents in mainstream schools (2.8). This final section looks at the music therapy literature on youth at risk: who have emotional and behavioural difficulties and therefore at risk of exclusion from school, to identify and define the gap in the literature which this study hopes to address.

For each section, texts and papers which focused on work with adolescents were reviewed. Online sources included Google scholar, Wiley library, Music Therapy World databases and conferences. Manually searched journals included the British Journal of Music Therapy, Nordic Journal of Music Therapy, The Arts in Psychotherapy, Musiktherapeutische Umschau, Music Therapy Perspectives and Music Therapy Today. Some sections in this review are divided into descriptive articles, specific approaches and research projects. Much of the music therapy literature is recent so, for this reason, literature up to September 2011 has been included. Unless otherwise stated, the literature is from the UK.

2.2 Literature on adolescence

There are comprehensive guides to understanding adolescence (Adelson, 1980; Kimmel and Weiner, 1995; Adams, 2000; Kehily, 2007; Berk, 2008) and literature about working with adolescents and their families (Herbert and Harper-Dorton, 2000; Meeus et al., 2005). Psychoanalytic interpretation of adolescence in literature explains this developmental stage and the issues which young people face (Blos, 1962; Winnicott, 1964; Bowlby, 1969; Erikson, 1968; 1980; Stern, 1985; Briggs, 2008) and the issue of identity is given specific attention (Rosenberg, 1965; Marcia, 1980; Erikson, 1994; Kroger, 1996; 2000; Meeus et al., 2005; Vleiroas and Bosma, 2005). Other prolific writing on living with teenagers is an indication of the trials that occur in families (Wolf and Frank, 2008; Parsons, 2009) and popular self-help books for parents suggest ways of navigating successfully through the tough and turbulent teenage years.

As described in chapter one, adolescence is a developmental period of rapid physical, socio-cultural and psychological changes and it is fraught with threats to the young person's well-being (Kerfoot and Butler, 1988; Dogra et al., 2002; Geldard and Geldard, 2009). The healthy young person can experience identity crisis as they experiment with others' values and goals before finding their own (Erikson, 1968) and many adolescents suffer from self-doubt and low self-esteem and have significant worries about everyday issues and the future (Geldard and Geldard, 2004; Berk, 2008). Lying, for example, is a behaviour which can be an indicator of self-doubt, poor self-image or fear (Oaklander, 1978) and adolescents who have a poor sense of self may resort to telling frequent lies, in order to hide and pretend, rather than cope with the truth and the real world.

The general literature on understanding the developmental stage of adolescence and adolescents' behaviour is vast and will therefore not be reviewed in detail here. However, some of the texts cited above have led the author to more detailed literature reviews later on in this chapter and may be referred to again.

2.2.1 Literature on adolescents and challenging behaviour

Difficult behaviours can arise when students' stress and emotional difficulties are not managed which can also have an impact on teachers and other pupils in schools. There is a considerable amount of literature concerning how schools can, or should, respond to challenging behaviour at school. This includes how a school deals with disaffection (Pickles, 1992; Boucher 1999; Newburn, Shiner and Young, 2005), with children in trouble (Hayden, 2007) and the consequences of disruptive behaviour (Bowen, Jenson and Clark, 2004; Rogers, 2005; Cole, 1998). There are positive behavioural support programmes for students with emotional and behavioural difficulties (Cole, Visser and Upton, 1998; Boucher 1999) and approaches to how poor behaviours and attendance can be managed and improved (Hallam and Rogers, 2008).

Challenging behaviour is most common among students with emotional and social difficulties and the literature on this subject tends to emphasise the need for early interventions and establishing frameworks of support in the childrens' early years (Kay, 2007). In the UK, the earliest formal efforts to cater for pupils with behavioural problems required their removal from mainstream education into residential establishments (Bridgeland, 1971). However this is now seen as a last resort (Cole, 1986). Students are increasingly offered more options, such as support from a Pupil Referral Unit (1.3), where an individual approach can be taken to meet a pupil's needs (Daniels et al., 1998; Cole, Daniels and Visser, 2001). In the UK there is a contradiction between the requirement to attend school, with parents ultimately liable to being prosecuted and fined, and the ability of schools to exclude pupils (Cole, Daniels and Visser, 2001). The scale of the problem was monitored in the 1990s, at the same time that Social Inclusion Centres were introduced.

Exclusion is not a new phenomenon. It was previously known as expulsion, as set out in the 1944 Education Act⁹. However, it is now understood from research that there is a connection between exclusion from school and children living in families with other difficulties. This was addressed by several government initiatives and culminated in 1998/9 with the white paper 'Learning to Succeed' which announced the Connexions

⁹ This Act was repealed in 1996 and there are no known outstanding effects from it.

strategy¹⁰ and formally recognised youth disaffection. Working with young people at risk of exclusion has been increasingly well documented in the last two decades (Cooper, 2000; Riley and Rustique-Forrester, 2002; McNamara, 2000; Vizard, 2009). There are studies and projects which look at ways to help youth at risk to be included and succeed (Cooper, 2000; Riley and Rustique-Forrester, 2002; Abrams, 2010), literature on adolescent coping, with stress, anxiety or family separation for example (Coleman, 1987; Frydenberg, 2008), literature that examines different ways to help disaffected students (Daniels et al., 1998; Huskins, 2000; Hayden, 2007) and acknowledges the nature of risk and resilience in adolescence (Coleman and Hagell, 2007). The research study Positive Alternatives to Exclusion (Cooper, 2000) focussed on the process of inclusion and how six different schools responded to the needs of all their students.

2.2.2 Literature on adolescents, moods and music

Adolescents are familiar with music, can relate to one another through it and it is often the only tool that can enhance communication with this population (Brooks, 1989; McIntyre, 2007). Gordon and Grant (1997) carried out an innovative survey in secondary schools in Glasgow to show the emotional health of a cross-section of young people on one day. They asked students how they felt, what sorts of factors influenced their feelings and what made young people value themselves. In the final section they were asked to complete the sentence “If I felt bad I would...” (p.40). Listening to music was a common strategy listed by both boys and girls as a way of expressing and releasing feelings and as an attempt to cheer themselves up. Girls in particular said that they were more likely to use music in this way to cope with their bad feelings.

Another study (North, Hargreaves and O’Neill, 2000) which involved more than two thousand participants, found that music met the adolescent’s emotional needs and allowed them to portray an image to the outside world. Girls, more than boys, were shown to listen to music to change their mood, and boys tended to use music to

¹⁰ The Connexions Service was developed in 2000 to help coordinate the needs of all disaffected young people age 13-19 to help them benefit from education and training opportunities.

influence or impress others as a means of asserting their identity. North, Hargreaves and O'Neill (2000) found that adolescents might typically listen to almost three hours of music a day. It is therefore not surprising that music is often mentioned in studies that address adolescent culture (Corrigan, 1979; Gordon and Grant, 1997; Csikszentmihalyi, Rathunde and Whalen, 1997; North, Hargreaves and O'Neill, 2000; Taylor, 2003; Frydenberg, 2008). The importance of listening to music with students in therapy sessions is discussed in chapter four (4.4.2) but these surveys confirm my belief that using pre-recorded music and attention to lyrics is crucial in therapeutic work with this age group.

Much of the literature mentions the use of music with groups and how it can bring young people together. Frydenberg's study in Australia of how adolescents cope with stress and anxiety (2008) referred to music. A 16-year old pupil who took part described music as something which was important to him. "It's important to all my friends. It's unbelievable how important music is to us if it's looked at closely because it gives us a feeling like nothing else. Everyone relates to it" (p. 204). This was the only reference made to music in the study but does not lessen its impact. Laiho (2004) had also reviewed how playing and listening to music contributed to an adolescent's development and mental health in four different areas of psychological functions: interpersonal relationships, identity, agency and emotional field.

Taylor (2003) addresses the importance of music when young people gather together at youth groups because of its vital role in helping to form friendships. Peer relationships 'may provide security in an unfamiliar environment, be a source of emotional support, give shape to social identity and provide a launching pad from which to meet others' (p.63). These relationships are crucial for healthy development. Peer groups which young people join are social systems where individuals share interests, attitudes, and often abilities and personal characteristics as well (Brown, Mory and Kinney, 1994; Tarrant, North and Hargreaves, 2000). A shared taste in music can help teenagers to bond and help create a way of social networking and fitting in (Cotterell, Coleman and Cotterell, 2007).

In an interview for a study by The Open University (Garrett, Roche and Tucker, 1997), one young person said that music and drugs 'definitely go hand in hand' (p.9). The importance of music was reflected in another comment later: 'The first thing I

look for in a party is what the music's going to be like, and if I don't like it then I won't go' (ibid. p.10). The use of music, as well as other art forms, can be a good way for students to express themselves, grow in confidence and share their experience with others. Young people who are faced with emotional problems can use creative activities as an important way to express emotions and even offer them 'a means of exploring painful memories or anxieties' (ibid. p.56). Batsleer (2008) recommends drumming and voice workshops for bringing youths of different race or faith together working in potentially conflicting communities.

Music is also mentioned in a creative arts-based programme for bereaved teenagers as an effective means to reach adolescents at their level and help them connect with their emotional self. 'The physical act of involvement in the arts often allows adolescents to release unspoken pain, thereby creating a foundation for healing' (Baughman and Kiser, 2007, p.227). When the group works together in a songwriting project it is noted that the teenagers 'feel relief to know that they are not alone in their grief...Music brings adolescents together in a very positive way' (ibid. p.228). Such bereavement support from group music therapy is echoed by Krout (2005) and McFerran (2010) in their detailed approaches to group work with adolescents experiencing all kinds of loss.

Corrigan (1979) carried out a sociological research programme which involved interviewing teenage boys who frequently played truant from school. Amongst other things, they were asked for their opinion on music. Despite evidence that teenage culture embraces a wide range of music, the teenagers rebelled against the structure of music lessons in school such as orchestral playing and the tendency towards learning only classical music. This is generally a different story in today's schools but Corrigan's discovery that pop music meant something to all of the teenage boys was significant. His results showed that the boys related to music and pop stars, not only for themselves as individuals but as part of groups. Another interesting finding showed that whilst all the boys in the survey considered popular music to be an important way of connecting to peers, it was rarely discussed in conversation, unlike football.

Learning music can build confidence and create a sense of achievement in young people (Craig, 2007). More research is needed into the effects of learning music and

how it can ‘enhance a variety of learning, intellectual, personal and social outcomes’ (Hallam and MacDonald, 2009). However some projects have already shown that music lessons can help to improve social skills with disaffected pupils (Shuler, 1991; Spychiger, 1993). A programme in America, using rap music with adolescent African Americans who have behavioural problems (De Carlo, 2001), also proved to have some success in improving social skills. Disadvantaged youth were given the opportunity to play music alongside professionals, in a project at a festival reported by Sapin (2009). ‘It had such an effect on them...I really think that they will be much less likely to be involved in the risky and destructive behaviour that they used to get up to. It was a truly transforming experience’ (p.95). A case study by Csikszentmihalyi, Rathunde and Whalen (1997) illustrated how music helped a young person to deal with stress that might otherwise have been overwhelming. Ron, a gifted saxophonist who enjoyed playing in a band, described music as ‘the force that keeps him together’ (p.236) that offered him a shield against his unhappiness and stopped him from worrying about his home situation. His musical skill helped him ‘to live enjoyably in the moment and to look to the future’ (ibid. p.236) which, as Erikson (1968) states, is crucial to the healthy achievement of this developmental stage.

Alvin (1975) described how the preparation for a concert helped adolescents with behavioural difficulties to communicate with one another and to do so positively with enthusiasm, instead of with their usual patterns of aggression. *Boys Don’t Sing*, broadcast by the BBC in 2008, followed professional musician, Gareth Malone, as he set up a choir at an all-boys school in Leicester which had no previous tradition of choral music-making. The teenage boys who had grown up listening to R&B and rap were unwilling at first and had no interest in singing, but in the end performed on stage in front of thousands.

As well as actively playing or singing, music can help students in other ways. Two studies by Hallam, Price and Katsarou (2002) showed that the use of background, relaxing music helped primary school pupils’ performance in both arithmetic and memory tasks but music which was loud and stimulating did not. Older children often use music to accompany their studying (Hallam and MacDonald, 2009) and the concentration of children with emotional and behavioural difficulties can be improved with background music (Hallam and Price, 1998; Savan, 1999). Vizard

(2009) also suggests that music can help students, with emotional and behavioural difficulties and who have some musical intelligence, to concentrate and learn if they put key ideas to their favourite song.

In summary, the literature shows that young people often proactively choose to use music to help themselves and as a way of connecting to others. This is the basis for using music in therapy with this age group: it is accessible and always in trend. The Special Educational Needs Code of Practice (DfES, 2001b) lists counselling as a top priority as a basic provision for pupils with emotional and behavioural difficulties. However, Farrell (2006) specifically lists music therapy among arts therapies that should be offered: 'With such provision the pupil is more likely to benefit from the education that the school offers for all pupils and to make better progress reaching higher standards of achievement, including personal and social development and self-esteem' (p.8).

2.3 Music therapy for adolescents in settings other than schools

Although adolescents spend most of their weekdays in school, the majority of music therapy work does not take place in educational settings but in hospital, inpatient health care settings or hospices (Karkou, 2010; McFerran, 2010). The music therapy literature of work with adolescents covers a wide range of settings and reasons for referral and includes, for example, work with those who have been abused (Lindberg, 1995), adolescents with eating disorders (Robarts, 1994; Sloboda, 1994; Loth, 2002; McFerran, Baker and Kildea, 2008), suffering bereavement (McFerran-Skewes and Grocke, 2000), those in an inpatient psychiatric unit (Tervo, 2001; Mitchell, 2002; Tyson and Baffour, 2004), those in hospital or hospice with a terminal illness (Grießmeier, 1990; 1994; Henderson, 1983; Aasgaard, 2005; Eaves, 2005; Casey, 2012) and those in care (Austin, 2007; Hasler, 2008).

As in the previous section, the predominance of literature of work with children does not always single out adolescents but may in some cases include this age group, for example in the work of Child and Adolescent Mental Health services (Saville, 2002; Molyneux, 2005; Oldfield, 2006b).

2.3.1 Descriptive articles

In a published case study, Lefebvre (1991) describes music therapy work with a sixteen-year-old girl at Montreal's children's hospital. Lefebvre reflects on the need to know the client musically: by looking back at the role that music had played in her life she enables the girl to make links with her past. Lefebvre also responds to the girl's desire to learn music theory and concludes that whatever direction the therapy takes, responsibility must be given to the teenager for their session and the therapist must 'trust in both the therapeutic process and the teenager' (p. 230).

The value of learning an instrument for clients with poor self-esteem is documented by Kivland (1986). In a case study of an adolescent with a conduct disorder, Kivland describes how the boy, after learning the piano in music therapy, was soon able to accept praise and make positive self-statements. Frank (2005) describes an adolescent's request to learn and be taught guitar, which is not uncommon with this age group, and how this worked in therapy. His client was on a hospital ward and suffered from schizophrenia. When his therapy finished and the young man left hospital, he planned to continue learning the guitar, thus hold the relationship with his therapist in mind.

Other published case studies include a piece of long term work with a teenage girl (Schönfeld, 2003), and with an adolescent on an inpatient unit with a diagnosis of Borderline Personality Disorder (Dvorkin, 1991). Dvorkin highlights the value of using song and improvisation for dialogue and, in a later paper (Austin and Dvorkin, 1998), also discusses resistance in music therapy which is typical of the work with adolescents and has been reported by other music therapists (Behrends, 1983; Mark, 1986).

Teenagers in a hospital setting often respond well to the use of guided imagery to distract them from painful procedures (Lorenzato, 2005) which is accredited to their openness and willingness to try new things, unlike some younger children. In a hospice setting, Eaves (2005) describes the use of, and need for, music technology in sessions with adolescent boys with muscular dystrophy and considers 'there isn't anything that is so accessible and 'cool' that also meets teenagers' needs for support to express themselves...' (p.109).

2.3.2 Specific approaches

McFerran (2010) presents an overview of some key ideas in relation to four elements of adolescent health: resilience, identity formation, competence and connectedness. She concentrates on the use of group work to help adolescents address their desire for freedom and simultaneous control. Her approach is about being active with teenagers and working with the chaos that can ensue. She compares songwriting and improvisation within this approach (McFerran, 2003) and discusses the normal difficulty for this age group of verbalising their feelings.

Songwriting has been documented by many music therapists as part of their approach (Robb, 1996; Aasgaard, 2005; Derrington, 2005; Krout, 2005). Baker and Krout (2009) compared an online music therapy intervention to face-to-face work with students with Asperger's Syndrome and found that all participants were equally engaged in the songwriting and therapy process.

Flower describes the non-directive approach to work with adolescents in secure care (1993) and the use of control and creativity. Fully aware of the lack of control these young people have because they are in such a unit, Flower's approach provides important opportunities for choice. Flower addresses the need for play and creativity, 'a vital part of healthy development which may have been lost' (p.42) and, through improvisations, enables them 'through play [to] move towards a deeper sense of self' (p.43).

Describing her work with an abused and emotionally disturbed adolescent girl suffering from post-traumatic stress disorder at the inpatient clinic unit of a children's hospital in South Africa, Henderson (1991) stresses the importance of considering the client's cultural beliefs. By embracing the trans-cultural setting and using a combined approach of music therapy, play therapy and psychotherapy, Henderson enables her adolescent client to feel safe enough to manage and experience feelings that are dangerous and confused. The client uses puppets, improvised song, African lullaby, songs from Christian worship and drumming in the Xhosa tradition. The therapist recognises all these elements, the associations that her client has with the different music and thus enables the client to communicate her story.

De Backer (1993), in his account of music therapy work with an ego-weak adolescent, explains the importance of containment as a basic requirement in the therapeutic relationship. The boy demonstrates chaotic and alarming feelings through play and musical improvisation, projecting them onto the therapist, who in turn 'enables him to bear what seem uncontainable feelings' (p.35). By empathically accompanying the boy, the therapist enables him to connect to his 'world of experiences' (p.38) without using words, and the child feels supported and can acknowledge that his feelings were not too overwhelming for the therapist and can be survived. 'Music offers the advantage that the patient need not be alone in his chaotic expression and experience' (ibid. p.36).

2.3.3 Research projects

Some music therapy studies show that using music as an intervention can be of great value for those who have difficulties with self-control, thinking, responding appropriately and social interaction (Stratton and Zalanowski, 1989; Friedlander, 1994). Teenagers' lives can be 'centred on music' (Hendricks et al., 1999) so it is strongly indicated that music therapy with these students would have highly successful outcomes. A study by Montello and Coons (1999) supports this notion. Their research showed that students who were experiencing severe obstacles in forming relationships with others and their environment began to show evidence of improved self-worth and self-esteem as a result of making live music. The Australian music therapy programme 'Sing and Grow' (Abad and Williams, 2006), for adolescent mothers and children, developed into a nationwide service following parental feedback and documentation of successful outcomes, but needs to be systematically evaluated.

A small randomised control trial, led by Alborno (2011), hypothesised that the effects of group improvisational music therapy would relieve depressive symptoms in adolescents who were receiving treatment for substance abuse. One of the scales used in the study was the Hamilton Rating Scale for Depression (Hamilton, 1960). It showed substantial differences in the scores of participants who had had music therapy compared to those who had only received regular treatment, and thus showed that music therapy did have a clinically significant effect.

Gold, Voracek and Wigram (2004) analysed eleven music therapy studies, comprising a total of 188 children and adolescents, and found that the benefits were greater for those who had behavioural problems. This supports the case for work with adolescents who often present their emotional difficulties with challenging behaviour. In November 2010, a randomised controlled trial called 'Music in Mind' began in Belfast, Northern Ireland. The primary focus of the study is to examine whether improvisational music therapy helps young people who attend health services for children and young people. It aims to measure the effects of music therapy on the communicative skills of children and adolescents with emotional and behavioural problems and/or pervasive developmental disorders (Doran, 2010).

2.4 Arts therapies for adolescents in settings other than schools

The expressive arts, such as art, drama, story-telling and music, are central to the development of mental, emotional and social competences (Greenhalgh, 1994; Meyer, 2010; Thomas, 2010), especially as adolescents can resist verbal psychotherapy (Frisch, 1990; Berkovitz, 1995). The fact that arts can directly appeal to young children and adolescents and engage their emotions is well documented. However, there is often less distinction made between the age groups and work specifically looking at adolescents is not prolific (Arguile, 1992). It also becomes evident that much of the literature about adolescents refers to group work rather than individual.

2.4.1 Art therapy

There is a particular focus on role experimentation in adolescent group and family work in art therapy (Linesch 1988; Waller, 1993; Riley, 1999). Waller (1993) describes group interactive art therapy as an opportunity for adolescents to express themselves within the contained space of sessions and in ways which may not be possible without both the symbolism and verbal communication. American art therapist, Linesch (1988), suggests that 'group therapy is the modality of choice with the emotionally disturbed adolescent' (p.133). She advocates group work as a place where adolescents form peer relationships in the group and can safely wage battle

with authority figures, even ganging up on the therapist, creatively and expressively, but in a safely contained way. Similarly, Dorr (2007) examines how art therapy groups provide meaningful and effective ways to help excluded students manage unresolved feelings of conflict, anger and low self-esteem. The combination of the collaborative group process and the creative art-making process helps students to address such issues with others who are in a similar position.

Creating artwork specifically for public display can satisfy the desire of the adolescent to be heard. Graffiti produced by a group of traumatised Israeli students was the focus of a study by Klingman, Shaley and Pearlman (2000). They describe the importance of graffiti and 'graffiti writing as construction of a unique youth ritualistic medium' (p.300) and go on to observe the different creative stages of the artwork, which clearly depict how imaginatively the students used the medium to cope with their trauma. Similarly, Summer (2007) describes a mural-making process in art therapy with a group of students in New York who, traumatised by a shooting of one of their friends, needed to work through feelings of loss and grief. The mural became a lasting depiction of their feelings.

The development and growth of art therapy in young offender institutions and group work with adolescents who have committed crime is the focus of several authors (Baillie, 1994; Hagood, 1994; Liebmann, 1994). Smeijsters et al. (2011) are currently developing, evaluating and aiming to improve all arts therapy interventions for young offenders in secure care. Their preceding article (2001) looked at youth's core problems with self-image and inability to express themselves and the implications of art as well as drama, music and dance-movement therapy.

Raghuramann (2000) presents an individual case example of art therapy and uses it to illustrate how this medium can help chronically ill adolescents who, in addition to the expected pressures of their age, have an overwhelming amount to deal with emotionally. Being creative in a therapeutic environment can provide an outlet for the individual's feelings, however Raghuraman points out that the success of therapy depends on the therapist's open-mindedness and tact for honest communication to occur. 'The most important element of the therapeutic process is that it represents a two-way street. Both the therapist and patient need to work together to promote healing and growth' (p. 39).

2.4.2 Drama therapy

Drama therapist, Naitove (1981), uses a multi-arts approach in group work with adolescents and includes sound, movement, mime, art and puppetry. Her approach aims to reaffirm the adolescent's individuality by responding to the client's creative ideas. Naitove notes the importance of working with the individual within the group, the need for group solidarity, the way groups can be motivated and how opportunities for humour and play make the therapy particularly attractive to adolescents.

Drama therapy as one of the forms of treatment for disturbed adolescents in a therapeutic community is arguably 'an essential treatment for those groups which, because of poorly developed ego structure, find verbal expression difficult' (Shuttleworth, 1981, p.171). Shuttleworth describes the use of talking groups as well as drama therapy for these young people but argues that the drama group can feel more secure and where problems can be addressed directly. 'It is often easier to act out conflicts and so initiate new ways of coping than it is to talk about them' (p.159). A key feature of his work is the use of sculpting, where group members are invited to use either inanimate or animate objects in the room to present themselves and their life, thus providing the therapist with insight into how the adolescent views his world and an opportunity to respond.

American drama therapist Hollander (2002) illustrates how psychodrama can engage 'at risk' youth and how by acting with family members, can learn to communicate with creativity and humour. Kruczek and Zigelbaum (2004) present the case for psycho-educational drama as a way to help adolescents look at risky behaviours and Dayton (2007) offers practical ideas for experiential group therapy where the actor's stage, as in ancient Greece, can be 'a safe place to explore and explain psychological and emotional themes through role-play (p.197).

Emunah's (1985) student-centred approach to drama therapy describes adolescents' resistance, rebelliousness and ways to work constructively with them. Drama can provoke high levels of anxiety in teenagers and three areas of resistance are highlighted: adolescents are very self-conscious and concerned with appearance; adolescents may associate drama with performance and are fearful of being on show; acting out may be seen as being childish and acting out in role-play can be 'extremely

threatening for the adolescents who are undergoing a period of instability and flux' (p.75). Emunah understands that the extreme low self-esteem of some adolescents makes their anticipation of failure even more exaggerated but describes her approach in three stages. At first, she works with their resistance in a playful way and allows the students to share control and let them take the lead. Secondly, the group may be willing to engage in dramatic play, having relinquished some of their resistance, but they may still need to act cool so as not to threaten their identity and approval from others in the group. At this stage both the adolescents and the therapist can work together on a scene which allows the final stage of therapeutic direction and improvisation to take place. The adolescent's use of drama to re-enact realistic situations 'in an attempt to understand and master their conflicting emotions' (ibid. p.120) can provide perspective but the initial task for the therapist is to overcome the adolescent's resistance.

2.5 Arts therapies for adolescents in schools

Pioneers in the arts therapies, including Nordoff-Robbins (1971, 1977), Alvin (1975, 1978), Jennings (1987) and Waller (1991), work in different school settings. There are articles on school-based programmes for mental health promotion (Durlak and Wells, 1997), specifically for looked-after children (Christensen, 2010; Prokofiev, 2010; Tortora, 2010) and studies which highlight the role of therapy in mainstream schools (Karkou, Fullarton and Scarth, 2010; Koshland, 2010; Tortora, 2010). Even though they may not specifically address adolescents, some texts do refer to children and include those who are secondary-aged (Donnelly, 1992; Tytherleigh, 2010). Karkou and Glasman (2004) advocate the role of the arts and arts therapies in schools to promote the emotional well-being and social inclusion of young people.

There are several descriptive articles and case studies which focus on the use of arts therapies with disaffected and disturbed adolescents in schools (Jennings and Gersie, 1987; Riley, 1999; Christensen, 2010; Karkou, Fullarton and Scarth, 2010; Quibell, 2010). Karkou, Fullarton and Scarth (2010) argue that the arts therapies, and in particular dance movement psychotherapy, benefit adolescents with emotional and behavioural difficulties to engage and explore emotional and social issues in a non-threatening way. Other case studies describe work with students who have Autism or

Asperger's syndrome (Brown, 1994; Elkis-Abuhoff, 2008). The need for a collaborative approach and joint working between arts therapists and other professionals is highlighted in much of the literature (Long and Soble, 1999; Oldfield, 2006a; Fearn et al., 2008; Twyford, Parkhouse and Murphy, 2008; Holmes et al., 2011). It is also evident that the adolescent's need for containment, trust and acceptance, is central to most therapeutic approaches.

There is evidence of many school-based interventions using the creative arts. For example, Weare (2000) cites Roberts (1997) who uses story-telling to improve the behaviour of pupils with emotional and behavioural needs; Ings (2004) presents the case for creative work and its ability to restore a young person's sense of identity and purpose; Walsh (1990) describe a creative arts programme in the UK that was set up specifically to teach social skills to young adolescents; and Moneta and Rousseau (2008) describe school-based drama workshops to help immigrant adolescents with behavioural difficulties.

A six-week arts therapy project for sixth-grade students in the US (Long and Soble, 1999) offered students the opportunity to work together and explore their attitudes and feelings about violence in their community. Through individual and group activities such as art, writing, discussion and drama, all the students learned the balance between individual expression and communication with others. 'Combining interactive art, drama and health education models to engage children in exploring their attitudes, thoughts and feelings about violence in their worlds provided a living laboratory for these students to express themselves' (p.344). Students were able to express feelings of despair and fear, and the therapists were the mentors and containers for this expression. The class teacher was involved in discussions after each session, showing the essential collaboration that is needed in schools work, and one of the positive outcomes was the recognition by other schools of the need for creative arts programmes.

Art therapy is a thriving and fulltime resource at a special school in East Sussex. Arguile (1992) describes, through examples of case work, how trust, which comes from offering adolescents a safe space and time to be themselves, is essential to the success of the work.

Recurring themes in drama therapy at a school with disturbed adolescents are described by Jennings and Gersie (1987) as boredom, anxiety and dependency. They argue that group work can be used productively to work on body and spatial awareness, role identity and how the 'self' fits into the family and society. The use of basic ground rules and keeping the structure firm with some flexibility is, they write, crucial to establishing a healthy group in therapy. In my experience, the rules are well respected if they are set by the group members themselves and may, therefore, vary from group to group.

Working with boys in inner city, drama therapist, Haen (2007), discovers that drama is effective because it 'is compatible with boys' natural propensity toward action rather than words' (p.223). This need to be doing rather than talking is necessary to any arts therapy approach with this age group. Teenagers need to be able to explore feelings creatively without pressure and in a safe environment which is contained by the therapist. Weiner (1981) discusses the implications of psychodrama with teenagers who drink and whose parents are alcoholics; that despite their emotional deprivation and significant peer pressure, they can role-play and be spontaneous.

Grimshaw (1996) suggests that pupils, whose behaviour is unacceptable and antisocial, can arouse feelings of helplessness and anger in teachers. The drama therapist, therefore, needs to work with the wider culture, such as the teaching staff within an educational unit, if the work is to be effective. Positive behavioural changes in the young people need to be acknowledged by the whole team and this liaison is also a valuable experience for the young person who experiences adults communicating and co-operating.

Leigh's document (2001) of the process of establishing drama therapy in a secondary school describes the difficulties and the reality of working in schools. The constant need to explain the concept of therapy, and its difference from an educational view, can be challenging and require patience. Her work for students with real difficulties around the learning process and its environment is similar to the music therapy work in this study. 'Therapy in education goes alongside teaching. It underpins the child's ability to learn. No one can learn much if they are in turmoil for one reason or another' (p.9). Leigh works with an eclectic, integrative and holistic approach within the whole school, recognising the importance of therapeutic work to resolve conflict,

enable communication, improve relationships and help adolescents to focus on the bigger picture and not to feel alone with their fears. She describes short-term crisis intervention with boys who have been fighting or involved in bullying. Leigh's enthusiasm for this work is clear and when funding runs out in one school, she is able to build up work at another.

2.5.1 Research projects

Quibell (2010) suggests that drama therapy for small groups of disaffected students to address social and emotional aspects of learning could have an impact on the whole school. Having previously used a randomised controlled trial to deliver and research a form of drama therapy called Action Skills Group Intervention in secondary schools to address truancy from school, Quibell had proven that the intervention was effective both in the short and long term (McArdle et al., 2002). Quibell's subsequent study showed that teachers and parents reported positive changes in the children after group drama therapy intervention but the children gave less positive answers to the questionnaires. Despite this, the study concluded that the children did benefit and made an impact on the school: 'When the school culture begins to reflect the values that we know are essential to the running of effective groups, then the emotional and social needs of the children are being accounted for' (Quibell, 2010, p.126). This is reminiscent of Pavlicevic's view (2004) of 'the ripple effect' with the idea that 'the impact of music therapy can work outwards [...] and can create community within a building' (p.16).

Ottarsdottir (2010) conducted a research study in a mainstream school in Iceland, to see how coursework could be integrated into art therapy. Working as both art therapist and art teacher in a school, she recognised the potential to help students who had learning difficulties with their coursework whilst maintaining the emphasis on spontaneous artwork. Hall (2012) also acknowledges the advantages of working as both teacher and arts therapist in a large special school and suggests that, by knowing a child's particular difficulties from individual therapy sessions, she can be of more help to the child as a teacher. However, this approach is not without some difficulties due to the overlap of boundaries and the potential confusion of rules for pupils.

In the UK, a randomised, controlled trial of group dance movement psychotherapy (Karkou, Fullarton and Scarth, 2010) took place in secondary schools where therapists worked with adolescents at risk of developing mental health problems. The project aimed to improve the emotional and social well-being of young people aged 11-13, and encourage awareness and understanding of arts therapies amongst staff by running an educational programme. The quantitative results were positive but the study was too small for any firm conclusions to be drawn. However, it did show that teachers needed to be sufficiently informed about arts therapies and mental health issues for any such work to be effective.

The same conclusion had been drawn by Ierardi, Bottos and O'Brien in America (2007). A creative arts research programme for vulnerable youth in Philadelphia, called Safe Expressions, was designed 'to measure improvements in self-esteem, interpersonal skills, anger management, impulse control and development of new coping strategies' (p.254). The researchers found that, without administrative support, findings were negative and unreliable. They also concluded that the use of pre- and post- self-surveys by the teenage participants 'did not prove to be a statistically reliable measurement of self-recorded progress' (ibid. p.259). The lack of honest answers was linked to a lack of reading comprehension and the questionnaires being too lengthy. The study revealed several factors that contributed to unreliable answers but its early findings indicated positive change in the participants' skills assessments and it continues to be carried out in other schools to create a larger database.

Based on her clinical work, Christensen (2010) describes the role of drama therapy in a UK student support unit and her research study which sought to find out the experiences of adolescent boys and the effects of short-term drama therapy. Using a qualitative approach, including the review of case notes, thematic analysis of recorded interviews and case studies, Christensen discovered that drama therapy could help students to be re-integrated into mainstream school but it was difficult to separate the effects of the support offered by the unit from the drama therapy. Her study concludes that there is an absence of research studies in this clinical area and echoes that of Karkou (2010) who calls for more evidence-based research.

Finally, the impact of dance movement therapy was investigated by Koshland (Koshland and Whittaker, 2004; Koshland, 2010). The quantitative study of a

violence prevention programme took place in a primary school but was based on a similar study for bullying prevention for adolescents aged 12 -15 (Beardall, 1998). Both studies showed that there was a significant decrease in aggressive behaviours in some cases and the children were able to show greater ability to control disruptive behaviours, such as instigating fights (Koshland, 2010). However, there were limitations to the projects and recommendations were made for further exploration of the use of drama therapy to help decrease violence in schools.

The majority of the research to-date in the other arts therapies has involved groups. This may be in response to student need but also to pressure from schools when the benefits of arts therapies for their pupils are recognised but funding is limited. The research shows that clinicians are increasingly evaluating their work and it is recognised that there is a need for more research within schools with pupils with a variety of needs.

2.6 Music therapy in schools I: for adolescents with learning disabilities in special schools

The practice of music therapy is not uncommon in educational settings in the UK as approximately 25% of music therapists are employed within schools (Carr and Wigram, 2009). It is recognised that children and adolescents who have learning disabilities are more likely to be offered music therapy than those without diagnosis as there is wider provision in special schools and child development centres. Music therapy work with children and young people with learning disabilities is well cited in the literature (Nordoff-Robbins, 1971; Warwick, 1995; Oldfield, 2006a; Howden, 2008; Twyford and Parkhouse, 2008; Tomlinson, 2010). There is extensive anecdotal literature concerning children and young people with Autism and Asperger's Syndrome (Storey, 1998; Woodward, 1999; Loi, 2010; Tomlinson, 2010) and literature about work with severely learning-disabled adolescents (Strange, 1999 and 2012; Nicholls, 2002; Jones, 2008).

Robbins and Robbins (1991) worked as a team in a special school following their own Creative Music Therapy approach, originally developed in 1977. Their approach helps the severely disabled child to develop a musical response and be motivated to

acquire musical skill. 'First and foremost the therapist improvises music which accepts and meets the child's emotional state, while also matching, accompanying, and enhancing how the child is expressing it' (p.234). In one article they use a case study of a brain-injured sixteen-year old girl to describe their work. Without knowing much about the teenager's background, the two therapists work together with her and are specifically aware of the tempo of the music. They describe the development of the relationship between the client and her music and how her compulsive fast beating slows down as she gains control and can work rhythmically with the therapist. Her 'consolidation in musical participation [leads to] an intimately real sense, consolidation of self' (ibid. p.248). After twelve sessions it was noted that the girl's disruptive behaviour had decreased, her mood seemed lighter and she had a greater sense of self and purpose.

Strange (1999) describes his client-centred approach using three case studies to explain how emotionally disturbed students with moderate learning disabilities should be able to choose how to use music therapy. He argues that the therapist needs to accept and support unforeseen developments, to let the therapy take its course and not impose his or her own direction. 'Many clients have already experienced rejection and have difficulties which increase the likelihood of further rejection. To insist on a way of working which these clients find threatening can endanger the whole therapeutic relationship' (p.135). Many young people at risk of underachievement or exclusion have known rejection and failure, which supports the case for a student-centred approach to their therapy, even when there are specific developmental aims which the therapist might hold in mind.

McFerran and Stephenson (2006) argue the case for more evidence-based practice in special education, approaching the topic as a music therapist and a special education academic respectively. McFerran presents the importance of qualitative research and wealth of research studies that have been carried out in special education and cites, among others, Elefant and Wigram, 2005; Perry, 2003; and Rickson, 2003. However, from a scientific point of view there is as yet not enough evidence to prove that music therapy can help students with learning disabilities to achieve educational goals and Stephenson writes, 'At this point, the use of music therapy as an educational intervention has support only from case studies: well designed quantitative studies are needed' (McFerran and Stephenson, 2006, p.125). As a response to their different

viewpoints the authors collaborated on a proposed research study to investigate ‘the efficacy of music therapy with students with severe intellectual disability, a specific area identified as lacking an evidence base in terms of the standards’ (p.127).

2.7 Music therapy in schools II: for adolescents with emotional and behavioural difficulties in special schools and specialist support units

Young people at risk of exclusion can benefit from using live music to express themselves with methods already mentioned such as songwriting (Goldstein, 1990; McFerran, 2003; Robarts, 2003; Derrington, 2005) and experimental improvisation (Bruscia, 1987; Round 2001). According to a survey by Karkou and Sanderson (2006), 31.1% of music therapists work with clients with emotional and behavioural difficulties, but not necessarily adolescents.¹¹

Brackley (2007; 2012) describes the increasingly common need for music therapy work on a behavioural support programme at a Pupil Referral Unit for pre-adolescents, aged between five and nine, who have been excluded from mainstream education. She refers to music therapy’s potential ‘to recreate the conditions of the early dyadic relationship, allowing the music therapist to re-visit problematic stages of the pupil’s early development and aid their ego-development’. De Silva (2006) also illustrates how music therapy can bring about radical transformation in the behaviour and emotional interaction with younger children and Montello and Coons (1999) concentrate specifically on the usefulness of music therapy group work. Cobbett (2007) has an integrative approach of using other creative arts in music therapy, specifically drama and play, with primary-aged children who have emotional and behavioural difficulties. Cobbett makes the case for a flexible approach for vulnerable young people of any age and for children to lead, choose the route of their therapy and use play in spontaneous interactions.

¹¹ The largest client group, 50%, for music therapists was for clients with learning difficulties. This was only 15.6% for other arts therapists. However figures for music therapists working with clients with emotional and behavioural difficulties was 31.1% compared to 67.6% for other arts therapists (Karkou and Sanderson, 2006).

2.7.1 Descriptive articles

There are some published case studies with adolescents with emotional and behavioural difficulties, such as Nirensztein's (2003) work with a maladjusted teenager after an attempted suicide and Fruchard and Lecourt's (2003) account of music therapy with a fostered teenager. Cobbett (2009) supports school-based work for students with social, emotional and behavioural difficulties. He stresses the importance of making therapy accessible to them, not only practically in terms of getting to sessions, but also on a social and cultural level, by using rap and computer composition.

In a project review, McIntyre (2007) describes the results after nine weeks of music therapy sessions for adolescent boys with behaviour and/or emotional disorders. The outcomes included developing new skills, enjoying music, experiencing group cohesion and having increased self-esteem. Neale (2009) and Jenkins (2006) examine the techniques used by music therapists working with children and adolescents who have emotional and behavioural difficulties. Neale presents case studies of work in Pupil Referral Units with children who had been excluded or were at risk of exclusion from school. Her mix of using play and computer software to meet the child's needs is similar to Jenkins' summary that a flexible approach is essential for these pupils.

Sausser and Waller (2006) define a model for students with emotional and behavioural difficulties in a psycho-educational setting. They contend that proper planning of musical activities in a structured music therapy programme helps students more than a client-centred approach. To optimise services, their design combines the music therapy process with the nine-week pattern of the American school setting to help the therapists cope with large caseloads and they provide suggestions for activities which, they suggest, work well with these students.

2.7.2 Research projects

Gold, Wigram and Berger (2001) developed a research design to measure the effects of individual music therapy with mentally ill children and adolescents showing behavioural problems, on symptoms and their quality of life. The children's needs for

relationship and opportunities for emotional expression were the main therapeutic aims and, post-treatment, it was found that the children improved in all three outcome areas. These results support the continuation of this research with a larger sample.

Music therapy has been shown to be effective in experimental studies with children and adolescents. However, there is little empirical research knowledge about what elements of music therapy influence its effectiveness in clinical practice. Gold, Wigram and Voracek's study (2007b) of individual music therapy with 75 children and adolescents and 15 music therapists, showed that the children's symptoms showed greater improvement when music therapy was limited to discipline-specific music therapy techniques and did not include other media such as play therapy elements.

Horton (2005) shows that a group music therapy intervention with female adolescents in an educational treatment centre involving stepping, which is described as a series of body percussive movements such as foot-stomping and hand-clapping, paired with chanting or singing, significantly increases group cohesion. The adolescents who took part were identified as being at risk of dropping out of school and were engaged in violent and risky sexual behaviours. The results from this study suggest that stepping can promote positive social behaviours in adolescent youth¹².

A study by Boussicaut (2003) of students with behavioural difficulties, set out to see if the use of tokens as rewards, to reinforce students demonstrating appropriate behaviours during music therapy sessions, would decrease behavioural problems. From the school's behaviour data sheet it was shown that the group who had received tokens showed some improvement on social behaviours but there was no significant difference between groups in the reduction of inappropriate behaviour.

An interesting study was reported by Chong and Kim (2010). It examined how an after-school education-oriented music therapy programme impacted on students'

¹² Stepping was trialled by Long (2007) with an original rhythm-based scheme to improve reading amongst low-ability readers in primary schools. This followed research that linked a child's sense of rhythm to their reading ability. Some children at primary school were taught to clap or stamp their feet in time to a simple piece of music for ten minutes a week and this improved their level of reading comprehension.

emotional and behavioural problems and academic competency. The students received a block of music therapy sessions for 16 weeks which involved playing music and other activities to promote academic, social and emotional skills. The Social Skills Rating System (Gresham and Elliott, 2008), which measures social skills, academic competency and problem behaviour, was used by teachers before and after the programme. Some areas of social skills and problem behaviour improved significantly after this structured music therapy programme but it did not affect the students' academic competency.

Montello and Coon's study (1999) on both active and passive group music therapy with pre-adolescents with emotional, learning and behavioural disorders, asked teachers to rate and confirm any noticeable changes in the students' attention and motivation. Results showed that, after a period of four months of music therapy, the most significant change was found in levels of aggression. This ground-breaking piece of research showed that group music therapy was effective in facilitating the process of self-expression and could provide a channel for frustration, anger, and aggression.

2.8 Music therapy in schools III: for youth at risk and disaffected adolescents in mainstream schools

There are fewer therapists working specifically with this client group in mainstream schools, as highlighted in the systematic review of literature by Carr and Wigram (2009). However the literature, mostly by therapist reporting, does suggest that music therapy is an effective intervention. The majority of the research literature is qualitative with an emphasis on case studies. More of the quantitative studies are from the USA but the increasing need for evidence-based practice is promoting outcome-based studies in Europe (Carr and Wigram, 2009).

Music therapy is gradually carving out a role in some mainstream schools, particularly for children with special needs. As more students with special needs and diagnoses such as Autism and Asperger's syndrome are choosing to attend mainstream schools, these schools have an obligation to provide an accessible and broad education following British government inclusion policies (DfES, 2001b;

DfES, 2005). This is the same practice in other countries and music therapy is reported within this role in Germany (Palmowski, 1979; Neels, Lang and Wegener, 1998; Koch-Temming, 1999; Kartz, 2000; Mahns, 2002; Hippel and Laabs, 2006; Kok, 2006), in Italy (D'Ulisse et al., 2001; Pecoraro, 2006) and in Canada (Buchanan, 2000). However, there is no literature from the UK which specifically looks at integration as an aim for music therapy for students with special needs in mainstream schools (Carr and Wigram, 2009).

In their review, Carr and Wigram (2009) only found six papers in the UK which specifically address work within mainstream schools and four in secondary mainstream schools (Butterton, 1993; Strange, 1999; Derrington, 2005; Jenkins, 2006). Only a few music therapists have published work specifically about work within mainstream education. However, it has been found that songwriting is an effective technique of music therapy for young people (Derrington, 2005; McFerran and Hunt, 2008), that improvised music can tap into the world of an emotionally disturbed teenager with learning disabilities (Strange, 1999), that pre-composed music has its place in sessions (ShIPLEY, 2008; Derrington, 2012), and that being in a therapeutic relationship, perhaps without music at times, is also valuable (Cobbett, 2007; 2009).

2.8.1 Descriptive articles

Several therapists have documented the benefits of music therapy as a way to increase a student's self-esteem, address challenging behaviour, motivate learning and help develop interpersonal relationships (Sausser and Waller, 2006; Cobbett, 2007; 2009; McIntyre 2007; Derrington, 2012). Derrington (2005), Procter (2006) and Cobbett (2007; 2009) advocate the need for music therapy on the school site whether special or mainstream for reasons such as easing communication between the therapist and other professionals, reducing the stigma and practical difficulties of attending appointments outside school: parents often find it very difficult to attend hospital or clinic-based services due to transport issues and costs which results in many students not having access to therapeutic support (Daniels et al., 1998). This was also the finding of a creative arts research project led by Ierardi, Bottos and O'Brien (2007). They found that off-site or after-school programmes did not work as well as during

school time and attendance was higher and more consistent if the work took place during school hours.

Krüger (2000) set up work in a contemporary secondary school in Norway as part of a new strategy for helping secondary-aged students with emotional and behavioural problems. The students had been labelled as the 'bad guys' and were living up to this name and, by gaining attention from their challenging behaviour, were able to maintain that role within the school. Within this setting, Krüger found the computer to be a source of new meaning for clients who had not learned to play an instrument. Technology leads to 'broad possibilities of exploring, mastering, arranging, creating and improvising music' (p.80) and, importantly, the client can quickly become confident at using it and being in control. Krüger's case example clearly shows how the computer can offer structure as well as a virtual pool of ideas and endless creative play. His client, Robert, threatened other pupils, had very low respect for authority and was difficult to talk to but he was able to engage in music therapy. Through the shared use of information technology the process of a trusting and communicative relationship was able to develop. Krüger reports how he sat alongside Robert and encouraged him to master recording techniques. It was important that he allowed Robert to get angry with him and shout at him too which 'showed him that I would always be present and it helped to create bonds between us, giving us the opportunity to talk about what was wrong in his life' (ibid. p.82). Ultimately, the process of using information technology led to a product. Robert became very involved in music-making, burning CDs and creating covers for the CD cases, selling his work and even publishing his music on school radio.

A preventative approach is described by Nöcker-Ribaupierre and Wölfl (2010). A music therapy project, introduced into two boarding secondary schools in Germany, had the aim of helping students to express their emotional state and release aggressive tension. The project proved particularly successful in classes with migrant students from diverse cultures who were able to communicate and share effectively through shared improvisation (p.151).

2.8.2 Research projects

Several research studies from abroad set out to investigate and prove the effectiveness of music therapy, however, there is less literature in this field from the UK.

A study by Rüütel et al. (2004) used vibro-acoustic therapy to help adolescent girls from secondary schools in Tallinn, Estonia, who suffered from anxiety and low self-esteem. The girls were interviewed and the texts analysed using principles of grounded theory (Glaser and Strauss, 1967). The results showed that the therapy enhanced relaxation, the girls' coping ability and improved their physical self-awareness.

A study to examine the effects of a short-term music therapy programme on the classroom behaviours of newly arrived refugee students in a secondary school was run in Australia (Baker and Jones, 2005; 2006). A cross-over design with two five-week intervention periods of group music therapy twice a week, and data collected from the Behaviour Assessment Scale for Children, were used to evaluate a range of positive and negative school behaviours. Results showed a significant decrease in externalising behaviours, with particular reference to hyperactivity and aggression.

In the US, Hendricks et al. (1999) introduced a music-based programme for students in a secondary school who demonstrated depressive symptoms. Results from this study with pre- and post-testing showed a decrease in their symptoms. Hendricks (2001) continued this line of investigation further, aiming to determine the effectiveness of adding music therapy techniques to cognitive behavioural group treatment for depressed adolescents. The Beck Depression Inventory was used as one of the measures before and after a twelve-week period of treatment. There were 63 participants and results clearly showed that, by adding elements of music therapy, there were reduced scores in depression and an increase in self-concept.

In Denmark, Roca (2011) explored how music and a humanistic approach to group music therapy helps in the formation of identity in adolescents through emotional expression and interpersonal relationships. Her study was undertaken in a secondary school with a group of nine adolescents who had chosen music as an optional subject in their fourth year, at the age of 14. They received 30 sessions over three months.

The sessions aimed to increase the adolescents' learning resources and their social and emotional development. The study found that adolescents benefitted from having a space where they were encouraged to communicate honestly within a group.

An innovative music therapy group project run by Fouché and Torrance (2005) in Cape Town, South Africa, involved youth rival gang members and was successful. Brought in by police escort, the young people voluntarily met each week, shared their stories and improvised together joined by the magnet of music. The authors write: 'Music is a 'cool' thing to do. Within the gangs' rap/hip-hop culture, the musicians are the heroes, looked up to by the youth; the ones who give social commentary'. The importance of using rap and hip-hop in music therapy is also reported by Elligan (2000 and 2004), Tyson (2002), Tillie Allen (2005), Kobin and Tyson (2006), Cobbett (2009) and Uhlig (2011b).

Uhlig (2011a and 2011b) looks at the effects of vocal interventions in music therapy on the emotional and cognitive development of at-risk children and adolescents. Having developed a rap music therapy method to support the child's expression 'of emotional and cultural values sustained by a rhythm' (2011a, p.79) she suggests that, together with the therapeutic relationship based on sharing rap, behavioural changes can occur. This is the focus of her on-going research investigation.

In the UK, music therapy in mainstream schools has been the focus of some student therapists (Carson, 2007; Hitch, 2010; Crookes, 2012), interested to know how music therapy promotes inclusion of children with special needs, how the mainstream school environment can impact on practice and how methods of engagement may be diversified in response to mainstream children. Hitch concludes her findings with the need for further research and, in particular, longitudinal approaches with quantitative methods.

Pethybridge and Robertson (2010) call for a new approach to working in schools and advocate the distinction between clinical music therapy and educational music therapy, an approach which they define as 'the potential to guide the student into areas of learning about music as a result of the musical experience acquired through musical interaction' (p.131). Students from a language and communication unit attached to a mainstream school took part in their research study, called Youth Music

Initiative, and the intervention involved both child-led creative music-making and structured activities to enhance social skills. Findings showed that such involvement in small group work led to greater ability 'to address educational objectives, both musical and non-musical' (ibid. p.142).

Haines' (1989) study of group music therapy with emotionally disturbed adolescents showed that music therapy enhanced group cohesion and cooperation. Students were more willing to work together after they had taken part in a music therapy group together. Some specific problems, such as school refusal and bullying, have been looked at in smaller scale studies. According to Shipley (2008) music therapy can offer highly anxious, school-refusing adolescents the chance to discover meanings and truths about themselves. She argues that without a coherent sense of self and identity, the adolescent can encounter difficulties, resulting in school refusal and music therapy can help 'as part of a multi-modal treatment approach, to come to terms with their identity in a safe environment' (p.2).

2.9 Conclusion

This literature review has shown that there are different approaches for clinical work with adolescents in a variety of settings and there is considerable evidence of research in the other arts therapies. However, there are fewer quantitative studies in music therapy with this client group than with others and an outcome-based research project has not been carried out for youth at risk. Therefore this research area is new and much needed.

From the Office for National Statistics (2004) 'at least one in ten children aged between five and fifteen faces emotional, social or behavioural problems such as anxiety, depression, conduct, hyperkinetic and other less common disorders' (Karkou, 2010, p. 59). 'In a survey (Health Advisory Service 1995), head teachers of schools for students with emotional and behavioural difficulties, estimated that 46% of their pupils needed therapeutic support but only 9% received any' (Cobbett, 2007). The increasing number of adolescents with an emotional disturbance and/or behaviour disorder, indicates the need to develop more specific programmes and approaches that work with affecting self-regulation and communication. Wherever the students

are, whatever educational setting they are in, there is a need to offer them therapeutic support.

Music therapy's impact on improving emotional well-being in young people needs to be evaluated to meet the demand for evidence-based practice. The gap is not just in the published literature but in the clinical field which is why there needs to be further research. The findings from this review led me to design a method that would systematically gather data from students receiving music therapy, both through quantitative and qualitative means. For example, the study by Ierardi (2.5.1) influenced the development of my design and in particular on the choice of questionnaires and how they would be administered.

It is also not surprising that another project looking at the effects of music therapy on adolescents with emotional and behavioural problems (Doran, 2010), referred to in section 2.3.3, began soon after mine as the literature calls for more research. Such studies together will hopefully help to promote the development of new work as well as present evaluation to established services and further the cause for music therapy with adolescents.

CHAPTER 3

THE CONTEXT AND SETTING

3.1 Introduction

This chapter describes the background to music therapy at The Cottenham Academy and its development in line with the many changes made in the school over the last ten years. It sets out the context for the research project, the reasons some students are referred to music therapy and a description of the monitoring system and other evaluative tools. Some case vignettes illustrate how music therapy fits into this educational system and examples are given of the practical issues of providing music therapy in a special and mainstream school. It requires a flexible approach by the music therapist to meet students' needs, fit within the short school day and work around the busy schedule of secondary schools. The impact of the school environment and how it can affect the student having therapy is also considered.

Music therapy was first introduced to Cottenham when it was a mainstream school for students aged 11 -16 with a Learning Support Unit. It is now known as The Cottenham Academy¹³ and consists of two schools: a mainstream secondary school for pupils aged 11 -18 (Cottenham Village College with a Sixth Form Centre) and a special school for students with emotional and behavioural difficulties (The Centre School). When the Learning Support Unit's status changed into a school it was a significant development and the two schools, sharing one site, became federated¹⁴ in 2008. This means that they share a governing body, senior leadership team and many teaching resources.

Learning at Cottenham is centred round the individual which means there is as much emphasis put on vocational training as there is on academic achievement. The different avenues for learning demonstrate proactive inclusion and the school's efforts to meet the needs of all its students. Inclusion, defined in section 3.2.2, has

¹³ The school agreed to be named but it is still difficult to identify individual students involved in the project and names have been changed in all cases.

¹⁴ A federation is a formal arrangement between two or more schools to work together under a single governing body and usually share a head teacher.

had an impact on music therapy and other services provided for students in education, particularly in mainstream. The school's openness to new ideas, and crucially its focus on supporting and including children with special needs, was evident from day one.

Throughout the research, I continued to be employed by The Centre School (two days a week) and for one day a week by Cambridgeshire's hearing support service, whose only unit for secondary-aged deaf pupils is based at Cottenham Village College (Derrington, 2010). These two employers oversee all referrals to music therapy, most of which are for students in The Centre School or the hearing support service and this study includes both populations. Some referrals may relate to students who do not come under their remit but whose referral they may still recommend. For example, students in the mainstream school have been referred in the past for reasons such as bereavement, following an incident of severe bullying or for ongoing emotional stress as a young carer. This illustrates how the teams and the schools collaborate and support each other.

3.2 The mainstream school: Cottenham Village College (CVC)

Cottenham Village College is a large campus mainstream school with about a thousand pupils aged between 11 and 16 (Key stages 3 - 5) and is situated in a semi-rural village six kilometres outside Cambridge. Mainstream means it is a school for all children, not just those with special educational needs (SEN). The catchment area includes an army base and a Travellers' site so the registration of some pupils can be fluid, with many pupils leaving and joining school at different times.

Traveller students should be registered at a school but many grow up outside educational systems (Garrett, 2004). Cultural differences can make Traveller students feel isolated and, since their schooling is frequently interrupted, it can be difficult for them to make friends and be well integrated at school. Due to the lack of continuity in education they may be of lower ability in their age group. This can lead to 'acting out' behaviours in order to mask their difficulties or to gain peer approval, or they may even challenge or be challenged to fight to determine the pecking order (Derrington and Kendall, 2004). Throughout their schooling students are supported

by Traveller Education Services who serve as mediators between the school and home, which is particularly important when the students who demonstrate challenging behaviour are put at risk of exclusion.

The majority of the college's students attend all classes and follow the National Curriculum¹⁵, achieve good grades and go on to further education. There are more than the average number of students with special needs and disabilities at the College largely due to the facilities and courses it offers. As well as its federated school which specialises in helping students with emotional and/or behavioural difficulties (described in 3.3), it has a designated unit for students with speech and language difficulties and hosts the county's only hearing support unit for secondary-aged pupils.

Hearing-impaired students at Cottenham Village College are well supported by a strong team of teaching assistants and two teachers of the deaf which is crucial for the student's integration and access to the National Curriculum. In addition to offering academic support, staff often need to take on a pastoral role and deal with students' emotional needs. Encouraging students to be independent and take responsibility for their learning, assisting in lessons and even intervening in social situations, also creates a dichotomy which is difficult for the teaching assistant who is only too aware of the sensitivity of their role. This level of surveillance and protection can lead to the disempowerment of the supported student in developing their own independent learning strategies. It is also only normal that students work closely with their key-workers and support staff, sharing issues as they arise. Part of the vision for music therapy within the hearing support service was to alleviate some of these pressures on staff by providing students with another place to express themselves and talk about feelings which are confusing or difficult.

¹⁵ The National Curriculum is the school curriculum authorised by the UK government for state primary and secondary schools in England, Wales and Northern Ireland.

3.2.1 Inclusion

The Government Green Paper ‘Every Child Matters’ (DfES, 2003), focused on five main areas: staying healthy, keeping safe, enjoying and achieving, contributing to community and achieving social and economic well-being. In response to this, the Office for Standards in Education, Children’s Services and Skills¹⁶ (Ofsted) developed an integrated inspection framework for education, health and social care services around the needs of children. The Children Act 2004 which followed set out to ensure the well-being of children from birth to 19. This Green Paper aimed to address the problem of children falling through the gaps between different services and was designed to change the social and educational provision for children by creating a framework of services to support children, with particular attention to those in care, from impoverished backgrounds or suffering abuse.

Inclusion, as defined by The Department for Education and Skills, ‘is a process by which schools, local education authorities and others develop their cultures, policies and practices to include pupils’ (DfES, 2001b, p.2). The idea that parents could choose where to send their children with special needs was part of the UK government’s policy on inclusive education which was established in the 1990s. Since the document ‘Inclusive Schooling: children with special educational needs’ (DfES, 2001b) was introduced by the government, it has meant that over the years increasing numbers of children with special needs have been attending mainstream schools. Children with special needs are children with ‘learning difficulties or disabilities that make it harder for them to learn than most children of the same age... [and who] may need extra or different help from that given to other children of the same age’ (DCSF, 2007a, p.6).

Every school’s provision for special needs is an essential part of any inspection but it is not just about inclusion for special needs: ‘It is much more to do with creating and sustaining systems and structures which develop and support flexible and adaptable approaches to learning’ (Corbett, 2001, p.2). Minimising barriers to learning is a new term to help define inclusive education (DfES, 2001b). Inclusion is ‘a process by which schools... and others develop their cultures, policies and practices to include

¹⁶ A government department set up in 1992 to be responsible for regulating childcare and inspecting schools.

pupils... [Schools] should actively seek to remove the barriers to learning and participation that can exclude pupils with special educational needs' (p.2). Therefore, it involves maximising resources to support learning and participation for everyone. However practically speaking, it may be more straightforward for a school to address the physical access needs of students than manage those disruptive and disaffected students with challenging attitudes and threatening behaviour. According to Ofsted's report (2004), students with emotional and behavioural difficulties were putting the biggest strain on the inclusion policy and mainstream school resources and there was a huge need for more specialist units attached to mainstream schools. The Learning Support Unit at Cottenham Village College was one such specialist unit.

My suggestion that music therapy can support students and promote inclusion in mainstream schools is one of the key aspects of this study. Music therapy has an increasing role in supporting students with special needs such as Autism, physical disability or sensory impairments (Tomlinson, 2010; McTier, 2012; Strange, 2012). However its role in supporting students at risk of underachievement or exclusion due to emotional and/or behavioural difficulties is much less evident and lends weight to the reason for this research.

3.2.2 Music therapy for students at risk of exclusion at Cottenham Village College

This section describes the system of referral to a Learning Support Unit which was in place when I set up music therapy at CVC: initial problems with students who exhibited challenging behaviour were dealt with firstly by form tutors, then by head of department and ultimately by head of year, if problems persisted. One of the outcomes from such a process was for the student to be placed within the specialist unit for a while and an individual timetable to be created. During this time the whole staff team would be asked for feedback on the student in their lessons, both positive and negative. Communication across subjects is always vital because students can behave differently in different subjects and with different teachers. This is the reason that three teachers for every student were asked to complete questionnaires for this research study (5.5).

The Learning Support Unit at Cottenham Village College worked in a similar way to a Pupil Referral Unit (PRU) or Social Inclusion Centre (described in 1.3), which meant that it provided specialist education and support to students in a mainstream environment. A Learning Support Unit is part of a whole school systematic approach to behaviour management and where students, often with complex needs, are referred for additional support to help them achieve their potential (McSherry, 2004). At Cottenham, the students followed a reduced and individually-tailored timetable. They continued to attend mainstream lessons which they could manage and enjoy but other lessons were spent in the unit, where they received help with homework and could relax or do activities such as cooking and play board games. The individualised timetables were designed to meet the students' learning and emotional needs. Reintegration to full-time mainstream classes was often the end of the process for students with behavioural difficulties although this was not possible in all cases.

Some students used the Unit all the time and were not included in any mainstream lessons. The Unit offered these excluded students an alternative programme which was unique in Cambridgeshire. Its school day was short and divided into two, with small class lessons forming the first part of the day and activities, usually off-site, the second. Students in this Learning Support Unit, whether full or part-time, could be referred to music therapy. The majority of referrals indicated that the students' learning was affected by severe emotional difficulties, either as a result of one-off trauma or from ongoing emotional stress¹⁷. The head teacher of the unit recognised the impact that emotional distress had on learning and the fact that, when these feelings were overwhelming and unaddressed, they could cause many difficulties in the student's behaviour in school. Music therapy with students with learning disabilities, and for the ones following the alternative programme for those whom mainstream schooling had failed, was a way to directly address their emotional needs.

Strategies put in place by teachers and head teachers in schools and Learning Support Units to manage disaffected students have included counselling, mentoring and other in-school support services (Riley and Rustique-Forrester, 2002). Doherty (2009) stresses the importance of play in inclusive education and opportunities for all to interact with peers that promote social and communication skills and realistic life

¹⁷ Referrals were made by teachers, other professionals, the school nurse or the students themselves.

experiences. The leadership team at Cottenham recognises this need to play and be creative which is one reason it has fully supported music therapy.

It was unusual for a mainstream secondary school to have music therapy when I first set up the post in 2003 and, according to published literature, it was the first secondary school in the UK to employ a music therapist directly. This new music therapy post was the focus of an article in the Times Educational Supplement (TES) the following year. This is significant because the research project arose from this early innovative work. It was necessary to consolidate and provide an evidence base for this new field. My work in a mainstream secondary school (and its local feeder primary school) attracted attention because it was a new direction for music therapy in education. Although I worked with students with learning disabilities, as is more commonplace in special schools, I also worked with students with complex emotional difficulties such as those who had suffered loss through bereavement or been excluded from their previous school. It was reported in the TES that ‘for music therapy to find a place in a mainstream secondary school – furthering the cause of inclusion and helping pupils with a wide range of needs – is a significant departure’ (Hinds, 2004).

3.3 The special school: The Centre School

In November 2008, when the Learning Support Unit had over 50 registered full-time students, it became a school in its own right and was named The Centre School. It is organised specifically for students with complex emotional and behavioural difficulties who cannot manage in mainstream education. This school is distinct because it is on the site of a normal secondary school so, whilst the students are excluded and attend a separate unit, they are not isolated. The Centre School is federated with the college and the schools share their resources so they remain firmly linked. The mainstream college plays an important role in helping to reintegrate students from The Centre where possible. For example, a student in The Centre School can access mainstream classes with support, and a mainstream student who is struggling can be helped by attending The Centre School.

The school focuses on individual learning where students follow personalised learning plans which can be tailored to their strengths. The students are taught core subjects, such as literacy, maths and science, in small classes in the morning. After break they usually go off-site and learn through other activities such as art, cooking and shopping. The students are also offered lots of different sports including swimming, tennis, boxing, horse-riding, golf, sailing, go-karting, driving and quad-biking.

The Centre School has a student-centred approach and its ethos is about helping students see the positives and celebrating small changes. It could be seen to provide support which allies with Bowlby's attachment theory (Bowlby, 1988) and his concern for children to have a secure base. Students need a constant and dependable space from which they can operate, that is a secure physical base, and a place to which they can return (Bombèr, 2009). The staff team does not have a separate staffroom which means that all the teachers, instructors and students share the same space at break times. They play games such as table tennis, pool, cards or board games together allowing healthy and positive relationships to develop which are based on mutual respect and trust. Such interaction, together with the dependable infrastructure of school, enables students to become more confident and try new things with people they know will help them.

This sense of holding, described by Bowlby (1984) as an essential environmental provision for the baby, and the term 'container' from Bion's psychoanalytic theory (Bion, 1962), is helpful to consider within the context of school. For some students this holding provides security that they are not experiencing at home. The caregiver and teaching staff learn to hold the young person, providing 'a capacity to identify' (Bowlby, 1988, p.28). In this way staff understand what is going on and what the young person may be feeling. Alongside the emotional stability which The Centre School provides for students, this holding facilitates the student's personal development and a sense of self and autonomy.

A school's systems approach (Dowling and Osbourne, 1994; Farrell, 2006b) looks at challenging behaviour in context and not just for a rationale to explain it. This can be healthy and empowering for the young person who is then involved in their schooling and, for example, will know and understand their own behaviour plan. Similarly, a

close joint systems approach between the school and family can promote better communication and behaviour management. ‘However well systems are set up and monitored, the vital component for success is the relationship between teachers and their pupils’ (McSherry, 2001, p109). Systems which reward positive progress are invaluable and students at The Centre School work with clear targets and performance indicators. Section 3.5 explains how music therapy fits into this scheme of work.

Incidents of challenging behaviour and incidents which involve restraint are logged by the school staff team. Howarth and Fisher (2005) clearly define levels of challenging behaviour as follows:- Level 1 refers to a student who swears, answers back, gets out of their seat and constantly makes noises; Level 2 is when a student becomes verbally abusive to another pupil, continuously swears and refuses to work, preventing the teacher from speaking to the whole class; Level 3 relates to verbal abuse to an adult, a student’s refusal to obey reasonable requests, assault on another pupil, or leaving the classroom without permission; Level 4 relates to behaviours such as verbally and/or physically threatening an adult, assault on an adult, leaving the school grounds without permission, providing illegal substances, or a violent attack on another pupil. The logbooks at The Centre are essential for tracking the behaviour of pupils and intervening with behaviour plans before things escalate to incidents at level 4. Referrals to music therapy are generally made when a student’s behaviour is getting worse, as shown by entries in these logbooks.

3.3.1 Students at The Centre School

On the whole, students at The Centre School are very troubled young people. All the students have complex needs and many are battling against economic and social difficulties as well as emotional and behavioural problems. The majority of students have a statement for special needs¹⁸ for social, emotional and behavioural difficulties, and many have associated learning difficulties. Some of them have parents with

¹⁸ A statement of special educational needs sets out a child’s needs and the support they need in school. This is reviewed annually.

alcohol or drug addictions, many are in care¹⁹ or may even have a child protection order²⁰ and some are additionally supported by the youth offending service. The students are probably the most vulnerable in the county and many have to travel long distances as the school serves a wide geographical area. They can exhibit extremely challenging behaviour and have usually experienced failure in other forms of education: some have been excluded from primary school and others from mainstream secondary or special schools. Some have been moved from Cambridgeshire's EOTAS service (Education Other Than At School) and others may be from out-of-county specialist provision that has proven unsuccessful. These young people become expert at handling normal school methods of discipline and sanctions become less effective. 'Not doing' usually becomes the students' established pattern of behaviour which may be linked to their consistent rejection and inability to fit in. The Centre School, as a whole, tries to think differently, leading by example so the students can start to think differently.

More male students have managed moves within the education system and more boys attend schools such as The Centre School. In fact, boys' behaviour was also reported as being more challenging and often more aggressive than girls' (ATL, 2011). At the start of the project, in the school year 2009/2010, there were 55 students aged between 11 and 16 of which only four were girls. From September 2010 there were fewer students due to the school's status of special measures²¹ and no new pupils were admitted until changes were made in the school. From September 2011 figures had risen again and there were 49 students on roll, of which five were girls.

A high percentage of students with complex emotional and behavioural difficulties have Attention Deficit Hyperactivity Disorder (ADHD) and some students at The

¹⁹ The majority of children in care are there because they have suffered abuse or neglect. At any one time around 60,000 children are looked after in England, either in foster care (73%), children's homes (10%) or other settings including residential schools. Around 90,000 children are looked after at some point in any one year (DfE, 2012).

²⁰ A child protection order is an order usually made by the Children's Court, when a child is considered to be in need of protection under the Child Protection Act 1999.

²¹ In November 2009 The Centre School was put in 'special measures'²¹ by Ofsted which meant that throughout the time that the research project ran significant changes to the school's practice were made, with a clearer focus on teaching and learning. In June 2011, as the project neared its completion, the school was taken out of special measures and deemed to have made good progress in all areas.

Centre School have a diagnosis of Autism or Conduct Disorder. All of these conditions have higher prevalence rates among males than females²². On average, 25% of pupils at The Centre School are medicated for ADHD. In adolescence the condition may predominantly present with attention and concentration difficulties without the physical restlessness and over-activity which are seen in younger children (Vostanis, 2007). Managing behaviours due to ADHD is easier in smaller classes and when students have more time they can cope more easily because they do not feel stressed or panicky. Conduct disorders are commonly associated with ADHD and can include a range of behaviours such as aggression, destroying property, stealing, truancy, breaking into houses and other violations of social rules. Children with conduct disorders tend to have deficits in social skills and lack skills to understand or find alternative solutions to problematic social situations.

Other than clinically defined needs, students at The Centre School may be emotionally traumatised from abuse, been subject to neglect, for example, or witnesses to domestic violence. Boys frequently react to such trauma by manifesting physical aggression towards others. Girls may play truant, lie, run away, misuse substances, suffer from extreme anxiety or have problems either by refusing food or over-eating. This difference in behaviour is reflected in the statistics which show that exclusion for boys is higher than for girls²³. Particularly low self-esteem is a common feature associated with emotional and behavioural difficulties and students are ‘unlikely to make good academic progress commensurate with their ability and present exceptional and extreme behaviours either on spectacular one-off occasions or persistently over time’ (Daniels et al., 1999, p.10).

3.3.2 Music therapy for students at The Centre School

Due to their past experiences and usually low self-esteem, students at The Centre School often find reasons not to try something new and prefer to give up. My aim for

²² ADHD is diagnosed two to four times more frequently in boys than in girls (Singh, 2008). There is evidence to suggest that there are more boys with Autistic Spectrum Disorders than girls (Jenkins et al., 2009).

²³ School exclusion statistics from the Department for Education 2009/10 showed that the exclusion rate for boys was approximately four times higher than that for girls (DfE, 2011).

all students in music therapy is to increase their confidence, encourage creativity and help them recognise what they have achieved. Taking away the barriers of their fixed mindset so that they gradually adopt an 'I'll give it a go' attitude, is central to my work.

The importance of learning social skills and helping young people to make changes is also key to the work, especially as young people spend much of their free time playing games on play stations. I have often wondered at the 'lives' the players are given and how they can get up and start again even if they are shot down. Games can also make students think that they are experts and if they go wrong or mess up they can hit the re-start button, but, when things do not go their way or they make a mistake in life, they can react aggressively and need to kick out or hit a wall. Improving listening and waiting skills, sharing control in a musical exchange, turn-taking with different instruments and making things up in music therapy, whether they sound right or wrong, can be a rewarding and a positive experience and, importantly, help students to find ways to cope when things do not turn out as they expect.

As discussed in chapter one, adolescents find expressing their feelings through music easier than talking about them. They do not all have a huge verbal repertoire nor the capacity to articulate thoughts, which is why music therapy can be so effective: it provides alternative ways of self-expression and communication. The music is relevant and maintained within the teenager's cultural context. As Ruud (1998) suggested, music is related to our experiences and helps build identity. Music therapy, like the secure base provided by The Centre School, offers students the opportunity to explore who they are and how they feel as well as developing a good, secure sense of self.

In school, I talk to students on a regular basis and remind them about their sessions but many of these young people doubt that something positive such as music therapy will last. As school holidays approach, this becomes much more pronounced. I frequently have to reassure students that sessions will continue after the holidays as many become very anxious about endings and dread the uncertainties which breaks usually bring. For some it is expected that they will get into trouble and for others the idea of holidays is filled with fear that there will be nothing to do and no one to see. It

is critical that music therapy remains consistent as each end of term approaches. Bombèr (2009) refers to the school's role as holding everything together as 'emotional scaffolding [from which these young people can grow in] confidence, courage and curiosity to explore and attempt new tasks and learning' (p.41). This explains why school breaks are so difficult for many of the young people as well as perhaps reminding them of other endings and breaks which have been abrupt and difficult. Sometimes it is enough to talk about the break and the return to school. At other times it is helpful to think about future projects which the student might like to do on their return and think together about things they can do to prepare. School breaks remind me how important it is for these students to know that they will be kept in mind, as illustrated in vignette 3.1.

Vignette 3.1

Billy, who is 13, was referred because of his challenging behaviour. He attended weekly sessions unstintingly and jammed for an entire year. He either played the drum kit, electric guitar or piano and each time, usually playing different instruments, we improvised together. It was difficult to discern who was following who at times as the music felt intrinsically shared. We usually got into a common groove before moving on to explore a range of dynamics and styles. With most improvisations exhaustively covering a multitude of moods the piece of music could sometimes last as long as 40 minutes, the length of the session itself. Billy hardly ever said a word and did not respond to my reflections on the music. If he took time out in a session, he liked to swivel on a chair or gaze out of the window. It was only as we approached the end of the first term that the value and purpose of these improvisations really became clear. "Is it gonna carry on after the holidays?" he asked. Knowing this student's background it was only too clear that his experience of good things often ended abruptly.

Although he seemed to hear my assurances that music therapy was not finishing and that our work would continue, he still seemed agitated and, unlike his usual quietness, talked about death and unexpected disasters such as earthquakes and floods. We talked about looking ahead and the music we would play when we were back and then, just before school broke up, he

asked if he could take one of the whistles home for the holiday. He promised to look after it and I knew it was important that he should take it. Winnicott (1971) identified such a physical object as a transitional object. It was an object reminder that music therapy would continue, that he was held in mind and that school was a familiar and supportive place to return to.

After the holidays our improvisations continued in the same way but now, having survived a break, seemed more meaningful and communicative. Billy had a greater trust in the therapeutic relationship which had been formed through shared music-making. He knew that he was expressing himself in a way that felt listened to and understood and that it was safe to do so, as the process was ongoing, consistent and reliable.

3.4 The music therapy garage

This section describes the setting up of music therapy at a mainstream secondary school which could provide a useful model for others. When I began at the school I was offered two possible places to work, either a small room off the main area of the Learning Support Unit or a slightly damp garage which was full of bikes. I thought the garage was ideal. It was a separate building away from other classrooms but still very close to the school. It had been converted into a bike workshop so it had heating, power and windows. It was spacious and there was a graffiti logo across one wall claiming 'Wheel Fix It!' I began with just a few percussion instruments but soon afterwards bought a drum kit and digital piano which helped to set aside one corner of the room for music therapy.

Within a few months, the school had increased my employment from half a day to two days a week. I continued to collect instruments by finding bargains on 'ebay' and responding to adverts for instruments which were being given away. I also managed to retrieve various items which the school was throwing away. With the gradual accrual of resources, including a piano, guitars, congas and a violin, cupboards, a table and chairs, I was gently able to extend the boundaries of the music therapy corner using old exhibition boards to mark out the music space from bike repairs. The instructor who supervised the bike repairs was a keen drummer and understood the

importance of music for the students. It was therefore easier when, after two years of sharing the garage, the time came for music therapy to have full use of the garage and for the bike workshop to move on.

Colleagues in the Design and Technology department, who I also played with in a band, helped me clad the long back brick wall to provide sound-proofing and extra insulation. Innovation and change often relies upon networking and relationship building which is why the school community and my position in a band with colleagues was an important element in the development of this work. Over another weekend, having recruited friends' and my parents' help, the garage was transformed into a fully furnished and carpeted music therapy room free from tools, bike chains and oil. Despite some suggestions to change its name to Sound Lab or Music Shed it is still known as The Garage. The 1990s genre of electronic dance music sharing the name seems to add kudos and appeal to the teenagers who use it because even the most resistant students admit the garage is cool.

The photographs below, figures 3.4.1 - 3.4.3, show how the music therapy room developed. Unfortunately, there is not a picture from the very early days when I worked in a small corner of the room surrounded by bikes, but these three photographs show how the space changed.

Figure 3.4.1 A workshop for music therapy and bike repairs



Figure 3.4.2 After the bike workshop closed down, before the renovation work



Figure 3.4.3 The renovated music therapy garage



As well as enormous support from the school, music therapy received grants for instruments from the High Sheriff's Award from the Cambridge Community Foundation. It now has all the usual instruments you would expect to find in a well-equipped music therapy room plus several large African djembes, electric and bass guitars, a PA system with microphones and two full-size drum kits. The choice of instruments is crucial. I am aware of keeping a balance between having enough large and loud instruments to withstand big and boisterous feelings and smaller percussion instruments which may be used in different ways. As well as some instruments that make unusual sounds, I have an accordion, harmonicas, two ukuleles and a trumpet.

All the instruments are of good quality and therefore do not tend to break easily. It is important 'not to limit the individual's expression by instruments which can be broken or blown to pieces' (De Backer, 1993, p.37). The room is full of equipment but roughly speaking everything has a place and I try to reset it at the start of every session.

There is a range of CDs and playlists on computer, including rap, Hip Hop, dance, rock, pop, grime, garage and R n B music. The video camera is always out on a tripod and ready to be used as the students choose. Each student has their own digital tape and any filming is transferred onto computer, edited and burned to disc. Other technical equipment includes a DVD player and a laptop. I have used a computer and DJ equipment in the past but found that the student's intense focus on these distracted from the impact that therapy could have with interpersonal and lively engaging exchanges. I continue to use a laptop for recording and mixing, otherwise the work is interactive, face-to-face and usually relies on live music-making.

Preparation before a session is important. It is necessary that the equipment is ready to be used, for example, that everything is switched on, the drum sticks are on the drum-kits and the guitars are tuned. With teenagers, music comes about because instruments are left out so the layout of the room is important and makes a difference. There is a bass xylophone, acoustic guitar, cajon drum and glockenspiel alongside the comfy chairs. I have found that students who prefer to talk or who are reluctant to play instruments tend to fiddle as they talk and create accompaniment which allows a natural progression from talking to playing. For students who start playing in this way, I might arrange a different instrument by the chairs each week so that they try new instruments and can become more experimental.

The windows do not face directly onto busy areas such as a playground but the garage is adjacent to another one which stores the fishing equipment. Occasionally, sessions can be disrupted by excitable students who are about to go out on their activity but it is accepted that to keep a music therapy room uninterrupted in a school environment is bound to be difficult at times. Finally, concerning safety, it is imperative that I watch for aggressive cues and inappropriate behaviours so that the session is kept safe both for me and the student. At times this may involve filming, audio recording or, in a few cases, having to finish a session prematurely.

3.5 Music therapy and the educational system

A music therapist in an educational setting needs to proactively promote the work almost all the time. It can never be assumed that teaching staff understand the role of music therapy and, as much of the work is confidential, its purpose needs to be communicated even more. Giving presentations to staff on training days is a vital way to promote and further the understanding of the work and its relation to the students' learning. Just as importantly, for effective communication, the therapist needs to be aware of communication systems already in place in a school (McLaughlin, 1991).

The music therapist also needs to have a flexible approach when working with students who can be absent from school for so many different reasons. The nature of the students' needs and lives adds a certain amount of unpredictability so I rearrange sessions when possible to see everyone each week. There are always more students on my caseload than there are sessions available in the week and so a precarious juggling act has evolved. With this accommodating approach and a clear register of who has attended, I can make sure that students who are absent for a session do not necessarily miss out on music therapy for that week.

The number of sessions might also be unknown and endings can occur unexpectedly. For example, students may be excluded or moved abruptly for other reasons, such as changing foster home or being given a sentence by a juvenile court. It is important to create a positive and clear ending to each session and pre-empt any sudden ending as far as is possible. This may be done by using the video camera and allowing time at the end of the session to reflect on what has been played and enjoyed in music therapy. Vignette 3.2 highlights the importance of using the video camera for students who need to keep a record.

Vignette 3.2

Tim, who is 15, was a student who approached life with particular trepidation. He had known loss of family members, illness and separation from loved ones. He always looked forward to sessions and found it difficult to leave at the end. As he enjoyed using the video camera, watching part of the film in the last five minutes of each session became an integral part of the structure of

the session. His home life was chaotic and he showed no interest in taking a DVD away. Instead, our regular pattern of watching the film and talking about it afterwards became as important as our playing.

Then, in his third school term of music therapy, Tim asked to see some of his video from the first term. In this session he did not want to play any instruments but rather watched many different excerpts and, following the usual pattern, watching the videos encouraged him to talk. He spoke openly about how he felt watching the different films and was keen to reflect on the past. He was able to comment on how he felt now compared to then and all the changes that had occurred in his life.

This was an interlude and subsequent sessions were full of playing, using the camera, watching and talking about what we had played, as before. However, it was this predictable structure that added to his sense of security which allowed him to look back and consider feelings which were difficult and uncomfortable. The videos were also a real record of his playing and feelings at different times which he was able to keep and refer to when he wanted.

Music therapy is made particularly effective by its strong position in the school; due to the fact it is embedded within the system it has been a good site for academic research. The school set-up and time-tabled day already provides the structure which students need, so that therapy can take place: this culture helps students to attend their sessions regularly and on time (Derrington, 2005). The work also has to be clearly boundaried to protect students from peer pressure and knowing what other students do or play in therapy. Competition could come about if the work was not kept clearly confidential and students generally understand and respect this.

3.5.1 Monitoring and evaluation

The head teacher of The Centre School has supported music therapy right from the start and the provision has built up with the development of The Centre School. The need for monitoring and evaluation has challenged my work and reinforced an approach which has been shaped by the school's changes and its culture. At the

beginning I used to talk to staff as I saw them around school, informally and in meetings, to comment on students' music therapy. Whilst this was an easy way to get feedback it soon became clear that it needed to be documented in a more formal way so I created forms (appendix 3.5.1a) for members of staff to complete. Most teachers were happy to write down some of their key points in this way and recognised the importance of such feedback.

During the course of this PhD research project, Ofsted made their initial inspection on The Centre School because it had changed status from a Learning Support Unit and had previously been inspected as part of the College. As a Unit in 2008 it was classified as outstanding but in 2009, as a school, it was placed in special measures. As a failing school it needed support for success, not just to be planned and delivered but provided with a procedure of monitoring and evaluation (Farrell, 2001). As a result, the inspectors made frequent visits and the way the staff worked and evaluated each student's progress was scrutinised. Music therapy was not an area that was deemed inadequate but the process made me, along with my colleagues, focus on the ways that I monitored my regular working practice and evaluate this provision in a school alongside teaching and learning targets. I designed questionnaires to be completed by staff before and after the student's music therapy (appendix 3.5.1b). I also created a half-termly monitoring system in line with all other subjects, contributed to students' personal learning records and continued to use the Assessment and Qualifications Alliance (AQA) unit award scheme. Regular monitoring in a variety of ways helps to promote the work in evaluation-biased educational settings, as they encounter Ofsted, struggle with over-stretched budgets and question the value and effectiveness of music therapy, particularly in secondary schools.

The short questionnaire (appendix 3.5.1b) that is used before and after a student's block of therapy is ideally completed by the same teacher or instructor each time. They are asked to comment on the student's attitudes to learning, behaviour, social skills and to provide any other general comments. The questionnaires are then compared and any positive changes after music therapy are highlighted. These can be shared with staff and provide ongoing informal evaluation of the work. The questionnaires are a useful way to guide discussion about a student with other members of staff, particularly after a referral has been made, for the therapist to gain

a good understanding of the pupil's strengths and weaknesses. Although these questionnaires were not used in the research design, they were an important indicator that teachers' reports provide important observation of a student's progress in school and a useful means of gathering evidence.

3.5.1.1 Personal learning records and half-termly monitoring

One of the ways in which a student's progress is monitored is by the students themselves who keep a personal learning record. These records show what the student has learned through various activities and tasks. Coming up with new ideas, thinking about what has gone well, setting goals, listening to others and reaching agreements are achievable through individual music therapy sessions. Students are encouraged to take responsibility for their attendance at sessions, unlike compulsory lessons, and to organise the time and their resources. This reinforces the personal learning record's reference to being independent enquirers, creative thinkers, reflective learners, team workers, self-managers and effective participators. Students can take photographs or write about their music therapy for their record if they choose. This sort of evidence is parallel to other subjects and the students' practice-based learning. Photographic evidence is a crucial means of evaluation in most subject areas. However, for some pupils music therapy stands apart from their learning, it is private and they do not want to refer to it in the classroom and this is always respected.

Other means of evaluation of music therapy include video evidence, song compositions and recordings. As well as writing regular reports for annual reviews for the students with statements of special educational needs and meetings as they arise, I complete half-termly monitoring forms in line with other subjects at school (appendices 3.5.1c and 3.5.1d). Half-termly monitoring aims such as improving communication, concentration or encouraging cooperation, link in with the student's Individual Behaviour Plan (IBP) and Individual Education Plan (IEP) which set out a pupil's needs with specific and achievable goals. These do not interfere with the student-centred approach which underpins my work but add constructive thought to it. My primary aim is always to help students express themselves and communicate through music but the half-termly monitoring may include additional goals such as encouraging a student to take initiative and lead or to develop turn-taking skills. As

many of these students can seem directionless and the provision has to be time-limited due to the demand on the service from the high level of need at school, this sort of monitoring helps me to regularly review the impact and benefit that the therapy is making and understand when an ending is necessary.

Relating work to the IEPs does not lessen the therapeutic value of the work. The purpose of IEPs is to enable the child to make progress, depending on their emotional state, not to change the child to fit the system (Cornwall and Todd, 1998). Music therapy adds to the student's social and emotional aspects of learning (SEAL) and development. The SEAL initiative addresses students' emotional literacy and promotes social and emotional skills that 'underpin effective learning, positive behaviour, regular attendance...and the emotional health and well-being of all who learn and work in schools' (DCSF, 2007b, p.4). These skills are based on Goleman's (1995) categories of emotional intelligence: self-awareness, managing feelings, motivation, empathy and social skills (Vizard, 2009). Music therapy should be recognised as contributing to the emphasis on this aspect of learning and working with schools to meet these initiatives.

3.5.1.2 Assessment and Qualifications Alliance (AQA) unit awards

Achievement at The Centre School, however small, is acknowledged and congratulated. This is always recognised at each half-term's assembly when prizes and certificates are awarded. Therapy and education both help a person to acquire knowledge and skill (Bruscia, 1998a) but defining the work and maintaining boundaries can be challenging within a school environment that is based on awards, certificates and achievement. If therapy's goals are distinctly clear from these educational targets, the acknowledgement of musical skill that a student has acquired through therapy is safe.

Although the aims and the way of working may be different to other lessons and activities, music therapy can be included in one of the school's systems of assessment: using the Assessment and Qualifications Alliance (AQA) unit award scheme. It is a relevant and appropriate form of evaluation and it is obvious how important these awards are to the young people. They give students of all abilities

formal recognition of success in short units of work. The majority of students in the mainstream college achieve GCSEs but this is rare for students at The Centre School. The AQA Unit Scheme recognises the achievement in all non-qualification contexts which means that students can succeed as they go and, even though it is not a formal qualification, have a record of what they have learnt.

Their use of therapy is not being scored but the skills which students can acquire by default from using music as a means of self-expression can be acknowledged through these unit awards. To date I have written five unit awards for music therapy which have been validated by the AQA and are available on their national database for any assessment centres to use, such as schools, Pupil Referral Units or hospital education services. The units (appendices 3.5.5 – 3.5.9) are:- Exploring Self-expression Through Music; Communicating Through Music; African Drumming (2007); Expression Through African Drumming (2008) and Songwriting (2009). The certificates are awarded after the work has been completed and are only discussed in sessions if it seems important and useful for that student. At the end of term, on receiving his certificate, one student said: “That’s nice isn’t it... But it’s all about the music really”. This supports my view that such awards do not interfere with the therapeutic process.

Rewards are given generously and appropriately at The Centre School to encourage the will to succeed and a student’s belief in themselves. If students can start to lose the feeling that they always fail (some students even cite failing as something they are good at), they can begin to appreciate when things do go well and start the spiral of positive feedback (Stern, 1985). Students generally attend sessions on time, can organise their space, want to play and make the most of music therapy. It is this commitment and ability to apply themselves that is acknowledged through the AQA rewards and not how well they do in therapy.

3.6 Conclusion

‘Music is the art of expressing oneself in sound: through it, we turn inner body sensations, movements, feelings and ideas into external sound forms that can be heard’ (Bruscia, 1998a, p.62). This is the motivation for many students who want

others to hear what is being played and who fling wide the doors and windows for others to hear their music, even on the coldest day. However for others, making sounds that express how they are feeling and for these to be heard by someone else, even within the confidential setting of therapy, can often be the reason to refuse sessions. The way that music therapy is organised in school is very important. In order to help students get the most from music therapy, the setting and the systems have to be in place, including arrangements for when they refuse. If it does not feel safe and organised, vulnerable students with emotional and behavioural difficulties are not likely to keep attending.

As already considered, teenagers need structure and things to feel familiar and not unpredictable. The timing and the consistency of each session can be enough to hold this and provide the overall container, allowing students to feel safe enough to play. If a student's behaviour becomes very controlling it can be difficult to see the progress week after week. However, with the help of monitoring and reflection by notes written after sessions, as well as supervision, it becomes easier to see how a student has used the time in a way that works for them and how it has helped them. The specially designed music therapy assessments and the awards form just part of the monitoring of music therapy that has been set up at this school.

At every stage of its development, from Cottenham Village College with a Learning Support Unit to The Cottenham Academy encompassing two schools, the provision of music therapy has endured. Having made presentations to head teachers and Special Educational Needs Coordinators (SENCOs), and worked with other music therapists to promote music therapy, several other secondary schools in Cambridgeshire have followed suit and employ a music therapist to work with students with special needs.

However, music therapy needs to be made available to more disaffected students and to those who do not necessarily have special needs. As highlighted by the literature review in chapter two it has been recognised that music therapy helps adolescents with special needs (Flower, 1993; Strange, 1999; McFerran, 2010) but there is much less published evidence for its benefits for students at risk of exclusion due to emotional and behavioural difficulties. With an established pattern of working at Cottenham, good communication with the staff teams and a recognised referral

system, the research project was able to run efficiently with the support of both schools.

CHAPTER 4 (WITH DVD)

AN APPROACH TO MUSIC THERAPY WITH ADOLESCENTS

4.1 Introduction

Adolescents have much to express and plenty to say but are not always very good at conveying what they mean. Using music as a means of expression and inviting them to interact through improvisation can help young people to organise their thoughts, become more self-aware and begin to express themselves more clearly and with more confidence.

For students with emotional and behavioural difficulties, social interaction can be challenging and sitting still or concentrating for any period of time presents problems in schools:

‘Unlike most adult groups, adolescents do not often sit happily for an hour or so and attempt to sort out their problems in a mature and civilised way. More often they will be distracting each other by irrelevant chatter or thumping one another or the therapist’ (Shuttleworth, 1975, p.159)

The adolescent’s relationship to music provides scope for common ground which the therapist can use to engage the student in interactions which provide a basis for the therapeutic process. Healthy adolescents can often use their energy effectively. Youth at risk tend to behave more chaotically or put up an impassive front which either prevents them from showing interest in anything or diverts any energy they do have into negative behaviours.

This chapter describes an approach to music therapy with adolescents within a theoretical framework and highlights some of its characteristics. It is comprised of vignettes accompanied by video extracts on the DVD. Some of the original ideas were explored in a previous publication entitled “‘Yeah I’ll do music’: working with secondary-aged students who have complex emotional and behavioural difficulties’

(Derrington, 2012). Here, the ideas will be developed further focusing on individual rather than group music therapy due to the project's method.

The process of editing the video of sessions for the students revealed certain patterns and points of change that happen in the work and led me to recognise characteristics specific to this approach. All students and their parents or carers gave consent²⁴ for their work to be included on the DVD and in all cases the students' names have been changed. Specific details concerning their referral are not given for reasons of confidentiality.

4.2 Music therapy with adolescents

Nearly all teenagers relate to music and are actively interested in it as a way of communicating with their peers and socially identifying themselves. "You can't have parties without music" (Peter, in appendix 7.1.22, p.370) as earlier reinforced in 2.2.2 in the study by Garrett, Roche and Tucker (1997). 'The stereotype of a moody, monosyllabic and dreamy teenager is usually replaced by creative, communicative and dynamic play when music is the means of expression' (Derrington, 2012, p.195). Using musical improvisation with this age group can be particularly effective because it facilitates immediate and honest self-expression. However, there are lots of other ways in which teenagers can engage in music therapy and their ideas and responses to music have informed and continue to challenge how I work. "We are not what you think we are!" a chorus line by pop singer Mika (2009), suggesting that teenagers do not like to be 'worked out' but they do want to be heard, highlights the need to engage in the culture of adolescence (Cobbett, 2009) and understand its various forms of communication if therapy is going to be a successful intervention.

Adolescents can find it particularly difficult to focus, play musical instruments and improvise in ways which music therapists might hope and expect using traditional therapeutic means. My approach has been influenced by many music therapists (Alvin, 1975; Priestley, 1975; Oldfield, 1996a) however, some factors work

²⁴ The consent form used for each student is included as appendix 4.1. To be included on the DVD accompanying this thesis, the students and their parents/carers gave additional consent following the substantial ethics amendment (5.2.3)

particularly well with adolescents and appear key to a method that has come about from my work with adolescents.

Music therapy provides a time to share the experience of being creative and exploratory and a time to lead and make choices (Derrington, 2004). Away from peer pressure, students seem to enjoy this opportunity to express a part of themselves in a free and spontaneous way that can otherwise get ignored. Working on their own, they do not have to keep up with trends and worry about keeping their street credibility. Even those who are initially inhibited and guarded can become more open to the idea once they start playing and often realise that they do not have to keep up the appearance of being tough. Once they see what music therapy can offer them and are no longer held back by these constraints, more in-depth clinical aims can be set. These could include helping them to understand the impact of their behaviour both on themselves and on other people, increasing self-esteem and self-awareness.

Many students are referred to music therapy because they suffer from extremely low self-esteem and teenagers with emotional and behavioural difficulties often lack empathy so they are insensitive to the pain they cause others. Similarly they cannot always understand why others behave the way they do, so can quickly feel rejected. These difficulties mean that their need for individual attention can be great which is why the work is usually one-to-one.

4.3 A theoretical framework

Any encounter in music therapy sessions ‘presents a complex and multi-layered generating, expressing and conveying of emotional feelings and is dependent upon the music therapist’s capacity to generate, judge and read emotional responses to the music by patients within therapy’ (Bunt and Pavlicevic, 2001, p.184). Various theoretical approaches can be employed to help understand the therapeutic process and inform the therapist’s response.

Alvin’s model (1975; 1978) highlighted improvisation as a key way to relate to clients in an interactive approach that was not based on rules or structures imposed by the therapist. Her model of free improvisation, based on humanistic and

developmental psychology, is described as ‘where the music can be an expression of the person’s character and personality through which therapeutic issues can be addressed’ (Wigram, Pedersen and Bonde, 2002). Free improvisation is sometimes the means by which students choose to communicate but there are times when more structure, rules or themes are called for (4.4.1 and 4.4.5).

Writing by psychoanalytic theorist Stern (1985) on mother-infant interaction and affect attunement has been paralleled by music therapists (Robarts, 1996; Pavlicevic, 1997; Wigram, 2002; Oldfield 2006a) to show how the therapist can use music to relate to, and be with, clients, as a mother is with her baby. Mirroring by sound or gesture allows the mother to communicate that her baby’s feelings are being recognised and acknowledged, and therefore attunes to the child. Priestley (1994) describes improvised duets with a client as ‘special opportunities for the expression and exploration of transference emotions’ (p.79). This awareness of transference, counter-transference and other non-observable parts of therapy helps make sense of the work. Other influences from psychotherapy include setting clear guidelines and boundaries, as described in chapter three, to create a safe enough and confidential setting.

Behavioural music therapy is a treatment geared towards the modification of behaviour (Wigram, Pedersen and Bonde, 2002) to address specific symptoms rather than focusing on the client’s general development and well-being. The aims of behavioural music therapy (Madsen, Cotter and Madsen, 1968) can be relevant in an educational setting. This method is defined as the use of music ‘to increase or modify adaptive (or inappropriate) behaviours and extinguish maladaptive (or inappropriate) behaviours’ (Bruscia, 1998a, p.184). It only focuses on the observable part of the therapy and it fits in with the current climate for evidence of effective music therapy work in schools. Although my work with some students might have specific behavioural targets, the humanistic approach of client-centred psychotherapy, as developed by Rogers (1951; 1961), underpins my approach. Rogers describes the core conditions for a helping relationship as congruence, unconditional positive regard and empathic understanding. These conditions are crucial for the client to change and for a healthy therapeutic relationship to develop.

Rogers' methods, and the form of counselling based on them, follow the understanding that if the therapist puts their trust in the client then the client will be able to trust themselves. However, Rogerian therapists 'do not confront defences or interpret unconscious processes such as transference phenomena' (Brown and Pedder, 1991, p.95). In the same way, I do not interpret but may occasionally reflect back a thought to recognise and acknowledge a student's feelings. When working with a student who disapproves of everything, is oppositional and considers music therapy useless, I do not introduce the feelings evoked in me but refer to the student's mood. One student, for example, who complained of being bored and that I was boring him was able to expand further when I reiterated what he was saying; he was then able to talk about being bored in a different way, to explain that music always felt the same but actually liked its familiarity. Another student acted out a violent incident by hitting castanets aggressively using drumsticks. I observed him and joined in some parts of the role-play in order to help him recognise both the playful and realistic elements of the drama. By engaging in this way and listening to the student, he was able to talk about the bullies that needed to be punished and share what was happening through the play.

Congruence essentially means that the client is true to himself and does not need to shelter behind others or different roles. In the same way it is important that the therapist too should be genuine, not judgemental and communicate naturally. For teenagers, it is often crucial to help them to develop and understand their own identity. This can be particularly hard when so much of their identity might feel held together by peer group attitudes and trends (1.2). Individual therapy sessions provide a good space for young people to be true to themselves and react instinctively, away from peer pressure, to be playful and learn more about who they are and how they feel.

Unconditional positive regard is specific to the therapy setting within school. For teaching staff the boundaries have to be different and the use of sanctions helps students to learn that there are consequences to actions. This means that students may receive a detention for wearing incorrect uniform, for example, or be internally or externally excluded for disruptive behaviour or persistent non-compliance. The positive regard from teachers is therefore conditional rather than unconditional but that does not mean that teachers do not attempt to understand reasons for children's

behaviour. In music therapy, this attempt to understand such reasons is also the student's work. There is space for them to be and do what they want. As the therapist I aim to be consistent and offer unconditional positive regard for them and their feelings, within the normal boundaries of safety.

Finally, empathic understanding is essential when working with teenagers: accepting students by actively listening to them and acknowledging their viewpoint without agreeing can affirm their sense of self, regardless of whether they know themselves or not. It relates to the aims set out earlier in this chapter because it can help them to understand the impact their behaviour can have, both on themselves and other people.

4.4 Characteristics of an approach to music therapy with adolescents

My approach has been shaped by my work and experience with adolescents with a variety of different needs. I have learnt to describe and define this approach through conversations with teachers and support staff who have frequently asked "What do you do in music therapy?" The need to refine my response to equal the speed of a 'corridor conversation' has made me concentrate on the aspects of music therapy with adolescents that seem relevant and most effective.

Youth culture shapes my work and everything from using recorded music, 'X-factor' re-enactments, recording on mobile phones, songwriting, play, chat and jamming all regularly feature in sessions. Sessions are non-stop and filled with the language and trends with which teenagers are familiar. This is where the therapy has to start and the point from which the student and I can begin relating to one another. Rather than waiting and responding, teenagers react to chat, action and ideas, as well as coming up with their own plans, such as making up music videos, dancing and playing.

When I began working at Cottenham Village College I was not aware of another music therapist working in a mainstream secondary school in the UK. At times it could feel that I was making it up as I went along, remembering in sessions Robbins' idea that 'immediately you have to go in with all your abilities and sensitivities, as they are, and shape them in the course of therapy' (Robbins, 1998, p.73). To some extent, I expect the work will always have this improvised and unprepared feel but

my approach has been shaped by the needs of adolescents, their creative input and the recognition of themes and patterns as they emerge. Without being inflexible and prescriptive, there are ways of working with adolescents and certain criteria which I suggest should be in place to enable the work to proceed and be most effective.

There can be a very busy feel to sessions and playing instruments, especially the drums, usually demands energy and action. An adolescent's eclectic taste and experience of music, from popular, rock and drum and bass to children's songs and film tunes, can enter into the improvised mix. Improvisation allows us to be flexible and playful and it supports a student-centred way of working. I aim to improvise with all the students I work with and there are various ways in which I try and achieve this. However, for some students it can take a while to arrive at a point of improvising freely and it may come about after taking several detours. Cobbett (2009) also reports that traditional methods of free improvisation may initially provoke anxiety for this client group.

The value of using pre-recorded and composed music is significant. Choosing what song to put on, offers teenagers another way of expressing themselves which can be equally as effective as improvising. Most of my work involves a combination of improvisation and the use of pre-composed music. Listening to pre-recorded music, talking, performing, drawing on the board, songwriting, playing games and creating live music can all play equally important parts in the teenager's therapeutic journey.

The quotes in the heading of each of the following sections are taken from students. I feel these quotes capture something of the way these young people perceive elements of music-making.

4.4.1 "Let's just play it!" Improvising with adolescents

Some students enjoy the freedom of jamming, the immediacy of making something up and living in the moment. They can express themselves and allow me to support them using musical structure, as Bruscia (1987) describes:

‘Through improvisation the therapist can give permission and support to the child to express feelings that the child perceives as forbidden, dangerous and overwhelming. The musical structure and context of the song makes it safer for the child to experience feelings kept out of consciousness because of their threatening nature’ (ibid. p.378).

Improvising is also about making use of what is available and students are resourceful and constantly find new ways of playing instruments, such as beatboxing down a penny whistle or making the most elaborate drum kit by hanging a ukulele or as many percussion instruments as possible on various stands. The enjoyment of setting up and preparing the ground for playing is important, not to mention testing out the instruments’ strength before starting!

Some students set about imitating a band or want to learn a riff from a certain song. This exercise can often lead the student to improvise as it provides a motivating and familiar starting block with musical structure in place. Some students want to learn how to play and need to pursue this for a while before they can enjoy playing more spontaneously. Improvisations might be talked about before or afterwards. It is usually helpful to have a chat with the student at the start of a session and find out how they are feeling before they begin.

The following five sections describe different forms that improvisation can take. These are accompanied by the examples 1 - 6 on the DVD.

4.4.1.1 Improvisation supported by familiar rhythmic structure (DVD clips 1 and 2)

The first video example (4.4.4.1.1a) shows Elliot, 12, who is a naturally musical boy and enjoys improvising but he is very easily distracted and struggles to stay on task so this clip is exceptional in that he stays focused, reassured by the familiar rhythmic structure. In the clip, when Elliot plays glissandi, he looks at me when he realises that there is moment of meeting (Stern, 1985). Then he pauses but the strong beat I am playing continues to hold his attention and he re-engages with the music and starts to create new musical ideas using the instruments nearby: “I’m playing both same

time!” he shouts and I react “That’s so good!” As he turns to rush off at the end, I make a clear ending using a catchy riff and he turns back to join in with me, smiling and looking at me in recognition of the shared music we have played.

The second video example (4.4.1.1b) also shows how familiar rhythmic structure helps Lewis, 13, to feel able to improvise. My repeated chord sequence (C major, A minor, F major and G major) does not vary and supports him and enables us to interact. For Lewis, this level of involvement and shared fun in an activity, as well as focusing in this way for an extended period of time, is extremely rare and the fact that his reaction is to laugh shows how much he relishes in it.

4.4.1.2 Improvisation supported by melodic structure (DVD clip 3)

The third video example (4.4.1.2) illustrates how melody supports an improvisation and encourages the student to play. Prior to the clip I was listening to Lewis experiment with beatboxing and being inventive with various wind instruments. When the clip begins, he is using the penny whistle to create a beat and I join in with a tune. Although Lewis usually prefers me to listen and would stop when I play, he relinquishes his control in this instance and allows us to play together. It is the melody that provides the support and is a suitable match for his beat.

4.4.1.3 Improvisation encouraged by humour and playfulness (DVD clip 4)

The importance of humour in sessions is documented by Amir (2005), Haire (2008) and Haire and Oldfield (2009). Humorous and playful exchanges are helpful ways to begin interactions. A shared sense of fun can produce an environment which feels free, creative and spontaneous. Winnicott’s (1971) theory that ‘children play more easily when the other person is able and free to be playful’ (p.45), underpins the importance of responding in a way that allows healthy playfulness to develop.

The fourth video (4.4.1.3) example shows William, 13, and I using kazoos to communicate, make sound effects and play. We take turns to introduce new ideas

which become more and more ridiculous. This playfulness seems to liberate him and it also puts us on an equal footing. This is demonstrated by William's delight when I don't manage to hit the glockenspiel. He is so involved and can't stop laughing that he has to stop playing the kazoo to yell: "You missed!"

4.4.1.4 Improvisation with a theme (DVD clip 5)

The build-up to an improvisation, including talking, choosing and setting up the instruments, can be significant. Discussion after an improvisation is an equally important part of the process: it can often expose how a student is feeling or what has been thought about. It is noticeable that students tend to talk more after we have shared an improvisation, which suggests that the student's experience of being heard and responded to, instils a trust that the therapist will listen to their words.

The fifth video example (4.4.1.4) shows Kyle, 12, improvising on a theme he has chosen. At the start of the session Kyle had talked about his lack of sleep and the bad dreams that he was having. We chatted about the impact his tiredness was having on his school work and how he was feeling before he decided to create a piece called 'creepy music'. He planned carefully which instruments would be used to make frightening sounds and how each of us should play. He directed me during the piece which lasted about ten minutes and had a clear structure, dynamic variation and persistent and unsettling rhythm.

4.4.1.5 Free improvisation (DVD clip 6)

This final section highlights the use of improvisation which occurs without any apparent planning or discussion. In the sixth video example (4.4.1.5) Tom, 14, is playing the piano and I join him on the keyboard. There was hardly any verbal communication between us from the moment he entered the room and no eye contact was made while we played. In his sessions, Tom usually went straight to the piano or picked up a guitar without saying very much but would indicate by facial expression that I could play too. His playing, which usually lasted for a whole session, was often

a free-flowing stream of expression which felt particularly significant because he could not stay on any task for long.

I sometimes reflected back to Tom my experience of the improvisation and at other times, waited and only responded if Tom made a comment first. Over the course of 20 sessions, Tom became able to reflect more on the mood of a piece that he had played and started to connect it to how he was feeling. This translation of mood and being able to acknowledge it signified a huge step forward. Tom was not usually able to reflect on his behaviour in school but, as he began to understand his feelings and express them he was able to make a connection between what he was expressing musically and what he needed to be able to express verbally.

4.4.2 “That’s sick, bruv, listen!” Using pre-recorded music

For many students, the idea of making something up can feel far too random and precarious so a lot of students choose to use pre-recorded music in their sessions. I encourage them to bring their own music, particularly at the start if I feel that they are slightly wary of playing instruments. The ‘headphone generation’ as described by Ruud (1998), able to listen to more music and music on the move with the invention of the Walkman in 1980, can now access their music everywhere using iPods and MP3 players, playstations and mobile phones. The use of electronic music technology, including music software, electronic instruments and music-based video games, have developed over the last ten years and become much more accessible for use in sessions (Whitehead, Clark and Spall, 2011). Listening to the student’s choice of music and talking together can provide a catalyst for the therapeutic relationship. Through conversation and discussion of musical taste the therapist can facilitate development, by understanding the student’s motivation and interest in music, as well as offer acceptance and establish an affiliation (McFerran, 2010).

‘When we listen to music we express ourselves vicariously [which] is very important when we have difficult feelings to express, feelings that we are unable to shape into a suitable form, as well as feelings we reject or do not want to own as ours. When we hear the composer or performers express their feelings, we can identify with them and experience the release as ours as well

as theirs, or we can be a part of their release but not identify the feelings as our own' (Bruscia, 1998a, p.62).

Receptive music therapy is a well-documented model (Grocke and Wigram, 2007) which prioritises active listening to music rather than creating it. Listening is about 'the ability to open oneself up to musical experience' (Copland, 1980, p.8). This is particularly relevant to teenagers who need to share their musical taste, talk about it and experience listening without being overly guarded or pressurised by their peer group. A student's song choices are often significant.

All students, whatever their background and whichever school they attend, will know about music and have an opinion on it. Music will hold memories regardless of whether it has played a large or small part in their lives. I am often struck by how many nursery rhymes or children's songs occur in sessions and early memories this can provoke. Odell-Miller (1995) describes using music as a kind of reminiscence therapy with elderly patients who make emotional links to music. This reiterates why the role of pre-composed and pre-recorded music is so valuable. As Sloboda and O'Neill (2001) make clear, there is more to the use of recorded music in the therapy context than simply influencing mood.

Many students who are referred to music therapy have little interaction with other people at home and do not live in a stimulating environment. They often spend their time listening to music or watching music channels on television. By bringing their own choice of music they make a link between home and music therapy and often with it, offer a snapshot of their life outside school. Listening to their music together is a shared activity and, having someone to talk to about their enjoyment of music and what it means to them, might be a new experience. Students show that this is meaningful to them because they often come equipped with music in anticipation of their session.

4.4.2.1 Playing and singing along to pre-recorded music (DVD clips 7 and 8)

Students usually describe their experiences of music in a positive way: it is often appreciated as something which can help lift their mood or calm down and relax.

Music is often related to on an emotional level and teenagers are generally aware that it can change their feelings and mood.

It can be difficult to keep up with the massive variety of music which the students are listening to but not knowing can also be an advantage. Giving the students the chance to inform me and show how much they know might be the first time that they have been heard and acknowledged in this way. This attentive response about their interests can provide ideas for further sessions and set up a strong rapport.

The seventh video example (4.4.2.1a) shows Louise, who is 12, singing ‘Wavin’ Flag’ (K’naan, 2009). Louise’s sense of strength and determination which is reflected in the lyrics of the song, was palpable and I supported her by playing the trumpet dynamically to acknowledge the resolution and vigour with which she sang. It is a powerful song for a young person who faces difficulties and an adverse home situation. Because the activity was given validity in this way, Louise talked more openly afterwards about the meaning of the song and thus effectively used the pre-recorded song to give voice to feelings which may have otherwise have felt too difficult to express.

The eighth video example (4.4.2.1b) shows Lewis singing ‘Airplanes’ (B.O.B featuring Hayley Williams of Paramore, 2010). Having chosen the song, he directed me to begin. Even though he joked about filming and pretended to be shy of it, he sang directly to the camera. The edited video shows Lewis having fun, singing along with my part as well. The structure of the song enabled us to both be involved equally with the parts clearly defined. As the rapper, he sang: “And back when I was rappin’ for the thrill of it, But nowadays we rappin’ to stay relevant”. I wondered out loud if the rapping gave him the chance to say something. Ten minutes later he came back to me and said “Yeah, you only rap if you’ve got a point to make”.

Two vignettes (4.1 and 4.2) show how recorded music can act as a precursor to using live music. It can be used as a sonic background, as support, as a way of getting used to filling the room with music or as inspiration for ideas. It often seems to give students confidence to improvise.

Vignette 4.1

Stephen was 14 and had been excluded from two schools before he began at The Centre School. His behaviour was difficult to manage, especially in groups, and he usually found it difficult to share in any activity with others, often becoming aggressive when he was not in control. In individual music therapy sessions he came prepared with a playlist of different music for us to listen to together and he talked confidently about the bands he liked and respected. Stephen liked to drum along to his favourite bands and at first I tried to jam with him, either on the electric guitar or bass, but it felt as if I was musically following him which he did not acknowledge. I felt cut off from what he was doing, rather like sharing the same stage but being in a different band. His command over the recorded music using the remote control to frequently change tracks, made it difficult to keep up and I felt he wanted me to stop playing so I listened to him and affirmed his drumming instead.

It was obvious that playing along to music like this was enjoyable for him and he was very settled and motivated by it, which strongly contrasted with his erratic behaviour in school. Stephen used recorded music in this way every week and rather than creating a barrier, I felt that his commitment to the sessions was communication itself and that, by listening to him, I was able to share his music despite his resistance to the two of us playing together.

As well as actively listening and verbally responding to his playing, I found other ways to join in. I held the microphone for him so that he could sing while he drummed, I worked meticulously on the PA system and even danced about playing the air guitar, much to his entertainment. I matched his energy, grabbed every chance to interact with him musically and gradually was allowed to join in with his music and his band. Stephen began to play in a more interactive way even to the extent of asking me what I thought of it afterwards, how we could improve the sound and eventually allowed me to take charge of the remote control to stop and start the tracks.

Recorded music provided the necessary backing to live playing and gave me the opportunity to join him and develop a relationship through it.

Subsequently he was able to share his enjoyment and cope with the experience of playing and not needing to be in control.

Vignette 4.2

Michael, 14, enjoyed repeatedly singing along to a song 'JCB' (Nizlopi, 2005). In the song, a son reminisces about having a fun day off school with his father.

'My dad's totally had a bloody hard day
But he's been good fun and bubblin' and jokin' away
And the procession of cars stuck behind
Are getting all impatient and angry, but we don't mind
And we're holding up the bypass, oh
Me and my dad having a top laugh
Sitting on the toolbox, oh
And I'm so glad I'm not in school, boss
So glad I'm not in school' (Nizlopi, 2005)

Listening to him at first, it felt that Michael enjoyed pretending to be the young boy in the song who sang about his happy memories. I asked him about the song and what he liked about it and he went into a rage about his father's chronic illness and the impact it had on all his family. The song was the opportunity and catalyst for him to express his anger and to tell me about it. In subsequent sessions, he sang songs from musicals, either with a piano accompaniment or to a recorded song because he dreamt of being a performer in a West End show and making his father proud.

4.4.2.2 Playing pre-composed music (DVD clip 9)

Students sometimes ask to be taught a certain riff or how to play a song. This happens again and again when working with this age group because they often want to recreate music they know. In response to this, I tend to teach them a basic familiar riff from a song but help them to create their own version rather than copying the song exactly. Their desire to make the music sound as it is on a record is usually beyond their ability and can often inhibit students to play. Learning even a short riff can take

time but gives the student a huge sense of achievement and for students, who find learning very difficult, such an activity can help to increase concentration. It can also build confidence in their playing which is a vital part of the work because it can lead to students feeling able to experiment musically.

The ninth video example (4.4.2.2) shows Dominic, 15. When he began music therapy he was really keen on learning set pieces so that he could impress fellow classmates and play to his friends at youth club. I taught him the opening riff to ‘Smoke on the Water’ (Deep Purple, 1973). It took a while for him to learn it but, being able to practise the notes in a slow and organised way, helped him to focus, play as a duet with drums and subsequently have a go at jamming. He played a recording to the school’s head teacher and played it to a few of his friends at youth club. The acknowledgement he gained from outside the music therapy room boosted his confidence.

4.4.3 “I’m gonna do the X-factor!” Using the video camera and performing

Using recorded music, microphones and the video camera is a winning combination with teenagers. Even though many students can be shy singing in front of others, they often enjoy using the video camera and become confident performers keen to communicate with the audience whoever that may be. Making a DVD of their performances for someone allows students to discuss whom they trust and who they want to share their music with.

Originally I used the video camera to record sessions to make my own observations and learning through supervision but it has gradually become evident that the camera is also an important tool for teenagers to use during their sessions. I now consider the video camera to be an intrinsic part of the work; it is almost as invaluable as any musical instrument in the room. It is a source of much inspiration and has made us into pop stars and musical lead singers, not to mention politicians, newsreaders and weathermen. Making videos for a song, even replicating dance moves, can be just as important as the song itself.

Adolescents who are not sure of themselves might find social situations terrifying. Away from peer pressure, students' ideas can be boundless. Using the video camera seems to foster playful and imaginative spirit, of being in a band, being famous or being a cameraman. Needless to say, the 'X-factor' and other television talent shows make a huge impression on this age group and many of the students are keen to recreate their own version of such a show, participating either as judge or performer.

The voice and self-identity are closely linked (Newham, 1999) and singing and being playful with the voice can be a way for young people to hear and express themselves in a new way. 'Our voice reaffirms who we are, how we are feeling and [...] serves an important function in maintaining our sense of identity, for the sound of our voice reminds us of who we are, it reinforces our sense of Self' (p.103). This is particularly meaningful and applies to work with adolescents who constantly question how others hear and perceive them.

With the aid of the camera in sessions, students can listen to themselves and become reflective learners. It can really boost their confidence and help them to think about the music, as well as how they look and perform. Sharing DVDs with staff, friends and family members can give students a new way of presenting themselves, their opinions and feelings and can enable them to be seen in a different light (Powell, 2004). They can be really proud of the outcome and the DVD is a tangible record of their achievement which they can take away from the music therapy session.

Vignette 4.3

Samantha, 16, saw a CD with the song 'What a wonderful world' (Thiele and Wiess, 1968) and declared emphatically: "I can't sing that!" Unlike Lewis (DVD clip 8) and Michael (vignette 4.2), who chose songs because they identified with the lyrics, Samantha felt strongly that she did not want to sing certain lyrics. Samantha had lived in many different homes and throughout her teenage years had frequently had to change foster family, sometimes moving twice a year. She began music therapy just before her fifteenth birthday when she was living in a children's home.

The 'X-factor' provided a lot of inspiration and made a big impact on her sessions. Although she liked the television show and it was familiar to her, she was not accustomed to singing and only sang along to recorded music together and if she agreed with the lyrics. It was surprising that she chose to film everything but the recordings became a video diary of sessions and, even though she did not want to be heard singing on her own, enjoyed looking back at the film together and laughing about our performances. Watching the video together was a way to reflect on what she was doing, encourage her and inspire her with new ideas.

Over time, singing together gave her confidence and then there was a breakthrough in a session: before I had found her chosen song on a CD, she began singing it on her own. I waited and listened to her for a while before starting the music. She was totally free in her singing and at the end was able to acknowledge how confident she had become and could accept praise.

After this we continued to sing songs together but I began to accompany her on the piano rather than using CDs. As she became more sure of herself, she started to enjoy taking more responsibility for how the music should sound. She began to choose upbeat, self-affirming and positive songs such as 'The Winner Takes It All' (Abba, 1980) and 'This is Me' (Dodd and Watts, 2008). With this new self-assurance, Samantha now had the confidence to write down some of her own ideas for lyrics. Having found her musical identity in pop music and in filming her performances, she had developed huge self-confidence and was able to make the music her own.

Music therapy, she said, was "a quiet place I come back to". It proved to be a consistent place through many difficult transitions and in the turbulent time, as she approached the end of her school days, it created a secure base. The confidence she gained from singing and performing in a safe place allowed her to face the future with a more positive outlook. At the end she told me: "music therapy's like a rehearsal for the real thing". I wondered whether she was reflecting philosophically on life or had a real hope to be signed up for the 'X-factor'.

It is important to address the use of the DVD because students often consider uploading excerpts onto 'YouTube' or social networking sites such as 'Facebook'. Therefore thinking ahead about the impact of sharing what they have done confidentially in music therapy and talking about others' potential comments, can be a useful exercise. In the same way that the judges are very harsh on the 'X-factor', I reflect on the critical comments they may receive once they have shared their music with the outside world. I spend time helping students to think about the process of filming, what has been important in therapy and the parts they want to share.

Music taken outside the music therapy room may be questioned by other therapists and even discouraged but, for some of these students who are coping with very difficult life circumstances, I consider taking the music away with them on DVD is just as important as the process of bringing those feelings to therapy.

4.4.4 "This is my song, man!" Songs and songwriting

Songs appeal to children (Campbell, 1998; MacGregor, 2005). Teenagers often recognise and like to reminisce about songs from their early childhood, particularly from primary school assemblies (4.4.2). The wealth of sheet music in the music therapy garage offers a variety of musical styles which can generate ideas for students.

Writing songs comes about in different ways. 'Indeed the process should not be formulaic as that would defy the very creative environment it attempts to create' (Davies, 2005, p.47). Songwriting can be a very effective way for teenagers to communicate their story and their ideas as a social activity and within a structure which feels predictable and purposeful (Derrington, 2005). For some it is a natural progression from improvising and for others it may be their aim from the outset; either way it is 'a powerful use of the existing relationship between teenagers and songs' (McFerran, 2010). Students may use a song to describe their feelings and, in doing so, use the song to communicate in a way that feels safer than talking about them directly (Dvorkin, 1991; McFerran, 2010). Most commonly, students write songs spontaneously, although some students like to substitute lyrics to tunes that

they know well. Vignettes 4.4 and 4.5 illustrate two ways of song creation in sessions.

Vignette 4.4

Ben, 14, often came over to the music therapy garage, to talk and fiddle with the instruments but found it hard to stay for a whole session of 35 minutes. After about ten minutes he usually asked if he could return to The Centre and I would accompany him back and continue using our time together, talking and playing countless games of table tennis. This pattern went on for a few weeks but, as I gradually developed his trust, he started to share more of his experiences, and was prepared to stay in the garage and use the instruments.

At this stage, improvisations felt far too uncertain for him so they were usually short-lived. However, Ben liked the idea of creating a song: this gave a clear purpose to the sessions and the idea of putting words to music made sense to him. Towards the end of his second term of music therapy, he wrote some words on the board, told me how to drum and, ready to play the electric guitar with the amplifier turned up to distorted levels, he climbed onto a cajon drum and, precariously balancing, announced at the top of his voice: “To anyone...it’s better to not be afraid!” Then he sang this song:

When you know that
You did not do nothing
Wrong so why are you
Afraid of him
You know you did
Nothing wrong to me
So why are you afraid. The End.

Despite the emotional intensity of his song, he did not want to discuss it afterwards. Instead, he finished the session by clearing away the instruments and chatting about which lesson he had next.

Vignette 4.5

Gary, 15, wanted to sing the moment he set foot in the music therapy garage. He improvised feely and told me how to play, often complaining that my piano playing did not sound sad enough. For three weeks in succession he sang his own song called 'Breathe'. He was probably inspired by Taylor Swift, the country singer, whose song with the same name had just been released and 'Breathe (2am)' by Nalick, the American singer-songwriter. He took the theme as his inspiration, directed my part to be improvised on the piano and together gave the song a new melody and he wrote the verses. These are a few lines from his song:

'All the people, can you help me, I'm alone out here
But am I, I can find you my baby
Breathe. Hope. Yeah.
Open my heart
And you breathe. And you breathe.
People can you see me, I've got no one
People can you hear me, I can only see you
Breathe, oh breathe.
Open your eyes towards a freedom...'

4.4.4.1 Rap (DVD clip 10)

In contemporary culture, rap is very popular. Rapping is very attractive to adolescents because the words are usually provocative, edgy and include a lot of swearing. It is also the music of marginalised youth and often associated with gang culture.

The tenth video example (4.4.4.1) shows Gee who is 13. He raps about The Centre School, his time in London and then his move to a village called Waterbeach. He has shown me how to beatbox and, satisfied with the beat, continues with his song. At the end he did not acknowledge the difficult issues he had just sung about, but talked about how much he had enjoyed creating music together.

4.4.5 “You’ve been mugged!” Using games and structured activities (DVD clip 11)

Incorporating games and activities can really help to engage teenagers. Simple games, such as who can play the loudest on the drums or turn-taking and copying rhythmic patterns, can be a good way to get started if students feel uncertain or nervous about playing. Winning can be really important to these young people, especially as many have known nothing but failure, so point-scoring and mini competitions can be motivating. A person-centred approach allows students control but games can re-engage students who need more structure.

The final video example (4.4.5) shows William, 13, leading a ‘drum off’ which was a game he had made up that featured regularly in his sessions. The rules varied but the general idea was to play quietly, build in speed and volume before ending quietly. The bowing before and afterwards was probably inspired by the standing bow in judo, which William enjoyed as a hobby, and interestingly is designed to help participants clear any evil thoughts and feel good about themselves. Although the ‘drum off’ is fun, William takes the activity seriously and, with the bow, suggests that we are showing respect and fairness towards each other.

Vignette 4.6 illustrates another use of structured activity.

Vignette 4.6

Tom was 13 at the start of music therapy. He had been excluded from primary school, had a difficult home life and tended to be isolated at school. He felt that there was not much that he could change in his life and he seemed resigned to this fact.

Sessions always began in the same way. Tom sat at the keyboard and told me: “Do your housework”. He would then play the telephone sound on the keyboard and I would stop my dusting to answer the phone. Tom and I would then have a conversation ‘on the phone’ without looking at each other. He would tell me how he was feeling and ask me how I was. Sometimes he told me about his weekend and football but he usually hung up quite quickly, turn

to me and say “that’s it”. Tom preferred to chat on a telephone as it was easier for him to tell me his news, or how he was feeling, indirectly.

After this beginning, Tom liked to sing songs he knew, from ‘Be bold, be strong’ (Chapman, 1984) to ‘Morning has broken’ (Farjeon, 1931) at the top of his voice as he sat alongside me at the piano. This was particularly remarkable and moving because he had a stutter and normally faltered over spoken words but when he sang his words came easily. The familiarity and structure of the songs made him feel safe and seemed to remind him of primary school.

He also enjoyed listening to music and making up songs but it was important that everything was done together. Through regular sessions and sharing these activities Tom began to develop a greater sense of self and appreciation of what he could do. He started to talk about things he was doing at school, outside music therapy, and what he was achieving. At the same time within music therapy he started to make up games. He became increasingly competitive and enjoyed playing against me. Tom needed to win and do better than me, shouting: “You’ve been mugged!” every time he scored meaning he’d beaten me.

One of these games was rather like musical statues where, if the player was spotted still moving after the other player had stopped drumming, he was penalised and, in this case, given a number of minutes as points against him. The time related to the number of minutes Tom had had removed from his break at his old school as a form of punishment for his disruptive behaviour.

Through this game he was able to win and instead of getting detention, could enjoy playing, feel independent and start to experience control in a playful way. Tom’s newfound confidence allowed him to face the past when he felt less in control.

4.4.6 “I’ll tell you like this!” Conversation, art, props, drama and play

In sessions, the exchange between talking and playing can be aided by the layout of instruments in the room (3.4). The comfortable chairs are surrounded by instruments so that even when chatting students have instruments within easy reach. Hald (2010) presented the idea that the main goal of verbal dialogue in music therapy is to find ways into musical interaction. I always encourage the use of music but there are times when students need to talk. For this reason, I tend to start a session with a chat as a way to touch base, establish how the student is feeling and what, if anything, has happened prior to the session. Teenagers can be quick to talk and complain about school and themes often arise through such conversations.

Throughout the summer term, for example, one student talked about ‘the lucky year 11s’ leaving school and how he could not wait for his turn. Yet the more he talked like this the reality seemed to me that, much as he moaned about school, he dreaded the day he would have to leave the security of it. On one occasion I dared to suggest that he felt nervous about that and he agreed. He seemed relieved to have been honest and even went on to talk about his future and how scary it felt.

Teenagers need to be able to relate verbally and ordinary conversation plays a big part of music therapy sessions because, as well as leading to playing, it is important that students can chat and vent their feelings. There is no video example of this for reasons of confidentiality.

Vignette 4.7

David was 15 when he was referred from the mainstream school because he was at risk of exclusion and was underachieving. In the summer holiday before our sessions began his 18-year old cousin died in a car crash, presumed to have fallen asleep at the wheel. In music therapy sessions David experimented with different percussion instruments. He was quite playful and liked sharing rhythmic patterns, made comments about the fun and how much he liked messing about: “It beats any lesson!” While he was playing, he talked a lot about discipline, school rules, detentions and teachers.

Then, in his sixth session he stopped playing altogether and only wanted to talk. He talked about his tiredness, need for a lot of sleep and even wanted to discuss the jobs he would not be able to do because he was always feeling so sleepy. As sessions progressed, David began to talk more about his cousin's accident, the funeral, his thoughts about learning to drive, his family and his anxiety about the future. Music therapy had given him a space to express feelings that he had not shared with his family for fear of upsetting them.

He spoke very openly and said that his perspective had changed while he was having music therapy: he had decided to work harder at school and avoid getting so many detentions. At the end of his last session, David played the drum kit and said it was good: "because it feels strong enough for everything". Perhaps the drums were symbolic of the music therapy process which had survived the fact that he had shared his feelings and worries about death.

Some students draw to show me how they are feeling: being able to doodle on the board can help them to focus while they chat and reflect on how they are feeling. For others, it can be used for printing their name or a gang's symbol at the start as a way of stamping out the space which is theirs for a time, or for leaving a message behind. The whiteboard also recreates an aspect of the classroom and has inspired some students to role-play. They adopt the part of a member of staff who can teach me, give me a detention or exclude me for bad behaviour. Such games further illustrate students' frequent need for playful control.

When a student seems very reticent about using any instruments in the room, I often introduce the whiteboard as a starting point to encourage musical exploration and interaction. On occasion, Winnicott's 'Squiggle Game' (1971) has been valuable and it can be easily adapted to incorporate musical improvisation. When the student draws, I accompany their movement and what they draw with music. This provides an opportunity for me to direct the student through music. Exchanging roles enables the student to overcome their inhibition with the instruments, as they usually prefer to be directing the activity rather than drawing.

Vignette 4.8

For one student at The Centre School, who I shall call Rose, 14, the whiteboard became the focus of many sessions when playing instruments just did not seem possible. She was referred because of her very low self-esteem and poor social skills. She was quick to make the most of her time playing music, improvising and working out musical effects. Then, towards the end of the first year of therapy, her mother died. Over the weeks Rose's behaviour became erratic and dangerous and there was grave concern for her welfare. At that time she was attending music therapy twice a week and she needed to fill almost every moment of every session listening to very loud, recorded music whilst drawing on the board. She never missed a session and clearly trusted the therapy space but she no longer wanted to touch the instruments. All I could do was to be consistent and respond genuinely.

Setting up the amplifier and all four large speakers to their maximum volume, pop music blared out session after session. There was little way to engage with her in conversation although I did try and this occasionally resulted in a game with the volume control where she turned it down, as if to allow me airspace and then turned it back up just as I started to speak. Through such games though, however short, I was able to regularly achieve a meeting point with her in all the chaos and din. It reassured me that she knew I was sharing the noise and confusion and that I was always listening.

The turning point came when the song 'Can't Get You Out of My Head' (Minogue, 2001) was playing. Rose had covered the board in drawings and, looking at one sketch (shown in figure 4.4.6), told me that her mother was always in her head: "What a shame we don't have brains like computers with a button you press for shut down".

Figure 4.4.6 Rose's drawing



She started to play certain songs on repeat which made the lyrics more noticeable and pertinent. She clearly wanted me to hear them as they blared out and occasionally allowed me to pause the CD so that we could talk and reflect a little on what was being sung. As we listened to Pink, Rose talked about some of her feelings.

‘You took my hand, you showed me how, you promised me you’d be around...
I took your words and I believed in everything you said to me...
If someone said three years from now you’d be long gone, I’d stand up and punch them out, ‘cause they’re all wrong
I know better, ‘cause you said forever, and ever, who knew?...
I’ll keep you locked in my head, until we meet again...and I won’t forget you my friend...
But I keep your memory, you visit me in my sleep...’
(‘Who Knew’, Pink, 2006)

Rose had initially used recorded music as background and noise to match her feelings, at times to block them out and certainly to try to prevent us from thinking about anything. She was able to draw on the board to express herself without words until she arrived at a point where the songs were allowed to the

foreground and we could both hear and begin to acknowledge the lyrics. The board continued to play an important part in music therapy sessions but, crucially, had provided her with another way to communicate with me when her feelings had felt overwhelming and chaotic.

I have found that having a variety of books and magazines about skateboarding, biking and go-karting can sometimes instigate ideas and themes for conversation, musical play and songwriting. Working with teenagers is constantly a fine balancing act between making suggestions and actively enabling them to come up with their own ideas.

Vignette 4.9

Jacob, a 15 year old student at The Centre School, had very low self-esteem when he was referred to music therapy. He had suffered neglect and been moved away from his family. At the time of his weekly session he was often over-excited and seemed to relish music therapy as a chance to be noisy, leap about and hit cymbals and cowbells with wooden beaters for maximum volume. He was moving about in this way one day, hitting as many different surface areas as he could find with a drumstick, always in time to the heavy metal music we were listening to, which he had brought along. I followed him to create moments of interaction, by mirroring his playing or holding brief conversations through rhythmic patterns. He always moved away from me if I went near to him and it was difficult to introduce change to this behaviour. It was loud and quite boisterous but it felt important to keep up with this slightly frenzied activity and support his mood and, most importantly, react to his playing.

He then hit upon a children's book 'Giraffes Can't Dance' (Andreae and Parker-Rees, 2001) on one of the shelves and was immediately drawn to it. He stopped playing, took the book and started to read out loud. He continued to wander around the room as he read but was engrossed in the pictures and story so I lowered the stereo's volume, wandered over to the piano and gradually introduced a musical accompaniment to his reading. Then, like

Gerald in the story, the most remarkable change occurred. Jacob came over to the piano where I was, stood in front of me facing the piano and continued to read and sway as he read the words in time to the music. The two were connected and the story held this time of change and stillness.

The story had introduced a different way of being in music therapy and, whilst sessions continued to be loud and chaotic at times, they could also contain periods which were quieter and unruffled. Jacob used the tale of the giraffe, who felt different to the other animals in the jungle, to start to address his own feelings. The story helped him to stop rushing around, stay with himself and consider his own feelings of being different and not accepted. This occurred in his own time when he was ready to do this. A few months later Jacob chose to make up his own song and he asked if we could write it up like a story and do all the pictures. He no longer needed to identify with Gerald, but had his own story to tell.

4.5 Dealing with resistance

Students with very low self-esteem might resist at first because the environment is unknown. I show students that there is no pressure and spend time showing them the room, chatting and playing some instruments in an introductory and cajoling way. Fervent resistance one day can equally be replaced with a sudden demand for a session at another time. Such evidence of control needs to be addressed and is usually best managed within a session where the timings for our next meeting and the guidelines of attending session can be set.

In the classroom setting students are used to sanctions and being marked for attendance, behaviour and cooperation. The teachers are authority figures and students often rebel and confront them, which can result in disruptive behaviour. At The Centre School there is a point scoring system used at three stages of each lesson marking the student's attitude and behaviour. At the end of each term, these points convert to rewards as a way of enforcing good behaviour. Restricting students' activities is a negative response and is used as well but, for some of these students

who have so little anyway, reducing their leisure activities does not impact as much as the vouchers which reward positive behaviour.

Initially, students may expect the same in music therapy. They may see the music therapist as an authority figure and test how I react but my response is different. I allow them to make decisions in the session and make it clear that they can choose what to do because it is their time; I do not judge their behaviour, nor is there a reward. This student-centred approach can take students time to get used to and resistance and challenging behaviour can persist. However, this approach does generally lead to cooperation as the students accept that music therapy is different and our relationship is based on mutual respect. Describing a similar approach in drama therapy, Emunah (2005) explains that 'with this approach...the clients have little to resist because they are allowed to act as themselves; in fact, they may even be encouraged to exaggerate their rebellious behaviour' (p.111). I am also reminded of Nordoff and Robbins' (1977) basic premise, that there is always client participation and resistance in the process of creative music therapy.

Structure is imperative with students who show resistance. During a session, it is up to the therapist to facilitate a practical framework that both creates space but also provides support to the student. If this is not in place the session will most likely end with the student leaving the room. Resistance from students, who refuse to attend and call it rubbish often occurs when therapy is addressing difficult feelings. Their protest is often made in front of other people and may be an act of bravado that claims they do not need support. However, even the loudest student in this situation will usually return to music therapy when they are ready.

If a student refuses to attend, I usually return to them the next day or when space is available. Students know that they are cared for, that their work in therapy is important and I have to allow for days when they are not able to attend because they are feeling totally unmotivated, depressed or angry. By picking up students soon after a missed session, I can work with their feelings that became a barrier to them engaging and try to find a way in to the student's thinking. There are numerous occasions when students have refused music therapy on one day and been very keen for a session the next. Managing young people and meeting their needs, whilst not

letting them rule, can feel chaotic. It is a balancing act that can only work when the staff team and I work closely together.

For a few students, music therapy can feel too intense and threatening and they choose not to attend. In such cases it is very important to keep the channels of communication open and offer them further sessions when it seems appropriate.

Adapting to the needs of each teenager and taking them as they are at that time is the only way to connect as well as understanding that the work is not bound to the music therapy room, as illustrated in vignette 4.10.

Vignette 4.10

Matthew, 15, refused to attend music therapy after trying it a few times but at school greeted me loudly everyday with ‘G’morning, Shorty!’ This was usually accompanied by slapping me on the back, or leaning on my shoulder, followed by some comments about my height (or lack thereof)! He did not greet other members of staff in this way and it quickly became apparent that his gestures and our chats were a part of the therapeutic work: he just did not want to commit to it fully.

His resistance to attending was made very clear to all the staff and he would shout over to me very loudly that he was not coming to music: “No-one’s gonna make me!” It became a humorous exchange on the mornings he was due to have music therapy. I always reminded him about his session but made sure that the humour and understanding was equal to his. This was the way I wanted to communicate with him and it enabled us to have a relationship.

It was a consistent one and one that he trusted: he came to rely on this chat everyday and it sometimes developed into longer conversations about other things he was doing and how he felt about them. If a therapist hopes to relate to young people, it is absolutely necessary to chat and connect with them at the level that they are ready to engage. This is the same within a session when a student chooses not to use music: play and communication never stops.

4.6 Conclusion

This chapter has shown a variety of ways of engaging teenagers in music therapy and described characteristics of the approach used in this study.

Listening to, composing and playing music can have equal importance in music therapy with teenagers. It is necessary to provide them with options and opportunity, be supportive and match their energy and ideas. Music is a fundamental part of a teenager's life and accompanies them as they mature and form their own identity. Work with teenagers ideally needs to be creative, intuitive, dynamic, reactive, flexible, consistent and persistent and is often about grabbing every opportunity for musical interaction.

CHAPTER 5

METHODOLOGY

5.1 Introduction

This study aimed to create hard evidence that extends beyond the acknowledgement of music therapy by one staff team in one academy. The research is needed for the young people at risk and for society's response to them, so that interventions which work can be made more available. The Music Therapy Charity recognised that some young people may have had years of limited support and supported this project because of music's 'universal appeal for young people and, more than almost any other medium, attracts kids from all backgrounds into motivated activity' (Wigram, Lumley and Steen, 2010).

Odell-Miller, Hughes and Westacott (2006) reported that 'the dilemma for the therapist is always whether to look at process or outcome' (p.123). The study assumed a mixed method, thus combining both quantitative and qualitative approaches (Creswell, 1995; 2007), to provide the most comprehensive results. Although this study was outcome-based and the primary objective was to examine the quantitative data, it was expected that the focus on the meaning of the use of music in therapy for young people could also be acknowledged in a unique way with the inclusion of qualitative aspects to the design through the use of semi-structured interviews.

These two approaches, named formulaic and clinical by Sechrest and Sidani (1995), meant that the inclusion of structured questionnaires and school data (the formulaic) and the qualitative data collection from semi-structured interviews, unstructured observations and case examples (the clinical), could be included in a single study and the data together could provide valid answers to the research questions. This chapter expands on this method, the rationale for it and the different ways that the data were analysed.

5.2 The study design

The overall design of the study was a wait-list controlled trial in which 22 students took part. The primary objective of the study was to find out whether music therapy can help to improve the emotional well-being of adolescents who are at risk of under-achievement or exclusion. It also asked whether music therapy can increase a student's self-esteem, impact positively on learning, behaviour and attendance and reduce anxiety. If there was evidence of such an impact, is the change sustained after therapy sessions have finished?

The flow chart of the study (figure 5.2a in appendix 5.2) is an overview of the compact, composite and creative design that was used and the lines of connection between the project groups and means of data collection. The design had the benefits of a parallel group trial but a control arm was unethical (5.2.2). Therefore both groups did receive therapy but the interventions were staggered. The chart shows how all the referrals were followed up, whether they chose to be involved in the project or not, and how the groups received music therapy alternately.

The original design (appendix 5.2b) indicated that 12 sessions would be offered to students in both groups. However, this was extended to 20 sessions considering the length of treatment usually offered in practice: students are usually offered 3 terms, or one school year, of weekly sessions. 20 sessions was the longest period of time that could be offered within the study's two-year framework.

Table 5.2 illustrates how students in two groups received music therapy once a week for 20 weeks, where group A was followed by group B. This longitudinal and balanced design allowed comparisons between the two groups at four data collection points in time. In order to maintain important internal validity, the study was designed with the students and environment in mind, anticipating factors which could impede results so, for example, the summer holiday in the middle of a block of therapy was avoided.

Table 5.2 Overview of the design and points of quantitative data collection

	January 2010 Data collection 1	20 weeks	July 2010 Data collection 2	20 weeks	March 2011 Data collection 3	16 weeks	July 2011 Data collection 4
Group A	Pre - therapy: Baseline	Music therapy	Post - therapy	No music therapy	Short - term follow-up	No music therapy	Long-term follow-up
Group B		No music therapy	Pre - therapy: Baseline	Music therapy	Post - therapy	No music therapy	Short-term follow-up

The first data collection took place before any clinical work began and created baseline scores for group A. Data collection 2 provided the baseline scores for group B, post-therapy scores for group A and comparison data between the groups when only one had received music therapy. Data collection 3 provided the post-therapy scores for group B and short-term follow-up scores for group A, who had received no further music therapy intervention. The fourth and final data collection, after a further 16 weeks when neither group had had music therapy, provided short-term follow up scores for group B and long-term follow-up scores for group A. The times had to fit around school terms and data collection 4 was undertaken in July, as long a time as possible within the school year after group B's intervention had finished. Ideally, a further data collection should have taken place to create follow-up data for group B as well, however this would have meant that students were involved in a study that extended over three academic years and this would have had a significant impact on the age eligibility of participants (5.3.1).

The quantitative data collected each time from the students consisted of three of the Beck Inventories for Youth (Beck et al., 2005) and the music therapy project

questionnaire. Teaching staff also completed questionnaires and data were retrieved from school log-books and attendance registers. Qualitative data were collected before and after each student's block of music therapy. Their honest comments about its influence are persuasive and add strong evidence to support the researcher's hypothesis that music therapy can address students' emotional needs.

5.2.1 Pilot study

The methodology arose from closely monitored clinical practice over a number of years using efficacy questionnaires (3.5.1). These questionnaires, which were completed by teachers, aimed to evaluate changes in the student's emotional awareness, sense of self, attitude to school, communication skills and behaviour (appendix 3.5.1b). Due to this practice, it was decided that it would not be necessary to complete an additional pilot project for this study. Nevertheless, the specific questionnaires proposed for this study were trialed before the project began with a few older students who were not invited to take part.

5.2.2 Control group

A control group of students receiving no music therapy could have been included in the design of a study which aims to distinguish the effect of therapy over and above random variation or the natural improvement or decline in behaviour. However, it was unethical to deny students therapy for research purposes as they had already been identified as being in need of extra support, in a school where music therapy was funded and available. Another option for collecting control data, considered at the beginning, was to ask the young people, who chose not to have music therapy, to complete the questionnaires at the same time of data collection as those who did. However this was not appropriate and not applied.

Where a control group is unethical, comparison to a gold standard can be recognised as a valid assessment. In this field of behaviour and evaluation of self-esteem, there is not a recognised standard therapy or care so this was also not an option (Hanser and Wheeler, 2005).

Group B could be considered as a wait-list group as a comparison for group A. It was not possible to control the many inter-individual confounding variables with two groups of individuals but counterbalancing in a cross-over style method eliminated these order effects. Therefore, one half of the participants completed therapy (a first condition), before stopping (a second condition), and the second group did the same two conditions in the reverse order. This design also allowed for the Hawthorne effect²⁵ to be explored.

5.2.3 Ethics

Once university registration for the study was complete, the next important step was to gain ethical approval. At the start of the project the work was employed through Cambridgeshire Music²⁶ and involved schools so both Cambridgeshire County Council and Anglia Ruskin University, where the PhD was registered, were approached for ethics approval.

Although Cambridgeshire County Council has a research governance framework, a clear application process and a well-outlined research proposal guide for research in social care, there was no proper system in place for research in educational settings. As a result of this study's application the County Council raised the issue at their next management team meeting. The therapist was authorised to continue with the research in the schools (appendix 5.2.3i), having discussed this with the executive head teacher of The Cottenham Academy²⁷ and received his letter of support (appendix 5.2.3j).

Following clear guidelines, ethical approval was applied for at the start of the project from Anglia Ruskin University Research Ethics Sub-Committee (RESC). Parents or carers had to give consent and, although not a legal requirement, students were also

²⁵ The Hawthorne studies were initiated in 1924 by research carried out by the Hawthorne Works of the Western Electric Company in Chicago, United States. They recognised effects on participants' performance caused solely by the knowledge that they were taking part in research (Coolican, 2009).

²⁶ A peripatetic music service of Cambridgeshire County Council

²⁷ This was also agreed by the new head teacher of The Cottenham Academy who came into post in January 2012.

asked for theirs. They were provided with information so that they had a full understanding of their involvement in the study and my responsibilities to the students as research participants, before they decided whether or not to take part. The application form for ethical approval, including information sheets and consent forms for parents or carers and students, are attached as appendices (5.2.3a- 5.2.3e). Approval from the RESC was granted (appendix 5.2.3ii) which meant that the project's clinical work could begin on time, in January 2010, as soon as consent forms had been returned.

A substantial amendment to this ethics application was made in November 2010 (appendix 5.2.3f). This was to allow the making of an accompanying DVD to the thesis to illustrate examples of the clinical work. The application included additional consent forms which were sent to all students, who had used the video camera in their sessions, and to their parents/ carers (appendices 5.2.3g and 5.2.3h). Consent was approved by the RESC and confirmed by email (appendix 5.2.3iii).

5.2.4 Setting up the project

Although music therapy was established and well-known at the schools, it was necessary to disseminate information about the project in many different ways throughout the first term so that everyone knew about it. This was mainly through informal conversations and meetings with all the teachers in the Senior Leadership Team and providing an information sheet about the project (appendix 5.2.4).

At the start of the spring term 2010, just before the clinical work began, I gave a talk outlining the project on a training day to all staff in the mainstream school (CVC). With support from the leadership team at this meeting, the research seemed to be accepted and welcomed. At The Centre School, the approach was different because the teaching team is much smaller and it was easier to have conversations with everyone individually. Many of the staff were interested in the project and supported the idea. Time spent setting up the project in this way was crucial for its smooth running.

5.3 Participants

Students at risk of underachievement or exclusion were referred to the project, however there were other criteria and guidelines for the referrers. Although the project was aimed at any secondary-aged students, the age of the students at the time of referral did matter due to the length of time required for participation.

5.3.1 Eligibility criteria of participants

The eligibility for participation in the project was defined by the following criteria:

1. Students should have had no previous music therapy intervention.
2. For CVC students, the end-of-year test results were used as guidelines to the year heads of seven, eight and nine to refer the top scoring underachievers in their year group. Many of these students were at risk of exclusion as well.
3. Any students in years seven, eight or nine could be referred from The Centre School.
4. Students had to be aged 11 – 14 years at the time of referral.
5. Referrals were not to be gender specific.

5.3.2 Referrals

In order to get appropriate referrals for the project, I met with each of the mainstream school heads of years seven, eight and nine and asked them to refer four students following the eligibility criteria. After meetings with teaching staff at The Centre School another twelve students were referred using the standard referral method (forms in appendix 5.3.2a and 5.3.2b) The fact that the students could have been referred regardless of the project, was termed ‘reality sampling’ by Aldridge (2005a).

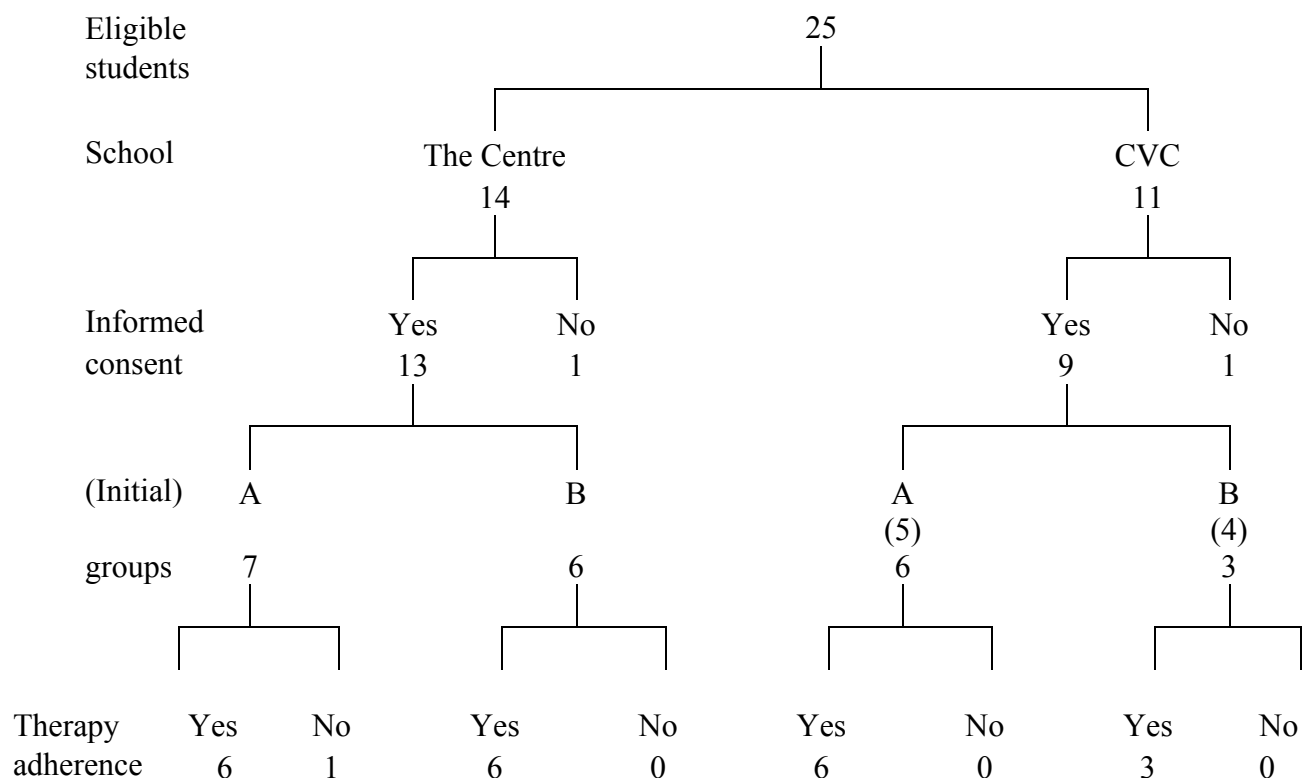
5.3.3 Recruitment and grouping

It had been hoped to recruit 20 young people to the study, ten for group A and ten for group B, with five students from The Centre School and five students from CVC in each. To cover dropout it was decided that up to 25 students could be referred. In total, 11 were referred from CVC and 14 from The Centre School.

These students and their parents or carers were given an introductory guide to music therapy which was created specifically for the project (appendices 5.3.3a and 5.3.3b). These leaflets, the participant information sheets and the consent forms (appendices 5.2.3b – 5.2.3e) were explained and read out to them, as necessary, by an instructor or teacher. In some cases, where a meeting with a parent or carer was not possible, the forms were sent home with the student and, once returned with both the parent's and student's signature giving permission, would be confirmed by a phone call from the head of year. A record was kept of consent and notes about each referral (appendix 5.3.3c) and a file was set up for each student (appendix 5.3.3e). Regardless of whether consent was given or not, the referral was followed up in the usual way and the student was still offered music therapy.

In total, 22 students and their parents/carers agreed to participate: thirteen students from The Centre School and nine from CVC. For ethical reasons, and particularly considering the volatile and vulnerable nature of this client group, those in greater need received therapy first. The teachers who made the referrals were asked to prioritise whom they considered to be more in urgent need of therapy and these were the students who formed group A. The lead teacher of the deaf was certain that both students with hearing-impairment needed to be placed in group A. Therefore, group A had twelve participants and group B had ten. Although group A was larger, following the teachers' prioritisation as requested, the groups were matched by age and schooling because of the eligibility criteria. Figure 5.3.3 shows the distribution of students in both schools from the time of referral to the end of the project.

Figure 5.3.3 Recruitment and grouping



Initial grouping resulted in five students from CVC being assigned to group A and four to group B. However, the week before sessions were due to start, having received the consent forms and having replied to all the students and their parents informing them which group they were in (appendix 5.3.3d), the head of year 7 approached me with an urgent request for a student in his year to be moved from group B to A (8.3.1). This resulted in six students from CVC in group A and only three in group B. At the start of the clinical work, there was therefore a total of thirteen students in group A and nine in group B. The groups were unbalanced and sparse data can lead to statistical assumptions being undermined, however no percentage is smaller than 5%, so this was not a concern (Breslow, 1981; Greenland, Schwartzbaum and Finkle, 2000). This figure also shows that all students, except one, attended their therapy sessions.

5.3.4 Sample size and power

The study was designed with the practicalities of a manageable caseload within the time allocated, rather than powering the study for a particular sample size, at 90% for example. It was difficult to increase the sample size, and therefore power, due to these time constraints. However, the ‘observed power’ given by the SPSS model was still useful, especially when the data were not significant. This gave the strength of the data to predict the parameter estimates and therefore help ascertain whether a non-significant result was due to a too small sample size and not enough power, or because there was no real effect from treatment.

The small sample size should not invalidate any findings because the sample was representative (Denscombe, 2007). However, to increase the Youth at Risk project’s sample size and power, it is explained in chapter nine how subsequent music therapy projects anticipate following this same research method and adding to the number of subjects.

5.3.5 Clinical intervention

Students were offered individual music therapy sessions, once a week for up to 20 sessions with each session lasting 40 minutes. The therapist kept notes after each session and conversations with teachers, as well as an attendance register noting reasons for a student’s absence. This meant that there was a record of how many sessions were offered in total and how many the students attended. It was right to provide as many sessions as possible in the two terms until the student had attended up to 20 sessions as it is known from experience that students can miss sessions for all sorts of reasons.

As described fully in chapter four, the music therapy approach is one which has been used, developed and been largely informed by experience and practice with teenagers with various emotional and behavioural problems over the last ten years. The main intervention methods were active music-making such as improvising and playing pre-composed music, songwriting, and receptive methods, such as listening to CDs of the

students' choosing. The work varied depending on the student's use of sessions but the work was consistent in what it offered.

The standard treatment for all students in addition to music therapy was schooling. For The Centre School students, this generally consists of a morning of lessons in small classes, some 1:1 work followed by activities in the afternoon. Music therapy is always in addition to what school offers and takes place during a class lesson which is time-tabled in arrangement with teachers. For the mainstream students music therapy also occurs during a lesson time and in arrangement with subject teachers. These students follow a full timetable at school in line with the National Curriculum (3.2).

Although there is no other therapy at the school, students are often referred to different health and support services. Interventions which the students could be offered, such as referrals to Child and Adolescent Mental Health Services, youth offending services or counselling provided by childrens' homes, were not limited by the running of this research project as this would have been unethical.

5.4 Quantitative data collection from students

Some of the research was by survey, known as a descriptive quantitative method. 'Survey research involves collecting information by asking a set of predetermined questions by means of a questionnaire to a sample of people who are selected to represent a particular population' (Prickett, 2005, p.50). This important means of data collection had the advantage that it could be replicated in future projects (9.7) and all the students were asked exactly the same questions which could be 'added together to produce results which apply to the whole sample' (Wigram, 2005a, p.274). Self-report measures have been shown to be an effective way of obtaining information about children (La Greca, 1990; Kazdin, 1990). However, this assessment which relies on self-report also had disadvantages (9.3.3). For example, there was no way of checking the truth of the students' answers but, by the set up and arrangement of the room with comfortable chairs and the warm-up conversation, it was hoped that students would feel relaxed and settled enough to answer as honestly as possible.

5.4.1 Choice of questionnaires

The decision over which questionnaires to use had to be led by the school context and the students who would be questioned. Time was the main factor because it was anticipated that students would not be able to cope with too many questions.

At the time when the project was being set up, students at The Centre School were accustomed to completing W3 Insight assessment tools (W3 Insights Ltd, 2002). They are short, online tests which ask students how they feel about school and learning and are an effective way to obtain data: they are quick to administer, which is good for students who generally struggle to stay on tasks for more than a few minutes, and offer a snapshot for the school to monitor student's feelings. However, there were several reasons why they were not suitable to use for this project: it would have been difficult to administer the tests consistently and the results could only be obtained as combined data for the school. As the data could not be student specific, gathering particular results to determine differences between the students receiving and not receiving music therapy would have been impossible and therefore pointless for this design.

Other available questionnaires were considered, including one that measured social functioning and mental health, known as CORE: Clinical Outcomes in Routine Evaluation (Evans et al., 2000). These questionnaires are short and based on a person's feelings over a past week. The questions are simple and consist of ten statements. The short length is designed to minimise demands on young people and to ease scoring in busy settings, however, this means that the data would have been too limiting for use in this research project.

Like the CORE questionnaires, the Beck Inventories for Youth are easy to administer but they are longer and more thorough. They are straightforward, relevant, written with young people in mind and comprehensively cover the areas of emotional and social impairment. These were the areas being investigated in this research and were therefore ideal for the study.

The Beck Youth Inventories of Emotional and Social Impairment (Beck et al., 2005) were created to meet the need for a short screening tool²⁸ that could be used by teachers and health workers to identify children who needed referral to further assessment services (US Department of Health and Human Services, 1999). The inventories are five self-report measures which can be used separately or in combination to assess a child's experience of depression, anxiety, anger, disruptive behavior and self-concept. They were designed for testing children who are distressed and can be administered individually or in groups. Each inventory contains 20 statements about thoughts, feelings, or behaviours, associated with emotional and social impairment, and the young person is asked to respond to each statement by indicating how frequently it is true for them, with the answer *never*, *sometimes*, *often* or *always*.

According to the manual for Beck Inventories for Youth second edition for children and adolescents (Beck et al., 2005), the Beck Self-Concept Inventory for Youth (BSCI-Y) includes self-perceptions, such as competence and positive self-worth. The items in the Beck Anxiety Inventory for Youth (BAI-Y) reflect children's fears and worries, for example about school, getting hurt and ill health, as well as physiological symptoms associated with anxiety. The statements in the Beck Disruptive Behavior Inventory for Youth (BDBI-Y) list behaviours and attitudes which are associated with conduct disorders and illustrate the student's self-report on their behaviour. These three inventories covered the primary research question so could therefore fulfil the study's primary objective and are included as appendix 5.4.1a.

An additional questionnaire, called the music therapy project questionnaire, was compiled by the researcher for the study (appendix 5.4.1b). The same pattern as the Beck inventories was followed, using statements which required an answer of *never*, *sometimes*, *often* or *always*, to make its administration as straightforward as possible. There were twelve statements to explore students' attitudes and feelings about school and three statements about feelings of anger which were taken from the Beck Anger Inventory for Youth (BANI-Y). This entire inventory could have been used, however

²⁸ More screening tools were needed following the US Individuals with Disabilities Education Act in 1999. This act required schools to provide special services for children with social and emotional impairments that interfere with their functioning in the school setting.

considering the students' levels of engaging in such tasks, it was decided that a shorter questionnaire to cover the outstanding necessary questions would suffice. As Denscombe points out, 'the researcher has to walk a tightrope between ensuring coverage of all the vital issues and ensuring the questionnaire is brief enough to encourage people to bother answering it' (2007, p.162). In total, the students were asked 75 questions.

5.4.2 Administration of questionnaires

The planning and micro-management of each day of data collection was necessary otherwise it would not have worked because time was limited. Most importantly, arrangements with all relevant teaching staff across the two schools had to be made, to allow students to miss part of a lesson for this. Mainstream students knew where the interview room was and were able to make their own way there and did not need to be collected. However, they did need reminders which were sent to them via student reception and correspondence with tutors by email was essential to ensure that students attended at the right times. For students at The Centre School, however, times had to be arranged with teaching staff and the students needed to be escorted to and from the interview room.

I collected students and managed the timetable for each day²⁹. Students were seen individually and I sat outside the interview room for each session in case a student chose to leave early or the interviewer needed support. Each student was allocated 40 minutes and a register was kept of students as they attended and completed the questionnaires (appendix 5.4.2a).

The students all followed the same procedure: they were interviewed by Dr. Long³⁰ and then they answered the questionnaires. However, the conditions in the administration of the questionnaires did vary because the students at The Centre

²⁹ Each data collection took an average of 3 days to complete.

³⁰ Dr. Marion Long is an experienced teacher and researcher who was involved in research studies at the Institute of Education, University of London (IOE) at the start of this project. As the IOE supports this project and The Music Therapy Charity's Youth At Risk study, as described in chapter one, Dr. Long was recommended as interviewer.

School generally find reading more difficult than mainstream students. For this reason, the interviewer read out the statements for each Centre School student, whereas mainstream students were usually able to complete the questionnaires on their own and were only offered assistance if they needed it. In all cases the interviewer checked that none of the statements were omitted, encouraged students to complete all of the tests and made the data collection as reliable as possible.

FM radio hearing aids³¹ were used for the hearing-impaired students. In all the self-report questionnaires there was no scope for an 'I don't know' answer which could be potentially very frustrating to a teenager but the interviewer encouraged them as much as possible to provide an answer through conversation. This method was good for students whose default answer can be 'I don't know'. Large, coloured, laminated cards with the possible response words were put on the table to help students to visualise the answers as well.

5.5 Quantitative data collection from teaching staff

As part of the monitoring, teaching staff also completed questionnaires at the same four data collection times as the students. The Re-integration Readiness Scale (RRS) developed by McSherry (1996), recommended by Professor Hallam³², was an assessment tool that could be adapted well for this investigation and the questions linked with the questions which were put to the students (appendix 5.5a).

This Re-integration Readiness Scale was written as part of a programme for pupils with challenging behaviour. It was originally devised for use in a special school for pupils with emotional and behavioural difficulties or Pupil Referral Units but was then further developed for use in a mainstream school. This version was named The Coping in Schools Scale (CISS), was designed for both teachers and pupils to complete. 'Completion of the CISS identifies the pupil who is causing concern, gives

³¹ An FM hearing system is a wireless communication system which consists of a transmitter which picks up the voice close to the speaker's mouth and transmits it via radio waves directly to the FM receiver, which is connected to the student's hearing aid.

³² Dean of the Faculty of Policy and Society and Professor of Education at the Institute of Education in London.

staff and pupils clear indications of what needs to be addressed, is able to offer an agreed set of criteria and a systematic and consistent way of assessing pupils and offers a comparison of perspectives between teachers and pupils' (McSherry, 2001, p.28).

The programme was developed as part of McSherry's research, with the aim of creating and implementing 'a practical tool and set of processes to promote the re-integration of pupils with emotional and behavioural difficulties into mainstream schools' (2001, p.18). It has a three-part structure of assessment, preparation or intervention, and support. Group work and the development of peer support are important elements of the programme. Students are aware of their targets for both their behaviour and work and know what they need to do to achieve them. This is the same for students at The Centre School who are also encouraged to think about how staff can help them with this.

Based on McSherry's programme, the teachers' questionnaire were designed to capture the teachers' perceptions of the student's behaviour in six sections: self-control, self and others, self-awareness, self-confidence, self-organisation and attitude³³. Three teachers scored 33 statements for each student, using an eight point rating scale (0 - never able to fulfil this criterion to 7 - always able to fulfil this criterion).

In the mainstream school, the three teachers asked were the form tutor or head of year, an English or humanities teacher and a maths or science teacher respectively. At The Centre School form tutors and different subject teachers were asked but there are only three teachers in the school so instructors were also asked³⁴. This triangulation resulted in three opinions on each student allowing students to be different in different lessons as a student's behaviour often changes according to the lesson and can be dependent on their relationship to the teacher.

³³ The sections on learning skills and literacy skills from the Re-Integration Readiness scale were omitted.

³⁴ Collecting the questionnaires was not an easy task as it involved over 60 teachers across the two schools. However, it was well-organised and a record was kept of the questionnaires as they were distributed and returned, along with a record of each teacher's subject (appendix 5.5).

Effort was made to match the subject teachers for each student but this was not possible in practical terms due to the large number of teachers involved. The assumption was that all teachers and instructors were equally qualified to assess the students and meant that, whether the assessments were done well or poorly, every student had an equal chance to be assessed accurately and any anomaly in the responses would be cancelled out. This assumption could be made because individual differences in scores would not count for much. The assumption had to be made because it was not just three teachers who were involved or even the same three teachers for each student at every point of data collection, mostly due to changes in the staff team over the project's duration.

5.6 Missing data imputation

The students were encouraged to complete all items but when this was not possible the response was estimated by the mean response value of the items answered by the student on that inventory. Total raw scores could only be converted to *T* scores with this imputation and this was according to the manual to the Beck Youth Inventories second edition (Beck et al., 2005, p.12).

When there were some missing data in the teachers' questionnaires, these following rules were used:

1. When an individual question was missing at any point after baseline, the standard method of last observation carried forward (Shao and Zhong, 2003) was used. Therefore the assumption was made that the response remains constant at the last observed value.
2. For missing baseline data, the mean was used for that cohort. For example, a student in group A from CVC with a missing baseline score for a particular question received, as their score, the mean for that question from all group A and CVC students.
3. There was no imputation of total scores. This meant that individual questions were imputed but the scores were not added up for analysis.

5.7 Quantitative data collection from school sources

Twelve sets of data were taken from attendance registers, logbooks of incidences, records of occasions when there was need for restraint, and from other on-line sources at school. The researcher collected the data at half-termly intervals over the two-year period as illustrated in table 5.7.

Table 5.7 Times of data collection from school sources

Data collection	1	2	3	4	5	6	7	8	9	10	11	12
Year	2009		2010						2011			
Half-term block	7Sept to 23Oct	2 Nov to 18Dec	4 Jan to 12Feb	22Feb to 1Apr	20 Apr to 28May	7 June to 23July	6Sept to 22Oct	1 Nov to 17Dec	5 Jan to 18Feb	28Feb to 8 Apr	27Apr to 27May	6June to 22July

In all cases of challenging behaviour and exclusion, the incidents were recorded by type. Categories included inappropriate behaviour, disruptive behaviour, damage to property, assault on pupil, non-compliance, fighting, verbal abuse, theft, dangerous behaviour, bullying and assault on staff. In CVC records, linked documents were manually searched to find letters to parents to confirm reasons for exclusion. Records of attendance including absence, both authorised and not, were made and other notes made by staff on the school Capita SIMS system³⁵ were collated. All emails sent to staff concerning students in the project were printed off and kept in the respective student's file.

5.8 Statistical analysis

Following the guidelines on using the Beck Youth Inventories, the raw scores for each inventory were calculated with one score for each item. The raw scores were then converted into standardised *T* scores³⁶, created for each inventory from means and standard deviations specific to the group for young people aged 11 -14 and separated by gender (Beck et al., 2005, p.65). *T* scores 'provide a common metric that

³⁵ This is a management information system used by most schools in the UK.

³⁶ These were developed using samples from a US population of children and adolescents.

allows profiling across scales...and a comparison of an individual's raw score relative to the total variability of that individual's norm group' (ibid. p.13). These *T* scores were used in all subsequent analyses in this study. The difference between scores before and after music therapy was calculated to show change and the scores were also compared to the Beck clinical ranges. Descriptive statistics were used to identify characteristics of the findings, which were then followed up by inferential statistics to observe the probability values.

Using the Statistical Package for the Social Sciences (SPSS), one of the most widely used software programs for statistical analysis (Meadows, 2005), data sets were created for the students' answers³⁷, for the teachers' responses and one for the incidents of challenging behaviour recorded in school. The data were entered manually into the software programme and the scores were entered with weighting³⁸. An independent person reviewed the data set after missing data had been imputed and the change scores had been calculated which added to their validity. The analysis was also validated by using the two data systems Excel and SPSS. This meant that, although the statistical tests were not carried out by an independent person, I could check the analyses against each other and errors could be detected.

In order to determine whether music therapy helped improve the student's emotional well-being, a multivariate analysis of variance (MANOVA) was used to see if there was a significant improvement in the three Beck Inventories of self-assessed self-concept, anxiety levels and disruptive behaviour, between the start and end point of music therapy in both groups. Therefore, for group A, data were analysed between the first and second collection point and for group B, between the second and third. It was decided before the study began, that if there was a significant result from the MANOVA for the primary question, the tests could be repeated with the secondary data but if there were no significant results, only descriptive statistics would be used.

³⁷ Additional details for potential further analysis after this study were also included. For example, if an instrument or activity dominated in sessions it was noted and listed: 1 for drums, 2 for keyboard or piano, 3 for percussion, 4 for singing, 5 for electric guitar, 6 for talking, and 7 for play; and whether recorded music, improvisation or songwriting were used at any time.

³⁸ This means that the scores were reversed if the statement was negative and therefore needed weighting differently.

Parametric tests are statistical tests of significance to infer differences and relationships between numerical data variables (Brown and Saunders, 2008). They require certain assumptions for the statistics to be accurate and reliable, including the assumption of normally distributed data and the homogeneity of variance. The homogeneity of variance is the assumption that variants should be the same throughout the data and the variability within the two groups is similar enough (Field, 2009). This assumption, using Levene's test (1960), tested the null hypothesis that the variances in the different groups were equal³⁹. The lack of fit was used to check that the model fitted the data and the residual plot used all the variables in the model, predicted the estimates and presented what was left over⁴⁰. These tests were used in all the inferential statistical analyses.

Descriptive statistics were carried out for the analysis of the secondary data from the teachers' questionnaires, then inferential statistics using a MANOVA were calculated. To determine any lasting effect of music therapy, short-term follow-up data were analysed (5.2).

The music therapy project questionnaire, which addressed students' feelings and attitudes about school and anger, was examined differently. The results for the three anger statements were separated from the twelve statements about school in the descriptive statistics. They were then tested using logistic regression in order to analyse the proportions. The Hosmer-Lemeshow test was set by SPSS and used as the goodness of fit for this analysis.

5.8.1 Multiplicity

The issue of multiplicity, which means having several endpoints of interest, led to the decision to do a combined analysis of the key endpoints in a multivariate analysis of variance (MANOVA). The benefit of combining the three Beck endpoints (BSCI, BAI and BDBI) into a single analysis meant that the 5% alpha level did not have to

³⁹ If the Levene's test is significant, and therefore less than 0.5, the variances are significantly different in different groups and homogeneity of variance cannot be assumed.

⁴⁰ If there is a pattern to this residual plot it shows an error in the method because the residual plot should be random if the method is good.

be shared out between them. As the primary analysis was of the Beck scores, no adjustment for multiplicity was made for the secondary endpoints: the importance was based on finding a significant result in the analysis of the Beck.

5.8.2 Blinding

To protect the study design from the introduction of bias, the following criteria were applied:

1. During the project, the music therapist's only involvement in the quantitative data was to distribute and collect in the questionnaires. These were then kept in a locked filing cabinet at school. Data analysis only began after the last wave of data collection had been completed.
2. The McSherry Re-integration Readiness questionnaire (5.5) was rated by three teachers who were not actively informed as to whether the young person was currently receiving music therapy or not. However, official blinding was unrealistic due to teachers' constant interaction with students and contact with parents and other members of staff.
3. An independent statistician, who had no contact with the students, became involved with the data after the final data entry had been completed.
4. Qualitative data were collected by an independent interviewer.

5.9 Qualitative data collection from students

Semi-structured interviews preceded the questionnaires to help students relax but the order of doing the questionnaires and the interviews had to vary and be tailored to the needs of each student to maximise the time with each student. The pre- and post-music therapy interview schedules are included as appendices 5.9a and 5.9b respectively, however they served as guides rather than a set formula and not all the students were asked all of the questions. They were designed as warm-up

conversations to question students about issues which they could relate to, such as school and friendship.

The interviews were designed by the therapist and interviewer with the students in mind. Careful consideration was given to the topics (shown in table 5.9.1) which were chosen specifically to appeal directly to students and enable them to answer as fully as possible. It was hoped that, by initially generating conversation about their interests, the student would engage more readily and this would lead to more open discussion about their perception of behaviour, discipline, respect and encouragement. The schedule also included the chance for students to reflect back on past events, friends, changing schools and interests. The second interview included questions about music therapy. Some of these were inspired by evaluation carried out previously at the school concerning students' opinions on music therapy. The therapist was keen to explore the student's reaction to the intervention, given this unique opportunity to have students interviewed by an independent and qualified person.

Table 5.9.1 Topics set out in the interview schedules

Topics	Before and after music therapy	Before music therapy	After music therapy
Interests	✓		
Means of self-expression	✓		
Importance of friendships		✓	
Attitude to school	✓		
Enjoying school			✓
Respect in schools	✓		
Encouragement from teachers	✓		
Feelings that day			✓
Thoughts about the future	✓		
Feeling about the future			✓
Views on world	✓		
Music therapy			✓

Table 5.9.2 shows the specific questions posed after music therapy that were suggested in the schedule. However, the interviewer was directed to follow the student's lead and only use the actual questions where appropriate in the conversation.

Table 5.9.2 Questions about music therapy suggested in the interview schedule

What was music therapy like?	Was a music therapy sessions different to another lesson? In what way?
	Did you feel listened to?
	Was there enough choice of instruments?
	Would you like to carry on with music therapy once this research project is over?

5.9.1 Administration of interviews

Magazines about activities and hobbies, from motor sport, dirt-bikes, quad-biking, street art, skate-boarding and internet applications, to drumming and wildlife, were available to look at and read in the interview room. Their purpose was to help students to feel comfortable and interested in the setting. Blair's (2000) review of protocols for child interviews suggests that drawing can be an aid to recall, so coloured pens, pencils and paper were also made available. The interviewer suggested students could draw pictures to illustrate what they are talking about or to do a time line as they thought and chatted about their past. If students wanted to listen to music they were able to use their own MP3 players or the CDs on offer⁴¹.

It was decided that using semi-structured interviews, rather than narrative interviews, would be the most effective way to engage with the students. The need to lead and follow could only be achieved sensitively in this way and it allowed students to talk about what they wanted to and for the interviewer to feed the questions into the conversation as appropriate (Coolican, 2009). This gave the interviews more internal reliability and validity because both interviewer and interviewee jointly constructed the interview (Mishler, 1986).

The school's system for child protection would have been followed had a student disclosed or said anything which gave the interviewer particular concern for the student's welfare. At the start of each interview, the student was reminded about the audio recording, who would be listening to it and its purpose. They were told that they could choose to stop the recording at any point and asked if they understood that, before the conversation began. At the end they were thanked for their time, for sharing their thoughts and asked if they had any questions.

⁴¹ Bottles of water were provided and sweets were offered as they left!

5.9.2 Thematic review of interviews

All the interviews were audio recorded and an additional back-up recording was made but deleted when one was successfully saved. The interviews were then transcribed into written form as accurately and truthfully as possible. I did this after the clinical work had finished. There were 43 interviews lasting an average length of 25 minutes each. As I knew the students well, I was able to tune in to the students' language which made the task a bit easier, although it was a lengthy process. The transcriptions, including scans of any drawings which were made, are included as printed appendices (7.1.1- 7.1.43).

Transcription software (Express Scribe Transcription Software, NCH) and a foot pedal to control the recording were used. Where a word was inaudible or unclear, it was marked on the transcription. Pauses in the flow of verbal interaction were marked with dots but no other detail was given to hesitation or intonation because this could not be analysed in this research investigation. The transcripts were checked back for accuracy against the original recordings.

A rich thematic description set was chosen as the form of analysis. Braun and Clarke (2006) identified this method for areas that are under-researched and where the views of participants are not known. It has already been argued that young people with emotional and/or behavioural difficulties have not been asked their opinions about music therapy in a research study such as this. Therefore, the identification of themes that could reflect the contents of the entire data set was an appropriate means of analysis and the decision to make generalisations was part of the strategic, analytic thinking (Coffey and Atkinson, 1996). Whilst this may not show every different opinion of the students, it does provide an overview and rich description of the client group and setting (Gibbs, 2007) which is new to music therapy literature.

5.9.3 Note-taking

As well as the interview transcriptions, notes were made after each session, as in usual music therapy practice and contributed to the qualitative data set. These notes included my thoughts after a session, detail of the music and the student's ideas and

responses. Further notes were added following feedback from staff at the end of the day and from other meetings so that a record was formed which was not solely concerned with the student during a music therapy session. If there was an episode that involved the student, this was also recorded in their file on a separate form (appendix 5.9c). Such close record-keeping and note-taking, as is the established practice at this school, allows a student's progress to be tracked more easily and feedback accurately in meetings with parents/carers (appendix 5.11).

5.10 Conclusion

This chapter has explained the design and methods chosen for the study, including the inclusion criteria, group size, consent, ethical issues, the methods of assessment and how the data were analysed. Both quantitative and qualitative sets of data were collected at the same time and could be analysed in a complementary manner (Tashakkori and Teddlie, 2003), to create a parallel and simultaneous mixed method design. This meant that the primary analysis of the change scores, from before to after music therapy, of the Beck Youth Inventories were collected at the same time as the pre- and post-music therapy interviews. The analysis process included data integration which involved examining both the quantitative and qualitative data as one coherent whole.

This method created two data sets of findings and these are presented in separate chapters, six and seven respectively. Some of the data are then combined in chapter eight in the discussion of some cases.

CHAPTER 6

KEY FINDINGS FROM THE QUANTITATIVE DATA

6.1 Introduction

This chapter presents the results from the study's quantitative data to help determine the effects of music therapy on two groups of students who each received 20 sessions of music therapy. The primary results were provided by changes in the students' scores from before to after music therapy (change scores), collected from the students' responses to three of the Beck Inventories for Youth (Beck). These primary data are firstly presented as descriptive statistics for each inventory in their school groups (6.2), then as inferential statistics (6.2.4). Initially it was decided to present the students' results by schools because there would be less data on each graph but the differences in these two groupings ultimately helped to explain the data more clearly.

Secondly, the difference in the Beck scores between the two groups of students (A and B) was compared at the second data collection point, when only one group had had music therapy. This meant that results between the groups of students, when one had received music therapy and one had not, could be compared (6.3). Short-term follow-up data from the Beck were also compared after both groups had had a period of no music therapy (6.4). The fourth wave of data collection also provided a long-term follow-up data set for group A and these results are explained in 6.4.4.

The results from the music therapy project questionnaire which looked at students' feelings of anger and their attitudes to school are shown in 6.5 and finally, the results from the questionnaires given to teaching staff (6.6) present their views of students' emotional well-being after music therapy. Other quantitative data, collected from the school records of incidents and attendance, are also reviewed in this chapter.

Examples of completed questionnaires, by both students and teachers, are included in the appendices (6.1a - 6.1c)⁴². The students' scores from all four waves of data

⁴² Hard copies of all the students' and teachers' questionnaires are available for reference.

collection and all the teachers' data for each student are in appendices, 6.1d and 6.1e respectively.

6.1.1 Baseline data and groups

Table 6.1.1 shows the baseline data for students in each group when they were due to start their block of music therapy - at data collection 1 for group A and data collection 2 for group B. The average age of the students was almost the same in both groups and of 21 students, 20 were boys.

Table 6.1.1 Summary statistics of the participants in groups A and B

Baseline characteristic	Group		School		
			The Centre School n=12	CVC n=9	Both schools n=21
Age	A	N	7	6	13
		Mean	12.6yrs	12.5yrs	12.6yrs
		Standard deviation (SD)	1.27	1.22	1.2
		(Min, Max)	(11, 14)	(11, 14)	(11, 14)
	B	N	6	3	9
		Mean	12yrs	13yrs	12.6yrs
		Standard deviation (SD)	1	1	1.06
		Min, Max	(11,13)	(12,14)	(11,14)
Gender	A	Male	6	6	12
		Female	1	0	1
	B	Male	6	3	9
		Female	0	0	0

Two students in group A had significant hearing-impairment and one in group B was visually-impaired. Two students (one in group A and one in group B) had English as a second language. Two students had specified learning difficulties and were diagnosed with ADHD, one of whom was on medication. Although it would have been ideal to have no students on medication, this was not able to be monitored as

part of the project (9.3.1). Overall, more students took part from The Centre School than CVC, as shown in table 6.1.2.

Table 6.1.2 The percentage of participants from each school

School	In Group A	In Group B	In Group A and B
The Centre School	54%	71%	57%
CVC	46%	29%	43%

The distribution of students in the groups is not even but, as described in the study's recruitment (5.3.3), there was a greater need for music therapy among The Centre School students and this resulted in an uneven balance of students from the two schools.

6.1.2 Dropout

Only one student chose to drop out of the study: Roger in group B from The Centre School. He refused to talk to the interviewer and left the interview room before he had answered any questionnaires. He also resisted music therapy sessions and only attended twice, leaving early on each occasion. During the twenty week period of music therapy offered, he was moved from The Centre School to home tuition because he became a considerable risk to other students. This reminds us how difficult things can be with these young people.

Two other students - Daniel and Harry, both at CVC in group A- had to drop out of the study because they moved schools but they were still able to contribute data to the primary analysis because their circumstances did not change until after the second wave of data collection. Daniel moved to a school nearer his home and Harry moved to an educational unit run by Education other than at School (EOTAS) for two terms. This meant that he missed the third round of data collection but was back at CVC for the fourth wave of data collection and wanted to take part (8.5).

Finally, a fourth student had to be withdrawn from the project: Clare in group A from The Centre School. She received 20 sessions of music therapy and was prepared for the sessions to end however, at the time, her home situation was chaotic and she was extremely vulnerable. There was much discussion with her teachers and other support staff. Together it was agreed that it was unethical to keep her from having further sessions just because she was part of the research study. As a result she was offered ongoing music therapy and was withdrawn from the project.

Stuart, from The Centre School, was not a dropout and did not withdraw from the study but he was unable to complete the fourth round of data collection because he left school in June when he turned 16.

The circumstances of four students resulted in slightly reduced data for the project. Despite this, the fact that 21 out of 22 students (95%) wanted to stay in the project which lasted longer than 18 months, and that of these 17 students (81%) were able to participate to the end, is a remarkable outcome. These high percentages of treatment adherence are extraordinary because students with emotional and behavioural difficulties often resist engaging and find it difficult to commit to anything.

6.2 Findings from the Beck Inventories for Youth: comparing results before and after music therapy

Does music therapy help to improve the emotional well-being of adolescents who are at risk of underachievement or exclusion? This main research question was answered by analysis of the data from the change scores in the three Beck Youth Inventories: (1) The Beck Self-Concept Inventory for Youth (BSCI), (2) The Beck Anxiety Inventory for Youth (BAI) and (3) The Beck Disruptive Behaviour Inventory for Youth (BDBI). These are included as appendices 6.1g - 6.1i.

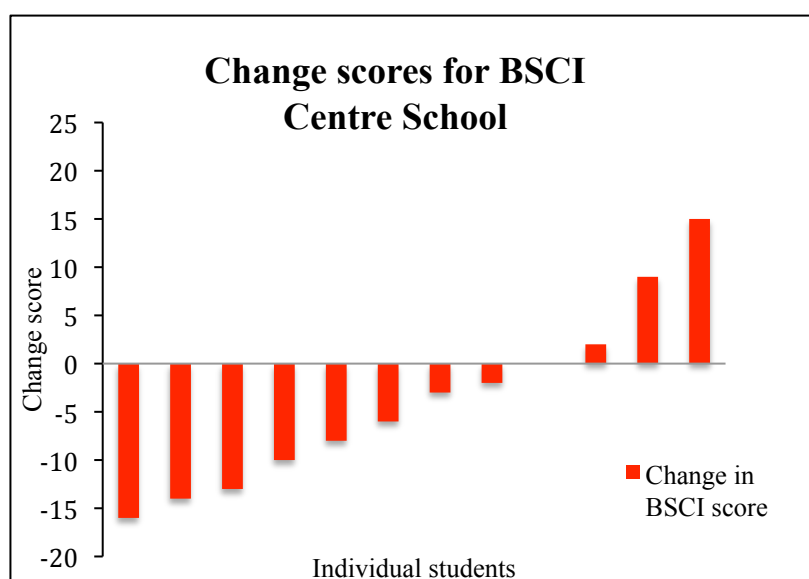
The raw scores from the Beck Inventories for Youth were calculated by adding up each item's score where Never = 0, Sometimes =1, Often =2 and Always =3. These total raw scores were then converted into *T* scores to allow profiling across scales to show a continuum of degrees of severity (Beck et al. 2005, p.19) because *T* scores provide a comparison of each individual to their norm group where they would be

expected to score, based on their gender and age. The tables in appendix 6.2b show the severity levels according to the Beck Inventories and the students' scores, together with their reference to the Beck clinical ranges, are presented in appendix 6.2c -6.2e. Graphs showing each student's scores are included as appendices 6.2a.1 - 6.2a.21. The *T* scores (appendix 6.2a) were used for all data analysis of the Beck given in this section, 6.2, which is separated into sections of descriptive statistics and followed by inferential statistics and a conclusion.

6.2.1 The Beck Self-Concept Inventory for Youth: descriptive statistics

The difference between The Centre School students' scores of self-concept from before to after music therapy are shown in figure 6.2.1.1.

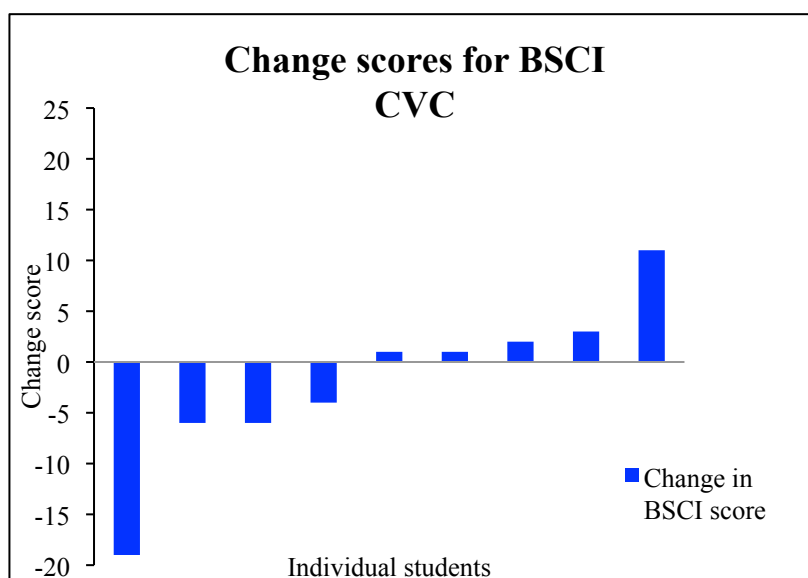
Figure 6.2.1.1 Centre School students: the difference between scores in pre- and post-tests for BSCI



This graph shows that a large proportion of students (67%) scored their self-concept as worse after music therapy than before. One student (8%) made no change and three students (25%) showed improvement. Therefore, most students scored their self-concept as lower after music therapy and fewer scored higher which could be seen as a negative result. However, it could also be seen as a positive result in the sense that students have become more self-aware and are able to answer more honestly.

Figure 6.2.1.2 shows a different picture in the change scores from before to after music therapy for the same inventory with CVC students.

Figure 6.2.1.2 CVC students: the difference between scores in pre- and post-tests for BSCI



These results show that four students (44%) scored their self-concept as lower and five students (56%) as higher. Therefore, more than half of the students' scores improved but there is a uniform and minimal amount of change across all the students from the lowest to the highest score which suggests that they have not changed very much. There are two exceptions which are shown at each end of the graph. They are outliers because their scores are very different to the others: Joe's score is extremely low compared to the others but his circumstances were also quite different to other students who were referred from CVC and his case study is given in chapter eight; and Daniel showed significant improvement compared to the others. Due to Daniel's difficulties, he had been moved forward into group A (5.3.3) because it was felt that he needed therapeutic intervention immediately and these statistics reflect the successful decision to begin his music therapy straightaway (9.3.2).

The summary statistics in table 6.2.3 include the mean increase and mean decrease, which show these steady changes in CVC students' scores.

Table 6.2.3 Summary statistics of all change scores in BSCI

Change in BSCI	Centre School	CVC	Modified CVC (without Joe)
N	12	9	8
Mean	-3.83	-1.89	0.25
SD	9.38	8.31	5.65
Min	-16	-19	-6
Max	15	11	11
N (%) positive change	3 (25%)	5 (55%)	5 (63%)
Mean increase	6.5	3.6	3.6
Mean decrease	-9	-8.75	-5.33

Students did not show as much change in their self-concept as The Centre School students and the standard deviation (SD) shows that the spread is consistent across both schools. The statistics for this inventory also confirm that without Joe the average score for CVC is an increase, and therefore a slight improvement of 0.25, and the number of students who made a positive change was 63%.

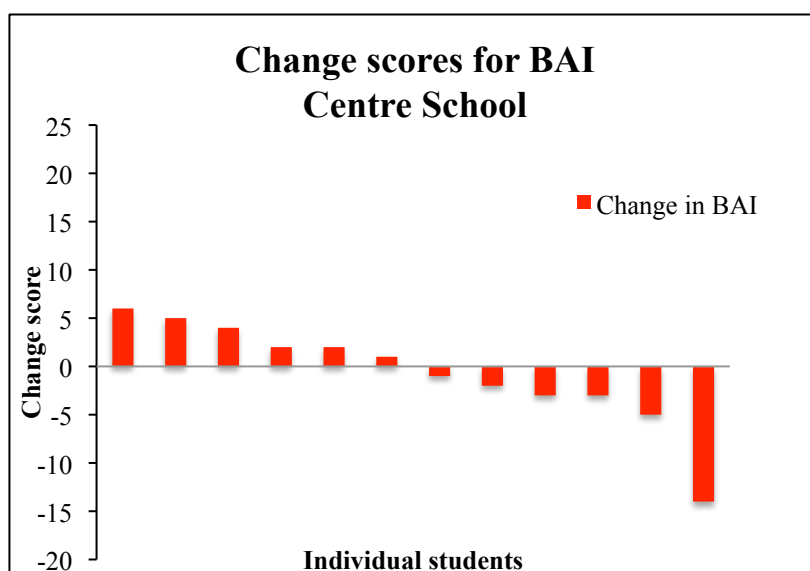
Figure 6.2e.i (in appendix 6.2e) shows the findings according to the Beck clinical range for the students in both schools before and after music therapy. It is interesting because before music therapy 38% of CVC students scored below average but this figure increased to 75% after music therapy, whereas 67% of Centre School students were below average. This shows that scores improved for the majority of students at CVC and to a much greater extent than for students at The Centre School.

In summary, it is the degree to which the BSCI results changed which highlights the differences between pupils in the two schools. The results suggest that The Centre School students have much greater need and were less self-aware before music therapy, achieving a more realistic sense of self after twenty weeks of therapy. For many of them, this was the first time they had somebody to listen to them which is backed up by their comments in their interviews (7.7.2). More students at CVC, on the other hand, were more self-aware and within the healthy range according to the Beck, at the start of music therapy and their scores showed less change.

6.2.2 The Beck Anxiety Inventory for Youth: descriptive statistics

The difference in the students' scores using the Beck Anxiety Inventory (BAI) were also compared before and after music therapy but these change scores were collated in descending order, so that the decrease in anxiety related to improvement in the student's emotional well-being. Figure 6.2.2.1 shows an even spread across the increase and decrease in scores of change in levels of anxiety after music therapy for students at The Centre School.

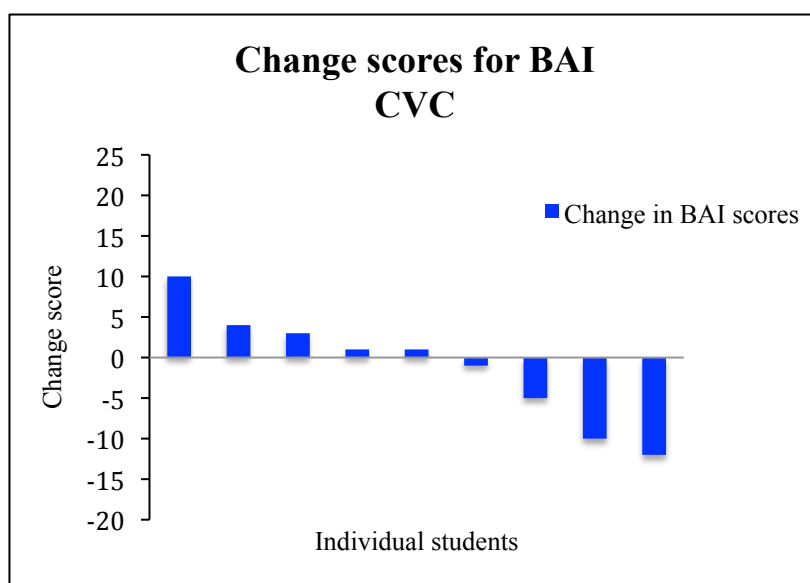
Figure 6.2.2.1 Centre School students: the difference between scores in pre- and post-tests for BAI



The pattern is much flatter than was seen in the previous inventory for self-concept (6.2.1.1) and the change scores hardly vary. John, who showed the greatest decrease in anxiety, is an outlier because the impact of music therapy was particularly significant for him (8.4).

The graph suggests that the students have tended to take the middle option (where 1 = sometimes or 2 = often) offered in the questionnaires because there is no evidence of students giving distinctive positive or negative results. This is known as tending to the norm. It may be that the students answered in this way because they did not want to be seen as anxious (9.3.3.1). Figure 6.2.2.2 shows the change scores for CVC after music therapy.

Figure 6.2.2.2 CVC students: the difference between scores in pre- and post-tests for BAI



Three CVC students showed clear reduction in anxiety levels and Joe scored the greatest improvement, three students recorded little change and three others considered their anxiety to have increased. The CVC students have a greater spread of results than those from The Centre School which suggests that they have not tended to the norm. The statistics in table 6.2.4 summarise the findings for the change scores in anxiety. They reveal that without John the standard deviation is half as spread out for The Centre School as at CVC. It only varies by 3.62 whereas CVC varies by 6.96. It is interesting that Joe made the most significant improvement in self-reported levels of anxiety, although he scored the lowest in self-concept (8.3) The table shows the modified data without Joe, as before, and without John who is another outlier.

Table 6.2.4 Summary statistics of all change scores in BAI

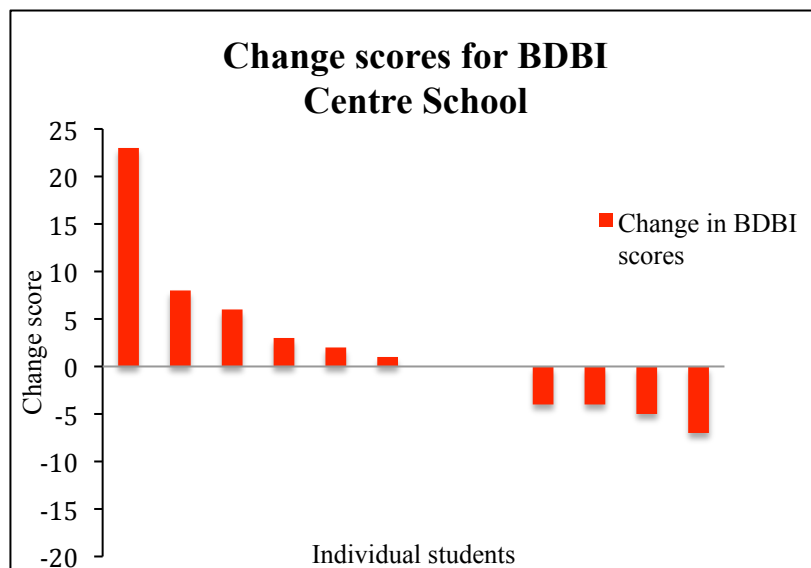
Change in BAI	Centre School	Modified Centre School (without John)	CVC	Modified CVC (without Joe)
N	12	11	9	8
Mean	-0.67	0.55	-1.00	0.38
SD	5.43	3.62	6.96	6.00
Min	-14	-5	-12	-10
Max	6	6	10	10
N (%) positive change	6 (50%)	6 (55%)	5 (55%)	5 (63%)
Mean increase	3.33	3.33	3.8	3.8
Mean decrease	-4.67	0.55	-7.00	-5.33

The results of the students' *T* scores according to the Beck clinical range (figure 6.2de.ii in appendix 6.2e) show that 71% of all students (8 students from The Centre School and 7 from CVC) are within the average range for anxiety. The large proportion of students shown to be in the Beck healthy range supports the view that anxiety is difficult to measure by self-report because it is evident from the referrals that the students do suffer from anxiety. The problems both in reporting and measuring anxiety are discussed in chapter nine.

6.2.3 The Beck Disruptive Behaviour Inventory for Youth: descriptive statistics

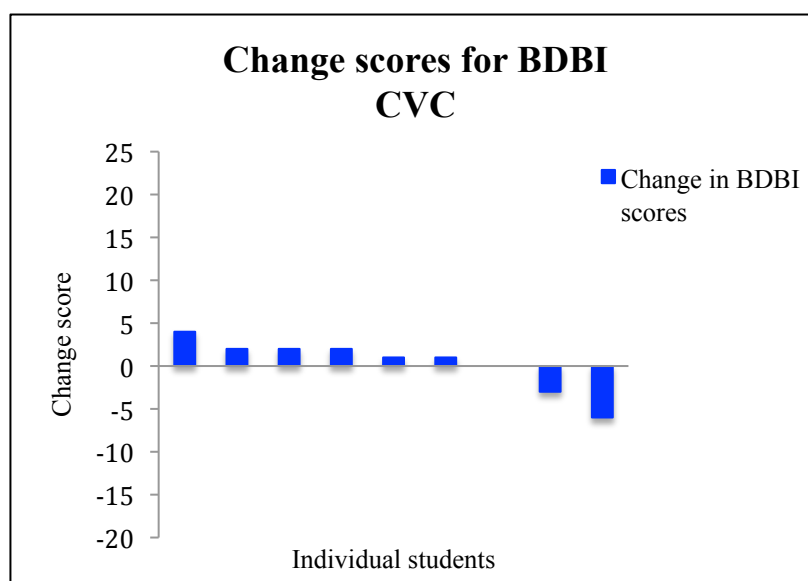
The results for the BDBI were calculated in the same way as for the BAI which means that a decrease in change score signifies improvement. Figure 6.2.3.1 shows the difference in scores which The Centre School students gave.

Figure 6.2.3.1 Centre School students: the difference between scores in pre- and post-tests for BDBI



This graph shows that there was no change for two students (17%) and changes in both positive and negative directions for others. Clare is the student with the greatest increase in self-reported disruptive behaviour and this is discussed in 6.2.3.1, when self-assessment scores are compared with the reality of reported incidents at school. Without Clare's result, there is a shallow slope encompassing both increase and decrease in student-reported disruptive behaviour. Figure 6.2.3.2 shows the changes in scores which CVC students made. It shows a different picture to the one presented by The Centre School students.

Figure 6.2.3.2 CVC students: the difference between scores in pre- and post-tests for BDBI



There is virtually no slope in this table. The student with the highest reported increase in disruptive behaviour is Joe, who has already been classed as an outlier (6.2.1 and 8.3), however all the other scores are comparable and there is little change amongst them. This suggests that students feel their behaviour has neither deteriorated nor improved. Table 6.2.5 shows that the means in both schools are similar if Clare is removed from the statistics, but there is a greater standard deviation among The Centre School students than CVC students.

Table 6.2.5 Summary statistics of all change scores in BDBI

Change in BDBI	Centre School	Modified Centre School (without Clare)	CVC	Modified CVC (without Joe)
N	12	11	9	8
Mean	1.92	0.00	0.33	1.125
SD	8.01	8.01	3.04	2.03
Min	-7	-7	-6	-3
Max	23	8	4	4
N (%) positive change	6 (50%)	5 (45%)	5 (55%)	5 (63%)
Mean increase	5.38	2.86	2.2	2.2
Mean decrease	-5.00	-5.00	-2.00	-0.67

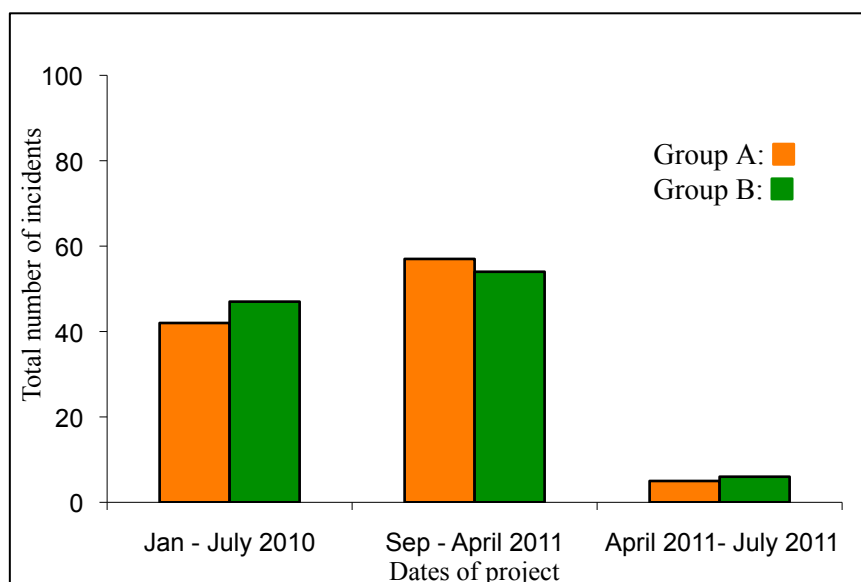
Figure 6.2e.iii in appendix 6.2e shows the findings of the students' *T* scores according to the Beck clinical range for disruptive behaviour: before music therapy, 67% of all

students scored in the average range which increased to 71% after music therapy. This led the researcher to consider how the students' perception of their behaviour might differ from the actual recorded number of incidents and to measuring the correlation between the two.

6.2.3.1 Correlation between perceived and actual disruptive behaviour

The data from the teachers' logs of incidents for the periods between each data collection are shown in figure 6.2.3.3.

Figure 6.2.3.3 Number of incidents recorded for students

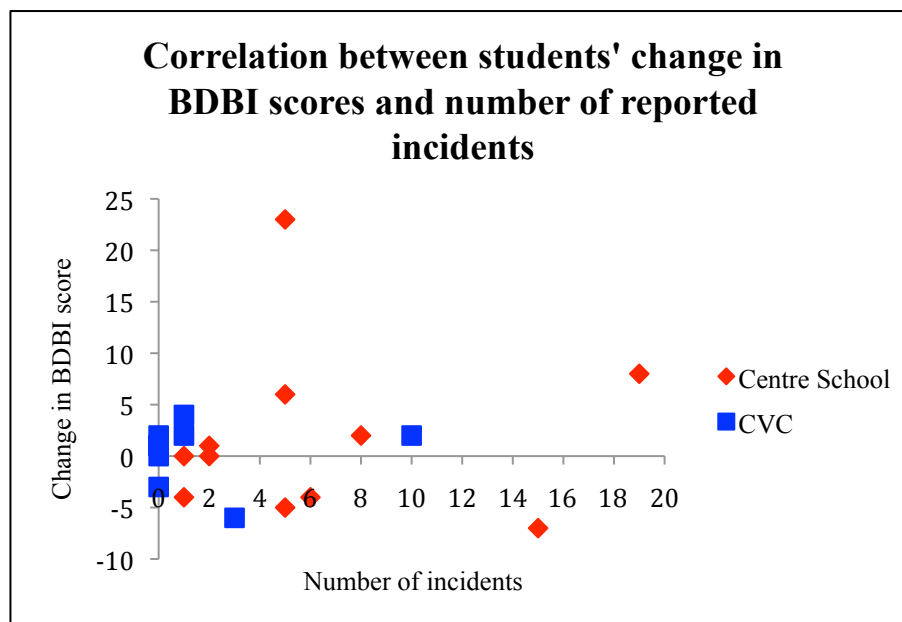


These results show that there were fewer incidents recorded for students in group A, who were having music therapy, than for those in group B who were not. When their music therapy finished, the number of incidents for the students in group A then increased by 17% which suggests that behaviour can deteriorate after students have finished having music therapy.

Once students in group B had finished music therapy the number of incidents recorded for them decreased dramatically and group A showed a similar change. However, the period between April and July is shorter (four months compared to six months) and some of the year 11 pupils had left school by this time so a smaller number of incidents would be expected.

It was interesting to compare these figures from the teachers' logs of incidents⁴³ with the students' self-reports of disruptive behaviour in the BDBI. In order to determine the relationship between these two figures (variables), their correlation was calculated to measure the strength of the association between the two, providing the correlation coefficient⁴⁴. The scatter graph in figure 6.2.3.4 shows the correlation between the two variables.

Figure 6.2.3.4 The correlation between the students' change scores in BDBI and the number of incidents logged at school



The change scores from the BDBI did not match the number of incidents reported by staff. Thus, the results of the correlation coefficient were very weak (CVC students: 0.0376, 3%; The Centre School students: 0.051, 5%). This potentially shows that students are not very good at self-reporting. For example, one student was involved in 19 incidents but his self-reported change score was only +7. Clare scored herself very highly (+23) but in fact she only had 5 reported incidents. Without Clare the correlation for The Centre School would improve and increase to 16%.

Therefore, the low coefficient could also mean that the students' perception of their behaviour is not directly related to the number of reported incidents. The students'

⁴³ The number of exclusions was small and related to more extreme behaviour, so the number of incidents was used and this included incidents which resulted in exclusion.

⁴⁴ These exploratory statistical findings were not in the method because they were not considered originally so the analysis was made on an adhoc basis.

perception of disruptive behaviour might be different from others because they attend a school for students with emotional and behavioural problems and are likely to witness challenging behaviour on a regular basis. They therefore either score themselves by comparing to others, according to their own set of rules, or trying to guess how others perceive their behaviour.

6.2.4 The Beck Inventories for Youth: inferential statistics

Having investigated the change scores with descriptive statistics, changes in the data from before to after music therapy were then analysed using SPSS (5.8). Parametric statistics from a multivariate analysis of variance (MANOVA) were based on the assumptions that the data have a normal distribution and groups have equal variance. Levene's test was used to look for equal differences in the variances in the different groups (appendix 6.2f). The degrees of freedom control the size of the effect that is being looked at and this proved to be non-significant because the p-values were 0.22, 0.4825 and 0.992 for BSCI, BAI and BDBI change scores respectively. This meant that the null hypothesis of equal variances could not be rejected and the MANOVA model could be reliably used.

The findings from the MANOVA (appendix 6.2g) revealed that the change scores for each inventory were neither dependent on which school the student attended nor in which group they participated. The interaction between these groups was also insignificant. This meant that, had any effect of school been found, it would have been independent of group and vice versa.

The tests showed that the only thing which had a significant effect at the pre-defined 5% level on the change scores of the BSCI was the baseline score (p-value = 0.001). So, regardless of school, group, or other baseline scores, the self-reported self-concept inventory made by students before music therapy was shown to influence their change score in BSCI so much that nothing else in the model could further explain any of the change.

The only thing that was important in predicting how the BDBI would change was the student's self-reported disruptive behaviour results they reported before music

therapy. The baseline score ($p\text{-value}=0.003$) change in BDBI was shown to be a significant influential factor but school or group continued to be non-significant factors.

This means that, even when the students had very different scores, their baseline scores for each BSCI and BDBI were the best indicators to predict variation in the change scores for each inventory. These findings are convincing because these tests also showed that there was more power, that is confidence, in the model to predict accurate results in the BSCI and BDBI variables: the model was robust for 90% of the time for the BSCI and over 70% for the BDBI.

However, there was nothing in this model that could accurately describe change in anxiety because there was no significant factor that was found to affect the change in students' self-reported levels of anxiety. There was also less power: only 31% of cases could be predicted with the model in the change scores using the BAI. In order to explain the parameter estimates more clearly, the means and the confidence intervals⁴⁵ for these data according to the model are shown in appendix 6.2h.

6.3 Findings from the Beck Inventories for Youth: comparing results between groups with and without music therapy

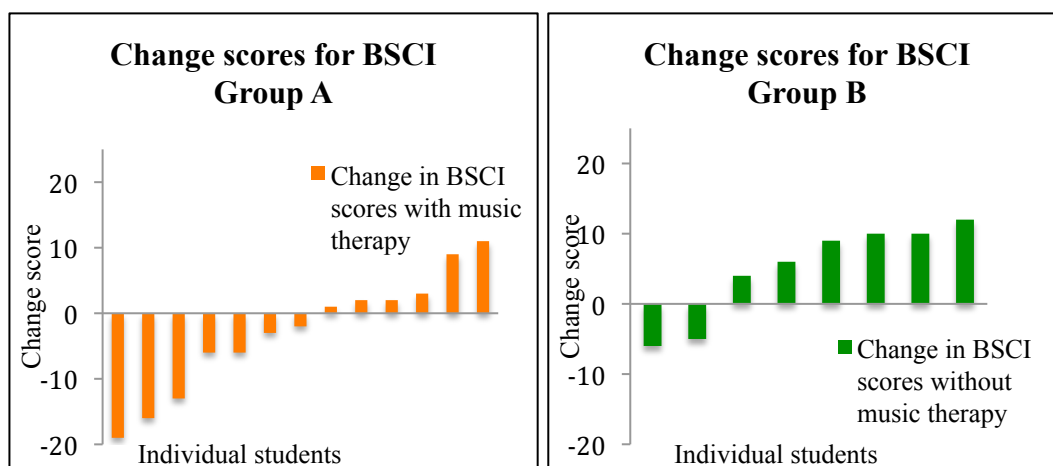
Having looked at the students' change scores from before to after music therapy, a secondary analysis investigated the difference in scores between the two groups at the second data collection point. This, therefore, compared the results of one group (A) who had had music therapy to the other (B) which had not. Observations for the Hawthorne effect, that is whether students' responses in group B altered because they knew they were participating in a project, could also be investigated. Bar graphs for each inventory show the change scores for the two groups. Descriptive statistics are presented first (6.3.1-6.3.3) followed by results from the MANOVA (6.3.4).

⁴⁵ A confidence interval is the degree of certainty about a population estimate which has been made from a random sample of data. The confidence interval shows that 95% of the data range between the lowest and highest values. Confidence intervals contain enough information to judge statistical significance (Howitt and Cramer, 2011).

6.3.1 The Beck Self-Concept Inventory for Youth: descriptive statistics

The graphs in figure 6.3.1 show the difference in the scores for each group's answers of the BSCI between the first and second wave of data collection.

Figure 6.3.1 Difference in groups' scores from the first two waves of data from BSCI



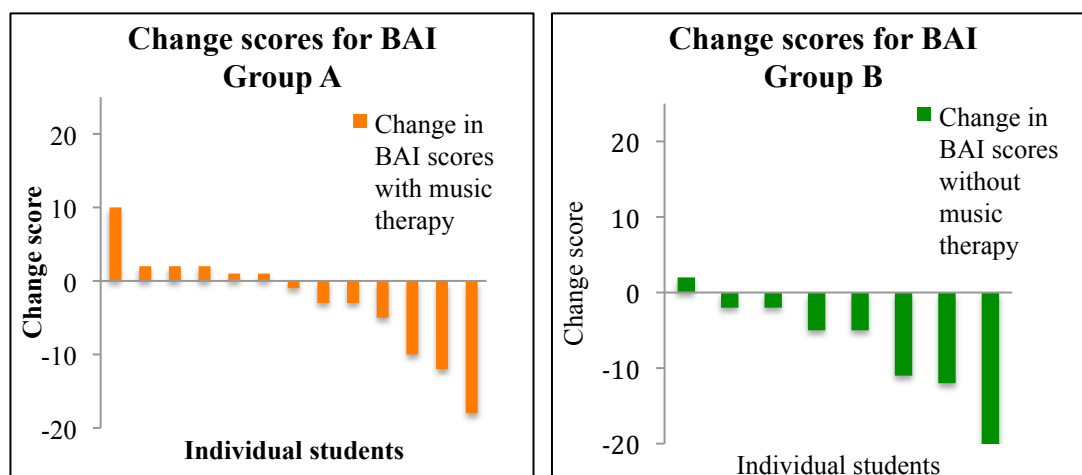
There was, approximately, a 50:50 split of students in group A showing an increase:decrease in their self-concept scores whereas in group B 75% reported an increase and only 25% a decrease. This could look as though students who have had music therapy scored less well than students who had not. However, it could further support to the suggestion made previously (6.2.1) that music therapy helps develop a stronger sense of self and group A, therefore, give more honest and insightful answers than B.

The summary statistics (table 6.3a.i in appendix 6.3a) show that the students in both groups have a similar maximum score (group A=11, group B=12) and, although the mean declines in group A (mean= -2.85), the standard deviation was wider than group B (SD = 9.06), which reflects the increased uncertainty in their responses. Group B answered more consistently (mean = 5.00, SD = 6.95) and came across as more self-assured.

6.3.2 The Beck Anxiety Inventory for Youth: descriptive statistics

The graphs in figure 6.3.2 show the difference in the scores for each group's answers of the BAI between the first and second wave of data collection.

Figure 6.3.2 Difference in groups' scores from first two waves of data from BAI

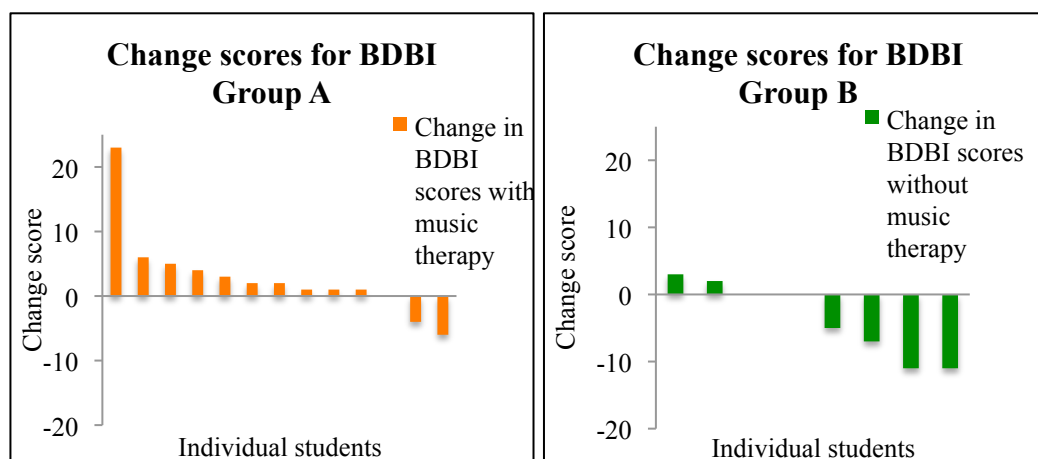


The similar spread of these two graphs highlight that, whether with or without music therapy, students find it difficult to be honest about feelings of anxiety. The standard deviation in the summary statistics for this inventory (table 6.3a.ii in appendix 6.3a) confirm this (group A = 7.29, group B = 8.18).

6.3.3 The Beck Disruptive Behaviour Inventory for Youth: descriptive statistics

The graphs in figure 6.3.3 show the difference in the scores for each group's answers of the BDBI between the first and second wave of data collection.

Figure 6.3.3 Difference in groups' scores from the first two waves of data from BDBI



77% of students in group A scored themselves higher on this inventory after music therapy which shows that they felt their behaviour had deteriorated. Ten students (77%) felt their behaviour had become worse, one student (8%) felt there was no change and only two students (15%) reported an improvement. However, in group B, four students (50%) felt that their behaviour had improved, two students (25%) reported no change and another two (25%) felt their behaviour was worse. The summary statistics for this inventory (table 6.3a.iii in appendix 6.3a) show that there is a big difference in answers between the two groups for behaviour.

The results of group A suggest that with greater self-awareness they are also more aware of their challenging behaviour whereas group B's results are much more positive. At this time, students in group B knew that they were due to start music therapy and might fear the consequence of having it withdrawn upon admitting bad behaviour. As this is something that students might expect, it could have influenced their response and this can be classed as the Hawthorne effect.

6.3.4 Reflection

In conclusion, these results from all three inventories look as though the students in group B are doing well but this is probably not the case as all the students were referred because they were at risk of underachievement or permanent exclusion due to significant emotional and behavioural difficulties. These results could indicate that students were reluctant to admit their feelings. The results from group B could also

represent a student's coping strategy which involves either an intention to hide, or an inability to show, signs of weakness or emotional distress. Students who have had no music therapy have not gained any further insight into their emotional well-being and might respond more defensively. Students in group A, on the other hand, had had the opportunity to express themselves in a therapeutic environment, develop greater self-awareness and understand their emotions and even reasons for their behaviour.

6.3.5 The Beck Inventories for Youth: inferential statistics

Inferential statistics were used to support the findings made by descriptive statistics, as with the primary data. The results from the MANOVA model (appendix 6.3c) show that the mean change for group A was not significantly different to group B for each of the Beck inventories' parameters (BSCI p-value = 0.925; BAI p-value = 0.409; BDBI p-value = 0.179)⁴⁶.

Table 6.3d in appendix 6.3 shows the change scores between the two groups. The means for each scale are very similar and, as expected from a non-significant model parameter, the 95% confidences are broadly the same. This suggests that the null hypothesis, that there is no difference between group A and B, could not be rejected. This means that the data did not show any significant influential factors. However, the observed power for these tests are very low (BSCI p-value=5%; BAI p-value=12%; BDBI p-value=26%), and this non-significant result is probably due to the small number of students involved and/or the imbalance in CVC and The Centre School students in the two groups.

6.4 Findings from the Beck Inventories for Youth: follow-up data

In order to show any change after a period of no music therapy, the short-term follow-up data were compared: group A's scores from data collection three to two, and group B's scores from data collection four to three. The results for each inventory

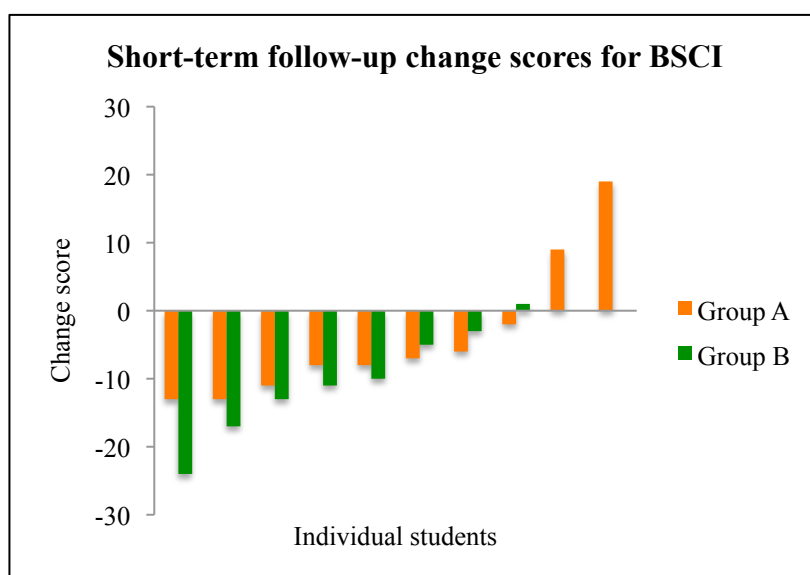
⁴⁶ Levene's test was carried out and is shown in table 6.3b (appendix 6.3b). It was non-significant which supports the model requirement of equal variances.

are presented in this section as bar graphs and, in appendix 6.4a, as tables of summary statistics.

6.4.1 The Beck Self-Concept Inventory for Youth: descriptive statistics

The results in figure 6.4.1 show that nine out of ten students in group A and seven out of eight students in group B, recorded a drop in their self-concept in the short-term follow-up data.

Figure 6.4.1 The difference in BSCI scores after a period of no music therapy



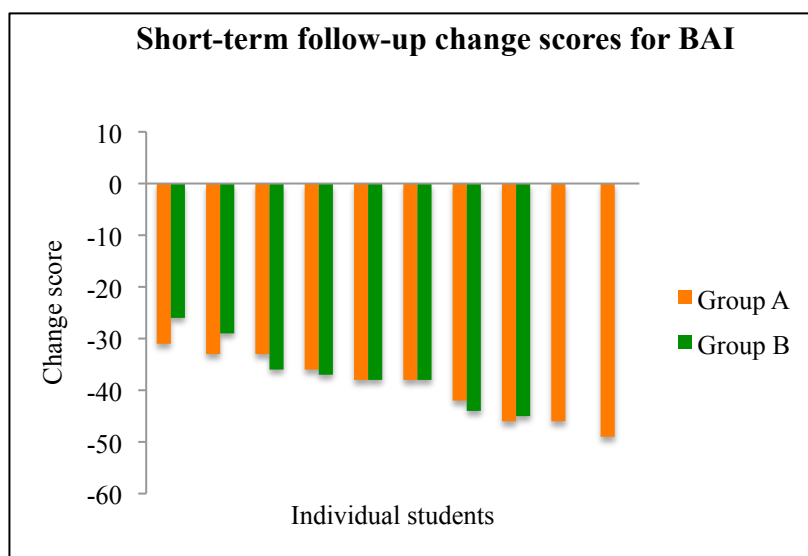
After a period of no music therapy, most students recorded their self-concept as lower than before. Table 6.4a.1 in appendix 6.4 shows that there is a similar standard deviation in the two groups (group A=9.81; group B=8.01). This supports the case that most students need on-going therapy rather than finishing at twenty weeks because the results have become worse rather than plateaued.

The students' follow-up data were compared in their school groups too (figure 6.4b.i in appendix 6.4b) and it shows that the three students who improved in their scores were all from The Centre School.

6.4.2 The Beck Anxiety Inventory for Youth: descriptive statistics

The results from this short-term follow-up data show that all the students reported a decrease in their anxiety levels, as shown in figure 6.4.2.

Figure 6.4.2 The difference in BAI scores after a period of no music therapy



The previous data from the BAI showed that most of The Centre School students tended to the norm in their self-assessments. These results show that the students in both groups, and therefore both schools, reported a decrease in anxiety. This is evident in table 6.4a.II (in appendix 6.4) which shows that the standard deviation is similar between the groups (group A=6.23; group B=6.54) and the minimum and maximum scores are comparable (minimum for group A= -49 compared to group B=45; maximum for group A= -31 compared to group B= -26).

These are positive results and at face value show that students are experiencing less anxiety. However, following the previous assertion that students can be reluctant to admit any feeling of anxiety (6.2.2), these results could also be interpreted in this way. Without further music therapy students have not been afforded the opportunity to address such difficult feelings.

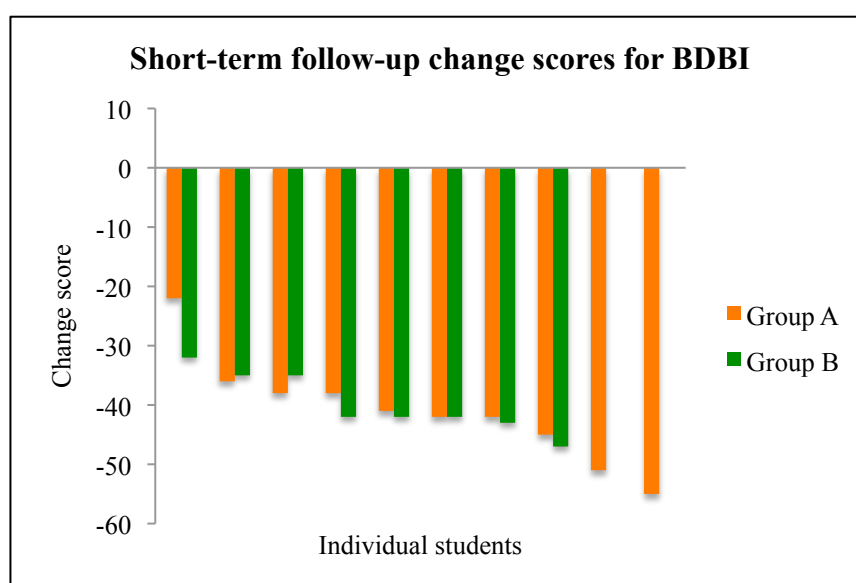
In order to understand these results further, the scores can also be observed using the Beck clinical range (table 6.2c.ii and table 6.2d.ii in appendix 6.2). These show that among The Centre School students, one is still at an anxiety level of extremely elevated, one is at moderately elevated and another is at mildly elevated. On the other

hand, CVC students are all settled in the healthy average range according to the Beck levels. Therefore, whilst anxiety is reported to be decreasing which is very positive, some students, particularly those at The Centre School, are still functioning with elevated anxiety levels.

6.4.3 The Beck Disruptive Behaviour Inventory for Youth: descriptive statistics

The results from the short-term follow-up data for the BDBI are similar to the BAI and show 100% improvement.

Figure 6.4.3 The difference in BDBI scores after a period of no music therapy



The scores between the groups are comparable, as shown in table 6.4a.III (in appendix 6.4a), because the groups share a similar standard deviation (group A = 6.29; group B = 5.12) and all students perceive an improvement. Figure 6.4b.vii in appendix 6.4b shows that scores are also comparable between schools: all students recorded improvement in their behaviour.

6.4.4 Long-term follow-up data

The fourth wave of data collection created a long-term follow-up data set for group A as it was a year after those students had finished music therapy. The data were

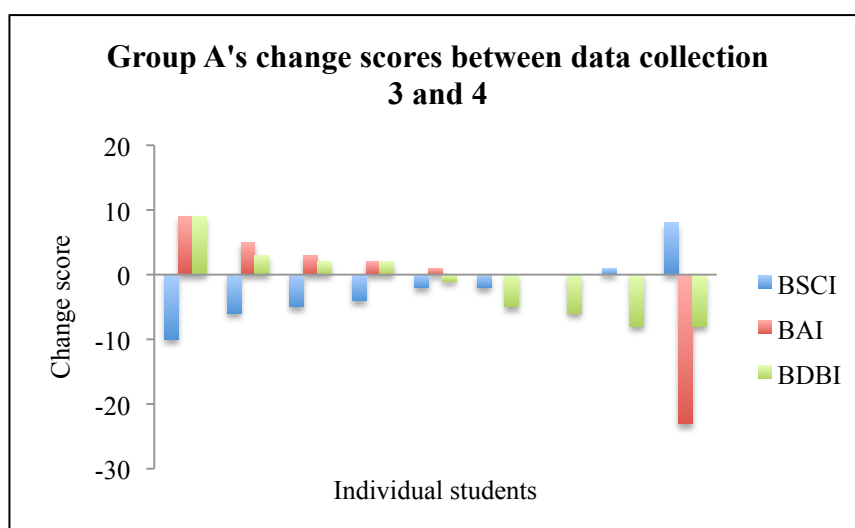
compared to the second wave of data collection (when their block of music therapy finished) and the results are included in appendix 6.4b. They are very similar to the results after the short-term follow-up and in summary show that:

- Most students scored a decrease in their level of self-concept
- All students reported a decrease in anxiety
- All students reported a decrease in disruptive behaviour

The scores according to the Beck clinical ranges in appendix 6.4c show that the students' levels of self-concept vary from below to above average: eight of the ten students (80%) reported a score which is an average level for anxiety and seven (70%) scored average for disruptive behaviour.

The data shown in figure 6.4.4 show the change scores for group A between the third and fourth data collection, during which time they had continued to receive no further music therapy. It is particularly interesting that some students (56%) reported an increase in anxiety and disruptive behaviour and most students (60%) considered their self-concept to be lower which suggests, as before, that some students need longer than 20 weeks for music therapy to build on this.

Figure 6.4.4 Group A: the difference between Beck scores from long-term follow-up



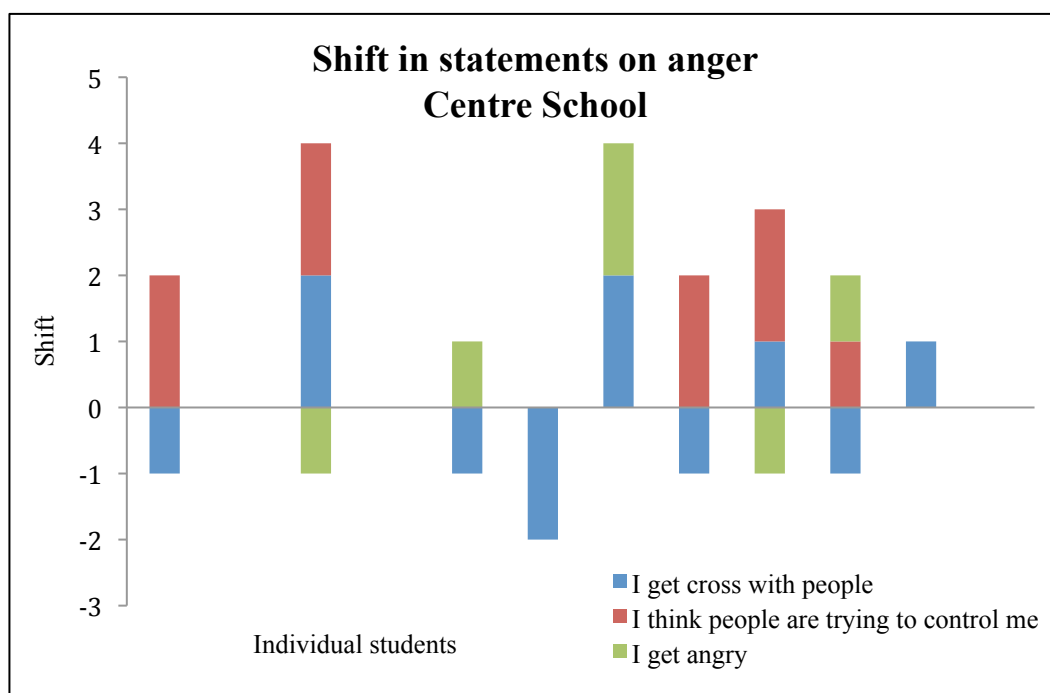
6.5 Findings from the music therapy project questionnaire: comparing results before and after music therapy

The music therapy project questionnaire consisted of statements put together by the researcher to investigate the students' feelings of anger and their attitude towards school (5.4.1). The students' possible answers were scored in the same way as the ones used in the Beck (0 = never, 1 = sometimes, 2 = often and 3 = always) and added together (appendices 6.5a – 6.5c). However they are not converted into *T* scores and are not standardised scores so a shift of change across the scoring system is used to show how students reported change from before to after music therapy. The students' responses to these questions are presented in their school groups and the statements on school are divided into two because the results of one (I) show improvement by a negative result and the other (II) by a positive.

6.5.1 Statements on anger: descriptive statistics

The Centre School students' scores to the statements on anger after music therapy, and whether they shifted up or down, are shown in figure 6.5.1.1. The minus shifts show improvement.

Figure 6.5.1.1 The Centre School students: responses to statements on anger



Overall, seven students reported improvement, three reported no change and eight students felt decline in some statements. The statement ‘I think people are trying to control me’ was not shown to improve by any student, in fact, the five students who recorded change shifted by two counts.

Five students (42%) showed improvement in the statement ‘I get cross with people’ and three (25%) felt no change. Two students (17%) reported that they felt less angry, six (50%) reported no change in this statement and three (25%) felt that they became angry more often.

Table 6.5d.I (in appendix 6.5d) shows the high percentages of students in each group who improved in at least one statement within The Centre School findings (group A = 63%; group B = 80%).

Figure 6.5.1.2 shows the findings from students at CVC. Overall, two students (22%) recorded some improvement, three students (33%) reported no change and five (56%) students felt that they were angry, cross with others and people were trying to control them, more often.

Figure 6.5.1.2 CVC students: responses to statements on anger

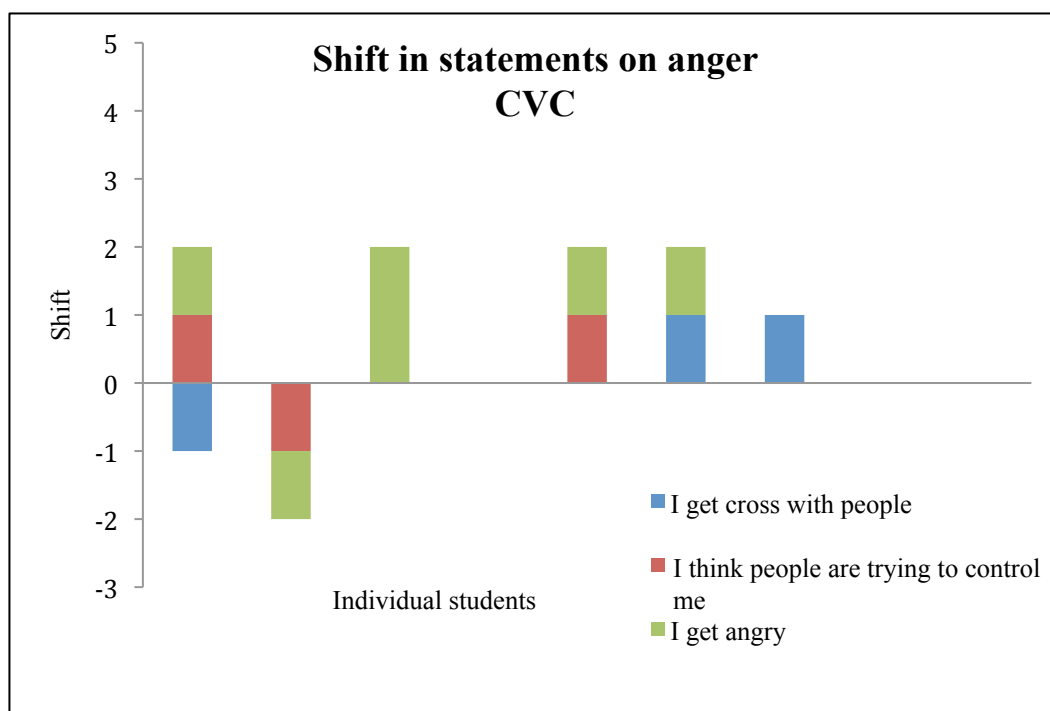


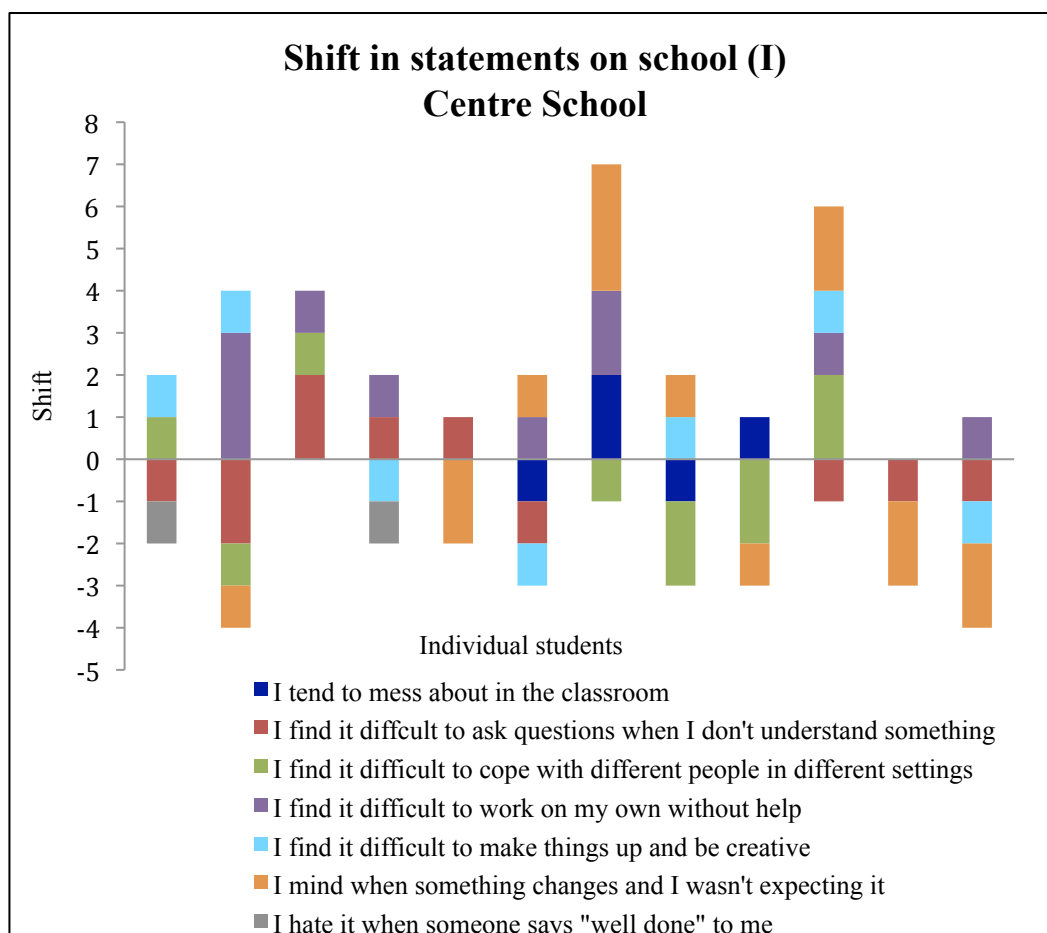
Table 6.5d.ii (in appendix 6.5d) shows the percentages of students in each group who improved in at least one statement within the CVC findings (group A=67%, and group B=0%). Compared to The Centre School students, CVC students did not make such notable shifts.

In summary, more students across both schools felt that they were angry more often. This could be that they are now more able to acknowledge their feelings and be open about them to others. In contrast, several students talked to the interviewer about feeling calmer and more in control (7.7.5).

6.5.2 Statements on school: descriptive statistics

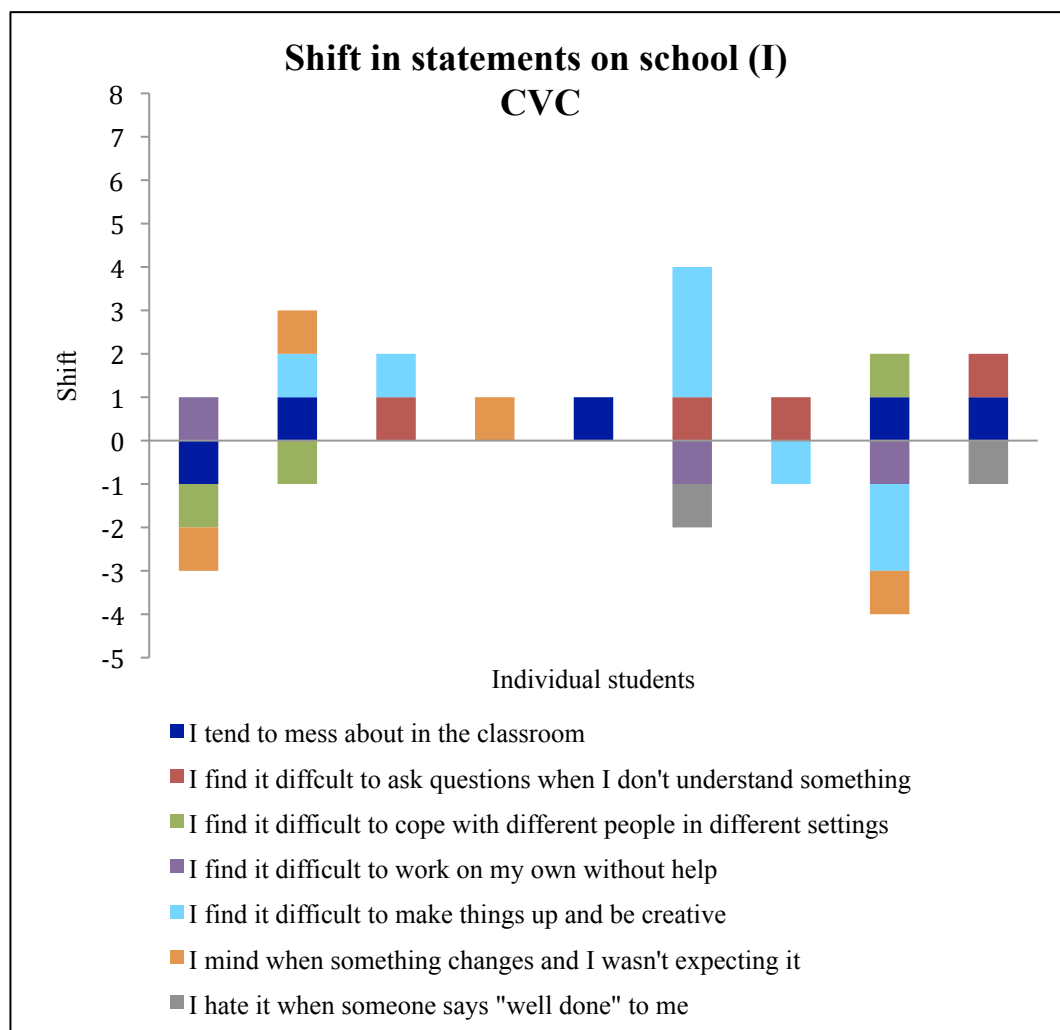
As in the previous figures, a negative shift for the statements on school (I) show improvement. The responses from students at The Centre School are presented in figure 6.5.2.1.

Figure 6.5.2.1 The Centre School students: responses to school (I)



It is very interesting that ten students (83%) reported improvement in the statements ‘I find it difficult to cope with different people in different settings’ and ‘I find it difficult to ask questions when I don’t understand something’ because this reflects a stronger sense of self and confidence. All students reported that the statement ‘I find it difficult to work on my own without help’ remained constant or became worse. This might reflect a new recognition of help, whereas before therapy they might have been less willing to acknowledge it. Although four students (33%) improved in the statement ‘I mind when something changes and I wasn’t expecting it’, five students (42%) did not. The student who recorded the largest increase in difficulties in this questionnaire was Clare who needed to continue with music therapy (6.1.2 and 8.2). The responses to the same statements on school (I) from students at CVC are shown in figure 6.5.2.2

Figure 6.5.2.2 CVC students: responses to school (I)

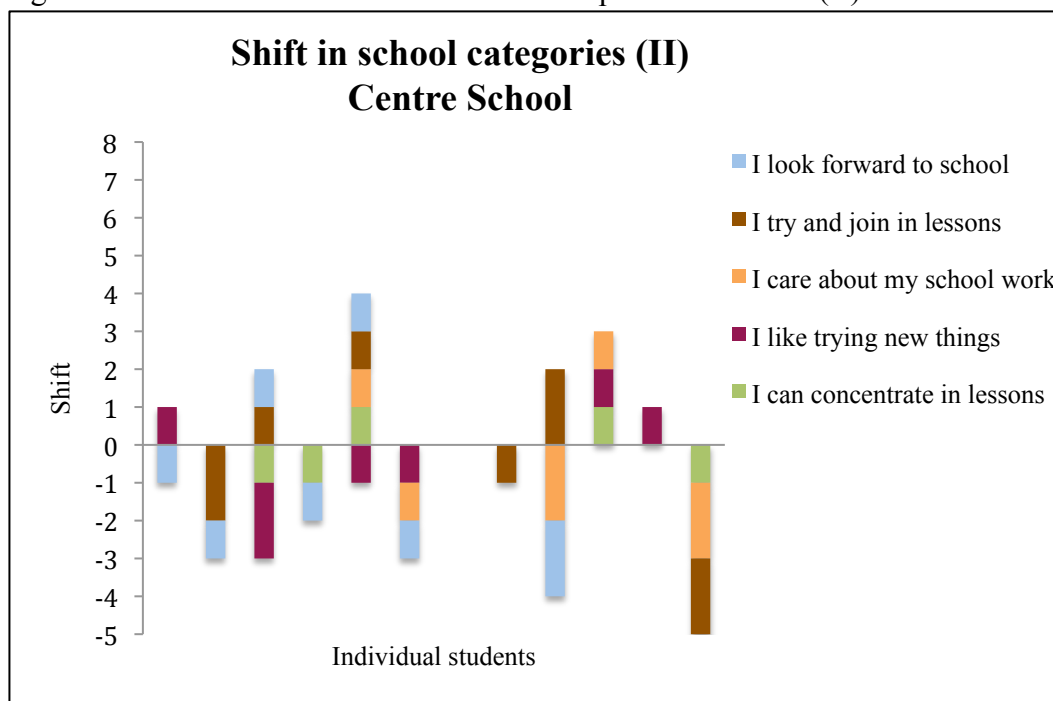


All nine students felt that at least one statement had become worse but they also all improved, or showed no change, in others. Of particular importance, all students showed improvement or no change in their answer to the statement ‘I hate it when someone says “well done” to me’. This is interesting because inability to accept praise is closely linked with low self-esteem and confidence in the classroom.

In both schools there is a mixture of results for the statement ‘I find it difficult to make things up and be creative’ with almost as many students reporting improvement as those who did not. This contrasts with the many comments the students made after music therapy to the interviewer about feeling spontaneous, free and creative when they improvised musically (7.7.1).

The Centre School students presented varied responses to the statements on school (II), as shown in figure 6.5.2.3. For these statements, an increase in shift indicates improvement.

Figure 6.5.2.3 The Centre School students: responses to school (II)

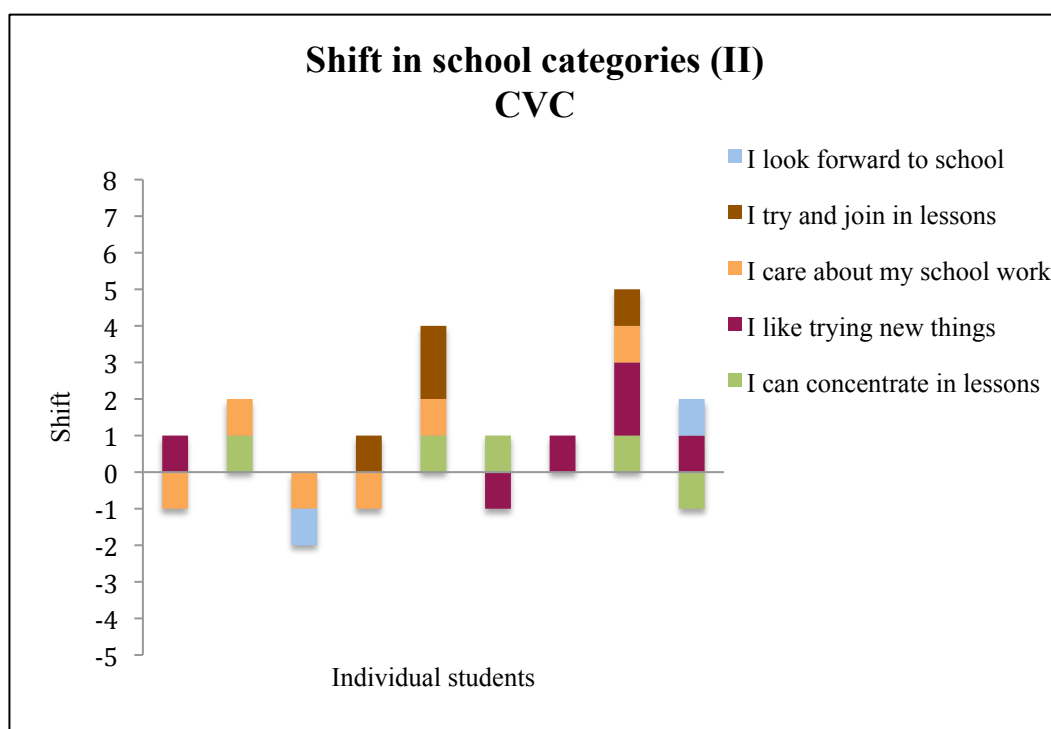


This graph shows more negative (64%) than positive shifts (36%) in these statements but more than half the number of students (52%) reported no change in one or more statement. Two students (25%) showed improvement in at least two statements. Considering how removed The Centre School students can feel from what the

education system can offer them, any changes they feel they have made with regard to these statements are significant.

The results from the CVC students showed much clearer improvement, as figure 6.5.2.4 illustrates.

Figure 6.5.2.4 CVC students: responses to school (II)



All except one of the CVC students (89%) showed improvement in one or more areas. The statement ‘I like trying new things’ was shown to improve or remain constant for all except one (89%). This is considerable change for the better because students who lack self-esteem usually find it difficult to do this. One of the students who improved in this area also reported that he found it less ‘difficult to make things up and be creative’ (figure 6.5.4). These two statements support each other and reveal a student who is more willing to take risks and be independent.

‘I can concentrate in lessons’ and ‘I try and join in lessons’ were two statements which five students (56%) felt had improved. This realisation that their concentration had increased and that they were joining in lessons more was also talked about in several of the CVC students’ interviews (7.7.4).

Table 6.5d.III (in appendix 6.5d) summarises the results to view the improvement as percentages in all the statements about school. The majority of students improved in one third of statements, that is, in four of the twelve questions (Centre School = 50%; CVC = 33%), which indicates that some students' attitude to school and learning did improve. However, the mixed pattern created by these results means that further investigation is needed for any real trends to be found.

6.5.3 The music therapy project questionnaire: inferential statistics

As it was not a standardised test like the Beck Inventories for Youth, logistic regression was used to observe the percentage of students who scored plus or minus by an analysis of proportions. The model was run with group and school as main effects but neither was shown to be significant (appendix 6.5e). The 95% confidence intervals (School=0.268 - 9.552; Group = 0.160 - 6.259) were very wide, reflecting the variability in the data as seen in figures 6.5.1 - 6.5.6 and showed no particular patterns. Although this weakens the results, it can be explained by the lack of data, and therefore very little power, provided by this questionnaire.

6.6 Findings from the teachers' questionnaire: comparing results before and after music therapy

The findings from the teachers' questionnaires add to the main research enquiry into the impact of music therapy on students' emotional well-being, as well as address the secondary questions concerning student's self-esteem, integration with peers and motivation to learn.

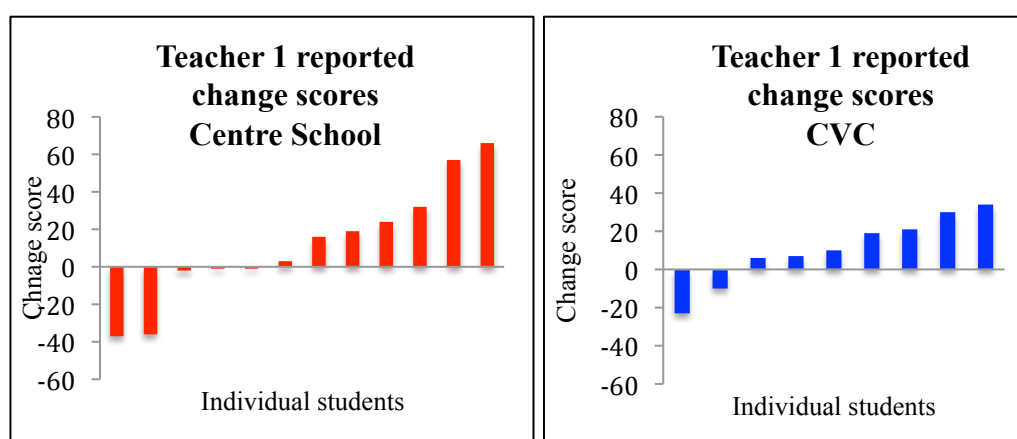
More than 60 teachers were involved in the study because three teachers completed a questionnaire for each student (5.5). Each was assigned as teacher 1, 2 or 3. Having responded using a scaling system of 0-7, their answers (collected at the same times as the students' data) were added together. The results in this section show the difference in scores which teachers gave after the student's music therapy, compared

to before⁴⁷. An increase in score relates to improvement in the student's personal and social development, behaviour and attitude.

6.6.1 The teachers' questionnaires: descriptive statistics

Teacher 1 was a teacher or form tutor at The Centre School and either the form tutor or head of year at CVC. The latter role is a pastoral one and therefore teacher 1 from CVC was likely to be aware of the student's home and school situation. Figure 6.6.1 shows the difference in scores made by teacher 1 for the students at each school.

Figure 6.6.1 The change scores from teacher 1

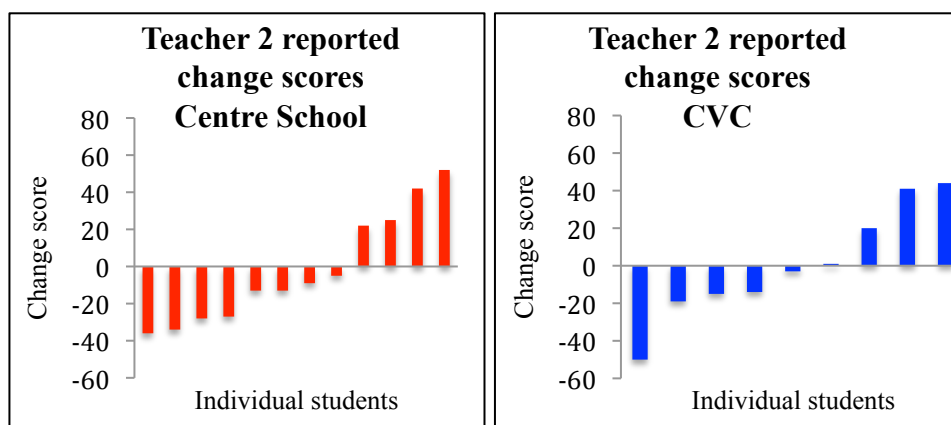


In both schools, teacher 1 reported improvement in most students (67%). The change scores for CVC students are more measured and uniform than The Centre School students, which are highlighted by the standard deviation (Centre = 31.43; CVC = 18.34) given in table 6.6a.i (appendix 6.6). As the CVC teacher has a welfare role, these are particularly important results. They suggest that students have made improvements after music therapy but their responses are perhaps made with caution, whereas teachers at The Centre School report much greater change.

Teacher 2 was an instructor at The Centre School who works closely with the student, and a subject teacher, such as English or Humanities at CVC. Figure 6.6.2 shows the difference in scores made by teacher 2 for each student from before to after music therapy.

⁴⁷ The teachers' change scores can be viewed for each student in figures 6.6b.i - 6.6b.vi (appendix 6.6b).

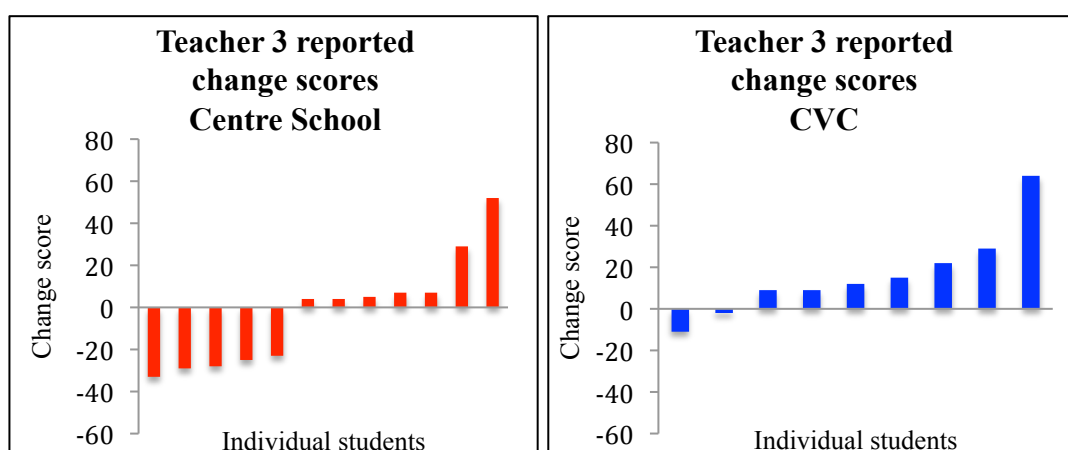
Figure 6.6.2 The change scores from teacher 2



The change scores by teacher 2 present a different picture to teacher 1 and are much more evenly divided. The summary statistics in table 6.6a.ii (in appendix 6.6) show the means for both schools are much lower (Centre = -2; CVC = 0.56) and only 38% of students are reported to have made improvements.

Teacher 3, like teacher 2, was an instructor or teaching assistant at The Centre School and a different subject teacher, such as maths or science, at CVC. Figure 6.6.3 shows the difference in scores made by teacher 3 for each student from before to after music therapy.

Figure 6.6.3 The change scores from teacher 3



Instructors at The Centre School may have different expectations of the student's personal and social development but they record substantial improvement in some and not in others. The subject teachers at CVC have noticed considerable improvement in all students apart from two, whose scores did not drop very much. The summary statistics in table 6.6a.iii (appendix 6.6) show that the mean scores are

more varied (Centre= -2.5; CVC=16.33). In total, 67% teachers reported improvement and that students were coping better at school after they had had music therapy.

6.6.2 The teachers' questionnaire: inferential statistics

The analysis of variants (ANOVA) was carried out on teacher 1 scores, to observe any statistical significance, or p-values. Levene's test (1960) assessed the quality of variances and tested the null hypothesis that the error variance of the dependent variable was equal across groups, shown in table 6.6c.i (appendix 6.6c)⁴⁸.

The test of between-subjects effects presented in table 6.6c.II (appendix 6.6c) shows that the baseline scores, made by teacher 1, were not a significant influence on the change in scores (p-value=0.205). Likewise, neither of the other main effects of school or group, nor their interaction, made a significant difference to the change in scores (p-values =0.900, 0.368 and 0.712, respectively).

The observed power for the main effects of the teacher's baseline assessment, the school and the group was just 24%, 6% and 14% respectively. This proves that the sample size was not large enough to reject the null hypothesis: the null hypothesis was that there was no effect of these variables on the change scores. Therefore this does not mean that there was no influence of the main effects but there was not enough data to show it. As a result, no further analysis using the other teachers' scores was carried out.

⁴⁸ Levene's test looked at all the possible variants and combinations between the groups and schools. The result proved that the standard deviation was not significant (p-value= 0.482) because it was similar enough between both groups, and therefore the null hypothesis need not be rejected. This is important because the assumptions for the ANOVA were that the data were normally distributed and of equal variances.

6.7 Findings from school attendance records

Attendance levels were included in the project's data collection because high absenteeism could have affected the study's results. When this project began in 2009, national truancy had risen to record levels with 1.05% of secondary-aged pupils missing lessons due to unauthorised absence (DCSF, 2010). However, the attendance records in figure 6.7a (in appendix 6.7) show that most students at The Centre School and CVC attended school regularly and therefore received consistent therapy sessions.

Average attendance was 87.6% for group A and 89.7% for group B. Table 6.7b (in appendix 6.7) is a record of the number of sessions each student attended. It shows that 67% of students attended at least 17 out of 20 sessions (85% or more) and demonstrates a high level of commitment (9.3).

6.8 Conclusion

The primary data, which looked at the difference in scores from the three Beck Inventories for Youth taken before and after music therapy, helped to determine the effects of music therapy. First of all the data showed that students became more self-aware through music therapy, and to a greater extent for students at CVC than for students at The Centre School. However, students at The Centre School generally have more complex emotional needs and this baseline factor was found to be statistically significant.

Secondly, there was no evidence of major change in levels of anxiety. The 50:50 split in results could indicate that students are reluctant or ambivalent about admitting to this difficult feeling. Thirdly, students at The Centre School gave a mixed response in reporting their disruptive behaviour whereas CVC students reported virtually no change. The baseline score was again shown to be statistically significant which, like the levels of self-concept, showed that the students' starting point was crucial to the changes they made.

Using the Beck Inventories for Youth, the groups' results were compared after one had finished music therapy and before the other had begun. This secondary data showed that the group who had not received music therapy appeared to be doing better, that is, they were more self-assured and reported less disruptive behaviour than the group who had received the intervention. However, this was not proved with any statistical significance. The follow-up waves of data collection, which compared results for each group after a period of no music therapy, found that students reported their self-concept as less certain than before, but for all students both their anxiety and disruptive behaviour had decreased.

Students generally reported that they felt angrier in the statements posed in the music therapy project questionnaire, but some of their responses contradicted views they gave in their interviews and no statistical significance was found with this questionnaire.

The questionnaires completed by teachers supported the claim that music therapy makes a positive impact on students: two out of the three groups of teachers reported 67% improvement. Most importantly, one of these groups who found the greatest improvement was made up of teachers who had close contact with the student, either as head of year or form tutor.

Finally, results from school records collection showed that while students in group A were having music therapy, fewer incidents were recorded but this number increased after they had finished. For group B, the number of incidents decreased after music therapy but there were confounding factors in this period. Correlation between students' scores of disruptive behaviour and school records was weak.

Despite some lack of statistical significance due to the project's size, these data are very interesting and discussed in more detail in chapter nine. The next chapter examines the students' interviews which they gave before and after music therapy. These conversations present a convincing picture of the impact which students felt music therapy made and reinforce the findings found in the quantitative data.

CHAPTER 7

KEY FINDINGS FROM THE QUALITATIVE DATA

7.1 Introduction

The interviews gave voice to the students in a way that was not predicted at the outset of this research: they provided rich insight into the students' attitudes, lifestyles and ideas. The anecdotal evidence also helps support the study's quantitative findings. 'The narratives of everyday life are used to construct and to share cultural values, meanings, and personal experiences. They also express - and indeed enact - the social conditions of power and influence in everyday life' (Coffey and Atkinson, 1996 p.76). The interviews were designed to be flexible and each question was open-ended, allowing students as much freedom as possible. Their main purpose was to put students at ease so they engaged in conversation.

In order to capture the participants' contribution, this review includes quotations most of the time, rather than paraphrasing, in order to keep the character and meaning of the student's language. The interview extracts are referenced by their appendix and page number. Any questions or comments made by the interviewer are shown in italics and the students' names have been changed.

Session notes also formed part of the qualitative data and together with the students' individual reports which are included as appendices 5.10a – 5.10x, helped to create the students' case studies presented in chapter eight and appendices 8.1 and 8.2. Complete transcriptions of all the interviews were made and are included as appendices 7.1.1 – 7.1.43⁴⁹. Any drawings which the students made were scanned and attached to the end of each relevant interview transcription.

⁴⁹ Original audio recordings are also available for reference.

7.1.1 The main findings from a thematic review of the interviews

‘Qualitative data are examples of human meaningful communication [...] Qualitative research is concerned with explaining what people and situations have in common’ (Gibbs, 2007, p.9). Incorporating a semi-structured interview into the student’s meetings with the interviewer, before and after their block of therapy, gave the research study ethnographical detail. Revealing ideas, attitudes and personal experiences from the students first-hand is a phenomenological approach and the data from these interviews proved a vital way to gain a better view into the students’ experience.

Table 7.1 shows the themes which emerged. They were generally linked to the questions that the interviewer put to the students (table 5.8).

Table 7.1 Themes from the predetermined topics of the interview schedules

Topic	Emerging theme (and ref. to section in chapter)
Interests	<ul style="list-style-type: none"> • The need for thrill from risk-taking hobbies (7.2)
Means of self-expression	<ul style="list-style-type: none"> • Broader interests shown by CVC (mainstream) students (7.2) • The use of music for expression increased after music therapy (7.2) • It was hard for students to comment on this specifically but were able to explain it in their own words (7.2)
Importance of friendships	<ul style="list-style-type: none"> • Students at The Centre School reported greater reliance on friends than mainstream students (7.3)
Respect in schools	<ul style="list-style-type: none"> • Students felt strongly about the issue of respect towards their peers and teachers (7.4)
Attitude to school	<ul style="list-style-type: none"> • School had improved since music therapy for many students. • Rather than talk positively about their current school they compared it to ‘bad’ schools they had been in (7.4)
Encouragement from teachers	<ul style="list-style-type: none"> • Students in both the mainstream and special school felt encouraged by their teachers (7.5)
Feelings about the present	<ul style="list-style-type: none"> • Students were all generally positive despite the very difficult circumstances they face ((7.5)
Feelings about the future	<ul style="list-style-type: none"> • Students were more optimistic about the future after music therapy (7.5)
Views on world	<ul style="list-style-type: none"> • Students used more positive adjectives to describe their world after music therapy (7.6) • More mainstream students suggested things were difficult
Music therapy – reviewed separately (7.7)	

Although not all the themes captured something directly relating to the research questions, they provided rich description of the students’ interests, opinions and lives, and therefore need to be included in the review. The comments about music therapy from the follow-up interviews are reviewed in the final section (7.7).

7.2 Students' interests and means of self-expression

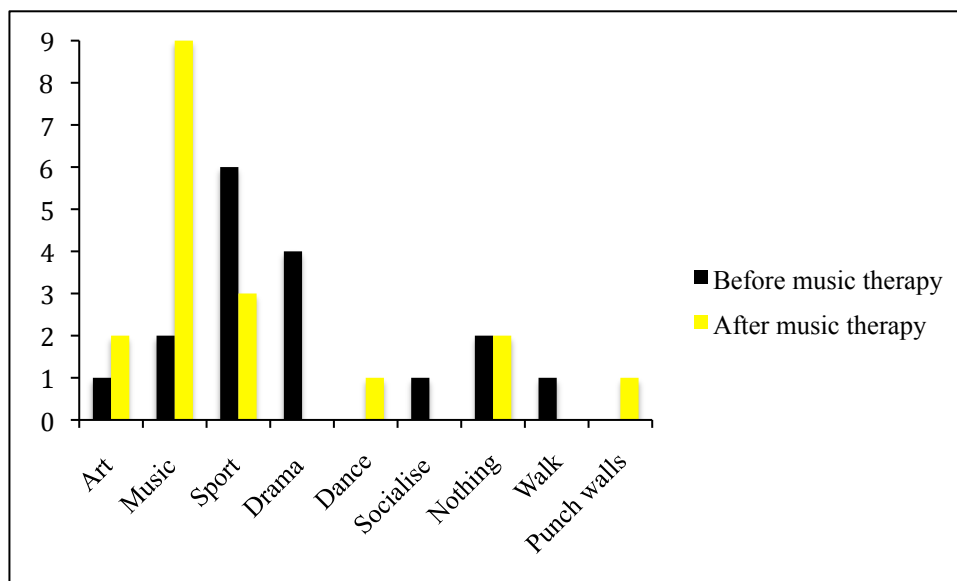
"I feel free...that's what I like about it" (Jamie, appendix 7.1.25, p.391).

The interviews generally began with a conversation about interests, which most students engaged in easily, and the interviewer used the magazines as prompts (5.8.1). Interests mentioned by students (appendix 7.2.a) in both schools, before they began music therapy, included sports, art, music and social networking. There was a wide variety of interests but 59% of students at The Centre School mentioned speed, the thrill of risk-taking and getting dirty as the attractions to outdoor sports such as quad-biking and dirt-biking. For example, Matthew explained why he liked quad-biking: "Cos it's dangerous...and because I like things with engines and stuff like that" (appendix 7.1.42, p.529). Some students were able to explain feelings associated with their interests, as Peter did: "Well like fishing. Go-karting and quad-biking is kind of like a thrill and excitement and fishing's like you get really happy cos you're like in there for five minutes, you just don't think about it and all of a sudden get a fish" (appendix 7.1.21, p.362).

The most interesting observation from the students' answers to the same question post-music therapy was the mention of music. Although music, as an interest, did not increase after music therapy, it was mentioned more often. Students talked more about their musical preferences and music featured as part of other interests, such as parties (appendix 7.2b). One student said he listened to music before he went to sleep: "Just like listening to it. Helps me relax at night and that" (Guy, appendix 7.1.6, p.228).

This question led into another which asked students how they were able to express themselves at school. The interviewer took time helping students to think about how it feels when they do certain creative things, such as art, music or sport. Several students explained what they did to calm down when they felt angry or frustrated. The responses from students at The Centre School are shown in figure 7.2.1.

Figure 7.2.1 *How do you express yourself?* Responses from students at Centre School



Before music therapy, four students in The Centre School mentioned drama and how it helped them. One felt “like, all my problems just go away” (Chris, appendix 7.1.23, p.379). Similarly, another explained how doing drama was a good release of self-expression, “I felt really like all the air just gone and I was just break free” (Clare, appendix 7.1.19, p.348). This graph shows that before music therapy, only two students mentioned music as a means of self-expression but this increased to nine after music therapy. This is the greatest increase of all the answers and demonstrates the impact that music therapy made.

Two students did not know how to express themselves and said they did nothing. Quickly reacting to the informal atmosphere of the interview, and perhaps aiming to impress the interviewer, John said: “Last time I expressed myself I tripped over my last headmaster and that was funny!” (appendix 7.1.37, p.502).

Before music therapy, the interviewer spoke to Chris (appendix 7.1.23, p.378):

And what about expressing yourself and letting off steam? Do you have things that you like doing? ...

“No I can’t express myself normally but I don’t know why I just can’t”.

Have you had any good experiences with art or music?

“No”

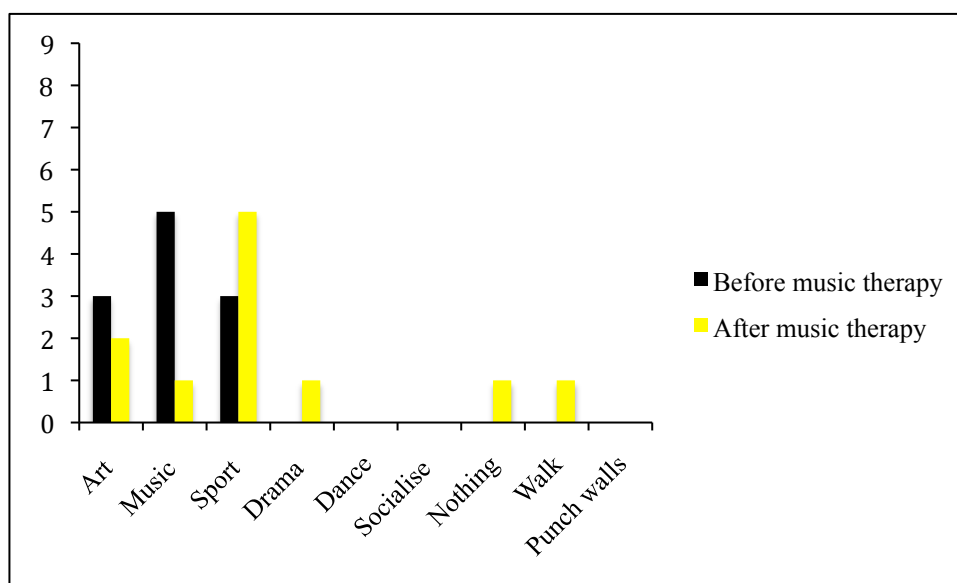
After music therapy, Chris's response was very different (appendix 7.1.24, p.384):

“I can um...express myself in music um, I can do much more things with it. I can, well like say drums can be for anger, piano can be for mood swings, um...guitar can be for sorrow. There's all different instruments that I can express myself on.”

Figure 7.2.2 presents the responses from students at CVC. These students tended to give more informed replies. For example, Andrew showed insight as he talked about enjoying drama, “I quite like performing. I suppose it's a bit like the attention-seeking thing but now I'm doing it in an actual lesson” (appendix 7.1.31, p.449).

Another student who liked drumming was able to link his enjoyment of being creative to the fact that it was an important outlet for his self-expression: “Sometimes, when I like to take my mind off things, drawing and playing drums. Playing drums more cos it's another target, there's something else to do and I really focus on it” (Harry, appendix 7.1.11, p.278). Their responses were varied and presented a broader interest in different activities, which is evident in the graph in appendix 7b. Perhaps this also accounts for the decrease in the number of times music was mentioned among these students as they became more interested in other things.

Figure 7.2.2 *How do you express yourself?* Responses from students at CVC



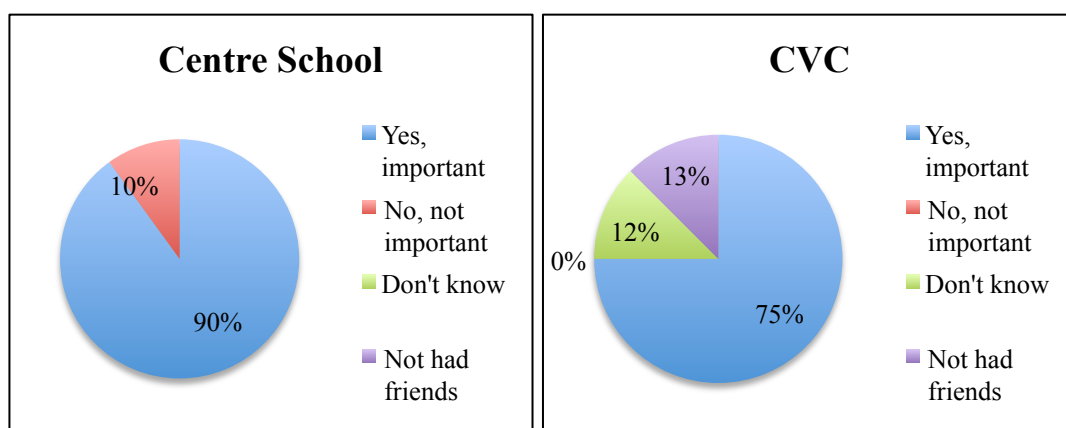
Daniel said he did “nothing” to express himself but later on in his interview explained very articulately that music therapy was a good way for him to “get things off my chest” (appendix 7.1.2, p.199). This is an indication that some students had limited understanding of what self-expression means but were able to talk about it in their own terms.

7.3 The importance and meaning of friendships for students

“A real friend will stick by a friend” (Giles, appendix 7.1.39, p.520).

When students talked about the value of friendship they confirmed the theory that the issue of identity and peer acceptance plays a vital role in their emotional well-being (1.2). Students were asked about the importance of friendships before music therapy but it was omitted in the post-test interviews as more time was needed for questions about music therapy (and the time allocated for each student was kept the same for each interview). The results in figure 7.3.1 show that for the majority of students in both schools, friends are very important.

Figure 7.3.1 *Do you think friends are important?* Responses from the students



The detail in the responses from some of the students at The Centre School was striking because friends carried so much influence on their sense of emotional well-being. For example, when they were asked how important friends were to them, one student replied: “really important cos like if I don’t have any friends then I don’t have anyone else” (Clare, appendix 7.1.19, p.348). Another student said: “Yeah, yeah they mean a lot to me. Without my friends I don’t think there’d be a point in life, without friends you’re nobody really” (Jamie, appendix 7.1.25, p.395). One student talked

about only being able to share sensitive things with his friends (Chris, appendix 7.1.23, p.376) and the majority talked about friends as the people with whom they liked sharing activities.

Students from CVC were equally keen to acknowledge that friends were very important but they were more measured and friends did not feature as the only key people in their lives. One student felt that they were “quite important. They help out and everything” (Mark, appendix 7.1.3, p.212) and another said “Yeah they mean a lot to me, they’ve always been there for me so I’m always going to be there for them” (David, appendix 7.1.27, p.407).

7.3.1 Reflection

This more measured reaction to the importance of friends from CVC students was different to The Centre School students and might be linked to their situations at home. Statistically, students at The Centre School are more likely to have more complicated and troubled families than mainstream students which would explain why they would rely more heavily on friends (3.3). This is supported by another study which asked 4,500 young people about their experiences of growing up in Britain in the 1990s (Katz, 2000). When asked who they would turn to for emotional support, only 48% of boys compared to 84% of girls said that they would turn to friends because ‘this involved no loss of face’ (p.82). However, more boys said that they would turn to their mothers. The value and use of friends does vary and, it could be argued, depends on the young person’s family situation.

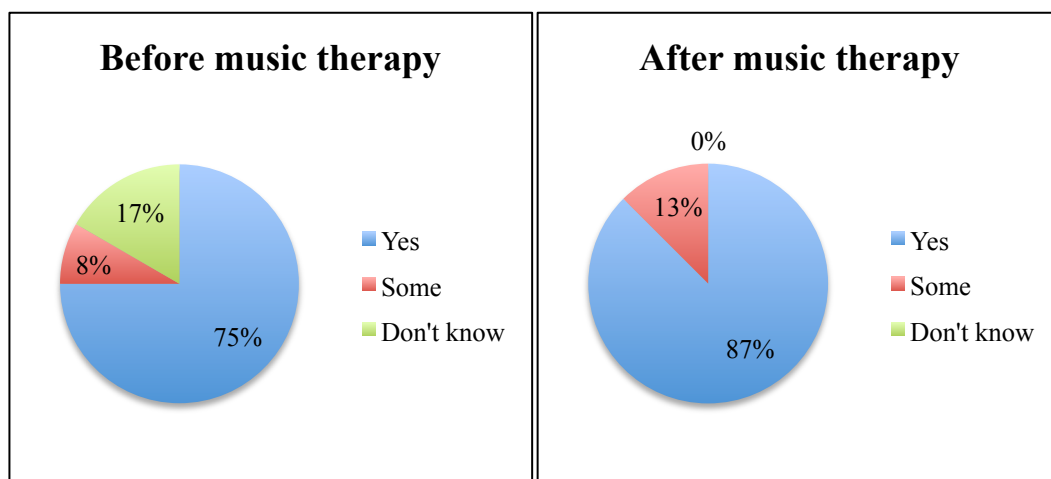
This could equally be dependent on the student’s school situation as well. The students who were most guarded about the value of friends were in the mainstream school. This may be because they do not ‘fit in’ and are not befriended. Perhaps there is potential for not having friends or acknowledging having friends for fear of being bullied? Students at The Centre school are in a smaller community and have had problems of fitting in before, which has been recognised, so it might feel easier for them to be able to admit to needing, and relying on, friends.

7.4 Students' attitudes to school and the issue of respect

"I'm not quite sure but they do give us respect cos they understand our needs and problems" (Chris, appendix 7.1.23, p.378).

Students were asked before and after music therapy about respect at school and whether they considered adults understood young people. 'It is suggested that when pupils are conscious of being respected, cared for and valued by their teachers, they experience benefits to their individual self-images, which in turn help to motivate and sustain their efforts to strive for further achievement' (Cooper, 1993, p.181). This question therefore helped the researcher to reflect on the setting and the relevance of music therapy taking place there. All students were keen to comment on this topic and their answers are shown in figures 7.4.1 and 7.4.2.

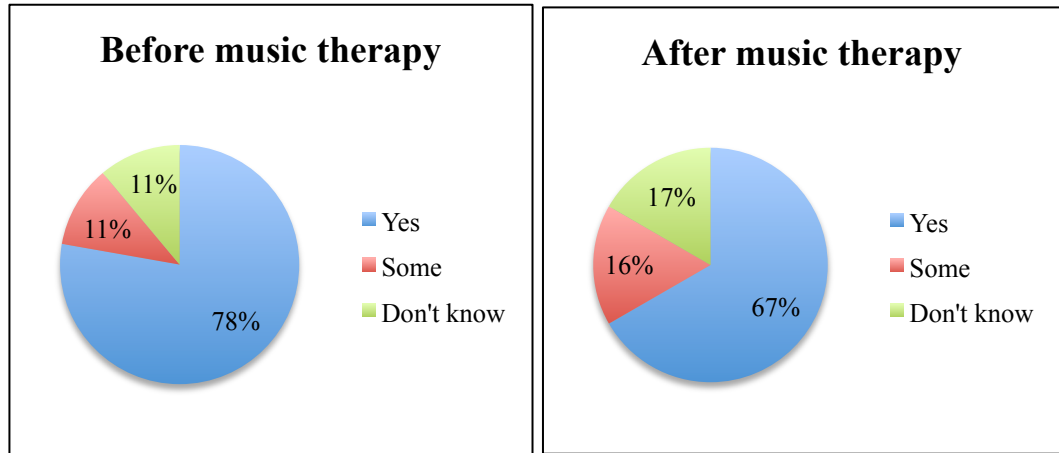
Figure 7.4.1 *Is there enough respect in schools for young people?* Responses from Centre School students



The majority of students considered that there was enough respect in their school. In the post music therapy interview the number of students who felt that there was enough respect increased. The Centre School students felt very strongly about this and talked about what respect meant to them. Clare also reflected on students' respect for one another: "The older, the more we get on, respect each other, that sort of thing" (appendix 7.1.19, p.351).

Figure 7.4.2 shows the responses from students in the mainstream school. Although the responses seem to show a large drop in numbers of students who feel there is enough respect, the overall picture is less discouraging.

Figure 7.4.2 *Is there enough respect in schools for young people?* The responses from CVC students



It is possible that after music therapy students have a more solid sense of self and are therefore able to consider this question in greater depth. This would explain the decrease in their positive response. However, The Centre School students who generally have much greater complex emotional needs will not have reached this depth of understanding because they are only just becoming aware of their own emotions and unlikely to be as emotionally literate.

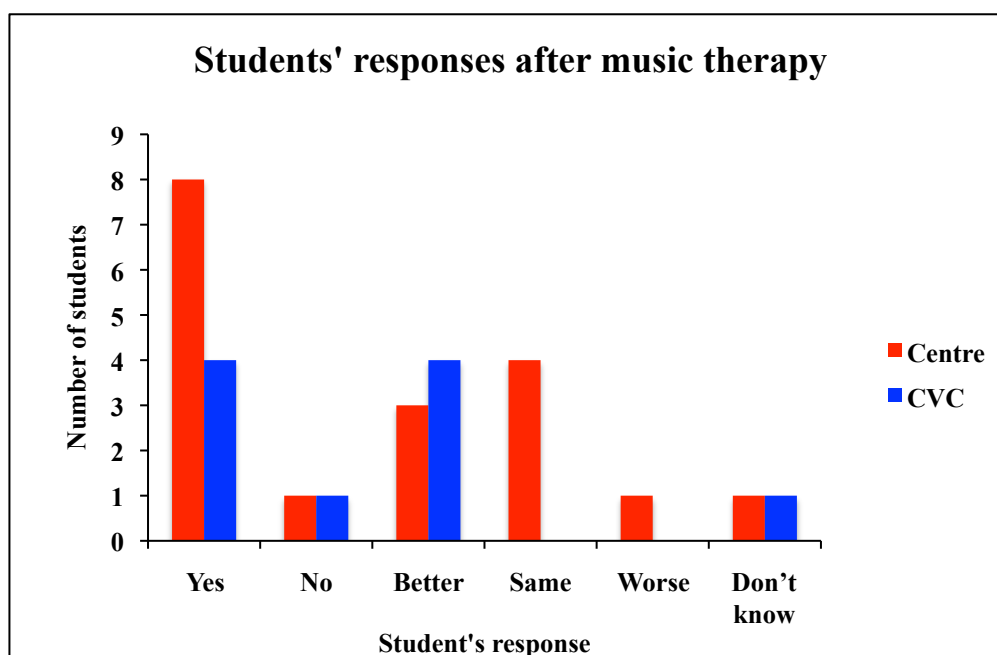
For many mainstream students, their understanding of respect was based on their experience of strict school rules and teachers' insistence on following them through, which could explain the difference between their answers and those from The Centre School.

This indication that the majority of students from both schools felt respected and therefore valued should therefore, according to Cooper (1993), mean that they have the maximum chance at school of being motivated and encouraged to learn. This brief assessment of the school setting (and also the setting for therapy) was important to the study because the link between respect and student motivation can be key to a student's chances and healthy emotional well-being at school.

One student reflected on respect among his peers and felt that teachers did not understand young people "as much as we understand each other" (Guy, appendix 7.1.5, p.224). Another felt that adults usually knew more and should therefore be

given respect, but if the student happened to know more, about computers for example, the adult should listen to the student (Harry, appendix 7.1.11, p.276). After music therapy, students were asked if they had enjoyed school since the previous interview and whether anything had got better or worse (figure 7.4.3). Although none of the students cited music therapy at this point, it is interesting that 43% had enjoyed school since the previous interview and 25% felt that school had improved.

Figure 7.4.3 *Have you enjoyed school since we last met? Has it got better or worse?* Students' responses



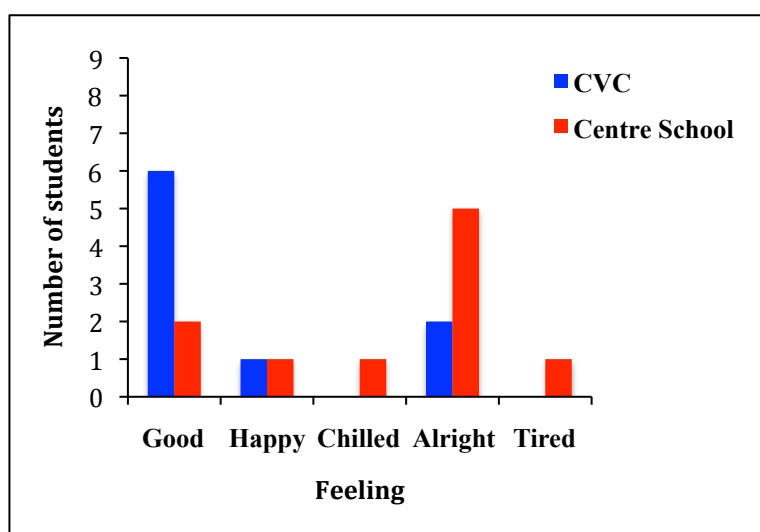
None of the CVC students felt school had got worse whereas one Centre School student did. Overall, however, the students had enjoyed school and more than 58% felt that school was better. Several students were open to discussing their feelings about school. Five from The Centre School drew comparisons between their current school and previous ones they had attended and they all preferred the smaller class sizes, unlike at mainstream schools.

7.5 Students' feelings about the present and the future

"I can't exactly plan for the future...you don't know what life's going to throw at you" (Ollie, appendix 7.1.30, p.440).

In the post-music therapy interview, students were questioned about how they felt on that particular day. The majority of responses were positive, shown in figure 7.5.1, and suggest that the students felt fine with the way things were at school.

Figure 7.5.1 *How are you feeling today?* Students' responses

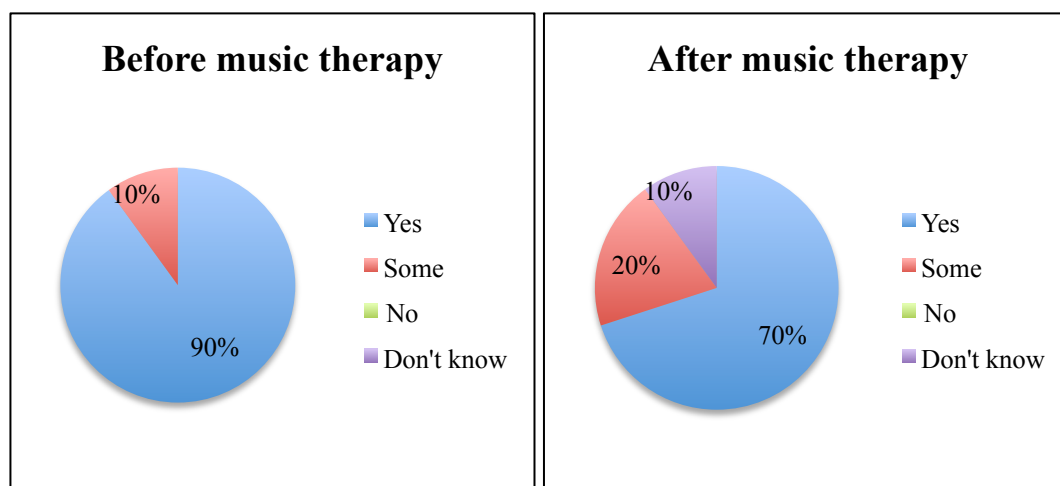


This presentation of positive moods might be due to the students' familiarity with the interviewer and the interview situation the second time. It might be, as suggested by the quantitative data as well, that students are used to presenting an unaffected, cheerful front which might not reflect their true feelings, or they might be having a good day - especially as they are missing a lesson to have a chat!

According to Erikson (1968), an important part of healthy adolescent development concerns the ability to look to the future. High self-esteem is a crucial factor in enabling students to feel positive and make plans, and this also requires encouragement from adults. Therefore, in both pre- and post-music therapy interviews students were asked how they felt about the future and whether they felt encouraged by teachers, to highlight the students' emotional development in this way.

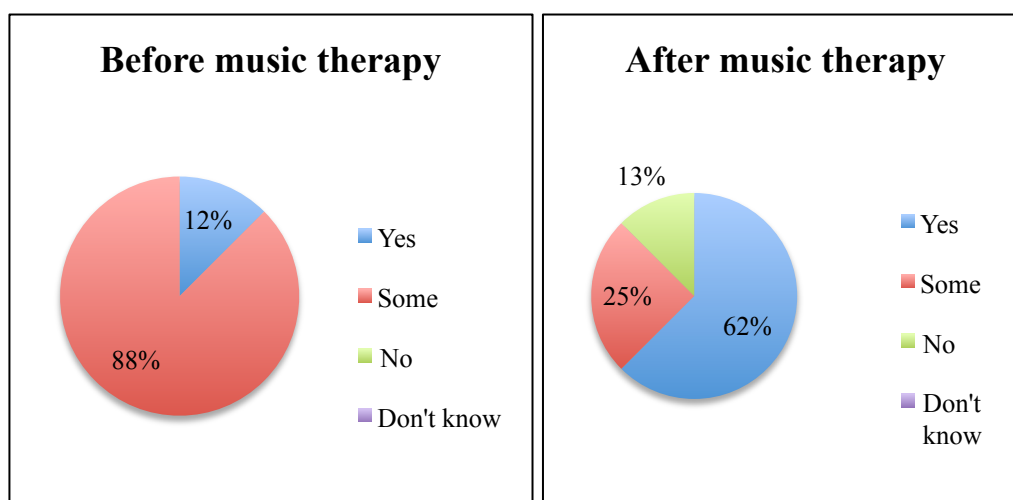
Figures 7.5.2 and 7.5.3 show a mostly positive response from all students about their encouragement from adults and indicate that they do feel well supported, in both the mainstream and the special school.

Figure 7.5.2 *Do you think you get enough encouragement from teachers?* Responses from Centre School students



Before music therapy, The Centre School students were all positive, and 90% definitely felt they were encouraged. After music therapy this figure decreased, however, together with those who said that there was some encouragement, the overall figures are more comparable. Rory said: “Well, if we like get stuck on something they’ll always help. And we’ve always got like enough teachers in the classroom to help us...” (appendix 7.1.35, p.482). None of the students said that there was not enough encouragement from teachers.

Figure 7.5.3 *Do you think you get enough encouragement from teachers?* Responses from CVC students



Before music therapy, all students at CVC felt that they were encouraged to some degree. David felt strongly and said “Yeah, if I ever need help they’re always there to help me” (appendix 7.1.27, p.409). The increase in those who felt that there was definitely enough encouragement increased from 12% to 62%. However, more students felt that they were not encouraged and that figure rose after music therapy from 0 to 13%. As suggested in the results in 7.4, considering the issue of respect, it is possible that as students have greater self-confidence after music therapy, they are able to give a more measured answer and might feel less reliant on teachers for encouragement.

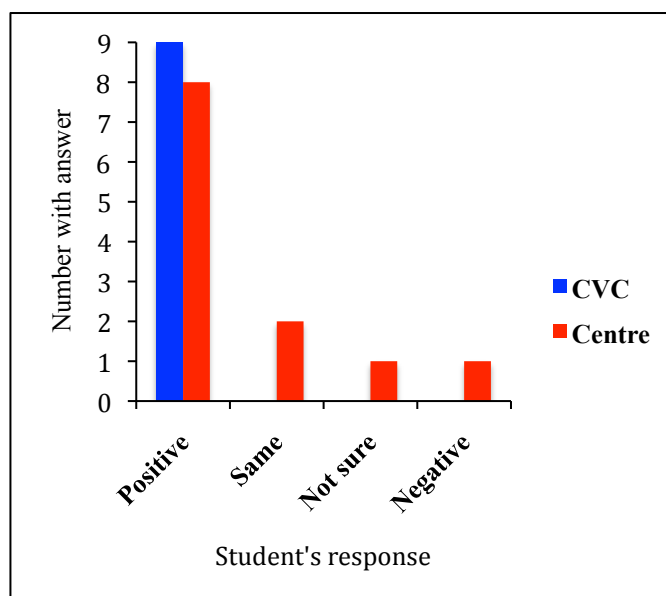
Students were then asked whether they thought about the future, had plans and knew people who could help them to achieve their goals. Every student answered this question in their first interview but the subject only came up in 13 cases (68%) after music therapy. The responses from The Centre School students were divided: 45% did think about the future and 54% gave it no thought. However the responses from CVC students were more marked in favour of giving the future some consideration: 88% thought about it and only 12% did not. After music therapy, 29% of Centre School students said they thought about the future, 57% did not and 14% did not care either way. Similarly, the number of CVC students who thought about the future (50%) was less than in their first interview.

The lack of directly comparative data from the interviews makes it difficult to draw any significant conclusions (9.2.1). However, the figures show that fewer students

thought about the future after music therapy than before and those who did not think about the future rose in both schools. This was a higher number for students from The Centre School and this nonchalant stance could suggest an inability to think ahead which was confirmed in some of their interviews: “Just wait when it happens...I’ll just work it out when it happens when I get older” (Iain, appendix 7.1.13, p.298), “Dunno about the future. It happens and it happens don’t it” (Iain, appendix 7.1.14, p.308), and “It’s best to think about the present rather than the future. If you think too far ahead, your mind gets stuck on something else” (Jamie, appendix 7.1.26, p.401). Despite their general disinterest in school and low self-esteem, many did have definite plans or at least a few ideas about what they wanted to do in the future, which included being in the army, flying jets, being a car mechanic, racing driver or training to be a chef.

In the post-music therapy interview, students were asked how they felt about the future, not just whether they gave it thought. The results are shown in figure 7.5.4.

Figure 7.5.4 *How do you feel about the future, after music therapy?* Students’ responses



All CVC students and 67% of students at The Centre School were positive and felt optimistic about the future despite the fact that in terms of ideas and thoughts, the majority did not have any plans. This hopefulness, particularly amongst The Centre School students, is worth highlighting. Considering the problems I know they have

faced, and which many continue to face, their optimism for the future is extraordinary.

The mainstream school students felt able to reflect more. Guy said: “I don’t know, I just think it’s going to be better” (appendix 7.1.6, p.234), Andrew said that he felt better and “not as nervous as last year. I pay attention more” (appendix 7.1.32, p.460), Ollie felt more positive about the future and said that this difference in feeling had been made by music therapy (appendix 7.1.30, p.441).

7.6 Students’ views on their world

“Just get on” (Harry, appendix 7.1.11, p.279).

In order to gauge insight into the teenage world and to provide further opportunity for conversation, students were asked to describe in three words what it was like to live in their world. Before music therapy, half of the words used by The Centre School students were positive, such as fun, good, happy and fine. The other half consisted of words that defined their world as difficult, for example annoying, disappointing and crap. More than half of the words (59%) which CVC students used to describe their world were positive adjectives such as good, energetic, exciting and easy. The negative words (40%) which they chose were sad, confusing, worrying and hard. These reflect how students with emotional difficulties find it hard to keep up in a mainstream school environment. 12% of all the students felt that it was too difficult to say what it was like.

This question arose in fewer interviews after music therapy than before and the responses they gave were very different. They showed an increase in positive adjectives: among The Centre School students, 60% used the words good, chilled, free or fun, whereas only 30% described life as boring or difficult; 68% of CVC students used positive words such as energetic, good, fun, easy or exciting, 29% said that they felt life was hard or confusing, and overall, 19% of students said it was hard to explain how they felt. These answers are consistent with their feelings about the future (7.5) and this more positive attitude reflects greater self-esteem.

7.7 Students' thoughts on music therapy

“Philippa gives me the opportunity to relax in music therapy, which helps me learn, which helps me feel better, so it’s just a gateway thing. It’s good. Amazing” (Harry, appendix 7.1.12, p.291).

Other research studies have asked clients or parents of children about their opinions on music therapy (Darrow, 1999; Oldfield, 2004) but this was the first time that secondary-aged pupils in the UK were asked how they felt about music therapy. Table 7.7 shows the questions that were set as guidelines in the interview schedule and the themes which emerged from these, which form the headings for each subsection.

Table 7.7 Themes from the suggested questions about music therapy

Question suggested in the interview schedule	Emerging theme (reference to section in this chapter)
What was it like?	<ul style="list-style-type: none"> • Students talked about sessions giving them a sense of achievement (7.7.1 and 7.7.4) • Sessions were fun and had a purpose (7.7.1) • CVC students noticed very marked changes in their concentration and towards calmer feelings which impacted on their behaviour. These were not transient but seemed to last (7.7.4) • Centre students generally considered it a time to chill and play and was fun (7.7.5) • Music therapy had an on-going effect (7.7.4)
Was a music therapy session different to another lesson? In what way?	<ul style="list-style-type: none"> • Students talked about different ways of improvising and feeling free (7.7.1). • Students felt that being able to talk was as important as playing (7.7.2) • Students liked being actively involved, in control and able to take the lead in sessions (7.7.3)
Did you feel listened to?	<ul style="list-style-type: none"> • Students felt safe and good (7.7.2) • Sessions felt confidential (7.7.2) • Students valued the time to talk (7.7.2)
Was there enough choice of instruments?	<ul style="list-style-type: none"> • Students overwhelmingly favoured the drums and electric guitars
What would you tell other people about music therapy?	<ul style="list-style-type: none"> • The sense of fun was reiterated (7.7.6)
Would you like to carry on with music therapy once this research project is over?	<ul style="list-style-type: none"> • All students said that they would like more music therapy

7.7.1 On improvising

“Yeah letting stuff out. Like on the piano when I just play it seems like nothing’s the matter, nothing’s the matter, when I play I just feel safe” (Chris, appendix 7.1.24, p.385).

In chapter four the use of improvisation as an effective means of self-expression was discussed as an important aspect of my approach (4.4.1). The students were not asked specifically about improvisation and this aspect of music therapy so it was particularly interesting that so many chose to mention it and say what this had meant to them. Many students talked about making up stuff and how improvisation had made them feel free, which supports the use of this (4.4.1.5).

“When I play the piano I just feel like letting in how I normally feel. When I’m on the piano I can just express myself fully and not have to fret at what people think about it” (appendix 7.1.24, p.385).

The same student, Chris, went on to explain how using different instruments matched different feelings:

“Like say piano for mood swings...you get different emotions like ones that could be happy and ones that can be sad so with the piano you can start with a happy song then to like a real sad song then to this real strong, angry, violent song, could be, like the music sounds much more louder, much more aggressive...the drums, that can be for sadness or anger cos with them you can just beat the drums it makes a big powerful noise so people feel good on the drums cos they make as much noise as possible, express their anger and strength ” (appendix 7.1.24, p.385-6).

40% of students went into detail about different improvisations and how they created music around themes (4.4.1.4). For example, Daniel explained his creepy music: “I make it up as I go along....You feel like you’re on the edge of it, of your seat in the dark” (appendix 7.1.2, p.201). He was also able to reflect on how it felt and said:

“Happy when I was doing it. It just like washed away all my feelings”
Ah. What sort of other feelings got washed away?

“Sadness...That’s it really”

Yeah. And what came along instead?

“Um, happiness, fun. Like that” (appendix 7.1.2, p.200).

A supportive structure to improvisation (4.4.1.1) was crucial to some students.

Andrew stressed the sense of fun and purpose in improvisations: “It’s good to feel like you’re inventing something, developing and building on improvisations each week...I felt like I’d achieved something that I didn’t have” (appendix 7.1.32, p.457).

Other students also talked about achievement (7.7.4). The sense of enjoyment from having someone else to play with, the musical support of the therapist and being able to play and make things up together was clear:

“I haven’t really done like guitars but when someone’s playing a different instrument beside you then that is like a bit better...I didn’t know the guitar could make such a good noise with someone else playing in the background...Cos if someone else is playing, it sort of helps you concentrate and get into the tune more that someone else is playing” (Ollie, appendix 7.1.30, p.439).

7.7.2 On talking, playing and being listened to

“Playing the drums...and being able to talk to someone about anything you want” (David, appendix 7.1.28, p.421).

As discussed in chapter four, students are encouraged to talk before playing (4.4.6) and some students mentioned this and the freedom to play, chat or listen, as they reflected on their sessions. “Before we play drums, or whatever, we talk about stuff that’s happened in the week” (Rory, appendix 7.1.36, p.491) and he said it felt good.

This mixture of talking and playing seemed to be an important aspect of sessions. Having space to talk in confidence was referenced by several students but having instruments to play and being able to communicate in this different way was significant to their enjoyment of sessions. Joe said: “Like I thought it would be just sitting around talking for an hour but I got to like express myself and play music and all of that. Like in a happy way not a boring way” (appendix 7.1.10, p.273). David

went on: “It’s like let the stress out. Not at her, just like let it out mentally. Just talk to her about it and stuff. So it got that out the way basically” (appendix 7.1.28, p.420).

Several students referred to the importance of confidentiality offered in individual sessions. David described it in detail and felt that having instruments also made a big difference:

“Cos of like been to one or two lesson things where they try talk about your problems, I can’t remember what it’s called, anger management or something, and it was just literally sitting down talking about things and like not much to do. So I tried that, didn’t really like it. Then music therapy was completely different. You can do things you want to, like play drums and do whatever, talk about things a lot simpler than in group. Like sometimes you just want to keep things between two people don’t you so. It was just like that really” (appendix 7.1.28, p.420)

He felt the combination of talking openly and playing shared rhythms had helped him:

“Um it’s really good. You can just sit down and talk about things. Like where I am to like basically worry about it. Cos she’s really nice to talk to. And you can talk about anything really. And it’s like play on the drums and stuff and find new beats and stuff like that basically” (appendix 7.1.28, p.418).

Harry also said that he enjoyed playing more when it involved conversation as well: “I think talking with the drums has made it even better...It’s made me feel sort of like the drums are there for me in a way” (appendix 7.1.12, p.285). He felt that it was the combination that helped: “It’s completely free and that’s what I like about it...music therapy has helped massively” (appendix 7.1.12, p.283).

It was interesting that, when two students compared music therapy to anger management, they preferred the physical act of playing music and the fun element, rather than just sitting and talking. The combination of having ordinary conversation, freedom to choose, to think and discuss something in particular, and time to be musically creative is the reason music therapy is so successful with this age group.

Did you feel listened to?

All the students responded positively to this question and some expanded on it. Chris from The Centre School said: “Really good. Better than I ever felt before” (appendix 7.1.24, p.385), and Jamie confirmed: “Yeah, she understood. She heard me out whereas most people wouldn’t” (appendix 7.1.26, p.401).

Students at CVC also said how it felt: “Like you had someone to talk to, like who listened, not like laugh at what you said. That’s good” (Andrew, appendix 7.1.32, p.460); “Um nice. Someone’s talking about my stuff” (Daniel, appendix 7.1.2, p.202); “Made me feel like that someone’s listening to me and not ignoring me anymore” (Joe, appendix 7.1.10, p.271); “Yeah cos she was like really nice and always understood what I said. And if she didn’t understand she’d try and understand why or whatever” (David, appendix 7.1.28, p.419). All these comments indicate that students valued the relationship with the therapist and felt heard and accepted. Feeling listened to is the crucial starting part of the therapeutic process from which trust and understanding develop.

7.7.3 On describing the difference between music therapy and other lessons

“Yes! It’s a lot of fun!” (John, appendix 7.1.38, p.507).

In an attempt to explore the students’ feelings about sessions even further, one question aimed to help students think about what it was that was different in music therapy to other lessons. All students had an opinion on this as school lessons generally incited strong feelings. Ollie said music therapy felt exhilarating but he felt it was still like teaching because it was at school. Rory said that I was like a teacher but “still different though, she’s not making you do work ’n that” (appendix 7.1.36, p.491). The sense of fun and use of humour (4.4.1.3) recurred in many conversations. Rory said it was fun (appendix 7.1.36, p.490) and Tom said it was different: “you get to do... mess about, in lessons you don’t” (appendix 7.1.8, p.250).

This sense of freedom was reiterated by others: “It’s more relaxing...Play what you want” (Mark, appendix 7.1.4, p.217). Just as some mentioned when they talked about their interests, this feeling of being free seems to stem from a sense of having choice

and control, and maybe explains why they attend sessions so readily. Creating choice, another aspect of the student-centred approach (4.2), was commented on by many students: “It made quite a difference knowing that you can have freedom of choice basically” (David, appendix 7.1.28, p.420).

A theme that emerged was how being actively involved and able to take the lead in sessions was important and some students said that this felt unusual. Andrew said that music therapy was different and gave him a special feeling:

“It’s kind of like when you help someone out you get that feeling, that real good feeling that you’ve helped someone out, it’s like the real good feeling. I’ve never left music therapy and thought that was bad, I’ve always left and thought oh yeah that was enjoyable, I enjoyed it” (appendix 7.1.32, p.457).

7.7.4 On the impact of music therapy: CVC students

“It makes you feel better about going to school as well. It makes you feel pretty much a lot more better about everything I would say” (Harry, appendix 7.1.12, p.282).

When students were asked about how they felt music therapy had helped them, most of the students from CVC were able to describe considerable change they had noticed in themselves and 30% felt that changes had an on-going effect even after sessions had finished. The interviewer asked the students questions about these changes, how quickly they had come about and whether others had noticed them too. This expressive and eloquent data from boys who only speak in short utterances at other times was unexpected and very moving.

In the following interview excerpt, Guy (appendix 7.1.6, p.232) shows his insight into how drumming relieved his feelings of anger and frustration, which led to change:

So tell me about what it’s like just playing?

“It’s good. You can take all your anger out on it”.

Ah. How do you do that?

“Banging the drums”.

[...] And why does your anger come out in that way?

“Cos like, you take your frustration out on it. I don’t actually know, it feels weird”.

Yeah. In what kind of way does it feel weird?

“Um, like after you do it, you don’t feel angry anymore”.

Oh I see. How did that make you feel afterwards?

“Like calm”.

Guy concluded that music therapy had, most importantly, helped him to be calmer and improve his behaviour (appendix 7.1.6, p.233). His change scores in the BSCI, BAI and BDBI before and after music therapy mirrored this change that he talked about because both his anxiety and behaviour self-reported scores went down by -10 and -6 respectively. Mark also felt that music therapy had helped his anger and behaviour in class. ‘It’s calmed me down quite a lot...I’m more sensible...I don’t mess about in class as much as I used to’ (appendix 7.1.4, p.219).

Andrew talked at length about how his concentration had improved with music therapy (appendix 7.1.32, p.458) and how that had helped him in lessons. He noticed that he could concentrate more and was not sent out of class as much, and that had made a big difference.

“I think it’s made me concentrate and think about stuff more and actually ask questions more and like people that find lessons hard should do music therapy because it really helps with that” (appendix 7.1.32, p.462).

He said he used to shout out or sit in class not understanding but not being able to ask, but he now had the confidence to put up his hand and ask for help. This made him feel much better about himself as well as consider the impact that his behaviour had on others:

“I don’t want to be like that anymore cos I probably stopped a few people learning by doing that. I interrupted their learning, I feel quite bad about that” (appendix 7.1.31, p.447).

He felt he was achieving more and this was noticed by teachers whose change scores were +7, -3, and +12 creating an improved average of +5.3. The change happened in

year ten, which directly coincided with his block of music therapy⁵⁰. When he was asked about the speed of the change he said:

“Probably like the third time I’d done music therapy I started to like... started to see it happening... Think it was gradual up to this day but now I think it’s getting better” (appendix 7.1.32, p.462).

His certainty about the change being as a result of music therapy is commanding evidence of its value to students.

Although Ollie’s Beck *T* clinical scores were all within the average range and there was little noticeable difference in his change scores, he reported a big change in his concentration in his interview. He took time to explain it to the interviewer and said that it had happened really quickly, about half-way through the block of sessions. He was surprised when he noticed that he could concentrate so much better in school and how much he had enjoyed sessions (appendix 7.1.30, p.440).

Another mainstream student, David, also reported noticing a change about half-way through music therapy when he started to feel that he could manage his problems with stress more easily:

“And basically I got a lot better at keeping stress in knowing that I wouldn’t flip out at someone for no reason cos of something else, so like it’s a lot easier” (appendix 7.1.28, p.422).

David said that he had been in a lot less trouble since he had had music therapy and he did not feel under constant suspicion from staff: “Now I’m focused and calmed down a bit, compared to what I used to be... I feel like a better person basically” (appendix 7.1.28, p.416). This had had a knock-on effect with his friendships which, he said, had also improved. His friends had noticed a change and they did not fall out as much, so things were better: “Yeah they said I’ve changed a lot in a good way, that I don’t take my stress out on them for no reason so it’s a lot better” (appendix 7.1.28, p.422). He also felt that the change had led to a significant improvement with

⁵⁰ A case study for Andrew is included as appendix 8.2.

teachers and his reputation: “If someone did something and it wasn’t me then they’d always go to me. It’s still like that a bit, but nowhere near as much” (appendix 7.1.28, p.416). He felt that he was able to manage situations more easily which was a change that he noticed about half-way through therapy. He felt he was more confident, could manage his stress problems and was able to think before he spoke. Some students commented on the sense of achievement from music therapy. Harry (8.5) made a link between having a good chat, expressing himself on the drums and guitar to feeling really good and more self-confident:

“It’s been really fun and it’s made me a lot more happy and a lot more head held high when I come out of there. Cos I do feel, I feel like I’ve achieved something more than anything” (appendix 7.1.12, p.282).

Considering the referrals were made for underachievers, these data become even more important and help validate music therapy for this client group. Harry noticed this change in how he felt and could explain it happening suddenly at the beginning:

“Yeah I remember uniquely coming out of that room and just going...Cos I used to do it in French and then go straight out to lunch. I was coming out feeling a lot better and I just wanted to talk to my friends and stuff, I felt really good. So I had a good conversation with them as well. And they noticed I was a lot happier, so they were happier. Cos at a certain point before I was doing music therapy I was in quite a sort of ‘down’ place, I wasn’t feeling very good and usually I’m quite a happy, nice person and that really sort of brought me back out again. I really, really, really enjoy it” (appendix 7.1.12, p.286).

The change was not temporary although he expected it to be and felt that teachers had noticed the difference too “I think they find that I’m enjoying myself a lot more” (appendix 7.1.12, p.285).

Five of nine mainstream students (56%) talked specifically about improvement in their concentration. Others felt they were better able to manage their feelings which led to a change in their behaviour and subsequent improved relationships with their peers.

7.7.5 On the impact of music therapy: The Centre School students

“Gives me a break” (appendix 7.1.14, p.306)

On the whole, when asked about how music therapy had helped them, The Centre School students were not as able as the mainstream students, to articulate the impact it had had. Their answers were often monosyllabic so the interviewer had to find different ways of approaching the same question. Despite this, they confirmed that music therapy had made a difference and a few could explain it. For example, Clare said: “Lessons they can sometimes be boring but when you do music you can let your expressions out onto it. So like say if there was a sad song, you feel the feelings in it...It’s actually made me a lot happier and has got me...what’s the word? Better” (appendix 7.1.20, p.358).

The sense of having free time and fun was important to them. “It’s fun. It’s like a good way of expressing your feelings and that” (Rory, appendix 7.1.36, p.491). Iain said that he gradually chilled out in music therapy and noticed that he felt different with this change. It helped him by giving him a break “Helps me relax, don’t get annoyed with any lessons” (appendix 7.1.14, p.306). He said he felt generally better since having music therapy and referred to the freedom in sessions. He liked the fact that there were no rules but he knew what to do: “Play and that’s it” (appendix 7.1.14, p.305). Music mattered to Iain and he had aspirations to be a music teacher. He felt that the most important thing about music therapy was learning, being able to play, trying things out and working hard. He said:

“It’s relaxing, chilling out time”

[...] Do you feel chilled out straight away?

“It just happens” (appendix 7.1.14, p.305).

Chris said that music therapy “helped me learn more about myself in music. I learned to control myself when I play the instruments. I just get lost in the music” (appendix 7.1.24, p.386). This is a particularly powerful quotation considering these students often find it very difficult to put their feelings into words.

“What’s the point in music therapy?” Jamie asked at the start of his interview. Then later on, when he was asked whether music therapy had helped him, he replied: “Not

particularly, but there's fuck all that will help me" (appendix 7.1.26, p.397). Yet, after this immediate response, he felt that there were benefits to music therapy: sessions got him out of lessons and, he added, "you go in, we chat about home, school all that sort of stuff and like we'd also listen to music, play the drums, violin and stuff like that. Been like quite good" (appendix 7.1.26, p.400). Jamie's self-esteem was rock bottom before music therapy: "Normally I don't tend to keep friends for very long cos I'm not very much of a likeable person" (appendix 7.1.25, p.395) but he felt that music therapy was about learning how to express himself (p.400) and good for "listening to music really loud... Like I'm not just sat in a room sitting down at a table, I'm doing things that are like more physical and fun" (appendix, 7.1.26, p.400).

7.7.6 On telling other people about music therapy

"It'll change your feelings very quickly...you won't feel any sadness anymore"
(Daniel, appendix 7.1.2, p.201).

If you were going to explain to somebody what to expect of music therapy what would you say?

When students were asked this question, it was interesting to hear how many said that there was no need to worry. This seemed to reveal some of their own anxieties before they began music therapy as well as their feeling that attending music therapy was not stressful. Others captured the element of confidentiality and said that they felt students should try it and find out for themselves. Several students emphasised the amount of fun. Daniel felt sure others would want to do it but it would be good to reassure them: "it doesn't matter if you can't play an instrument, you don't even have to be able to, to do that" (appendix 7.1.2, p.203).

Some students took this as an opportunity to say that music therapy was useful: "Music therapy is good and more people should be doing it" (Andrew, appendix 7.1.32, p.462). Harry was the only student who mentioned telling his family about music therapy. His brother could always express himself, he said:

"L's quite an open, nice person, which is sort of how I want to be and he's learnt that from expressing himself. Just like music therapy...So music

therapy does, it really does open up an opportunity to make you one of those people that can express themselves” (appendix 7.1.12, p.290).

Two Centre School students had used their DVD, made in sessions, as another way of sharing their experience with family members but they did not talk about this in their interviews. This shows that the work’s boundaries are still effective and any recordings or discussion of the work are generally shared carefully.

Would you like to carry on with music therapy once this research project is over?

All students who answered this question responded positively. Their optimism, as they had shown in their feelings about the future (7.5), confirmed an ability to look ahead and make a choice⁵¹.

7.8 Conclusion

The interviewer was surprised how ready students were to talk to her and trust her with sensitive information in their first interviews even though she was a stranger to them. Many students were quick to disclose lots of information and spoke openly about their past, their failings, their school exclusions and reasons for them, with little sense of self-regard and boundaries.

In the second interviews, the interviewer felt that students were more guarded with their answers and censored how much they were prepared to share. Their responses had become more socially appropriate to someone that they do not know very well and were, arguably, a result of therapy. In general, she felt that students were more self-assured and their behaviour also reflected greater confidence in themselves.

Whilst CVC students talked about achievement, increased concentration levels and how their improved well-being impacted on others such as friends and teachers, The Centre School students reported on the satisfaction of getting to a good place with

⁵¹ Of the twelve Centre School students who participated fully in the study, nine recommenced as soon as the project had finished. One had left school by this time and the other two were pursuing full-time vocational training off-site.

someone. The main themes which emerged were: feeling listened to, feeling safe, feeling relaxed and free, and feeling in control. These reflected, and therefore support, the student-centred approach of sessions which focused on congruence, unconditional positive regard and empathic understanding (4.3.1). Many students mentioned fun and others felt that the ability to choose and try something new was the best part.

The feedback from the students has created a solid case for music therapy intervention. It was surprising and moving to hear how these young people were able to reflect on their positive experience of music therapy. Many felt that it had made a very definite impact on their lives and helped them to make sense of some of their experiences.

The need to incorporate qualitative data into an outcome-based study has been supported by the wealth of evidence from these interviews. None of the students reported negative experiences. This could be attributed to wanting to ‘saying the right thing’, however their comments, as quoted verbatim throughout this chapter, generally suggest clear understandings of what music therapy was about and a genuine approval of its worth. The students who could not express themselves as easily tended to give shorter responses but their answers were just as clear and emphatic: “Erm, can help with everything” (Mark, appendix 7.1.4, p.218).

CHAPTER 8

CASE STUDIES

8.1 Introduction

The contribution of case studies and anecdotal evidence is vital because it offers insight into the experience and process of music therapy which cannot be fully reflected in quantitative data (Radhakishnan, 1981; Hooper, 1993; Elliott, 2005; Kenny, 2005). It is essential to describe the therapeutic process because ‘the way people respond in a therapeutic situation is determined by the way in which they understand the situation’ (Aldridge, 2005b, p.13). Therefore, to neglect to mention elements of the setting, the process and the approach is to ignore aspects of the work that were meaningful to the students.

Case studies were not selected and analysed as part of this research study, that is, case study designs were not used as a research strategy based upon empirical investigation (Aldridge, 2005a). However, they are included here alongside the other findings because they present a compelling account of the adolescent’s experiences in music therapy. ‘Our patients tell us dramatic stories and these need to be reflected in the research that we do...Music therapy is a social activity’ (Aldridge, 2005b, p.13).

Although the students were referred to the project because they were at risk of underachievement or exclusion, they all had very different needs. Research needs to be consistent but music therapy is always about the individual which is why five individual stories are given, including those of the outliers from the quantitative data results: Clare, Joe and John. Two extended case studies are presented in the appendices (8.1 and 8.2).

8.2 Case study 1: Clare

Music therapy essentially provided a space for Clare, 13, to think, sing, chat and be heard. Most of all, she liked performing and being creative. Sessions felt free and spontaneous which was at odds with life at home which did not allow her space to be

playful. Talking played an important part in every session and, in her interview, said: “It’s alright actually. The first time I did it I was a bit scared but ever since now it’s like ok, part of me, it’s real cool...She understands you and you can talk to her” (appendix 7.1.20, p.358).

Clare talked readily about the impact of music therapy and said that it made her feel special, “Like cos all my friends all don’t do it, its different for me. Actually like do drumming and that stuff and try new things, it feels good” (appendix 7.1.20, p.358). Although she was struggling with an extreme situation at home, Clare was committed to attending music therapy which was something that the quantitative data did not reflect.

She continued with music therapy after the rest of her group (A) had finished, as reported in 6.1.2. Her scores showed that she was an outlier in the change scores for the inventory of disruptive behaviour (BDBI) because she reported a huge increase in score, +23, which was more than three times the next highest score (figure 6.2.3.1). In the tests for correlation between the students’ change in BDBI scores and the recorded number of incidents at school (figure 6.2.3.4) her results were not significantly related. However, there was one major incident for which Clare was excluded. This probably led her to score herself very highly in the questionnaire because her perception was that she was very badly behaved.

Both her pre- and post-music therapy *T* scores were average according to the Beck clinical range for the self-concept and anxiety inventories. This is not surprising as Clare had been going through very difficult times and was used to keeping a lid on her emotions. She often talked about feeling numb, even when she had hurt herself, which suggests that she did not dare to feel anything and it was safer for her not to know how she felt. It was obvious that she was not going to reveal more in questionnaires.

The teachers’ scores, on the other hand, showed that her emotional well-being had improved. Although one teacher scored a total decrease of just one point, the other two were more convincing with a change score of +52. These two were both instructors who took her out on activities, which indicates that Clare was able to behave better outside school than in lessons and, as they spent time with her in this

way, were able to comment with understanding on her emotional well-being rather than focus on her behaviour.

8.3 Case study 2: Joe

Joe's history was sketchy but when he began music therapy at the age of 14, it was clear that he had not been offered any other therapeutic input to help him address or deal with his complex emotional issues. Despite a moderate hearing loss, Joe manages all mainstream classes with some support; he wears hearing aids and can communicate clearly with speech.

When he began music therapy he lacked motivation at school and his behaviour could be aggressive. He was regularly caught stealing and frequently involved in fights. He had few friends and seemed to live in a fantasy world, often telling elaborate stories and lying to both peers and teaching staff to impress them or elicit sympathy.

Unsurprisingly, Joe lied in his first music therapy session and told me that he had been a drummer in a successful rock band that had toured America. He also managed to take a pair of drum sticks away with him which he hid up his sleeves. It was clear that Joe had very low self-esteem, wanted to be liked and needed friends, but he did not know how to go about it. As I logged incidents that he was involved in at school, it became evident that he was getting into trouble for doing things that other students had asked him to do, such as climbing up on a roof to get a football.

Sessions were built around Joe's fantastic imagination. His favourite role was that of an American rock star. I felt that he could distinguish between truth and fiction but he seemed much happier and perhaps safer in make-believe play. I wondered if it felt too risky for him to unravel honest feelings which perhaps related to his past.

Sessions followed a similar pattern each week. He chose tracks on CDs, ranging from heavy metal band Metallica to pop ballads by Will Young, and played along to them, replicating the bands. He was the drummer and I was usually the guitarist. The music was amplified and the lights of the sound levels on the PA system helped him to keep time. One of his favourite songs was called 'How You Remind Me'. These words

from the chorus, which he usually sang along to as he drummed, seemed to reflect his own sense of self:

‘Never made it as a wise man
I couldn't cut it as a poor man stealing
Tired of living like a blind man
I'm sick of sight without a sense of feeling
And this is how you remind me
This is how you remind me
Of what I really am’ (Nickelback, 2001).

I sometimes played along on the saxophone which offered some diversion from playing along exactly to the recorded music and moved us towards making up our own music. He concentrated hard and wanted to play well but gradually became more interested in drumming and music than the idea of being in a band. Some of his drumming seemed cathartic and, after playing in an improvised way, he talked about being deaf and how he was bullied at his previous school.

Once, after playing the drums, Joe said “I got all shaky when I was playing.” I asked him “Do your hands shake or is it just a feeling inside?” to which he replied, “just a feeling inside. When I play loudly I feel it’s running out of control.” After another improvisation he stopped and said “I have to stop before I give myself nightmares”. When he expressed himself freely, it clearly threatened the firm hold he was keeping on some of his feelings. At this stage I felt it was important to continue to use pre-recorded music and the security of pretend play because improvising was potentially too overwhelming and Joe was troubled by some of the feelings it raised.

By entering in willingly to his realm of fantasy the therapeutic relationship developed and was strengthened. On one occasion, when I was interviewing him as a drummer in a famous band on television, I put on a different voice and overacted my part. He then answered in different voices, engaging in the humour and silliness. Joe always really enjoyed these exchanges; he knew that they involved honest feelings and accounts, as well as fun and imaginative play. Engaging like this seemed to invite a freedom which helped him to be more open and share some of his thoughts. He gradually talked more about where he used to live and that he never wanted to return. Without having needed to talk explicitly about the difficult time he had obviously been through, he had processed many of the feelings associated with living abroad and his subsequent return to the UK.

He started to be more honest in sessions and did not need to make up stories about a glamorous lifestyle past. His playing became very expressive and he seemed more confident about who he was. This was demonstrated by his decision to make a DVD of his drumming to show other people. He wanted to upload it to YouTube and we discussed this and the public's access to something that is very personal. I had to leave the decision to him and could not abandon the task of making a DVD which was the real and important record of his achievement. He chose to play along to 'Apologize' by One Republic (2006), which was maybe a reflection on his turn around? We filmed him playing the song, watched clips back together, discussed the good bits and other parts that we felt could be edited out. At the end he told me "It's for my dad".

In the last session, Joe did not play any drums and only talked about horror films and natural disasters. Everything was about loss and he told me how many tens of family members had died through disasters in America. It felt as if Joe was telling exaggerated stories for my sympathy and concern. Finishing music therapy was harder for him than I had anticipated. He wanted to continue with music therapy after the project and just before he left school in year eleven, he attended two sessions. In the first he chatted about the past and things he had done, about the present and how he felt about leaving school and going to the prom, and about his future plans to return to America to make links with his family. In the second session Joe and I improvised for the whole time, creating a medley of songs from previous sessions and some new ones, which included the American national anthem.

The initial block of sessions had helped him to settle and be more confident in himself and his own ability. He was now a confident, mature and honest young man. At the end of his block of music therapy, two of his support staff completed feedback forms. The first wrote: 'Joe has seemed much calmer and happier at break times recently. He was being provoked by another boy yesterday who was calling Joe names but Joe was able to stay calm and not respond physically'. The second wrote: 'Joe seems to have more concentration and more enthusiasm and willingness to learn. Before, he could be quite destructive – picking apart objects or drawing on resources, but now he makes more eye contact and engages more in conversation'. Staff now generally talked about Joe as a more sensible student and one who usually told the truth.

Joe was an outlier in the quantitative findings (6.2.1) because his self-concept score dropped much more than any other student at CVC. It was, however, more in line with a student from The Centre School which could reflect a similarity in their needs where emotional difficulties are more deeply rooted and complex. From his scores (appendix 6.2a.5) his anxiety is seen to decrease and to a much greater extent than his peers at CVC (6.2.2). This is reflected in his own account of how music therapy had helped him (appendix 7.1.10).

Joe found it difficult to identify specific change but felt that things had improved. He reflected positively on the experience of doing music therapy and, in particular, how playing music made him feel less like fighting:

“It actually feels quite good because you feel like you’re playing instruments which makes you get your aggressive out and your anger out on the instruments and not on someone else” (appendix 7.1.10, p.271-2).

He reflected briefly on his troubled past in his interview when he talked about how much happier he is at CVC. “Makes me feel quite surprised and makes me feel that I have more friends and it ain’t just me on my own anymore” (appendix 7.1.10, p.269). School is “going actually quite better than I thought it would be. I’m getting good grades and all that” (appendix 7.1.10, p.270), which he felt had changed having had music therapy. His outlook to the future was positive: “I’ll have a good life” (appendix 7.1.1.0, p.273).

8.4 Case study 3: John

“She likes listening to me. She listens to what my problems are and stuff”

What was more important, the listening bit or the instruments bit?

“Mm, both. Bit of both”.

So could you say a little bit about why they’re important?

“If you got nobody to listen to you then you got nobody at all...But if you got somebody to talk to and listen to you, then you got a say and that’s the way you get on with life cos if you just keep bottling it up, you’re just gonna let it go out then really” (John, appendix 7.1.38, p.507).

John's results were remarkable for a student at The Centre School because he benefitted so much from the limited amount of twenty sessions. There was a great deal of fun in his sessions and much of our communication was through the playful use of kazoos. This is why this quotation from his interview after music therapy is particularly striking. Unlike some students who choose to talk, John preferred to play and communicate through non-verbal means yet when he was asked about music therapy, he felt he had told me his problems and they were heard. This highlights how meaningful such non-verbal means of communication were for him.

John made a marked improvement and the biggest increase among all Centre School students for the change scores in self-concept (+15). His score remained within the range of below average but it is still a substantial change for a student who had barely any self-esteem at the start of the process. His change scores for anxiety had the biggest decrease among the students in his group and his BDBI scores did not change. John's intervention was timely and it helped him considerably (appendix 6.2.a.19). He was keen to resume music therapy as soon as the project had finished and continues to use every session to be playful and creative.

8.5 Case study 4: Harry

Harry was frequently absent from school and when he was on site was usually in trouble: he was prone to swearing at teachers, bullying other students and being disruptive in lessons. When he was referred to the project he was 15. His head of year wanted Harry to have music therapy but was not confident that he would attend and told me about his frequent periods of exclusions, both internal and external.

I met Harry in the main reception before his first session. His hair covered most of his face and made eye contact difficult. He stooped and seemed unsure of how to hold himself. When I suggested that we made our way over to the music therapy garage, he did not say anything but grunted in agreement. During that session, and all subsequent ones, he concentrated on playing the drums and the electric guitar but he never played for long. The fact that I joined him in his playing created a trust that allowed him to talk which seemed to be what he really wanted to do.

Some topics of discussion lasted a while and others were fleeting. Having the instruments there seemed to make it easier for him to talk because he could use them to control how and when we talked. The music was the catalyst that enabled the relationship to develop whilst being an excuse for him to attend.

Harry did not make many of his twenty sessions but in his interview clearly articulated the huge impact they had on him. The interviewer reported that his behaviour was different in his second interview (after music therapy): he entered the room confidently, relaxed and was ready to engage in conversation.

He was clear and determined to talk about how music therapy had helped him:

“It’s just made me feel really creative and really have like a spark of imagination just to do something which I’m really enjoying”

Wow. And does that happen quite a lot then, this creativity? This sparkle and everything?

“I can’t say it does all the time but after doing music therapy and stuff, it really has helped a lot. I feel a lot more open with people as well, which made me happier. Now I can sit down and have a conversation with people and I don’t feel sort of, not as bad, but I feel like I can express myself a lot more.

It’s a really weird experience as well cos all that has come from just playing the drums and just talking at the same time” (appendix 7.1.12, p.285-6).

In his interview he talked about the fact that his relationships with peers had improved, he had a better understanding of himself and was feeling more motivated. However, his self-reported change scores in the Beck Inventories for Youth did not reflect the changes that he felt music therapy had made for him (appendix 6.2a.6). His BSCI change score increased by +3, his BAI decreased by -1 and his BDBI increased by +2 which are minimal and do not reflect his positive statements about music therapy.

8.6 Case study 5: David

David's story was introduced in vignette 4.7 in chapter four to illustrate how conversation can form a large part of his sessions. He had lost a close relation his own age just before music therapy began and, on top of his own difficulties with low self-esteem and coping at school, he was worried about life and how it would turn out. David reported in his interview that he was pleased that his behaviour had changed since music therapy. The biggest difference for him was his self-confidence: he said he felt stronger and more resilient, less anxious and was able to face the future.

However, his self-assessment scores (appendix 6.2a.14) did not reflect what he said in his interview: his anxiety score increased by three although he felt his anxiety dropped after music therapy and his self-concept score decreased by three although he said that he felt more together. This sense of feeling more contained however, is a reflection that he feels closer to his real feelings and thus, he could have scored himself more accurately than before, as discussed in 6.3.4.

The teachers had also noticed a difference in David and this was reflected in all three of the teachers' change scores which increased by +34, +20 and +22 respectively. This created an average improved score of +25.3. One teacher reported back to me that he was a totally different boy and a pleasure to teach. David knew teachers felt positive: "Yeah they said I'm a lot calmer than I used to be" (appendix 7.1.28, p.422).

8.7 Conclusion

These case studies bring together elements from both quantitative and qualitative findings. In each case⁵² there is an underlying theme of finding identity which is central to adolescence: each student developed a greater understanding of their own feelings. For some this did not lead to improved behaviour but meant that they could recognise and acknowledge some of their reactions and feelings. Such a change in students may not be obvious and therefore not necessarily be revealed in any quantitative data. However, it is an extremely important development for the student

⁵² Including the case studies in the appendices (8.1 and 8.2).

and one that may help them handle a crisis differently the next time one occurs. This need for faith in the long-term effects of the work is essential.

CHAPTER 9

DISCUSSION AND CONCLUSION

9.1 The main findings

The main findings from the study's quantitative and qualitative data together provide a positive result to this research investigation: music therapy does make a difference and can improve the emotional well-being of students at risk of underachievement or exclusion. Overall, it was found that:

1. There was a need for this research. A review of the current literature made it clear that a study into the effectiveness of music therapy with youth at risk was necessary.
2. Using both quantitative and qualitative methods considerably enriched the findings. Evidence in the music therapy research literature shows that survey research of this type, which includes a mixture of questionnaires and semi-structured interviews, is an effective way of showing that music therapy has a positive impact (Wigram, 2005).
3. The music therapy approach used in this study is effective. During their interviews, students made positive references to feeling free and creative due to the way that sessions combined playing music and talking.
4. The detailed description of the music therapy approach together with the examples on the DVD demonstrate new ways of working with adolescents: the DVD has offered other therapists ideas for working with this client group and proven useful in teaching trainee music therapists at university and music therapists via presentations at conferences.⁵³

⁵³ "That's sick, bruv, listen!" Looking at ways to engage with teenage hoodies and X-factor hopefuls' presented at VIIIth European Music Therapy Congress in Cadiz, Spain, 2010; 'Improvisation in music therapy with excluded adolescents and how this fits into quantitative and qualitative research' presented at the Third International Music Therapy Research Conference in Waterloo, Canada, 2011.

In relation to the research questions it was found that:

1. Music therapy made a difference to a student's self-concept: 25% of students (at The Centre School) and 56% (at CVC) reported a greater level of self-concept. The baseline score was significant and showed that students with more complex needs (at The Centre School) required longer than twenty weeks of sessions for results to show greater improvement.
2. Music therapy can help improve integration with peers. Some students (10%) talked about having better relationships with their peers as a result of music therapy and 41% felt that they were socialising more.
3. Music therapy can help motivate students to learn. Several students (14%) felt that music therapy had directly helped their concentration and they were more willing to join in with lessons. The majority of teachers (58%) recorded improvement in the students' attitudes towards learning.
4. Music therapy gives students wider incentive. 95% of students committed to music therapy and their average attendance was 89%. Three students moved schools during the project but 82% participated fully in the project's data collection which lasted nineteen months. All students at The Centre School and all except one at CVC, wanted to continue with music therapy once the project had finished.
5. Whilst group A were having music therapy, staff reported 17% fewer incidents for these students. After music therapy had stopped, their behaviour deteriorated. 50% of students (at The Centre School) and 55% (at CVC) felt their behaviour had improved after music therapy.
6. Levels of anxiety decreased after music therapy for most students. 50% of students (at The Centre School) and 55% (at CVC) recorded a decrease. However, anxiety was also shown to be difficult to measure.

7. Positive effects of music therapy were mostly sustained after the course of music therapy. The long-term follow-up data for group A showed that some students reported an increase in levels of anxiety.
8. The course of music therapy provides a meaningful process and a sense of achievement to youth at risk: students spoke clearly about what music therapy meant to them.
9. Further research to increase the data set is needed. Despite many positive findings, there was not enough power for the statistical analyses to produce many significant results.

9.2 Reflections on the findings

It was striking that, whichever group students were in, there was a high level of treatment adherence (figure 5.3.3). This commitment to attendance was key. Why do students stick at music therapy? Choosing to attend a voluntary session is an active decision and one which the students made every week during the project. This study gave them the chance to say in their own words what they considered music therapy could offer them.

9.2.1 The interviews

Conversation through interviews as well as asking specific questions by survey was an effective way of finding out as much as possible from the students. With the semi-structured interviews, as many of the questions as possible from the schedule were put to the students. In some cases, despite the questions, the students wanted to talk about something else which meant that occasionally there was a lack of directly comparable data. Nevertheless, this system of collecting data had the advantage of being adaptable to each student. For teenagers who struggle with decisions and have hugely unpredictable lives, being able to answer questions on their own terms enabled them to be more open and inspired confidence.

The students were able to reflect on different aspects of music therapy which they felt were important. In particular, students talked about being able to play and feeling free and spontaneous. They enjoyed being in control and having the opportunity to talk openly. The approach used in this study (4.4) enabled the relationship which inspired students. Their explanation of its incentive and their commitment to sessions show the value of music-making and engaging in the 'here and now' which can alleviate difficult feelings, even though the quantitative data did not always reflect this.

The method did not set out to compare results between The Centre School and CVC students but, recognising the students' differences, helped to further explain the data. For example, those at risk of underachievement or exclusion but who can cope at a mainstream school generally have greater emotional and academic intelligence. On the other hand, students who have emotional and behavioural difficulties and attend a special school have more complex needs and may have known more interruption to schooling due to periods of exclusion. The baseline scores for self-concept and disruptive behaviour were shown to be significant which reinforced the need to discuss the students' results for each school separately.

9.2.2 The Centre School students

The Centre School students had very low baseline scores for their self-concept and this was found to be significant compared to the score that they gave after music therapy. The data showed that students recorded a lower self-concept after the block of music therapy than before. This presents the idea that things have to get worse before they can get better (Castonguay et al., 1998) and there are different ways of interpreting this result.

One argument is that music therapy did help students to become more aware of themselves and their emotions but the therapy process needs to continue, build on this level of self-awareness and bring about further understanding, change and development. It was interesting that almost all Centre School students were keen to continue music therapy after the project and reported this in their interviews. They wanted to attend music therapy on a regular basis for longer than they were offered. This issue of ending therapy for some might also be to do with endings in general and

how they raise difficult issues relating to attachment (1.2). Either way, it shows that their need was being met through the work.

Twenty sessions were not enough for students to show sustainable change in their self-awareness. Change in self-concept is known as resilience on the Music Therapy Star (Triangle and Coram, 2011) and is recognised as a stage which can take longer to achieve than the others. The results from this study indicate that the length of treatment was too short for this stage of resilience to be reached. However, it is also worth noting that students with complex needs might improve within a music therapy session but regress when they are back in the classroom or in another setting with their peers (Lindeck, 2012).

I was aware that during the project many students were living in very difficult circumstances which did not change whilst they received music therapy. As most of the student's time is spent away from the school environment and in potentially difficult situations, this has to be considered in the analysis of data. This makes the findings from the interviews even more poignant because many of The Centre School students talked about enjoying the freedom of being playful and creative. Even if this experience is limited to the therapy room, it can make a great impact on their emotional well-being. Quibell's drama therapy study (2010) with disaffected students, mentioned in the literature review (2.5.1), showed that both teachers and parents reported improvement in the students, but the students themselves found it harder to be positive in their answers about their emotional well-being.

Another thought about self-reporting could be that students at The Centre School are more likely to be used to various different professionals talking to them individually. On meeting the interviewer for a second time, acquainted with the setting and with the absence of any anticipated repercussions from the first meeting, the students may have been more trusting and felt able to reveal a more honest account of their feelings. This would also lead to differences in their scores.

9.2.3 CVC students

The CVC students presented with a stronger sense of self to begin with and showed less change in the inventory of self-concept. They indicated greater change in levels of anxiety which seemed to show that they were more in touch with this feeling after therapy. Shipley and Odell-Miller (2012) described how music therapy was shown to help adolescent school refusers with high anxiety, referring in particular to the effectiveness of therapeutic musical improvisation to address the adolescent's 'changing balance between moments of chaos and calm, risk and safety, exploration and retreat' (p.39). CVC students also generally coped better with finishing after twenty weeks and, on the whole, considered the work complete. These results are probably a reflection that CVC students have developed more appropriately for their academic age and have more emotional skills to help them cope.

The CVC students are generally further ahead than The Centre School students which was demonstrated in their ability to talk in much greater depth on their experience of music therapy and the differences they felt the sessions had made. They recognised change in themselves and some found their concentration and motivation to learn had improved. This was a very important finding and supports the case for music therapy: it addresses the hypothesis that school can be difficult for many adolescents with emotional problems which interfere with concentration, motivation and general ability to learn and can lead to disruptive and challenging behaviour (1.1).

Short-term work was arguably more effective for the mainstream students than for those in the special school. Daniel (6.2.1) for example, needed the intervention as a matter of urgency and the results show that it made a noticeable difference. He stopped refusing school and attended sessions regularly for the whole twenty weeks which, along with his data, demonstrate the impact that music therapy made. Several teachers at CVC commented to me on changes they had noticed in students and the progress they were making. One teacher said: "Whatever you did it worked! He wants to learn now."

9.3 Reflections on the method

The chosen study design was successful because it provided reliable and valid data from this group of students. It was an appropriate way to work with the young people and to answer the research questions based on the time available. The qualitative data collection was very effective and contributed important new evidence to the field of music therapy.

9.3.1 Method limitations

There were confounding variables which could have weakened confidence in the findings but they were taken into consideration and as many as possible were eliminated.

1. The study did not prohibit students from receiving other forms of help other than music therapy. This decision was based on the fact that it would have been unethical to deny a student further help for a period of two years, however, this meant that the students' experiences varied.
2. The categorical variable of gender was not included because only one girl took part in the project. The fact that this study involved almost all boys is in line with the population of the special school (3.3.1) and arguably, a reflection that boys more regularly manifest their emotional difficulties with challenging behaviour, which leads to a greater risk of exclusion. A project involving a higher percentage of girls would enable this variable to be explored further. Indeed, a larger sample size in general would lead to more power in the statistical analysis and greater strength in the findings.
3. The groups were created by putting students who were considered to be more in urgent need of therapy into group A (5.3.3). This selection meant that certain attributes of one group were different to the other before the study began which could have affected the data and weakened the results. Although this was not ideal for research, it was ethical and representative of the nature of the work with these young people.

4. The time limitation of this study meant that only 24 students could be referred to the project. Time also limited the music therapy input to 20 sessions for each student instead of open-ended therapy which is normally offered. The study by Karkou, Fullarton and Scarth (2010), which investigated how dance movement psychotherapy could improve the emotional and social well-being of young people aged 11-13 (2.5.1), showed some positive results but was also too small and time-limited for any firm conclusions to be drawn.

9.3.2 Discussion of time and timings

Time can affect a study in numerous ways. According to Tashakkori and Teddlie (1998) one particular threat to the validity of research findings is history. A lot changed for these young people over the course of almost two years and the fact that events occur during a study of this length can lead to differences in the data. For example, known factors that affected some students during the project included bereavement and change of home and family situations. Students might have become more distressed without music therapy intervention but this can only be conjecture.

The fact that students were growing up during the process could also change their responses and outlook as they matured. 'Difference between the pre- and post-tests might be the result of physical or psychological maturation of the participants rather than differences in the independent variable' (Tashakkori and Teddlie, 1998, p.87). These differences are likely to be even more extreme due to the changes that occur in adolescence.

The timescale of the project also meant that the referrals were made over twelve months before students in group B were able to start so it was to be expected that their needs could change in this time. The head of year who asked me to move a student from B to A (5.3.3) was responding to one such change. There was a great deal of concern that that particular student would not be attending school by the time group B began sessions, as he was already starting to refuse school on a regular basis. Following meetings with both the form tutor and head of year to discuss the student's needs he was moved to group A, which resulted in an uneven distribution of students in the groups (5.3.3). I chose to move him despite the potential for weakening the

results because this was my instinctive reaction as a therapist and his change scores (6.2.1) proved this to be the right decision as music therapy had supported him at a particularly difficult time.

The timing of the intervention was right for some students and it was evident from my clinical observations that music therapy made a big difference. However, time-limited work of therapy is not appropriate for all and it was difficult to finish after twenty weeks as in some cases it felt that the work needed to continue.

The emotional effects of the grouping on the students were also considered. Students in group A received therapy first, however they had to wait for a year before recommencing therapy. Creating DVDs for students to keep provided a tangible record of their sessions and helped them to hold their work in mind and we often had conversations in school as a way of keeping in touch. Students in group B, on the other hand, had to wait longer for therapy to start but did not have such a long gap afterwards and were able to recommence after a term.

9.3.3 Issues of asking students to self-report

“On the outside I am titanium, on the inside I’m mush!” How does a student decide which side to show on one particular day?

A research study such as this needs the students to self-report. Their voice has to be heard. All but one of the participants were boys and it was shown in a previous study that boys respond well to self-reporting and scoring on a rating scale (Jolly et al., 1994). However there are limitations to using self-report. Tourangeau (2000) suggested that the respondent needs to comprehend the question, make a decision and format an answer, which can all leave room for error. The accuracy of reports has been the concern of survey researchers, and Tourangeau and Yan (2007) carried out research into errors in self-reporting. They discovered that misreporting on sensitive topics frequently occurred which is particularly relevant to this study. The possible mistrust of the setting and interviewer is one that had been considered because of the possibility that students would edit their answers to avoid repercussions from other people.

Specifically, I would suggest that students at The Centre School, who have all known changes in schools and many in their home situations as well (3.3), could potentially be more wary of being honest in such a survey. They are more vulnerable and aware of the role of social services and therefore more likely to refrain from admitting how bad things really felt. Perhaps in the past this may have led to changes beyond their control. They also might have wanted to conceal emotional difficulties or be particularly afraid that their parents would discover what they had said (Kumar and Steer, 1995).

There was also the possibility that students wanted to make a good impression on the interviewer who they were meeting for the first time. They might want to 'do well', get the 'right' answer and say the 'right' thing. Budd, Sigelman and Sigelman (1981) warned of anxiety and response bias in survey research with children. Even amongst students who can be very antisocial in their behaviour, the drive to say the right thing and impress is often visible. 'Social desirability is probably more potent in surveys and interviews than in many simple experiments' (Coolican, 2009, p.86).

The questionnaire results could have been affected by any number of these issues. Another investigation into the reliability of survey measurement (Alwin and Krosnick, 1991) showed that young people with less schooling provided the least reliable data. Therefore were students at The Centre School more likely to have found it very difficult to know how to answer? In this light, did CVC students respond without the worry of consequences? Having known less upheaval from changing schools than The Centre School students, and with fewer gaps in their education, were they more literate and therefore able to think more clearly about their answers?

Another point to consider is the means by which the students in the two schools completed the questionnaires. The students in The Centre School answered out loud after the interviewer read out each statement. This may have felt more exposed, less private and could therefore have led to less honest answers? The students at CVC who could all read, were allowed to carry out the questionnaires on their own but could follow the same procedure as Centre School students if they preferred (5.4.2). This more anonymous approach might have felt safer for them to answer honestly.

All the students' responses to the questions had to be completed on trust and it was hoped that they completed them honestly and to the best of their ability. Dr. Long's experience of providing interviews and obtaining clear data was essential. She re-capped, checked answers and engaged conversationally with the students about the answers to help them to think and react genuinely without showing prejudice or judgment. Her knowledge in administering questionnaires and her wealth of experience working with young people meant that the data collected was as reliable and valid as possible. She knew the youth culture and was able to test for misinformation, as in the following example.

Vignette 9.1

Towards the end of the 75 questions, one of the statements read: 'I tell lies' to which one student ticked the response 'always'. At this point Dr. Long asked him whether he had told any lies that morning and whether any of his answers up to that point had been among them. He smiled wryly and said "yes". He agreed to go back over his other answers and point out the ones which he had lied about. Dr. Long thanked him for his honesty.

Finally, due to the large number of questions on each topic (self-concept, anxiety and disruptive behaviour), some students were likely to have become wary of the interviewer's motive and, on realising the theme, started to avoid giving honest answers. Alternatively, students might have lacked understanding or given a knee-jerk reaction to the questions.

'All self-reports are subject to response error. But validation studies, which incorporate a comparison between self-reports and records, suggest that some respondents sometimes perceive some topics as threatening... [and] seem to elicit from some respondents a tendency to present themselves in a socially desirable way. This tendency may lead to over-reports of socially desirable behaviours or to under-reports of threatening behaviours' (Schaeffer, 2000, p.105).

The data had to be accepted and viewed with these issues in mind. However, this method was still the most effective means for data collection and encouraged honesty as far as possible.

9.3.3.1 Self-reporting anxiety

The results from the BAI showed that anxiety was not alleviated by music therapy and in some cases was exacerbated, but many students seemed to conceal their anxiety. There were not enough covariates in the model to predict anxiety with any level of accuracy (6.2.4) and measuring anxiety in young people was difficult (6.2.2 and 6.3.2). The lack of accuracy in studies which measure anxiety in children and adolescents was highlighted by Dadds, Perrin and Yule (1998).

In this study, there was potential for students to tend to the norm and opt for either *sometimes* or *often*, rather than *never* or *always*. Students might have preferred to tick one of these two middle options as it was easier⁵⁴. However, this reaction was mostly apparent in The Centre School students' results and could be due to a defence system. The only way for some students to survive is to not show weakness or what could be considered as weakness which would have been more evident had they answered with either *never* or *always*.

It is as if some of the students need to adopt an armour to protect them from some feelings such as anxiety. In music therapy sessions students often talk about the adrenalin of fights, show me scars and bruises and claim nothing hurts as if they are immune to pain. Their focus on strength and invulnerability serves to impress, while they suppress any painful feelings. The results from group B, who showed positive scores before they began music therapy, revealed this. Anxiety can be deep-rooted and go undetected before therapeutic intervention.

If CVC students generally achieved greater self-awareness as the results from the BSCI showed (6.2.1), perhaps they were more aware of and able to understand their

⁵⁴ The hypothesis of one study, which sought to understand why people preferred the middle option in surveys and showed that 68% tended to the norm, was that it involved less mental effort (Shaw et al., 2000).

feelings of anxiety? It is also possible that CVC students felt they could afford to be more honest. They might not have felt the need to hide their emotions for fear of negative repercussions. For other students, though, concealing their true feelings is instinctive. In the past, admitting how they feel could have led to changes in their circumstances or bad reactions from peers.

The results of this study revealed how complicated it is to measure anxiety in youth at risk. Perhaps the question whether music therapy can reduce anxiety should be assessed in a single study using in-depth and applicable means, for example, using The Revised Children's Manifest Anxiety Scale (Reynolds and Richmond, 1985). This scale includes self-report assessment to measure 'the tendency of the reporting person to fake good in a socially desirable direction', known as the Lie scale (p.311) which would potentially reduce dishonest answers.

9.3.3.2 Self-reporting disruptive behaviour

Students gave a range of self-reported scores on disruptive behaviour and the baseline score was a significant factor, which indicated that the students' perception played a crucial part in how they answered. The scores revealed how students saw themselves and how they think others perceived them, rather than true association to their actual disruptive behaviour. Having seen from the BSCI results that The Centre School students' self-awareness was still below average (6.2.1.1), it was to be expected that their perception of their behaviour would be confused: 'Self-control is an area of particular importance; knowing when you are misbehaving is an important part of self-regulation, as is anticipating the consequences of your own actions' (McSherry, 2001, p.21).

When self-reporting disruptive behaviour, The Centre School students cited more extremes (6.2.3). Their perception could be distorted; what they deem as normal is not necessarily acceptable in society and their answers were relevant and relative to their, although arguably skewed, view of reality. Many Centre School students know police officers and are used to warnings, or at least are familiar with disruptive behaviour from other students in a special school. This understanding of behaviour could account for their difference in scores compared to mainstream pupils.

The Centre School students can also find it more difficult to assess their behaviour and the impact it can have on others. Due to their experiences growing up, some students frequently misjudge which behaviours are socially and legally acceptable. Others know exactly what is lawful and are practised at concealing criminal behaviour. Covering up for each other and not telling the truth perpetuates the culture of gangs (1.2). This both alienates them from wider society and strengthens bonds with their peers and their sense of belonging. Given this, it is no surprise that the correlation coefficient was so weak. Unlike admitting feeling anxious, which exposes weakness, according to gang culture, The Centre School students were more forthcoming to report on their behaviour as this has the opposite effect amongst their peers.

9.3.4 Issues of asking teachers to report on students

There are problems of asking people to comment on others. There is the challenge of ‘the possibility of conscious bias in the person providing the data’ (Baldwin, 2000, p.3). In a similar way to the students, the subjective element of the bias could have created error. A teacher’s perception of the student’s readiness to re-integrate could have affected their response and they might, for example, have been pessimistic about the future or affected by the emotional affects of good or bad behaviour.

There are many factors which influence teachers’ assessments of students’ attitudes to school and behaviour and more teachers from CVC omitted questions than those at The Centre School⁵⁵. The Centre School instructors generally know all the students because they tend to work closely with most students everyday due to the higher ratio of teaching staff to pupils (3.3). They are perhaps more sensitive to small improvements, however, they may also be emotionally involved and sometimes less objective in seeing changes they hope for. The work is very challenging and tiring and their responses could easily have been marred by a particularly difficult day or an incident which the students are prone to having. The subject teachers at CVC, on the other hand, have less contact with students outside of lessons which might have made it difficult for them to give informed answers to some of the questions.

⁵⁵ The most frequently omitted statements were the ones which questioned a student’s attitude to wanting change, concern for their appearance and their hygiene.

Lastly, there is the possibility that teachers, consciously or unconsciously, could have been envious of any successful outcomes of such a study. The students' ongoing willingness to engage in music therapy could be deflating for staff who have to constantly deal with pupils' resistance to learning due to their dislike of the subject. The openness of my approach not only with students but also with staff, helped to share the positive effects of music therapy. I used my role both as therapist and researcher to enable staff to see pupils in a different light. Once the project began, some staff wanted to know more about music therapy and I noticed that attitudes changed as they became more open to the influence of music therapy, especially for some of the most difficult students.

9.4 Reflections on the mixed methods study

The task of assessing the efficacy of music therapy faces the challenge of needing to produce objective data whilst holding on to the nature of therapy, which will always take a unique course for every student. Although it seems there were many limitations to this method, many of these were to do with the population rather than the study's design. The students' difficulties make them a hard-to-reach client group and this was the first study of its kind.

The systematic collection of quantitative and qualitative data were viewed separately and subsequently in conjunction with one another. This led the researcher to examine what the findings meant independently and collectively. When the data were brought together through case studies it provided a comprehensive view and highlighted how one complemented the other with regard to their meaning overall. These data, including observations of the clinical work on video, have thus provided evidence to support the hypothesis that music therapy can effectively address students' emotional needs and consequently improve their schooling (1.1).

The quantitative data showed that music therapy made a difference and the student's starting-point was the most crucial indicator of the positive change that could be made in the block of twenty weeks. Improvements which students made cannot all be accredited to music therapy but the convincing data from the CVC students highlight the impact of music therapy very clearly. Unlike at The Centre School, where the

standard care involves more 1:1 and small group work due to the students' needs, music therapy could be recognised as bringing about change in the CVC students.

One of the most surprising elements of this study was the abundance of qualitative data that students provided in their interviews. They used them to communicate the value of music therapy for them and to share how they felt. However without substantial quantitative data the study would have only provided a subjective view of the students' experience. Indeed, if only quantitative or qualitative data had been collected, the study would have lacked its depth and fullest meaning.

The study design was the most appropriate way to determine the effects of music therapy with this population because, although it was a quantitative study from the outset, the design of the interviews led to invaluable qualitative data. The study was designed with replication in mind, in order to obtain a greater data set, and one change that is recommended for such subsequent studies is to leave out the Beck Anxiety Inventory for Youth. The complex nature of measuring anxiety in young people revealed by this study (9.3.3.1) suggests that it should be the focus of a single in-depth research investigation.

This study has shown that the design led to robust evidence which will strengthen the current and emerging evidence-based practice in the field of music therapy as well as furthering the case for using mixed methods in research.

9.5 The study's contribution

This study has shown that music therapy makes a positive difference to adolescents with emotional difficulties at risk of underachievement or exclusion and it has added to the growing evidence of music therapy practice. It is particularly important to be able to contribute to helping adolescents in school at the present time. The riots in the UK in August 2011 did not help to reduce, and probably even fuelled, society's general blame that young people can be too unruly, anti-establishment, threatening and have a negative affect on communities. The introduction of Antisocial Behaviour Orders (ASBOs) in the late 1990s seemed to fuel ephebiphobia, the fear or loathing of teenagers, and create a distorted view that young people should be approached with

caution. These young people with antisocial and challenging behaviour are usually at risk of exclusion from schools and need to be given extra support.

‘Prior to being excluded, students are often already experiencing a set of difficulties that alone would tend to put them in the category of children at risk of further personal and social problems... Thus children who are excluded from school often have the burden of interrupted schooling added to their existing difficulties and unfavourable life-prognosis’ (Cooper, 2000, p.7).

Therefore, if things do not change at school, there are massive implications for the young person’s future⁵⁶. Figures obtained by The Trust for Adolescence 2005 showed a high level of self-reported offending by young people who were excluded from secondary school, regardless of their age. ‘This finding underlines just how important it is for high level resources to be directed at work with this particularly vulnerable group of young people’ (Coleman and Schofield, 2005, p.97).

There are many ‘adolescent boys who become ‘hard-to-reach’, eventually disengaging themselves completely from the school system and becoming permanently excluded’ (Pomerantz, 2000, p.74). However, secondary education is a cornerstone for many students and for those, whose parents have failed to provide care, teaching staff often become the adults to which they turn. To this end, McLaughlin (1996) makes the case for counselling skills to be a necessary part of every teacher’s repertoire. School is the obvious and most accessible setting to offer counselling and therapy (1.2 and 3.5) There needs to be a readiness to respond to the needs of these vulnerable young people and music therapy is one effective way.

The social pressure to conform and adapt to the standards of the peer group in order to belong, means that it is particularly important for the adolescent to have opportunities to be spontaneous and creative without this group. Many students find their identity and kudos by failing and are ‘good at being bad’, stuck in a spiral of failing with a reputation and being well-liked amongst their peers for being disruptive. Yet through the creative arts, they are able to express themselves in a way

⁵⁶ This dismal trajectory is highlighted in the NEET (Not in Education, Employment or Training) statistics from 16 -18 year olds: in 2010 the national average was 5.5%.

that connects them to the larger peer group of youth culture with its pop and rock music idols, sporting and acting heroes, whilst being able to explore their own identity which is crucial to their healthy development and feeling of self-worth. Students are often negative 'to help insulate themselves from the negative feedback they continually get' (Vizard, 2000, p.19) so the positive comments they gave about music therapy are even more profound.

Since the literature review was completed, inspiring stories of rap music reaching youth at risk and how adolescents can forge their identity through the songwriting process has been written (Ahmadi and Oostuizen, 2012; Donnenwerth, 2012; McFerran, 2012; and Macdonald and Viega, 2012). The adolescent's relationship with the genre of rap and hip-hop is also shown to help shy and introverted adolescents to speak out (Alvarez, 2012; Leafloor, 2012). These case studies highlight the adolescent's use of rap to express joy and hope for the future, unlike its frequent association with anger and oppression.

9.6 Research project spin-offs

As a direct result of this research, music therapy has become a permanent full-time post at The Cottenham Academy. Referrals are made for students across the two schools and new Sixth Form Centre. It is my aim to establish music therapy at other secondary schools.

This project has given me opportunities to present papers at conferences both nationally and internationally and to give lectures. This study has implications for the training of music therapists because the use of songwriting, microphones and pre-recorded music are new ways of working. They are different to the traditional improvisational methods on which music therapy teaching in UK universities tends to focus.

This project has influenced the evaluation and ongoing monitoring of music therapy at The Cottenham Academy and this has been shared with other music therapists. Such close monitoring is essential evidence for therapists working in schools and invaluable for a school's inspection by Ofsted.

9.7 Looking Ahead

Collaboration with The Institute of Education in London means that the profile of this research can be raised and the findings will be disseminated through supported publications and conference presentations. An overview of my approach has already been published (Derrington, 2012) and I am planning to write a book on the subject of music therapy with youth at risk in the future.

Such publications inform teachers and other professionals involved in education who want to know how music therapy helps and whether such a service is worth investing in. It can be difficult for schools to argue the case for employing a music therapist because of the lack of available systematic evidence that shows its benefits. This study goes some way towards addressing this and has given the young people involved a chance to share their thoughts on why music therapy should be made available.

The vision behind the Music Therapy Charity's Youth at Risk project was for different educational settings to replicate this lead research method. However, funding has been withdrawn and such a multi-site project is unlikely to continue. One condensed version of my design, to fit within one school year, was successfully carried out at The Bridge Learning Centre in Eastleigh. Ten students, with five in each group, received ten sessions and data were collected before and after music therapy in the same way as the original method. The qualitative data offered external validity to the findings from Cottenham and, most importantly, revealed that students felt that their concentration had improved. The findings from Cottenham and Eastleigh were presented together at a national conference (Derrington and Neale, 2012) and are to be published.

Replication of the method would increase the sample size and thereby the power which was found to be weak in this study and therefore it is hoped that the project will re-run at The Cottenham Academy. The study also leads to new research ideas, such as the need to investigate the effects of longer-term music therapy or examine the effects of music therapy on concentration as a particular area of change. This project has inspired me to continue with research, just as my enthusiasm for the work

continues to motivate me to find out more about music therapy and its value to adolescents.

9.8 Last word

This study has taken a step towards finding out how music therapy can help youth at risk and has given voice to a population which is often misrepresented and frequently misunderstood. Therefore, the last word goes to one of the students who participated in this project whose comment, in his interview (appendix 7.1.12, p.292), shows that he values music therapy and its relevance to others like him:

“I feel that hopefully more children can do music therapy because, whether it helps them or not, you’ve got to have a go at everything and I hope they have a go at this because it’s made me feel better and I really want to encourage them to make themselves feel better. Cos I feel that if they’re feeling better, if the whole world could be expressing themselves and just feel good, then it would be amazing.”

REFERENCES

- Aasgaard, T., 2005. Assisting children with malignant blood diseases to create and perform their own songs. In: F. Baker and T. Wigram, eds. 2005. *Songwriting. Methods, techniques and clinical applications for music therapy clinicians, educators and students*. London: Jessica Kingsley Publishers. Chapter 8.
- Abad, V. and Williams, K., 2006. Early intervention music therapy for adolescent mothers and their children. *British Journal of Music Therapy*, 20 (1), pp.31-38.
- Abrams, F., 2010. *Learning to fail: how society lets young people down*. London: Routledge.
- Adams, G.R. ed., 2000. *Adolescent development: the essential readings*. Oxford: Blackwell.
- Adamson, L. and Lyxell, B., 1996. Self-concept and questions of life: identity development during late adolescence. *Journal of Adolescence*, 19, pp.569-582.
- Adelson, J. ed., 1980. *Handbook of adolescent psychology*. New York: John Wiley and Sons.
- Ahmadi, M. and Oosthuizen, H., Naming my story and claiming my self. In: S.Hadley and G. Yancy, eds. *Therapeutic uses of rap and hip-hop*. New York; Hove: Routledge. Chapter 11.
- Alanne, S., 2010. *Music psychotherapy with refugee survivors of torture*. Helsinki, Finland: Sibelius Academy.
- Albornoz, Y., 2011. The effects of group improvisational music therapy on depression in adolescents and adults with substance abuse: a randomized controlled trial. *Nordic Journal of Music Therapy*, 20(3), pp.208-224.
- Aldridge, D. ed., 2005a. *Case study designs in music therapy*. London; Philadelphia: Jessica Kingsley Publishers.
- Aldridge, D., 2005b. A story told from practice: the reflective inquirer in an ecology of ideas. In: D. Aldridge, ed. 2005b. *Case study designs in music therapy*. London: Jessica Kingsley Publishers. Chapter 1.
- Aldridge, D., 2005c. Guidelines for case study design research in music therapy. In: D. Aldridge, ed. 2005c. *Case study designs in music therapy*. London: Jessica Kingsley Publishers. Chapter 11.

- Alvarez, T.T., 2012. Beats, rhymes, and life: rap therapy in an urban setting. In: S.Hadley and G. Yancy, eds. Therapeutic uses of rap and hip-hop. New York; Hove: Routledge. Chapter 7.
- Alvin, J., 1975. 1st edition 1966. Music therapy. London: Hutchinson and Co Ltd.
- Alvin, J., 1978. Music therapy for the autistic child. Oxford: Oxford University Press.
- Alwin, D.F. and Krosnick, J.A., 1991. The reliability of survey attitude measurement. *Sociological Methods and Research*, 20 (1), pp.139-181.
- Amir, D., 2005. Musical humour in improvisational music therapy. *Australian Journal of Music Therapy*, Vol. 16, pp.3-24.
- Andreae, G., and Parker-Ress, G., 2001. Giraffes can't dance. London: Orchard.
- Ansdell, G. and Pavlicevic, M., 2004. Community music therapy. London: Jessica Kingsley Publishers.
- APMT, 2009. Directory for Members 2009 - 2010, Association of Professional Music Therapists. London: APMT.
- Arguile, R., 1992. Art therapy with children and adolescents In: D. Waller and A. Gilroy, eds. 1992. Art therapy, a handbook. Buckingham: Open University Press, pp.140-154.
- ATL 2011. Boys' behaviour at school is still more challenging than that of girls but the behaviour of both is getting worse. London: ATL.
- Austin, D., 2007. Lifesongs: Music therapy with adolescents in foster care. In: V.A. Camilleri, ed. 2007. Healing the Inner City Child. Creative arts therapies with at-risk youth. London: Jessica Kingsley Publishers, pp.92-104.
- Austin, D.S. and Dvorkin, J., 1998. Resistance in Individual Music Therapy In: K.E. Bruscia, ed. 1998. The Dynamics of Music Psychotherapy. Gilsum, N.H.: Barcelona Publishers.
- Axline, V.M., 1971. Dibs: in search of self: personality development in play therapy. 1st ed. 1964. London: Pelican.
- Bailham, D. and Harper, P. B., 2004. Attachment Theory and Mental Health. In: K. Dwivedi and P. Harper ed. 2004. Promoting the Emotional Well-being of Children and Adolescents and Preventing Their Mental Ill Health London: Jessica Kingsley, pp.49-69.
- Baillie, C., 1994. Art as Therapy in a Young Offender Institution. In: M. Liebmann, ed. 1994. Art Therapy with Offenders. London: Jessica Kingsley Publishers, pp.57-76.

- Baker, F. and Jones, C., 2005. Holding a steady beat: the effects of a music therapy program on stabilising behaviours of newly arrived refugee students. *British Journal of Music Therapy*, 19 (2), pp.62-74.
- Baker, F. and Jones, C., 2006. The effect of music therapy services on classroom behaviours of newly arrived refugee students in Australia—a pilot study. *Emotional and behavioural difficulties*, 11 (4), pp.249-260.
- Baker, F. and Krout, R.E., 2009. An online music therapy intervention to enhance social skills in an adolescent diagnosed with Asperger's Syndrome. *British Journal of Music Therapy*, 23 (2), pp.3-15.
- Baker, F. and Uhlig, S., 2011 eds. *Voicework in music therapy*. London: Jessica Kingsley Publishers.
- Baldwin, W., 2000. Information no one else knows: the value of self-report. In: A. Stone, et al., eds. 2000. *The science of self-report. Implications for research and practice*. Mahwah, New Jersey: Lawrence Erlbaum Associates, Publishers, pp.3-7.
- Batsleer, J., 2008. *Informal learning in youth work*. London: Sage.
- Baughman, Kiser, 2007. Programs for teens and children. In: J. E. Rogers ed. *The art of grief: the use of expressive arts in a grief support group*. Hove: Routledge.
- Beardall, N.G., 1998. *Creating a peaceable school: confronting intolerance and bullying*. MA: Newton Public Schools.
- Beck, J.S., Beck, A.T., Jolly, J.B. and Steer, R.A., 2005. *Beck Youth Inventories second edition for children and adolescents: manual*. San Antonio, Texas: Harcourt Assessment.
- Behrends, L., 1983. Erfahrungen mit einer kombinierten Gruppenpsychotherapie bei Adoleszenten. *Psychiatrie, Neurologie, Medizin und Psychologie*, Leipzig 35 (3), pp.154-157.
- Berk, L.E., 2008. *Infants, children and adolescents*. 6th ed. Boston: Pearson/Allyn and Bacon.
- Berkovitz, I.H., 1995. *Adolescents grow in groups: experiences in adolescent group psychotherapy*. London: Jason Aronson Inc.
- Berman, G., 2011. *Prison Population Statistics Offender Management Statistics Quarterly Bulletin*, (SN/SG/4334).
- Bion, W., 1962. A theory of thinking. In: W. Bion, (1967) *Second thoughts: selected papers on psycho-analysis*. New York: Aronson.

- Blair, J., 2000. Assessing protocols for child interviews. In: A. Stone, et al., eds. 2000. *The science of self-report. Implications for research and practice*. Mahwah, New Jersey: Lawrence Erlbaum Associates, Publishers.
- Blos, P., 1966. *On adolescence*. New York: Free Press.
- Bombèr, L.M., 2009. "Survival of the fittest" Teenagers find their way through the labyrinth of transitions in schools In: A. Perry, ed. 2009. *Teenagers and Attachment. Helping adolescents engage with life and learning*. London: Worth Publishing. Chapter 2.
- Boucher, C.R., 1999. *Students in discord: adolescents with emotional and behavioural disorders*. Westport, Connecticut Greenwood Press.
- Boussicaut, C.R., 2003. *The effects of music therapy and token economy system vs. music therapy on decreasing inappropriate behaviors with students labeled emotionally disturbed*. Unpublished Masters dissertation: Florida State University.
- Bowen, J.M., Jenson, W.R. and Clark, E., 2004. *School-based interventions for students with behavior problems*. New York; London: Kluwer Academic/Plenum Publishers.
- Bowlby, J., 1969. *Attachment and Loss Volume 1: Attachment*. London: Hogarth Press.
- Bowlby, J., 1984. *Attachment and loss*. 2nd ed. Harmondsworth: Penguin Books, 1991.
- Bowlby, J., 1988. *A secure base*. London: Routledge.
- Bowlby, J., 1998. *Separation: Anxiety and anger*. London: Pimlico.
- Boys don't sing* [TV series], 2008. BBC.
- Brackley, J., 2007. *Music therapy on a pupil referral unit: what does music therapy have to offer pupils aged 5-9 on a behaviour support programme?* Unpublished Masters dissertation: Anglia Ruskin University.
- Brackley, J., 2012. *Music Therapy and The Expression of Anger and Aggression: Working with aggressive behaviour in children aged five to nine who risk mainstream exclusion* In: J. Tomlinson, P. Derrington and A. Oldfield, eds. 2012. *Music Therapy in Schools. Working with children of all ages in mainstream and special education*. London: Jessica Kingsley. Chapter 6.
- Braun, V. and Clarke, V., 2006. Using thematic analysis in psychology. *Qualitative research in psychology*, 3, pp.77-101.

- Breslow, N., 1981. Odds ratio estimators when the data are sparse. *Biometrika*, 68(1), pp.73-84.
- Bridgeland, M., 1971. *Pioneer Work with Maladjusted Children. A Study of the Development of Therapeutic Education*. London: Staples.
- Briggs, S., 2008. *Working with adolescents and young adults: a contemporary psychodynamic approach*. 2nd ed. Basingstoke: Palgrave Macmillan.
- Brooks, D.M., 1989. Music therapy enhances treatment with adolescents. *Music Therapy Perspectives*, 6, pp.37-39.
- Brown, B.B., Mory, M.S. and Kinney, D., 1994. Casing adolescent crowds in a relational perspective: caricature, channel and context. In: R. Montemayor, G.R. Adams and T.P. Gullotta, eds. 1994. *Personal relationships during adolescence*. Thousand Oaks, CA.: Sage Publications.
- Brown, D. and Pedder, J., 1991. *Introduction to psychotherapy: an outline of psychodynamic principles and practice*. 2nd ed. London: Routledge.
- Brown, R.B. and Saunders, M., 2008. *Dealing with statistics: what you need to know*. Maidenhead: Open University Press.
- Brown, S., 1994. Autism and music therapy: is change possible, and why music? *British Journal of Music Therapy*, 8, pp.15-25.
- Bruscia, K.E., 1987. *Improvisational models of music therapy*. Springfield, Illinois: Charles C. Thomas.
- Bruscia, K.E., 1998a. *Defining music therapy*. 2nd ed. Gilsum, NH: Barcelona Publishers.
- Buchanan, J., 2000. The effects of music therapy interventions in short-term music therapy with teens at risk: an opportunity for self-expression in a group setting. *Canadian*, 7 (1), pp.39-50.
- Budd, E.C., Sigelman, C.K. and Sigelman, L., 1981. Exploring the outer limits of response bias. *Sociological Focus*, 14 (4), pp.297-307.
- Bunt, L., 2003. Music therapy with children: a complementary service to music education? *British Journal of Music Education*, 20 (2), pp.179-196.
- Bunt, L. and Pavlicevic, M., 2001. Music and emotion: perspectives from music therapy. In: P. Juslin N. and J.A. Sloboda, eds. 2001. *Music and Emotion. Theory and Research* Oxford: Oxford University Press, pp.181-201.
- Butterton, M., 1993. Music in the pastoral care of emotionally disturbed children. *British Journal of Music Therapy*, 7 (2), pp.12-20.

- Campbell, P.S., 1998. Songs in their heads: music and its meaning in children's lives. New York: Oxford University Press.
- Carr, C. and Wigram, T., 2009. Music therapy with children and adolescents in mainstream schools: a systematic review. *British Journal of Music Therapy*, 23 (1) pp.3- 19.
- Carson, K., 2007. "Fank u for da musik...4 givin it 2 me": *How successful is music therapy as a supporting intervention for increased inclusion within British mainstream secondary education?* Unpublished Masters dissertation: City University, London.
- Casey, O., 2012. 'How can I consider letting my child go to school when I spend all my time trying to keep him alive?' Links between music therapy services in schools and a children's hospice. In: J. Tomlinson, P. Derrington and A. Oldfield, eds. 2012. Music Therapy in Schools. Working with Children of All Ages in Special and Mainstream Educational Settings. London: Jessica Kingsley Publishers. Chapter 11.
- Castonguay, L., Pincus, A., Agras, W. and Hines, C., 1998. The role of emotion in group cognitive-behavioral therapy for binge eating disorder: When things have to feel worse before they get better. *Psychotherapy Research*, 8 (2), pp.225-238.
- Children Act, 2004. London: HMSO.
- Chong, H.J. and Kim, S.J., 2010. Education-oriented music therapy as an after-school program for students with emotional and behavioral problems. *The Arts in Psychotherapy* 37 (3), pp.190-196.
- Christensen, J., 2010. Making space inside: The experience of dramatherapy within a school-based student support unit. In: V. Karkou, ed. 2010. Arts Therapies in Schools. London: Jessica Kingsley Publishers. Chapter 4.
- Cobbett, S., 2007. Playing at the Boundaries: Combining music therapy with other creative therapies in individual work with children with emotional and behavioural difficulties. *British Journal of Music Therapy*, 21 (1), pp.3-10.
- Cobett, S., 2009. Including the Excluded: Music therapy with adolescents with social, emotional and behavioural difficulties. *British Journal of Music Therapy*, 23 (2), pp.15-24.
- Coffey, A. and Atkinson, P., 1996. Making sense of qualitative data: complementary research strategies. Thousand Oaks, Calif.: Sage.
- Cole, T., 1986. Residential Special Education. Milton Keynes: Open University.

- Cole, T., 1998. Understanding challenging behaviour: prerequisites to inclusion. In: C. Tilstone, L. Florian and R. Rose, eds. 1998. Promoting inclusive practice. Abingdon, Oxon: Routledge.
- Cole, T., Daniels, H. and Visser, J. eds., 2001. Emotional and behavioural difficulties in mainstream schools. Greenwich, Conn; London: JAI.
- Cole, T., Visser, J. and Upton, G., 1998. Effective schooling for pupils with emotional and behavioural difficulties. London: David Fulton.
- Coleman, J.C. and Schofield, J., 2005. Key data on adolescence 2005. Brighton: Trust for the Study of Adolescence.
- Coleman, J., Brooks, F. and Treadgold, P., 2011. Key Data on Adolescence, 2011. Association for Young People's Health, London, UK.
- Coleman, J.C., Hendry, L.B. and Kloep, M. eds., 2007a. Adolescence and health. Chichester: John Wiley.
- Coolican, H., 2009. Research methods and statistics in psychology. 5th ed. London: Hodder Education.
- Cooper, P., 1993. Effective schools for disaffected students: integration and separation. 3rd ed. London: Routledge.
- Cooper, P., Smith, C.J. and Upton, G., 1994. Emotional and behavioural difficulties. Routledge.
- Cooper, P., 2000. Positive alternatives to exclusion. London: Routledge/Falmer.
- Corbett, J., 2001. Supporting inclusive education: a connective pedagogy London: Routledge/ Falmer.
- Cornwall, J. and Todd, J., 1998. Emotional and behavioural difficulties. London: David Fulton.
- Corrigan, P., 1979. Schooling the smash street kids. London: Mcamillan Press.
- Cotterell, J., Coleman, J. and Cotterell, J., 2007. Social networks in youth and adolescence. 2nd ed. London: Routledge.
- Courtney, R., 1981. An exploration of the therapeutic potential of song in dramatherapy. In: Schattner, G. and Courtney, R. eds. Drama in therapy Volume 2: clinical work and research into practice. Hove: Routledge.
- Cowie, H. and Sharp, S. eds., 1996. Peer counselling in schools: a time to listen. London: David Fulton.
- Craig, C., 2007. Creating confidence: a handbook for professionals working with young people. Glasgow: Centre for Confidence and Well-being.

- Creswell, J.W., 1995. *Research Design: Qualitative and quantitative approaches*. Thousand Oaks, CA: Sage.
- Creswell, J.W., 2007. *Designing and Conducting Mixed Methods Research*. Thousand Oaks, CA: Sage.
- Croll, P., 2002. Social deprivation, school-level achievement and special educational needs. *Educational Research*, 44 (1), pp.43-53.
- Crookes, L. 2012. *What are the key features of music therapy work with mainstream adolescents in mainstream secondary schools?* Unpublished Masters dissertation: London Guildhall School of Music and Drama.
- Csikszentmihalyi, M., Rathunde, K. and Whalen, S., 1997. *Talented teenagers: the roots of success and failure*. Cambridge: Cambridge University Press.
- Dadds, M.R., Perrin, S. and Yule, W., 1998. Social desirability and self-reported anxiety in children: An analysis of the RCMAS Lie Scale. *Journal of abnormal child psychology*, 26 (4), pp.311-317.
- Daniels, H., Visser, J., Cole, T., de Reybekill, N., Harris, J. and Cumelia, S. 1998. *Educational support for children with mental health issues: including the emotionally vulnerable*. Birmingham: University of Birmingham.
- Darrow, A.A., 1999. Music educators' perceptions regarding the inclusion of students with severe disabilities in music classrooms. *Journal of Music Therapy*, 46 (4), pp.254-273.
- Davies, E., 2005. You ask me why I'm singing: Song-creating with children at a child and family psychiatric unit. In: F. Baker and T. Wigram, eds. 2005. *Songwriting: Methods, techniques and clinical applications for music therapy clinicians, educators and students*, London: Jessica Kingsley Publishers. Chapter 2.
- Davis, H., 2008. Growing Success. Are care farms the answer to disaffected teenagers' problems? *The Guardian*, 12 March.
- Dayton, T., 2007. Emotional Repair through Action Methods: The Use of Psychodrama, Sociometry, Psychodramatic Journaling and Experiential Group Therapy with Adolescents. In: V.A. Camilleri, ed. 2007. *Healing the Inner City Child. Creative arts therapies with at-risk youth*. London: Jessica Kingsley Publishers, pp.197-212.
- DCSF, 2007a. *The Children's Plan*. Nottingham: Department for Children, Schools and Families Publications.
- DCSF, 2007b. *Social and emotional aspects of learning for secondary schools*. Nottingham: Department for Children, Schools and Families Publications.

- DCSF, 2010. *Pupil absence in schools in England, including pupil characteristics: 2008/9*. Nottingham: Department for Children, Schools and Families Publications. 25 March. Available at: <http://www.education.gov.uk/rsgateway/DB/SFR/s000918/index.shtml>. Accessed: 10 October 2011.
- De Backer, J., 1993. Containment in music therapy. In: M. Heal and T. Wigram, eds. 1993. *Music therapy in health and education*. London: Jessica Kingsley Publishers. Chapter 3.
- De Carlo, A., 2001. Rap therapy? An innovative approach to groupwork with urban adolescents. *Journal of Intergroup Relations*, 27, pp.40-48.
- De Silva, S., 2006. Music therapy. In: M. Hunter-Carsch, Y. Tiknaz, P. Cooper and R. Sage, eds. 2006. *The handbook of Social, Emotional and Behavioural Difficulties*. London: Continuum, pp.199-204.
- Denscombe, M., 2007. *The good research guide: for small-scale social research projects*. 3rd ed. Maidenhead: Open University Press.
- Derrington, C. and Kendall, S., 2004. *Gypsy traveller students in secondary schools: culture, identity and achievement*. Stoke-on-Trent: Trentham.
- Derrington, P., 2004. Music therapy on the time-table. Working with students in mainstream secondary schools. Conference paper given at 6th European Music Therapy Congress: Jyväskylä, Finland.
- Derrington, P., 2005. Teenagers and songwriting: supporting students in a mainstream secondary school In: Baker, F. and Wigram, T., ed. 2005. *Songwriting. Methods, techniques and clinical applications for music therapy clinicians, educators and students*. London: Jessica Kingsley. Chapter 3.
- Derrington, P., 2006. *Music therapy in a mainstream secondary school: A study of its role*. Unpublished Masters dissertation: Anglia Ruskin University.
- Derrington, P., 2010. "Yeah I'll do music!" Looking at ways to engage with teenage hoodies and X-factor hopefuls. Conference paper given at 8th European Conference: Cadiz, Spain.
- Derrington, P., 2011. Book review of 'Adolescents, Music and Music Therapy' by K. McFerran: London: Jessica Kingsley, 2010. *Nordic Journal of Music Therapy*, 20 (3), p.263.
- Derrington, P. ed., 2011. 3rd international music therapy research conference: Improvisation - exploring the art and science of clinical practice Waterloo, Canada. Paper available at www.soundeffects.wlu.ca

- Derrington, P., 2012. "Yeah I'll do music!" Working with secondary-aged students who have complex emotional and behavioural difficulties. In: J. Tomlinson, P. Derrington and A. Oldfield, eds. 2012. *Music Therapy in Schools. Working with children of all ages in mainstream and special education*. London: Jessica Kingsley. Chapter 13.
- Derrington, P. and Neale, L. 2012. Music therapy for youth at risk. Unpublished paper at Key Changes Annual Conference: 'Music Therapy - proving the case', Winchester.
- DfE, 1994. *Pupils with problems*. Circular. London: Department for Education.
- DfE, 2012. *Living in children's residential homes*. London: Department for Education.
- DfES, 2001a. *Inclusive Schooling: Children with special educational needs*. London: Department for Education and Skills.
- DfES, 2001b. *Special Educational Needs Code of Practice*. London: Department for Education and Skills.
- DfES, 2003. *Every Child Matters*. London: Department for Education and Skills.
- DfES, 2005. *Higher Standards, Better Schools*. London: Department for Education and Skills.
- Doherty, J., 2009. Play for children with special educational needs. In: Brock, A. Dodds, S. Jarvis, P. Olusoga, Y., eds. *Perspectives on Play. Learning for Life*. Harlow: Pearson Education Ltd.
- Donnelly, M., 1992. Art therapy with families. In: D. Waller and A. Gilroy, eds. 1992. *Art Therapy. A Handbook*. Buckingham: Open University Press, pp.125-140.
- Donnenwerth, A., 2012. Song communication using rap music in a group setting with at-risk youth. In: S.Hadley and G. Yancy, eds. *Therapeutic uses of rap and hip-hop*. New York; Hove: Routledge. Chapter 14.
- Doran, J., 2010. Music in Mind Study, Belfast. Available at: <http://www.qub.ac.uk/schools/SchoolofNursingandMidwifery/MusicinMind/AbouttheMusicinMindResearchStudy/> Accessed: 10 June 2012.
- Dorr, A., 2007. Collaboration and Creativity: Art Therapy Groups in a School Suspension Program. In: V.A. Camilleri, ed. 2007. *Healing the Inner City Child. Creative arts therapies with at-risk youth*. London: Jessica Kingsley Publishers, pp.164-180.

- Dowling, E. and Osbourne, E. 1994. eds. *The Family and the School: A Joint Systems Approach to Problems With Children*. 2nd edition. London: Routledge.
- D'Ulisse, M., Ferrara, C., Walter, D. and Valentina, M. V., 2001. Music therapy and integration: application within schools. Unpublished paper presented at the 5th European Music Therapy Congress. Naples, Italy.
- Durlak, J.A. and Wells, A.M., 1997. Primary prevention mental health programmes for children and adolescents: a meta-analytic review. *American Journal of Community Psychology*, 25(2), pp.115-152.
- Duxbury, R., 2006. Music and personal growth. In: M. Hunter-Carsch, Y. Tiknaz, P. Cooper and R. Sage, eds. 2006. *The handbook of social, emotional and behavioural difficulties*. London: Continuum, pp.187-198.
- Dvorkin, J., 1991. Individual music therapy for an adolescent with borderline personality disorder: an object relations approach. In: K.E. Bruscia, ed. 1991. *Case Studies in music therapy*. Phoenixville: Barcelona Publishers, pp.251-270.
- Dwyer, K. and Osher, D., 2000. *Safeguarding Our Children: An Action Guide. Implementing Early Warning, Timely Response*. .
- Eaves, N., 2005. "A Bohemian Rhapsody" Using music technology to fulfil the aspirations of teenage lads with muscular dystrophy In: P. Pavlicevic, ed. 2005. *Music therapy in children's hospices*. London: Jessica Kingsley. Chapter 6.
- Educating Essex* [TV series], 2011. Channel 4.
- Education Act*, 2005. London: HMSO.
- Elefant, C. and Wigram, T. 2005 Learning ability in children with Rett syndrome. *The Arts in Psychotherapy* 32 (4): 293 - 301
- Elkis-Abuhoff, D.L., 2008. Art therapy applied to an adolescent with Asperger's syndrome. *The Arts in Psychotherapy*, 35 (4), pp.262-271.
- Elligan, D., 2000. Rap therapy: a culturally sensitive approach to psychotherapy with young African American men. *Journal of African American Men*, 5 (3), pp.27-36.
- Elligan, D., 2004. *Rap Therapy: A Practical Guide to Communicating with Youth and Young Adults through Rap Music*. New York: Kensington Publishing.
- Elliot, J., 2005. Using narratives in social research. Qualitative and quantitative approaches. London: Sage Publications.
- Emunah, R., 1985. Drama therapy and adolescent resistance. *The Arts in Psychotherapy*, 12 (2), pp.71-79.

- Erikson, E.H., 1968. Identity: Youth And Crisis. Revised edition 1994. New York; London: W.W. Norton.
- Erikson Erik H., 1980. Identity and the life cycle. New York London: W.W. Norton.
- Evans, C., Mellor-Clark, J., Margison, F., Barkham, M., Audin, K., Connell, J. and McGrath, G., 2000. CORE: Clinical outcomes in routine evaluation. *Journal of Mental Health*, 9 (3), pp.247-255.
- Fak, H. and Schmidtmayr, B., 1997. Musiktherapie ohne Musik? Grenzen des Mediums Musik in der Therapie mit Kindern und Jugendlichen. In: E. Fitzhum, D. Oberegelsbacher and D. Storz, eds. 1997. Wiener Beiträge zur Musiktherapie. Vienna: Edition Praesens.
- Farrell, M., 2001. Key issues for secondary schools London: Routledge Falmer.
- Farrell, M., 2006. The effective teacher's guide to behavioural, emotional and social difficulties: practical strategies. London: Routledge.
- Fearn, M., O'Connor, R., Goodyear, C., Ledden, T. and Watts, D., 2008. Collaborative working at the Cheyne Day Centre, London. In: K. Twyford and T. Watson, eds. 2008. Integrated Team Working. Music therapy as part of transdisciplinary and collaborative approaches. London: Jessica Kingsley Publishers, pp.55 -62.
- Field, A.P., 2009. Discovering statistics using SPSS. 3rd ed. London: Sage.
- Flower, C., 1993. Control and creativity: music therapy with adolescents in secure care. In: M. Heal and T. Wigram, eds. 1993. Music therapy in health and education. London: Jessica Kingsley Publishers. Chapter 4.
- Fouché, S. and Torrance K., 2005. Lose yourself in the music, the moment, yo! Music therapy with an adolescent group involved in gangsterism. *Voices: A World Forum for Music Therapy*. 5 (3) 5 March 2012.
- Frank, G., 2005. David's music. An observation of musical interactions with a schizophrenic adolescent. *Nordic Journal of Music Therapy*, 14 (2), pp.179-186.
- Freud, S., 1958. The Standard edition of the complete work psychological works of Sigmund Freud Volume XII. London: The Hogarth Press and the Institute of Psychoanalysis.
- Friedlander, L.H., 1994. Group music psychotherapy in an inpatient psychiatric setting for children: A developmental approach. *Music Therapy Perspectives*, 12 (2), pp. 92-97.
- Frisch, A., 1990. Symbol and Structure: Music therapy for the adolescent psychiatric inpatient. *Music Therapy*, 9 (1), pp.16-34.

- Fruchard, G. and Lecourt, E., 2003. Music speaks of a story. The vocal universe of an adolescent. In: S. Hadley, ed. 2003. *Psychodynamic Music Therapy: Case Studies*. Gilsum: Barcelona Publishers, pp.241 – 257.
- Frydenberg, E., 2008. *Adolescent coping: advances in theory, research and practice*. London: Routledge.
- Garrett, D., Roche, J., Tucker, S. and Open University. eds., 1997. *Changing experiences of youth*. London: Sage in association with The Open University.
- Garrett, P.M., 2004. *Social work and Irish people in Britain: historical and contemporary responses to Irish children and families*. Bristol: The Policy Press.
- Gelddard, K. and Geldard, D., 2004. *Counselling adolescents: the proactive approach*. 2nd ed. London: Sage.
- Geldard, K. and Geldard, D., 2009. *Relationship counselling for children, young people and families*. Los Angeles; London: Sage.
- Gibbs, G.R., 2007. *Analyzing qualitative data*. Thousand Oaks, CA: Sage Publications.
- Gillham, B., 2008. *Developing a questionnaire*. 2nd ed. London: Continuum.
- Glaser, B.G. and Strauss, A.L., 1967. *The discovery of grounded theory*. Chicago: Aldine.
- Gold, C., Voracek, M. and Wigram, T., 2004. Effects of music therapy for children and adolescents with psychopathology: a meta-analysis. *Journal of Child Psychology and Psychiatry*, 45 (6), pp.1054-1063.
- Gold, C., Wigram, T. and Voracek, M., 2007a. Predictors of change in music therapy with children and adolescents: The role of therapeutic techniques. *Psychology and Psychotherapy: Theory, Research and Practice*, 80 (4), pp.577-589.
- Gold, C., Wigram, T. and Voracek, M., 2007b. Effectiveness of music therapy for children and adolescents with psychopathology: a quasi-experimental study. *Psychotherapy Research*, 17 (3), pp.289-296.
- Goldstein, S.L., 1990. A songwriting assessment for hopelessness in depressed adolescents: a review of the literature and pilots study. *The Arts in Psychotherapy*, 17, pp.117-124.
- Goleman, D., 1995. *Emotional intelligence*. New York: Bantam Books.
- Gordon, J. and Grant, G. eds., 1997. *How we feel: an insight into the emotional world of teenagers*. London: Jessica Kingsley.
- Gravetter, F.J. and Forzano, L.B., 2003. *Research Methods for the Behavioural Sciences*. Belmont, CA: Thomson-Wadsworth.

- Greenhalgh, P., 1994. Emotional growth and learning. Routledge.
- Greenland, S., Schwartzbaum, J.A. and Finkle, W.D., 2000. Problems due to small samples and sparse data in conditional logistic regression analysis. *American Journal of Epidemiology*, 151 (5), pp.531-539.
- Gresham, F.M. and Elliott, S.N., 2008. Social Skills Improvement System. Minneapolis, MN: NCS Pearson, Inc.
- Grießmeier, B. and Bossinger, W., 1994. Musiktherapie mit krebskranken Kindern. Stuttgart: Gustav Fischer.
- Grimshaw, D., 1996. Dramatherapy with children in an educational unit: the more you look, the more you see. In: S. Mitchell, ed. 1996. Dramatherapy: clinical studies. London: Jessica Kingsley Publishers, pp.50-70.
- Hadley, S. and Yancy, G. eds., 2012. Therapeutic Uses of Rap and Hip-Hop. New York; London: Routledge.
- Haen, C., 2007. "Make me wanna holler" Dramatic encounters with boys from the inner city. In: V.A. Camilleri, ed. 2007. Healing the Inner City Child. Creative Arts Therapies with At-Risk Youth. London: Jessica Kingsley Publishers, pp.212-228.
- Hagood, M., 1994. Group Art Therapy with Adolescent Sex Offenders: An American Experience. In: M. Liebmann, ed. 1994. Art Therapy with Offenders. London: Jessica Kingsley Publishers, pp.197-219.
- Haines, J.H., 1989. The effects of music therapy on the self-esteem of emotionally disturbed adolescents. *Music Therapy*, 8 (1), pp.78-97.
- Haire, N., 2008. *An exploration of the role of humour in music therapy with children in the psychiatric setting*. Unpublished Masters dissertation: Anglia Ruskin University.
- Haire, N. and Oldfield, A., 2009. Adding humour to the music therapist's tool-kit: reflections on its role in child psychiatry. *British Journal of Music Therapy*, 23 (1), pp.27-34.
- Hald, Søren, , 2010. The effect of active music therapy on interpersonal competences in persons with acquired brain injury (ABI). Unpublished paper presented at PhD Seminar, Aalborg University.
- Hall, J., 2012. The school challenge: Combining the roles of music therapist and music teacher. In: J. Tomlinson, P. Derrington and A. Oldfield, eds. 2012. Music Therapy in Schools. Working with children of all ages in mainstream and special education. London: Jessica Kingsley Publishers. Chapter 5.

- Hallam, S. and MacDonald, R., 2009. The effects of music in community and educational settings. In: S. Hallam, I. Cross and M. Thaut, eds. 2009. *The Oxford Handbook of Music Psychology*. Oxford: Oxford University Press, pp.471-480.
- Hallam, S. and Price, J., 1998. Can the use of background music improve the behaviour and academic performance of children with emotional and behavioural difficulties? *British Journal of Special Education*, 25 (2), pp.87-90.
- Hallam, S., Price, J. and Katsarou, G., 2002. The effects of background music on primary school pupils' task performance. *Educational studies*, 28 (2), pp.111-122.
- Hallam, S. and Rogers, L., 2008. Improving behaviour and attendance at school. Maidenhead: McGraw-Hill Open University Press.
- Hamilton, M., 1960. A rating scale for depression. *Journal of Neurology, Neurosurgery and Psychiatry*. 23, pp. 53-62.
- Hanser, S.B. and Wheeler, B.L., 2005. Experimental research. In: B. Wheeler, ed. 2005. *Music Therapy Research*. Second ed. Gilsum, NH: Barcelona Publishers, pp.261-271.
- Hasler, J., 2008. A piece of the puzzle. Music therapy with looked-after children and their carers. In: Oldfield, A. and Flower, C., ed. 2008. *Music therapy with children and their families*. London: Jessica Kingsley. Chapter 9.
- Hayden, C., 2007. *Children in trouble: the role of families, schools and communities*. Basingstoke: Palgrave Macmillan.
- Henderson, H., 1991. Improvised song stories in the treatment of a 13-year old sexually abused girl from the Xhosa tribe in South Africa. In: K.E. Bruscia, ed. 1991. *Case Studies in music therapy*. Phoenixville: Barcelona Publishers, pp.207-218.
- Hendricks, C.B., 2001. A study of the use of music therapy techniques in a group for the treatment of adolescent depression. Available at: <http://esr.lib.ttu.edu/dissertations/AAI3005267> Accessed: 4 March 2012.
- Hendricks, C.B., Robinson, B., Bradley, L.J. and Davis, K., 1999. Using music techniques to treat adolescent depression. *Journal of Humanistic Counseling, Education and Development*, 38 (1), pp.39-46.
- Herbert, M. and Harper-Dorton, K., 2000. *Working with children, adolescents and their families* Working with children, adolescents and their families: a psychosocial perspective. 3rd ed. Oxford: BPS Books.
- Hinds, D., 2004. A listening post. *Times Education Supplement*, September, pp.8 -9.

- Hippel, N. and Laabs, F., 2006. Musiktherapie in der Schule - ein neues Arbeitsfeld für Musiktherapeuten? *Musiktherapeutische Umschau*, 27 (3), pp.280-289.
- Hitch, Rebecca., 2010. *Removing 'Roadblocks': What is the role of music therapy in mainstream schools in promoting inclusion of children with special educational needs? And does this environment impact practice?* Unpublished Masters dissertation: Roehampton University.
- Hollander, E., 2002. Psychodramas with 'at risk' youth: a means of active engagement. In: A. Bannister and A. Huntington, eds. 2002. *Communicating with children and adolescents. Action for change*. London: Jessica Kingsley, pp.128.
- Holmes, J., Oldfield, A. and Polichroniadis, M. eds., 2011. *Creating change for complex children and their families: a multi-disciplinary approach to multi-family work*. London: Jessica Kingsley.
- Hooper, J., 1993. Developing interaction through shared musical experiences: a strategy to enhance and validate the descriptive approach. In: M. Heal and T. Wigram, eds. 1993. *Music therapy in health and education*. London: Jessica Kingsley Publishers. Chapter 18.
- Horton, M.M., 2005. *The Effect of Stepping as a Group Music Therapy Intervention on Group Cohesion and Positive Oral Statements of African-American Female Adolescents Attending an Educational Treatment Center*. Unpublished Masters dissertation: Florida State University.
- Howarth, R. and Fisher, P., 2005. *Emotional and behavioural difficulties*. London: Continuum.
- Howden, S., 2008. Music therapy with traumatized children and their families in mainstream primary schools: a case study with a six-year-old girl and her mother. In: Oldfield, A. and Flower, C., ed. 2008. *Music therapy with children and their families* London: Jessica Kingsley. Chapter 6.
- Howitt, D. and Cramer, D., 2011. *Introduction to SPSS statistics in psychology: for version 19 and earlier*. 5th ed. Harlow: Prentice Hall.
- Ierardi, F., Bottos, M. and O'Brien, M., 2007. Safe Expressions: A Community-based Creative Arts Therapy Program for At-Risk Youth. In: V.A. Camilleri, ed. 2007. *Healing the Inner City Child. Creative arts therapies with at-risk youth*. London: Jessica Kingsley Publishers, pp.254-268.

- Ierardi, F. and Jenkins, N., 2012. Rap composition and improvisation in a short-term juvenile detention facility. In: S.Hadley and G. Yancy, eds. *Therapeutic uses of rap and hip-hop*. New York; Hove: Routledge. Chapter 13.
- Ings, R., 2004. *Creating chances: arts interventions in Pupil Referral Units and Learning Support Units*. London: Calouste Gulbenkian Foundation.
- Jenkins, C., 2006. *Music therapy with adolescents with emotional and behavioural difficulties: a flexible approach*. Postgraduate Diploma London: Guildhall School of Music and Drama.
- Jenkins, R., Meltzer, H., Bebbington, P., Brugha, T., Farrell, M., McManus, S. and Singleton, N., 2009. The British mental health survey programme: achievements and latest findings. *Social Psychiatry and Psychiatric Epidemiology*, 44 (11), pp.899-904.
- Jennings, S., 1987. *Dramatherapy: theory and practice for teachers and clinicians*. Hove: Routledge.
- Jennings, S. and Gersie, A., 1987. Dramatherapy with disturbed adolescents. In: S. Jennings, ed. 1987. *Dramatherapy: theory and practice 1*. Hove: Routledge, pp.162-182.
- Jolly, J.B., Wiesner, D., Wherry, J., Jolly, J. and Dykman, R., 1994. Gender and the comparison of self and observer ratings of anxiety and depression in adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 33 (9), pp.1284-1288.
- Jones, E., 2008. *The use of words and music with a teenager with Duchenne's Muscular Dystrophy, and with adults with learning disabilities*. Unpublished Masters dissertation: Anglia Ruskin University.
- Karkou, V. ed., 2010. *Arts therapies in schools: research and practice*. London: Jessica Kingsley.
- Karkou, V., Fullarton, A. and Scarth, S., 2010. Finding a way out of the labyrinth through dance movement psychotherapy. Collaborative work in a mental health promotion programme in mainstream secondary schools In: V. Karkou, ed. 2010. *Arts therapies in schools: Research and Practice*. London: Jessica Kingsley. Chapter 3.
- Karkou, V. and Glasman, J., 2004. Arts, education and society: the role of the arts in promoting the emotional well-being and social inclusion of young people. *Support for Learning*, 19 (2), pp.56-64.

- Karkou, V. and Sanderson, P., 2006. Arts therapies: a research-based map of the field. Edinburgh; New York: Elsevier Churchill Livingstone.
- Kartz, B., 2000. Grenzen. Heilpädagogische Musiktherapie an einer Schule für Erziehungshilfe. Diploma in Music Therapy Germany: Enschede: Conservatory, Saxion Hogeschool.
- Katz, A., 2000. Promoting our well-being: A study of young people aged 13-19 in Britain. In: A. Buchanan and B.L. Hudson, eds. 2000. Promoting Children's Emotional Well-being. Oxford: Oxford University Press.
- Kay, J., 2007. Behavioural, emotional and social difficulties: a guide for the early years. London: Continuum.
- Kazdin, A.E., 1990. Assessment of childhood depression. In: A.M. La Greca, ed. 1990. Through the eyes of the child: Obtaining self-reports from children and adolescents. Boston: Allyn and Bacon.
- Kehily, M.J. ed., 2007. Understanding youth: perspectives, identities and practices. London: SAGE.
- Kenny, C., 2005. Narrative inquiry. In: B.L. Wheeler, ed. 2005. Music Therapy Research. 2nd ed. Gilsum, NH: Barcelona Publishers, pp.416-429.
- Kerfoot, M. and Butler, A. 1988. Problems of Childhood and Adolescence. Houndmills: Macmillan Education.
- Kimmel, D.C. and Weiner, I.B., 1995. Adolescence: Developmental Transition. New York: John Wiley and Sons.
- Kivland, M.J., 1986. The use of music to increase self-esteem in a conduct disordered adolescent. *Journal of Music Therapy*, 23 (1), pp.25-29.
- Klingman, A., Shalev, R. and Pearlman, A., 2000. Graffiti: A creative means of youth coping with collective trauma. *The Arts in Psychotherapy*, 27 (5), pp.299-208.
- Kobin, C. and Tyson, E., 2006. Thematic analysis of hip-hop music: can hip-hop therapy facilitate empathic connections when working with clients in urban settings? *The Arts in Psychotherapy*, 33, pp.343-356.
- Koch-Temming, H., 1999. Von der Behandlung der Krankheit zur Sorge um die Gesundheit. Musiktherapie in integrativen Kindergärten. *Musiktherapeutische Umschau*, 20 (1), pp.5-13.
- Kok, M., 2006. Neue Wege der Musiktherapie an der Musikschule - Kooeration mit allgemein bildenden Schulen. *Musiktherapeutische Umschau*, 27 (3), pp.269-274.

- Koshland, L., 2010. PEACE through dance / movement therapy: The development and evaluation of a violence prevention programme in an elementary school. In: V. Karkou, ed. 2010. Arts therapies in schools. London: Jessica Kingsley Publishers. Chapter 2.
- Koshland, L. and Whittaker, J.B., 2004. Peace through dance / movement: evaluating a violence prevention programme. *American Journal of Dance Therapy*, 26 (2), pp.69-90.
- Kroger, J., 1996. Identity in adolescence: the balance between self and other Jane Kroger. 2nd ed. London: Routledge.
- Kroger, J., 2000. Identity development: adolescence through adulthood. Thousand Oaks, California; London: Sage Publications.
- Krout, R., 2005. The music therapist as singer- songwriter. Applications with bereaved teenagers. In: F. Baker and T. Wigram, eds. 2005. Songwriting. Methods, techniques and clinical applications for music therapy clinicians, educators and students. London: Jessica Kingsley Publishers. Chapter 10.
- Kruczek, T. and Zagelbaum, A., 2004. Increasing adolescent awareness of at risk behaviours via psychosocial drama. *The Arts in Psychotherapy*, 31 (1), pp.1-10.
- Krüger, V., 2000. The use of information technology in music therapy: behavioural problems in contemporary schools. *Nordic Journal of Music Therapy*, 9 (2).
- Kumar, G. and Steer, R.A., 1995. Psychosocial correlates of suicidal ideation in adolescent psychiatric inpatients. *Suicide and Life-Threatening Behaviour*, 25, pp.339-346.
- Laevers, F. and Heylen, L., 2003. Involvement of children and teacher style: insights from an international study on experiential education. Leuven: Leuven University Press.
- La Greca, A.M., 1990. Through the eyes of the child: Obtaining self-reports from children and adolescents. Boston: Allyn and Bacon.
- Laiho, S., 2004. The psychological functions of music in adolescence. *Nordic Journal of music therapy*, 13 (1), pp.47-63.
- Leafloor, S., 2012. Therapeutic outreach through Bboying (break dancing) in Canada's arctic and first nations communities: social work through hip-hop. In: S.Hadley and G. Yancy, eds. Therapeutic uses of rap and hip-hop. New York; Hove: Routledge. Chapter 8.

- Lefebvre, C., 1991. All her yesterdays: an adolescent's search for a better today through music. In: K.E. Bruscia, ed. 1991. *Case Studies in music therapy*. Phoenixville: Barcelona Publishers, pp.219-230.
- Leigh, L., 2001. Taking dramatherapy and emotional support into London secondary schools. *Journal of the British Association of Dramatherapists*. Vol. 23 (1), pp.9-16.
- Levene, H., 1960. Robust tests for equality of variants. In: I. Olkin, et al., eds. 1960. *Contributions to Probability and Statistics: Essays in Honour of Harold Hotelling*. Stanford, California: Stanford University Press, pp.278-293.
- Liebmann, M. ed., 1994. *Art Therapy with Offenders*. London: Jessica Kingsley Publishers.
- Lightstone, A.J., 2012. Yo, can ya flow! Research findings on hip-hop aesthetics and rap therapy in an urban youth shelter. In: S.Hadley and G. Yancy, eds. *Therapeutic Uses of Rap and Hip-Hop*. New York; Hove: Routledge. Chapter 12.
- Lindberg, K.A., 1995. Songs of healing: Songwriting with an abused adolescent. *Music Therapy*, 13 (1), pp.93-108.
- Lindeck, J., 2012. The Outcomes Star. A published tool for music therapists working with children. Unpublished paper at Key Changes Annual Conference: 'Music Therapy - proving the case', Winchester.
- Linesch, D.G., 1988. *Adolescent art therapy*. New York: Brunner-Mazel.
- Loi, W. M., 2010. *Effects of songs and improvisations used in music therapy on the communication skills for children diagnosed with autism spectrum disorder*. Unpublished Masters dissertation: Anglia Ruskin University.
- Long, M., 2007. *The effect of a music intervention on the temporal organisation of teaching skills*. PhD. London: Institute of Education, University of London.
- Long, J.K. and Soble, L., 1999. Report: An arts-based violence prevention project for sixth-grade students. *The Arts in Psychotherapy*, 26 (5), pp.329-344.
- Lorenzato, K., 2005. *Filling a need while making some noise: a music therapist's guide to pediatrics*. London; Philadelphia: Jessica Kingsley Publishers.
- Loth, H., 2002. There's no Getting Away From Anything in Here: a music therapy group within an inpatient programme for adults with eating disorders. In: A. Davies, A. and E. Richards, eds., 2002. *Music therapy and group work: sound company*. London: Jessica Kingsley.
- MacDonald, S. and Viega, M., 2012. Hear our voices: a music therapy songwriting program and the message of the little saints through the medium of rap. In:

- S.Hadley and G. Yancy, eds. *Therapeutic Uses of Rap and Hip-Hop*. New York; Hove: Routledge. Chapter 9.
- MacGregor, H., 2005. *Bingo lingo: supporting literacy with songs and rhymes*. 2nd ed. London: A. and C. Black.
- Madsen, C.K., Cotter, V. and Madsen, C.H., 1968. A Behavioural Approach to Music Therapy. *Journal of Music Therapy*, 5 (3), pp.69-71.
- Mahns, W., 2002. The psychodynamic function of music in analytical music therapy with children. In: T.J. Eschen, ed. 2002. *Analytical Music Therapy*. London: Jessica Kingsley Publishers.
- Marcia, J., 1980. Identity in Adolescence. In: J. Adelson, ed. 1980. *Handbook of adolescent psychology*. New York: John Wiley and Sons.
- Mark, A., 1986. Adolescents discuss themselves and drugs through music. *Journal of Substance Abuse Treatment*, 3 (4), pp.243-249.
- McArdle, P., Moseley, P., Quibell, T., Johnson, R., Allen, A., Hammal, D. and LeCouteur, A., 2002. School-based indicated prevention: a randomized trial of group therapy. *Journal of Child Psychology and Psychiatry*, 43 (6), pp.705-712.
- McFerran, K., 2003. Active methods for working with adolescents: A comparison of songwriting and improvisation. Paper presented at the 4th Nordic Music Therapy Conference: Bergen.
- McFerran, K., 2010. Tipping the scales: A substantive theory on the value of group music therapy for supporting grieving teenagers. *Qualitative Inquiries in Music Therapy (A Monograph Series)*, 5, pp.2-49.
- McFerran, K., 2012. "Just so you know, I miss you so bad": the expression of life and loss in the raps of two adolescents in music therapy. In: S.Hadley and G. Yancy, eds. *Therapeutic uses of rap and hip-hop*. New York; Hove: Routledge. Chapter 10.
- McFerran, K., Baker, F., Kildea, C. and Sawyer, S., 2008. Avoiding conflict: what do adolescents with disordered eating say about their mothers in music therapy? *British Journal of Music Therapy*, 22 (1), pp.16-24.
- McFerran, K. and Hunt, M., 2008. Learning from experiences in action: music in schools to promote health coping with grief and loss. *Educational Action Research*, 16 (1), pp.43-54.
- McFerran, K. and Stephenson, J., 2006. Music Therapy in Special Education: Do we Need More Evidence? *British Journal of Music Therapy*, 20 (2), pp.121-128.

- McFerran-Skewes, K. and Erdonmez Grocke, D., 2000. Group music therapy for young bereaved teenagers. *European Journal of Palliative Care*, 7 (6), pp.227-229.
- McIntyre, J., 2007. Creating order out of chaos: Music therapy with adolescent boys diagnosed with a behaviour disorder and / or emotional disorder. *Music Therapy Today*. VIII (1).
- McLaughlin, C., Clark, P. and Chisholm, M., 1996. Counselling and guidance in schools. London: David Fulton.
- McLaughlin, C. and Rouse, M., 1991. Supporting schools. David Fulton.
- McNamara, S., 2000. Stress in young people: what's new and what can we do? London Continuum.
- McSherry, J., 1996. A re-integration programme for pupils with emotional and behavioural difficulties. London: SENJIT, Institute of Education.
- McSherry, J., 2001. Challenging behaviours in mainstream schools: practical strategies for effective intervention and reintegration. London: David Fulton.
- McSherry, J., 2004. Learning support units: principles, practice and evaluation. London: David Fulton.
- McTier, I., 2012. Music therapy in a special school for children with autistic spectrum disorder, focusing particularly on the use of the double bass. In: J. Tomlinson, P. Derrington and A. Oldfield, eds. *Music Therapy in Schools. Working with children of all ages in mainstream and special education*. London: Jessica Kingsley. Chapter 10.
- McWhirter, J.J., McWhirter, B.T., McWhirter, A.M. and McWhirter, E.H., 2006. *At-Risk Youth: A Comprehensive Response*. 4th ed. Belmont, California: Wadsworth Publishing Co. Inc.
- Meadows, A., 2005. Computer Programs for Quantitative Data Analysis. In: B. Wheeler, ed. 2005. *Music Therapy Research*. Second ed. Gilsum, NH: Barcelona Publishers, pp.168-179.
- Meeus, W., Iedema, J., Maassen, G. and Engels, R., 2005. Separation-individuation revisited: on the interplay of parent-adolescent relations, identity and emotional adjustment in adolescence. *Journal of Adolescence*, 28, pp. 89-106.
- Meyer, K., 2010. Dramatherapy with adolescents living with HIV: story making, drama and body mapping. In: P. Jones, ed. 2010. *Drama as Therapy Volume 2: clinical work and research into practice*. Hove: Routledge, pp.126-151.

- Miller, A., 1997. *The drama of being a child: the search for the true self*. London: Virago.
- Mishler, E.G., 1986. *Research Interviewing: context and narrative*. Cambridge, MA: Harvard University Press.
- Mitchell, C. E., 2002. *Music Therapy in adolescent psychiatry: Evaluation of a six month pilot project in an inpatient adolescent unit*. Unpublished Masters dissertation: Anglia Polytechnic University.
- Molyneux, J., 2005. Music Therapy as a short-term intervention with individuals and families in a child and adolescent mental health service. *British Journal of Music Therapy*, 19 (2), pp.59-66.
- Moneta, I. and Rousseau, C., 2008. Emotional expression and regulation in a school-based drama workshop for immigrant adolescents with behavioral and learning difficulties. *The Arts in Psychotherapy*, 35 (5), pp.329-341.
- Montello, L. and Coons, E.E., 1999. Effects of active versus passive group music therapy on preadolescents with emotional, learning, and behavioral disorders. *Journal of Music Therapy*, 35 (1), pp.49-67.
- Naitove, C., E., 1981. A multi-arts approach to drama therapy with adolescents and young adults. In: Schattner, Gertrud and Courtney, Richard, ed. 1981. *Drama in therapy*, volume 2. New York: Drama book specialists, pp.243-262.
- Neale, L., 2009. *How can we play? Music Therapy with children excluded or at risk of exclusion from school: An investigation into the use of different techniques*. Unpublished Masters dissertation, Anglia Ruskin University.
- Neels, M., Lang, S. and Wegener, W., 1998. Therapeutisches Musizieren an der Musikschule. *Musiktherapeutische Umschau*, 19 (3), pp.216-217.
- Newburn, T., Shiner, M. and Young, T., 2005. *Dealing with disaffection: young people, mentoring and social inclusion*. Cullompton: Willan.
- Newham, P., 1999. *Using voice and song in therapy: the practical application of voice movement therapy*. London: Jessica Kingsley.
- Newton, C., Taylor, G. and Wilson, D., 1996. Circles of friends. *Educational Psychology in Practice*, 11 (4), pp.41-48.
- Nicholls, T., 2002. 'Could I play a different role?' Group music therapy with severely learning disabled adolescents. In: A. Davies and E. Richards, eds. 2002. *Music Therapy and Group Work: Sound Company*. London: Jessica Kingsley, pp.231-249.

- Nirensztein, S.K., 2003. The knight inside the armor: music therapy with a deprived teenager. In: S. Hadley, ed. 2003. *Psychodynamic Music Therapy: Case Studies*. Gilsum: Barcelona Publishers, pp. 225 – 241.
- Nöcker-Ribaupierre, M. and Wölfl, A., 2010. Music to counter-violence: a preventative approach for working with adolescents in schools. *Nordic Journal of Music Therapy*, 19 (2), pp.151-162.
- Nordoff, P. and Robbins, C., 1971. *Therapy in music for handicapped children*. London: Gollancz.
- Nordoff, P. and Robbins, C., 1977. *Creative music therapy: individualized treatment for the handicapped child*. New York: John Day.
- North, A.C., Hargreaves, D.J. and O'Neill, S.A., 2000. The importance of music to adolescents. *British Journal of Educational Psychology*, 70, pp.252-272.
- Oaklander, V., 1978. *Windows to our children: a gestalt therapy approach to children and adolescents*. California: Real People Press.
- Odell-Miller, H., 1995. Approaches to music therapy in psychiatry with specific emphasis upon a research project with the elderly mentally ill. In: T. Wigram, B. Saperston and R. West, eds. *The art and science of music therapy: A handbook*. Amsterdam: Harwood Academic Press. Chapter 4.
- Odell-Miller, H., Hughes, P. and Westacott, M., 2006. An investigation into the effectiveness of the arts therapies for adults with continuing mental health problems. *Psychotherapy Research*, 16 (1), pp.122-139.
- Oldfield, A., 2004. *Music therapy with children on the autistic spectrum: approaches derived from clinical practice and research*. PhD: Anglia Polytechnic University.
- Oldfield, A., 2006a. *Interactive music therapy: a positive approach: music therapy at a child development centre*. London; Philadelphia: Jessica Kingsley Publishers.
- Oldfield, A., 2006b. *Interactive music therapy in child and family psychiatry: clinical practice, research and teaching*. London; Philadelphia: Jessica Kingsley Publishers.
- Ottarsdottir, U., 2010. Art therapy in education for children with specific learning difficulties who have experienced stress and / or trauma. In: V. Karkou, ed. 2010. *Arts therapies in schools*. London: Jessica Kingsley Publishers. Chapter 8.
- Palmowski, W., 1979. Music therapy for students with behaviour problems. *Zeitschrift für heilpädagogik*, 30 (8), pp.546-550.

- Parsons, R., 2009. Teenagers! What Every Parent Has To Know. London: Hodder and Stoughton.
- Pavlicevic, M., 1997. Music therapy in context: music, meaning and relationship. London: London: Jessica Kingsley.
- Pavlicevic, M., 2004. The ripple effect. In: M. Pavlicevic and G. Ansdell, eds. Community Music Therapy. London: Jessica Kingsley Publishers, pp. 15-31.
- Pecoraro, E. P. 2006. The pleasure of being “differently able”: Integration through music therapy in primary schools. *Music Therapy Today* (Online) 7 (2) pp.413-429 available at <[http: musictherapyworld.net](http://musictherapyworld.net)> [Accessed 10 January 2012].
- Perry M., 2003. Relating improvisational music therapy with severely and multiply disabled children to communication development. *Journal of Music Therapy*, 40 (3), pp. 227 – 246.
- Pethybridge, E. and Robertson, J., 2010. Educational music therapy: theoretical foundations explored in time-limited group work projects with children. In: V. Karkou, ed. 2010. Arts therapies in schools. London: Jessica Kingsley Publishers. Chapter 7.
- Pettiti, G.J., 1989. Video as an externalizing object in dramatherapy. *The Arts in Psychotherapy*, 16 (2).
- Pickles, T., 1992. Dealing with disaffection: Practical responses to school related issues. London: Longman.
- Plass, A., 1989. Broken Window, Broken Lives. London: Hodder and Stoughton.
- Pomerantz, K.A., 2007. Containing the emotional needs of adolescent boys 'at risk of exclusion' in mainstream schools. In: K.A. Pomerantz, M. Hughes and D. Thompson, eds. 2007. How to reach 'hard to reach' children. Chichester: John Wiley and Sons.
- Powell, H., 2004. A dream wedding: From community music to music therapy with a community. In: M. Pavlicevic and G. Ansdell eds., Community Music Therapy. London: Jessica Kingsley Publishers.
- Prickett, C., 2005. Principles of Quantitative Research. In: B. Wheeler, ed. 2005. Music Therapy Research. 2nd ed. Gilsum, NH: Barcelona Publishers, pp.45-59.
- Priestley, M., 1975. Music therapy in action. London: Constable.
- Priestley, M., 1994. Essays on analytical music therapy. Gilsum, NH: Barcelona.
- Procter, S., 2006. Music Therapy: why not in education? In: A. Paterson and S. Zimmerman, eds. 2006. No Needs for Words: Special Needs in Music Education. Matlock: National Association of Music Educators.

- Prokofiev, F., 2010. "Give me some paper": The role of image-making as a stabilizing force for a child in transition. In: V. Karkou, ed. 2010. Arts therapies in schools. London: Jessica Kingsley Publishers. Chapter 9.
- Quibell, T., 2010. The searching drama of disaffection: dramatherapy groups in a whole-school context. In: V. Karkou, ed. 2010. Arts therapies in schools. London: Jessica Kingsley Publishers. Chapter 6.
- Radhakishnan, G., 1991. Music therapy - A review. *Health Bulletin*, 49 (3), pp.195-199.
- Raghuraman, R.S., 2000. Dungeons and dragons: dealing with emotional and behavioural issues of an adolescent with diabetes. *The Arts in Psychotherapy*, 27 (1), pp.27-40.
- Reynolds, C.R. and Richmond, B.O., 1985. Revised Children's Manifest Anxiety Scale (RCMAS): Manual. WPS: Western Psychological Services.
- Riley, S., 1999. Contemporary art therapy with adolescents. London: Jessica Kingsley.
- Riley, K.A. and Rustique-Forrester, E., 2002. Working with disaffected students: why students lose interest in school and what we can do about it. London: Paul Chapman.
- Robarts, J., 1994. Towards Autonomy and a Sense of Self: Music Therapy and the Individuation Process in Relation to Children and Adolescents with Early Onset Anorexia Nervosa In: D. Dokter, ed. 1994. Arts therapies and clients with eating disorders. London: Jessica Kingsley Publishers.
- Robarts, J., 1996. Music therapy and children with Autism. In: C. Trevarthen, K. Aitken, D. Papoudi and J. Robarts, eds. 1996. Children with Autism. Diagnosis and Intervention to Meet their Needs. London: Jessica Kingsley Publishers.
- Robarts, J., 2003. The healing function of improvised songs in music therapy with a child survivor of early trauma and sexual abuse. In: S. Hadley, ed. 2003. Psychodynamic Music Therapy: Case Studies. Gilsum: Barcelona Publishers, pp. 141 – 183.
- Robb, S.L., 1996. Techniques in song writing: restoring emotional and physical well-being in adolescents who have been traumatically injured. *Music Therapy Perspectives*, 14, pp.30-37.
- Robbins, C. and Robbins, C., 1991. Creative music therapy in bringing order, change and communicativeness to the life of a brain-injured adolescent. In: K.E.

- Bruscia, ed. 1991. Case studies in music therapy. Phoenixville: Barcelona Publishers, pp.231-250.
- Robbins, C. and Stige, B., 1998. It's so universal! Clive Robbins interviewed by B. Stige. *Nordic Journal of Music Therapy*, 7 (1), pp.70-75.
- Roberts, D., 1997. Developmental groupwork: encouraging skills in self-expression for pupils with emotional and behavioural difficulties *Educational Psychology in Practice*, 13 (2), pp.122-129.
- Roca, N. G., 2011. *Songwriting with adolescents in a secondary school*. Unpublished Masters dissertation: Aalborg University.
- Rogers, B., 2005. Teaching students with emotional behavioural disorders. In: P. Clough, P. Garner, J.T. Pardeck and F. Yuen, eds. 2005. *Handbook of emotional and behavioural difficulties*. London: Sage.
- Rogers, C. R., 1951 *Client-centered therapy*. Boston: Houghton Mifflin.
- Rogers, C.R., 1961. *On becoming a person: a therapist's view of psychotherapy*. 2nd ed. London: Constable.
- Rogers, S., 2011. Data journalism reading the riots: what we know. And what we don't. *The Guardian*. Accessed 3.1.12.
- Rosenberg, M., 1965. *Society and the Adolescent Self-Image*. Princeton, New Jersey: Princeton University Press.
- Round, C., 2001. *An exploration of the role and function of music therapy in a multidisciplinary service for adolescents*. Unpublished Masters dissertation: Anglia Polytechnic University.
- Rutter, M., Maughan, B., Mortimore, P. and Ouston, J., 1979. *Fifteen thousand hours*. Harvard: Harvard University Press.
- Ruud, E., 1998. *Music therapy: improvisation, communication and culture*. Gilsum NH: Barcelona.
- Rüütel, E., Ratnik, M., Tamm, E. and Zilensk, H., 2004. The experience of vibro-acoustic therapy in the therapeutic intervention of adolescent girls. *Nordic Journal of Music Therapy*, 13 (1), pp.33-47.
- Sapin, K., 2009. *Essential skills for youth work practice*. London: Sage.
- Sausser, S. and Waller, R.J., 2006. A model for music therapy with students with emotional and behavioral disorders. *The Arts in psychotherapy*, 33 (1), pp.1-10.
- Savan, A., 1999. The effect of background music on learning. *Psychology of Music*, 27 (2), pp.138-146.

- Schaeffer, N.C., 2000. Asking questions about threatening topics: a selective overview. In: A. Stone, et al., eds. 2000. *The science of self-report. Implications for research and practice*. Mahwah, New Jersey: Lawrence Erlbaum Associates, Publishers, pp.105-122.
- Schönfeld, V., 2003. 'Promise to take good care of it!' Therapy with Ira. In: S. Hadley, ed. 2003. *Psychodynamic Music Therapy: Case Studies*. Gilsum, NH: Barcelona Publishers, pp. 207 - 225.
- Sechrest, L. and Sidani, S., 1995. Quantitative and qualitative methods: Is there an alternative? *Evaluation and Program Planning*, 18 (1), pp.77-87.
- Secondary SEAL 2008. *Social and Emotional Aspects of Learning for Secondary School (SEAL)*. Secondary National Strategy for School Improvement UK.
- Shao, J. and Zhong, B., 2003. Last observation carry-forward and last observation analysis. *Statistics in medicine*, 22 (15), pp. 2429-2441.
- Sharp, S. and Cowie, H., 1998. *Counselling and supporting children in distress*. London SAGE.
- Shaw, J.I., Bergen, J.E., Brown, C.A. and Gallagher, M.E., 2000. Centrality preferences in choices among similar options. *The Journal of general psychology*, 127 (2), pp.157-164.
- Shipley, A., 2008. *The role of music therapy for anxious, adolescent school refusers: identity and the self*. Unpublished Masters dissertation: Anglia Ruskin University.
- Shipley, A. and Odell-Miller, H., 2012. The role of music therapy for anxious adolescent school refusers: the importance of identity. *British Journal of Music Therapy* 26 (1), pp.38-53.
- Shuler, S.C., 1991. Music, at-risk students, and the missing piece. *Music Educators Journal*, 78 (3), pp.21-29.
- Shuttleworth, R., 1975. Psychodrama with disturbed adolescents. In: S. Jennings, ed. 1975. *Creative Therapy*. Banbury: Kemble Press.
- Shuttleworth, R.E., 1981. Adolescent drama therapy. In: Schattner, Gertrud and Courtney, Richard, ed. 1981. *Drama in therapy*, volume 2. 1st ed. New York: Drama book specialists, pp.157-174.
- Singh, I., 2008. Beyond polemics: science and ethics of ADHD. *Nature Reviews Neuroscience*, 9 (9), pp.957-964.
- Singh, N.N. and Oswald, D.P., 2004. Evaluation issues in evidence-based practice. In: P.M. Barrett and T.H. Ollendick, eds. 2004. *Interventions that Work with*

- Children and Adolescents. Prevention and Treatment. Chichester, England: John Wiley and Sons.
- Sloboda, A., 1994. Individual music therapy with anorexic and bulimic patients. In: D. Dokter, ed. 1994. *Arts Therapies and Clients with Eating Disorders*. Fragile Board. London: Jessica Kingsley Publishers, pp.247-261.
- Smeijsters, H., Kil, J., Kurstjens, H. and Welten, J., 2011. Arts therapies for young offenders in secure care - a practice-based research. *The Arts in Psychotherapy*, 38 (1), pp.41-52.
- Spychiger, M. 1993. Does more music teaching lead to a better social climate? In: R. Olechowski and G. Svik, eds. 1993. *Experimental research in teaching and learning*. Bern: Peter Lang.
- Stern, D.N., 1985. *The interpersonal world of the infant: a view from psychoanalysis and developmental psychology*. London: Karnac Books.
- Storey, J., 1998. *Music therapy with children with Autism and Asperger's syndrome within the context of special needs schools*. Unpublished Masters dissertation: Anglia Polytechnic University.
- Strange, J., 1999. Client-centred music therapy for emotionally disturbed teenagers having moderate learning disability. In: T. Wigram and J. de Backer, eds. 1999. *Clinical applications of music therapy in developmental disability, paediatrics and neurology*. London: Jessica Kingsley Publishers. Chapter 7.
- Strange, J., 2012. Psychodynamically-informed Music Therapy Groups with Teenagers with Severe Special Needs in a College Setting: Working Jointly with Teaching Assistants. In: J. Tomlinson, P. Derrington and A. Oldfield, eds. 2012. *Music Therapy in Schools. Working with children of all ages in mainstream and special education*. London: Jessica Kingsley. Chapter 12.
- Stratton, V.N. and Zalanowski, A., 1989. The effects of music and painting on mood. *Journal of Music Therapy* 26 (1), pp.30-41.
- Street, C., Stapelkamp, C., Taylor, E., Malek, M. and Kurtz, Z., 2005. *Minority voices: research into the access and acceptability of service for the mental health of young people from black and ethnic groups*. London: Young Minds.
- Summer, D., 2007. Honouring Timothy's Spirit: Mural Making to Express, Process and Overcome Grief and Loss. In: V.A. Camilleri, ed. 2007. *Healing the Inner City Child. Creative arts therapies with at-risk youth*. London: Jessica Kingsley Publishers, pp.119-131.

- Tarrant, M., North, A.C. and Hargreaves, D.J., 2000. English and American adolescents' reasons for listening to music. *Psychology of Music*, 28, pp.166-173.
- Tashakkori, A. and Teddlie, C., 1998. Mixed methodology: combining qualitative and quantitative approaches. Thousand Oaks, Calif. London: Sage.
- Tashakkori, A. and Teddlie, C., 2003. Handbook of mixed methods in social and behavioural research. Thousand Oaks, CA: Sage.
- Taylor, G., 1996. Creating a Circle of Friends: a case study. In: H. Cowie and S. Sharp, eds. 1996. Peer counselling in schools. A time to listen. London: David Fulton Publishers.
- Taylor, A.M., 2003. Responding to adolescents: helping relationship skills for youth workers, mentors and other advisers. Lyme Regis: Russell House.
- Tervo, J., 2001. Music Therapy for adolescents. *Clinical child psychology and psychiatry*, 6 (1), pp.79-91.
- Thomas, B., 2010. Creative expression activities for teens: exploring identity through art, craft and journaling. London: Jessica Kingsley Publishers.
- Tillie Allen, N.M., 2005. Exploring hip-hop therapy with high-risk youth. *Praxis*, 5, pp.30-36.
- Tomlinson, J., 2010. Music therapy for children with autism in an educational context. In: V. Karkou, ed. 2010. Arts therapies in schools. London: Jessica Kingsley Publishers. Chapter 13.
- Tomlinson, J., Derrington, P. and Oldfield, A. eds., 2012. Music therapy in schools: working with children of all ages in mainstream and special education. London: Jessica Kingsley.
- Tortora, S., 2010. From the dance studio to the classroom: translating the clinical dance movement psychotherapy experience into a school context. In: V. Karkou, ed. 2010. Arts therapies in schools. London: Jessica Kingsley Publishers. Chapter 1.
- Tourangeau, R., 2000. Remembering What Happened: Memory Errors and Survey Reports. In: A. Stone, et al., eds. The science of self-report. Implications for research and practice. Mahwah, New Jersey: Lawrence Erlbaum Associates, Publishers, pp.29-49.
- Tourangeau, R. and Yan, T., 2007. Sensitive questions in surveys. *Psychological bulletin*, 133 (5), pp.859- 864.
- Trevarthen, C., 2000. Musicality and the intrinsic motive pulse: evidence from human psychobiology and infant communication. *Musicae Scientiae*, 2 (2), pp.155-215.

- Triangle and Coram, 2011. Music Therapy Star. Available at <http://www.outcomesstar.org.uk/music-therapy> [Accessed 20 April 2012].
- Twyford, K., 2008. Collaborative and transdisciplinary approaches with children. In: K. Twyford and T. Watson, eds. Integrated team working. London: Jessica Kingsley Publishers. Chapter 1.
- Twyford, K. and Parkhouse, C., 2008. Collaborative working in a special needs setting. In: K. Twyford, K. and T. Watson, eds. Integrated team working. London: Jessica Kingsley Publishers, pp.62-68.
- Twyford, K., Parkhouse, C. and Murphy, J., 2008. Transdisciplinary assessments with children with complex needs. In: K. Twyford and T. Watson, eds. 2008. Integrated Team Working. Music therapy as part of multidisciplinary and collaborative approaches. London: Jessica Kingsley Publishers, pp.48-55.
- Tyson, E.H., 2002. Hip-hop therapy: An exploratory study of a rap music intervention with at-risk and delinquent youth. *Journal of Poetry Therapy*, 15 (3), pp.131-144.
- Tyson, E.H. and Baffour, T.D., 2004. Arts-based strengths: a solution-focused intervention with adolescents in an acute-care psychiatric setting. *The Arts in Psychotherapy*, 31 (4), pp.213-228.
- Tytherleigh, L., 2010. Dramatherapy, Autism and Relationship-building: A case study. In: V. Karkou, ed. 2010. Arts therapies in schools. London: Jessica Kingsley Publishers. Chapter 11.
- Uhlig, S., 2011a. From violent rap to lovely blues: the transformation of aggressive behavior through vocal music therapy. In: A. Meadows, ed. 2011a. Developments in Music Therapy Practice: Case Study Perspectives. Gilsum, NH: Barcelona Publishers.
- Uhlig, S., 2011b. Rap and singing for the emotional and cognitive development of at-risk children. In: F. Baker and S. Uhlig, eds. 2011b. Voicework in music therapy. London: Jessica Kingsley Publishers, pp.63-83.
- Underwood, 1955. *Report of the committee on maladjusted children*. London: Her Majesty's Stationery Office. Available at: www.educationengland.org.uk/documents/underwood/underwood00a.html [accessed no 6 June 2011]
- U.S. Department of Health and Human Services, 1999. *Mental health: a report from the surgeon general*. Rockville, MD: Author.

- Vizard, D., 2009. Meeting the needs of disaffected students: engaging students with social, emotional and behavioural difficulties. London: Network Continuum.
- Vleioras, G. and Bosma, H.A., 2005. Are identity styles important for psychological well-being? *Journal of Adolescence*, 28, pp.397-409.
- Vostanis, P., 2007. Mental health and mental disorders. In: J.H. Coleman A., ed. 2007. *Adolescence, risk and resilience: against the odds*. Chichester: John Wiley, pp.89-107.
- Waller, D., 1991. *Becoming a Profession: The History of Art Therapy in Britain 1940-1982*. London and New York: Tavistock/ Routledge.
- Waller, D., 1993. *Group interactive art therapy: its use in training and treatment*. London: Routledge.
- Walsh, R., 1990. A creative arts program in social skills training for early adolescents - an exploratory study. *Arts in Psychotherapy*, 17 (2), pp.131-137.
- Warwick, A., 1995. Music therapy in the education service: research with autistic children and their mothers. In: T. Wigram, B. Saperston and R. West, eds. *The art and science of music therapy*. Amsterdam: Harwood Publishers. Chapter 12.
- Weare, K., 2000. *Promoting mental, emotional, and social health: a whole school approach*. London: Routledge.
- Weiner, H.B., 1981. Return from "splendid isolation": the uses of psychodrama, sociodrama and drama in the process of recovering from substance addiction. In: Schattner, G. and Courtney, R. eds. *Drama in therapy*, volume 2. 1st ed. New York: Drama book specialists (publishers), pp.129-156.
- Wheeler, B.L. ed., 2005. *Music therapy research*. 2nd ed. Gilsum, N.H.: Barcelona.
- Whitehead, A.M., Clark, S.L. and Spall, L.E., 2011. Indications and counterindications for electronic music technologies in a paediatric medical setting. *Music and Medicine*, 3 (3), pp.154.
- Wigram, T., 2002. Indications in music therapy: evidence form assessment that can identify the expectations of music therapy as a treatment for Autistic Spectrum Disorder (ASD); meeting the challenge of Evidence Based Practice. *British Journal of Music Therapy*, 16 (1), pp.11-28.
- Wigram, T., 2005a. Survey research. In: B. Wheeler, ed. 2005a. *Music therapy research* 2nd ed. Gilsum: Barcelona Publishers. Chapter 22.
- Wigram, T., 2005b. Music and sound vibration: testing hypotheses as a series of case studies. In: D. Aldridge, ed. 2005. *Case study designs in music therapy*. London: Jessica Kingsley Publishers, pp.163-190. Chapter 8.

- Wigram, T., Lumley, J. and Steen, C., 2010. The Music Therapy Charity.
Disenchanted Youth. *Incorporated Society of Musicians (ISM) Music Journal*,
May.
- Winnicott, D.W., 1964. The child the family and the outside world. Harmondsworth:
Penguin.
- Winnicott, D.W., 1971. Therapeutic consultations in child psychiatry. Hogarth Press.
- Winnicott, D.W., 1984. Deprivation and Delinquency. London: Tavistock.
- Wolf, T. and Franks, A. 2008. Get Out Of My Life: But First Take Me And Alex Into
Town. London: Profile Books
- Wölfl, A., 2006. Gewaltprävention mit Musik und Improvisation - ein Pilotkonzept.
Musiktherapeutische Umschau, 27 (3), pp.290-299.
- Woodward, A., 1999. *The emotional experience of an autistic child explored through
music therapy*. Unpublished Masters dissertation: Anglia Polytechnic University.
- W3 Insights Ltd, 2003. W3 Insights assessment tools. Available at:
www.w3insights.pass-survey [accessed 4 April 2011].