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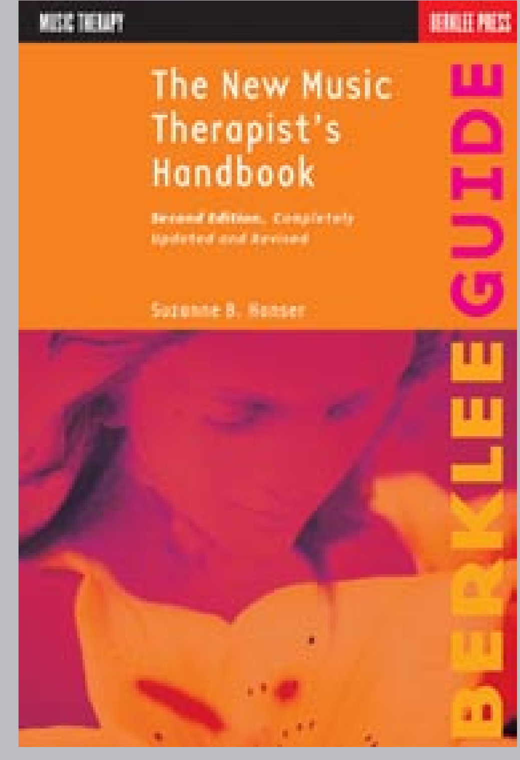
The New Music Therapist's Handbook, Second Edition
Suzanne B. Hanser

Chapter 6
Goals, Objectives, and Target Behaviors



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Identifying Problems, Behaviors and Goals

Joshua has been institutionalized at a large state residential treatment program for the last 18 of his 20 years. His diagnosis was updated from "profound retardation" to "pervasive developmental disorder" in keeping with changes in special education terminology. The staff is hopeful that he will be able to start a vocational training program at a community-based workshop.

Ann is old and sick. It could be said that this is the problem. After an energetic and successful career as a teacher, she must now rely on others to assist her with the most basic daily living tasks such as toileting and eating. She seems to have given up the struggle to help herself. At the skilled nursing facility, she does not even look at the nurse's aides who help her with basic activities of self care. She stares at the ceiling from her bed during waking hours.

Michael says that he does not have a problem. His third grade teacher disagrees. Michael says the teacher is the problem. He is bored with classroom activities, and prefers to spend his time playing tricks and bothering his classmates. He has been diagnosed with attention deficit/hyperactivity disorder.

Fortunately, Joshua's residence, Ann's nursing home, and Michael's school each have a music therapist on staff. As part of

the team of concerned professionals, the music therapist helps decide what to do in each case. The team is confronted with the challenge of identifying the problem or target behavior for therapy.

The Real Problem

At the residence, the team meeting focuses on Joshua's potential for workshop placement. He appears to have the prerequisite skills necessary for admittance. He has made consistent progress in social and perceptual-motor development, has learned some basic academics, and displays no disruptive behavior. The team decides to concentrate therapeutic efforts on those skills necessary for success at the workshop. Joshua has little opportunity to practice fine motor tasks like those required in simple assembly jobs, and sometimes has difficulty manipulating and grasping small objects. It is agreed that, for now, improvement in fine motor coordination is the most important goal.

The nursing staff is caring for Ann's physical needs as best they can. The music therapist is the professional whose primary responsibility is meeting the patient's psychological and social needs. After observing Ann with her family, the therapist decides that the problem may be seen as a lack of behavior. Ann is unresponsive to the environment and non-interactive with others. Records reveal that, though weak, she is capable of speech and movement, but chooses not to engage in these activities. The therapist ponders a realistic goal. Will she ever get out of her bed, care for herself, and happily stride down the hall, chatting with others? Perhaps, it is advisable to consider a more probable short-term objective. At least, she opens her eyes when awake. The first step would seem to have her focus visually on an object or person.

At Michael's school, a group of teachers, parents, and other support personnel are meeting to construct the IEP (Alley, 1979; Levine & Wexler, 1981). Michael's test scores reflect little academic progress in the last year. The teacher advises the staff that Michael is capable of greater achieve-

ment. When his attention is on his lessons, he accomplishes a great deal. Unfortunately, he spends a major part of the school day out of his seat, disrupting his peers' concentration. Michael says he does not like school and cannot stay in his chair in that "stupid classroom." His mother reports that as soon as he comes home, Michael turns on the radio full blast, and proceeds to run about the house, singing along with his favorite rock songs. Given his interest in music, the IEP team refers Michael to a music therapist in an attempt to control disruptive behavior.

These three clinical situations exemplify distinctly different people, settings, and problems. When first introduced, Joshua's, Ann's, and Michael's problems are presented as institutionalization, physical deterioration, and lack of problem recognition, respectively. As we become privy to team discussions, however, we learn that these are not necessarily the real problems. Rather, there are a series of behaviors which are amenable to change, and will form the focus of therapy (Madsen & Madsen, 1998).

Identifying Target Behaviors

In Joshua's case, the behavior of interest is not a "problem" behavior at all. Central to therapeutic intervention at this time is improvement in fine motor coordination. The team comes to this decision after setting a goal (placement in a community-based workshop) and examining the skills required to meet the goal (fine motor coordination). Having met other prerequisites, Joshua must improve finger dexterity to achieve optimal success in the program. Finger dexterity, perhaps more specifically, grasping small objects, is identified as the target behavior for treatment.

Ann does not engage in very much behavior at all. In an attempt to identify an area for change, the therapist looks for an approximation of awareness in Ann. "Staring at the ceiling" is pinpointed as a problem behavior. "Visual focusing on an object or person" is a more desirable and

incompatible behavior to replace it. In this case, visual focusing is selected as the target behavior.

Michael, in contrast, exhibits an array of clearly unacceptable behaviors. In his classroom, his behavior disrupts his own concentration and that of others. Overactivity, manifesting itself in inappropriate ways, is the problem which comes to the attention of the IEP team. Disruptive behavior is easily identified as the target problem. But, decreasing a behavior without substituting an appropriate and functional set of responses is an incomplete solution to the problem. Perhaps, the team is already anticipating a way to increase positive social behaviors by referring Michael for music therapy. They acknowledge 1) an inappropriate target behavior to be decreased: out-of-seat behavior, and 2) an appropriate target behavior to increase: attention to a task.

The examples illustrate various decision-making tactics for both setting goals and identifying target behaviors. A target behavior is not necessarily a problem behavior. It is, rather, a set of responses toward which therapy will direct its efforts. In most cases, a client is referred to a clinical facility or to music therapy, in particular, because of a problem. Obviously, the target behavior should relate to the problem and its alleviation, but may involve a constructive set of skills or competing behaviors. Joshua's successful completion of the vocational training program may lead to eventual deinstitutionalization. Ann's efforts to focus on others may help her to deal with her age and illness. Michael's substitution of more socially acceptable behaviors will, undoubtedly, assist him to achieve more in school.

Setting Goals

Goals, indicating expected outcomes in the targeted area, are clarified, based on the reason for referral and the information gleaned from the assessment. They offer a purpose for therapy as well as a direction. Goals may be long-term (Joshua's deinstitutionalization), or short-term (his successful completion of the vocational program), but the terms themselves are relative.

Ann's *long-term goal* may be to initiate positive social interaction with others outside of her room. A more immediate, or *short-term goal* would involve an increased awareness of others. Michael's long-term goal is to improve scholastic achievement and eliminate disruptive activity overall. In the shorter term, the therapist would seek to minimize disruptions in the classroom. Although they may be stated broadly, goals must be amenable to definition, observation, and measurement. After all, one of the reasons for setting these expectations is to facilitate an objective evaluation of changes throughout therapy.

Criteria for Selecting Goals and Target Behaviors

There are numerous criteria to consider when selecting goals and target behaviors:

1. Value: Does this behavior have major impact on present functioning? Could change in this area positively affect other related behaviors? Is this the most important area to change?

2. Prerequisites: Is the goal too far removed from the present behavior? If prerequisite behaviors have not been met, do these constitute more appropriate target behaviors and goals?

3. Interference: Are there inappropriate social behaviors which interfere with achievement of the goal? If so, ought these be targeted for change first?

4. Assessment: Is the target behavior able to be observed and measured over time?

5. Referral: Was the client referred for a specific area of remediation? Does the target behavior reflect the reason for seeking music therapy?

6. Agreement: Do others working with the client agree that this is the most appropriate target area? Secondly, does the client (if capable) agree on this focus for therapy and believe that the goal is attainable?

7. Success: Is there a relatively high probability that this behavior can be changed and the goal can be reached? Does the music therapist have sufficient control over the behavior?

8. Foundation: Is there evidence that this behavior truly requires change? Do data exist to support the view that this is, indeed, a problem?

9. Efficiency: Is there reason to believe that music therapy is the most appropriate treatment? Is it possible for the therapist to devote the necessary time or intensity to attain the goal?

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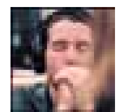

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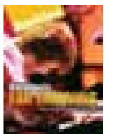

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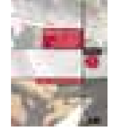

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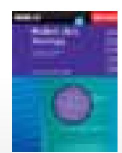

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