THE MUSICAL AND PERSONAL BIOGRAPHIES OF ADOLESCENTS WITH FOSTER CARE EXPERIENCE

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ABSTRACT

This qualitative study examines the personal and musical lives of adolescents with foster care experience. Based on the researcher's experience, it seemed that foster care adolescents had a different life experience with music than adolescents who were never in foster care. A structured interview, developed by the researcher, was used with a sample of 10 participants (6 males, 4 females) enrolled in out-patient therapy. Participants were chosen based on three criteria: 1) between the ages of 13-18 years, 2) present or past experience in foster care placements, and 3) willing and able to discuss their lives and musical backgrounds.

Biographical inquiry was the specific method used to gather data on the musical lives of adolescents in foster care and to discern how the musical and personal biographies may have been related to one another. In this context, a musical biography was defined as the sum total of music experiences a person has had and the various meanings given to them, both in the past and present. It was assumed that one's musical life is part of one's personal biography, which also includes non musical events, experiences, and meanings. The study was organized according to two basic questions: 1) What music experiences had these adolescents in foster care had throughout their life span, and what meanings had they attached to those experiences, and 2) What relationships could be found between the musical and personal biographies?

Results of the study showed that these adolescents with foster care experience used music consciously and actively in their everyday lives, similar to ways that adolescents with no foster care experience do. For example, adolescents with and

without foster care experience share the same listening habits, music preferences, and how they use music.

The results also showed that the music experiences of these adolescents did affect their life in foster care, and that their life in foster care did affect their overall relationship to music. In regards to foster care's influence on an adolescent's relationship to music, the results showed that when an adolescent had a relationship to music that was shared with a biological family member before foster care, this music relationship ceased when the participant entered foster care. Also, adolescents generally had a positive relationship with their foster family when involvement with music was encouraged. Conversely, music influenced the foster care experience of these adolescents. First, listening to music by oneself tended to increase in frequency and importance when the adolescent did not have a positive relationship or healthy attachment with the foster parent. Second, formal and active involvement in music (e.g., participating in school or group music, or taking lessons) seemed to be associated with a positive or healthy relationship with the foster family. Third, adolescents tended to listen to music for personal, psychological reasons, often to cope with the trauma, grief, and loss they continued to encounter throughout their lives. Implications for music therapy research, theory, and practice were drawn based on the conclusions.

DEDICATION

This dissertation is dedicated to my sweet little "guy" Max, and my lovely wife Gina. To Max, thank you for being so gentle and sensitive, and for waiting so patiently to play while I was busy doing my "homework." I love you very much and I promise we will be out playing Wiffleball again soon.

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CHAPTER ONE:

INTRODUCTION

This qualitative study was conceived as a result of my experience with foster care children and adolescents. What I realized was that foster care children, and particularly adolescents, have a different life experience with music than adolescents who were never in foster care. As a result, they also have a different relationship with music. This difference affects the benefits they can derive from music therapy, and the ways that music therapists can best work with them. The current research and literature related to foster care adolescents and their personal and musical biographies are examined. In my initial review of the literature I noticed a lack of systematic research on both foster care adolescents' experience in foster care, and on music therapy with foster care adolescents. It is hoped that this research will provide a foundation for future research and instill value and meaning to the adolescents experience in foster care through their personal and musical biographies.

Foster Care

Protecting children is the primary obligation of public child welfare agencies, particularly with regard to preventing the recurrence of child maltreatment for those who already have been identified as victims. Child welfare agencies typically meet this obligation by removing children from their homes and placing them in safe out-of-home care environments, or by providing services to the children and their families to ensure the child's safety while they remain in their homes. Many situations come to the attention of child welfare agencies in which it is necessary for a state to remove a child

from home and place him or her in a temporary living situation. This practice is commonly referred to as “foster care”. Foster care is intended as a temporary, not permanent, living arrangement. Once removal occurs, it is the responsibility of the state (usually the child welfare agency working in conjunction with the family and the courts) to return the child or adolescent to his or her home after foster care or find another permanent home for the child (US Department of Health and Human Services, Children’s Bureau, 2008).

One of the challenges in protecting children is gathering and maintaining current data on the frequency and outcomes of foster care. In 1997 the United States Congress passed the Adoption and Safe Families Act (Public Law 105-89). Section 203 of this law stipulates that State and local public officials responsible for administering child welfare programs, and child welfare advocates, must develop a set of outcome measures. These measures include length of stay in foster care, number of foster care placements, and number of adoptions, which are then used to assess the performance of states in operating child protection and child welfare programs (US Department of Health and Human Services, Children’s Bureau, 2008). The Adoption and Safe Families Act created the Adoption and Foster Care Analysis and Reporting System (AFCARS). The AFCARS collects case level information on all children in foster care for whom state child welfare agencies have responsibility for placement, care or supervision, and on children who are adopted under the auspices of the state's public child welfare agency. The obtained data are used to 1) rate the performance of states, with respect to the outcomes measures, 2) prescribe regulations on obtaining the appropriate data, and 3) annually prepare and

submit to Congress a report on performance (US Department of Health and Human Services, Children's Bureau, 2008).

Recent AFCARS data shows that the number of children in foster care in 2007 was 496,000 while the total number of children being served by child welfare agencies was 783, 000. The difference in numbers includes the number of children who may have at one time during the reporting year been in and are subsequently out of foster care and also children who are not necessarily legally in foster care but are still served by child welfare agencies who specialize in foster care.

Delivery of Services in Foster Care

Typically, children become involved with foster care due to a report of abuse or neglect. When child protective services become involved with families they are required to attempt to preserve the family, rather than to automatically seek removal (Lane, 2004). After a report is substantiated, a disposition hearing is held wherein a case plan for the family is formulated (Halperin & Harris, 2004). "The case plan includes the specific services to be provided to the child and her or his family, detailed conditions of visitation and child support, and requirements the parent(s) must fulfill to achieve reunification" (Halperin & Harris, 2004, p. 341).

Child welfare agencies have strict limits on how long a child stays in foster care. In 1997, the Adoption and Safe Families Act (ASFA) was passed, primarily to address the problem of children languishing for years in foster care without a permanent home and family (Halperin & Harris, 2004). Specifically, agencies focus on reunifying the family for the first twelve months; "thereafter it mandates the initiation of proceedings to

terminate parental rights when a child is in foster care for fifteen of the past twenty-two months" (Halperin & Harris, 2004, p. 340). Although the intention of child welfare agencies is to reunify the family, a report on the foster care system in Philadelphia found that within a year of release from foster care, 43 percent of children are back in the system (Lubrano, 2008). Also, among Philadelphia children ages 13 to 15, the reentry rate in to foster care is 60 percent (Lubrano, 2008). Other studies have noted that only 18% stay in foster care less than 1 month, with an additional 32% between 1 and 12 months (Dozier, et al., 2006); while 21% stay in foster care between 1 and 2 years, and 29% longer than 2 years (Dozier, et al., 2006). Goncik and Gold (1991), note that despite the fact that the structure of foster care is temporary, "it continues to be the basis of our child placement system" (p. 434).

While children are in foster care, child welfare agencies assist families through the foster care system by providing a variety of services. Typical services include case planning and case management, supervising parent–child visits, providing physical and mental health care, delivering parent education and training services, and locating and linking clients to specialized services in the community (McBeath & Meezan, 2008). Despite policies and laws to protect families and assist those entering into foster care, when children do enter, the impact on them is severe. For example, the child or adolescent has to adjust to a new school, home and community while having no or limited contact with parents, close relatives, siblings and friends.

Although there are policies and procedures that mandate the provision of necessary services, foster children are at an increased risk of not receiving services

necessary to address their needs (Kerker & Morrison-Dore, 2006). Kerker & Morrison-Dore (2006), noted that "financial costs, coupled with a fragmented health care system, often result in children's mental health needs being unmet" (p.138). McBeath & Meezan (2008), find that high proportions of foster children often do not receive "needed physical and mental health services" (p. 404). Problems that were present before entry into care become compounded by problems arising in response to the experience of being in care. The mental health issues are further compounded when the mental health and protective care systems have few resources for ongoing psychotherapeutic work, which then often prevents or delays appropriate treatment of mental health problems (Milburn, Lynch & Jackson, 2008).

Additionally, unmet mental health needs place great demands on the child welfare system. For example, children's emotional and behavior difficulties often exhaust both foster parents and caseworkers, resulting in a need to replace both foster families and caseworkers frequently (Kerker & Morrison-Dore, 2006). In fact, studies have shown correlations between the severity of children's behavior problems and the number of foster care placements a child has (Kerker & Morrison-Dore, 2006). Foster homes and agencies often turn to medication as a way to fix these problems, particularly if they are understaffed. In one agency, for instance, there was only one person assigned to oversee the mental health care of 600 children (Feldman, 2004).

Problems in foster care also affect children educationally. Children in foster care are more likely than other children to have academic and behavioral difficulties in school. Their academic difficulties include weaker cognitive abilities, lower academic

achievement and classroom performance compared to non foster care children. Also, 30% to 50% of children in foster care are placed in special education compared to 2% of the general school population. Children in foster care have higher rates of absenteeism and disciplinary referrals; 75% perform below grade level and more than 50% have been retained at least one year in school. Many of the educational problems they encounter revolve around placement instability and multiple school transfers (Zeltin, Weinberg & Kimm, 2004).

An interesting phenomenon related to delivery of services is the rapid increase in the number of mothers incarcerated for long periods for drug use (Allard, 2006). The number of women incarcerated in state and federal prisons has been climbing steadily since the 1980s. The lack of treatment programs that effectively address women's needs has been identified as an important contributor to women's continued drug use and, ultimately, contact with the criminal justice system (Allard, 2006). The impact on their children is severe. Children of incarcerated mothers are three to five times more likely than children of incarcerated fathers to be placed in a foster home (Allard, 2006).

Finally, in some instances, children present such serious behavior problems that parents may refuse to accept responsibility for meeting their ongoing needs and abandon them to the care of the state (Armour & Schwab, 2007). Armour and Schwab (2007) note that there are as many children now placed in the custody of the child welfare system for the legal reason of "unruly" behavior as there are for neglect and abuse. The most severely disturbed are:

> Referred to hospital and residential treatment for 1) behavior that is bizarre, disruptive, or dangerous to the youth or others, 2) failure of the youth to respond sufficiently to outpatient services, and 3) because home, school, and other social settings are unable to cope with the behaviors of the youth or are maintaining or exacerbating the symptoms. (Armour & Schwab, 2007, p. 72)

John Cortney, a former executive in the child welfare system, notes in an article that "The foster care system, with some minor exceptions, is not a positive experience for children… to keep them out of foster care is to keep them healthier" (Feldman, 2004, p. 10).

Therapy Protocols for Foster Care Children

Children who enter foster care have usually experienced maltreatment as well as disruptions in relationships with primary caregivers. These children are at risk for a host of problematic outcomes. In addition, placement into foster care, while providing a respite from problematic care, also paradoxically involves a disruption in care (Dozier, et al., 2006). In order to meet the demanding need for therapeutic services, several main protocols have been developed. These are described below.

Intensive Case Management

This is typically provided by a Masters level social worker who has either clinical expertise or is a licensed clinical social worker. The child's case is managed intensively, and the social worker is adept at providing the most appropriate mental health services. In some instances, the social worker functions as both social worker and therapist. Part of the job is also for the worker to keep in very close contact with other professionals also

working with the child. Therefore the case management includes a substantial amount of case coordination.

Multi-dimensional Treatment

This therapy protocol can be viewed as family-based treatment. Family-based treatments focus on the family as well as on the child and/or adolescent with serious emotional disturbance. The aim is to help parents acquire the skills and knowledge needed to better manage a challenging child (Kerker & Morrison-Dore, 2006). For children and adolescents in foster care, this requires an ongoing relationship with committed foster parents who are willing and able to engage in treatment with them. For this protocol to be successful, however, the child welfare system must empower foster parents with training and support (Kerker & Morrison-Dore, 2006). The main difference with these family-based treatments and traditional mental health therapies is that family-based treatments are accomplished within the child's and family's home and community. Therefore the therapists will see the child for therapy in the home while also providing social work functions such as case management and case coordination within the community.

Currently, Multi-dimensional Treatment is the most frequently used evidence-based intervention for foster care children and adolescents. Multi-dimensional Treatment is commonly referred to as "Wrap-around" and/or Behavioral Health Rehabilitative Services (BHRS). This intervention offers "a multi-faceted approach to treatment and . . . intensive intervention for difficult-to-treat youths" (James, Landsverk, Leslie, Slymen & Zhang, 2008, p. 357).

A 1998 review of research on Multi-dimensional Treatment outcome studies, of varying levels of design, reported positive changes in problem behaviors, particularly regarding placement stability, behavioral adjustment, and school adjustment (as indicated by higher attendance rates (Kerker & Morrison-Dore, 2006). A recent study comparing multi-dimensional therapy participants with a foster care sample receiving non multi-dimensional therapy found decreased behavior symptoms (Kerker & Morrison-Dore, 2006).

Treatment Foster Care

For children who cannot be maintained in a regular foster home even with mental health services and/or family-based treatment, there is evidence that treatment foster care (TFC)—specialized foster care with highly trained foster parents for children with special mental health needs—may be effective in providing the safety, stability, and community-based care required (Kerker & Morrison-Dore, 2006). TFC requires foster parents to function as one of the main agents of change, and thus demands their extensive training and involvement in the behavior management of the youth (Kerker & Morrison-Dore, 2006).

Outpatient Therapy

This service is the most common for children in foster care. Out-patient services include ongoing or long term therapy with a Masters level psychotherapist. Children and adolescents who receive out-patient therapy are typically under the auspices of a

psychiatrist for psychiatric evaluations, medication evaluations, and medication management if needed. The psychotherapy includes traditional forms, such as cognitive/ behavioral therapies and insight-oriented therapies, to more recently used contemporary forms of psychotherapy such as music and art therapy.

Youth Mentoring

Many child welfare agencies provide services that more readily assist practical applications of the child's life such as vocational training. For example, Philadelphia's Department of Human Services finances a program called the Achieving Independence Center. This center assists foster care youth with pre-job training, e.g., resumes, interview skills, etc. to after-job follow up. As the youth goes through the different levels of training he/she receives monetary rewards. This provides extra incentive for the motivated foster care youth.

Other Protocols

Therapy protocols are also defined in the foster care system from a least restrictive to most restrictive level of care. The goal of the system is to allow foster care youth to be placed or live within the least restrictive environment. The least restrictive setting is commonly known as kinship care.

In kinship care, the youth are moved to the home of a relative or very closely related friend of the family. This is deemed as least restrictive due to the child still living with people close to her/his biological family. The foster care system encourages this level of placement because of the prevailing thought that children in foster care have less emotional and behavioral problems when they are placed with family or friends of family.

The most restrictive care settings include group homes, residential treatment, and inpatient psychiatric care. Although inpatient psychiatric care is not necessarily considered a child welfare placement, it is symbolic of the most restrictive placement possible and is part of the continuum of services available to foster care children with emotional and behavioral problems (James, et al., 2008). Current federal estimates indicate that about "one fifth of the foster care population resides in various group homes and residential treatment facilities" (James, et al., 2008, p. 349).

A similar least restrictive level of care to kinship care is called Performance Based Contracting (PBC). This level of care is commonly referred to as general foster care and is provided by private foster care agencies. General foster care implies that the child's emotional or behavioral difficulties are not severe enough for a more restrictive level of care, but there are no family members/close relatives that can take care of the child who would normally be placed in kinship care. Within the PBC level of care, private foster care agencies have more regulatory requirements to provide the most significant services than kinship care. For PBC, if certain requirements are not met, e.g., child is not re-unified with parent; the agency loses money that was given to them by regulatory agencies. Thus the "performance based" title. The next level of care after PBC is Treatment Foster Care.

Treatment foster care (TFC), as noted above, is specialized foster care with highly trained foster parents for children with special mental health needs. Foster care children needing TFC receive an assessment entitled the Child and Adolescent Needs and Strengths (CANS). The CANS assessment also rises out of the CASSP initiative and its

strength based approach to working with youth and families. Several reviews of TFC have found, in general, that it is effective at reducing behavior problems and increasing stability for foster youth (Kerker & Morrison-Dore, 2006). If TFC is not appropriate, then children move into the most restrictive levels of care. There are frequent instances where children move back and forth along the continuum from least to most restrictive level of care. Also, children move in and out of foster care based on their parent's readiness.

Psychological Problems of Foster Care Adolescents

Adolescents in foster care exhibit an array of behavioral and adaptive functioning problems that far exceed those of the general population. One research study notes that children entering foster care are up to 80% more likely to have significant mental health problems. This is evident even when foster care children are compared with non foster care children with similar socioeconomic and demographic profiles (Kerker & Morrison-Dore, 2006). Other estimates indicate that children in foster care are as much as eight times more likely to have a mental health diagnosis than the population overall. Research suggests that the possibility of multiple foster placements, disrupted medical and educational services and the potential for abuse while in foster care all place children and adolescents at risk for increased adversity and concomitant psychiatric symptoms (Sieracki, Leon, Miller & Lyons, 2008).

For example, a study of 17-year olds in the Missouri foster care system found that 61% met criteria for at least one psychiatric disorder during their lifetime and 60% experienced the onset of at least one disorder before entering foster care (McMillen, et

al., 2005). A large-scale regional study found that 48% of adolescents in the foster care system met diagnostic criteria for at least one psychiatric disorder (Garland, et al., 1996); similarly, a nationally representative sample of children ages 2 to 14 years with completed child welfare investigations yielded 48% with clinically significant emotional and behavioral problems (Burns, et al., 1998). In California, children in foster care account for 41% of all users of public mental health services, although they constitute less than 4% of the eligible population (Halfon, Berkowitz & Klee, 1992).

There are numerous studies which document the specific types of psychological programs foster care children exhibit, including attention deficit/hyperactivity disorder, other anxiety disorders, and brief psychotic disorders, as well as mood disorders, suicidal ideation, suicide attempts, and disruptive disorders (Armour & Schwab, 2007); however, there are two main themes that permeate these problems: attachment issues and post traumatic stress disorder.

Children in the foster care system tend to be insecurely attached because they have often been denied the essential "reciprocal relationship" with a fully committed caregiver (Goncik & Gold, 1992). Goncik and Gold (1992), note that, "without such a relationship, the child's capacity for positive self-esteem and trust in others can never fully develop" (p. 434). Ainsworth's (1969) longitudinal study of attachment during the infant's first year provides one of the earliest descriptions of how the responsive mother effectively provides her child with a secure base. Whereas some children develop a secure maternal attachment and can rely on her presence to explore the environment and develop healthy autonomy, foster care children are less fortunate (Goncik & Gold, 1992).

Broken attachments in childhood create serious psychological problems for later development. These problems include impaired conscience development, trouble with basic cause and effect awareness, impaired sense of time, and difficulty with auditory processing (Goncik & Gold, 1992). Also common are difficulties in verbal expression, and delays in both gross and fine motor skills (Goncik & Gold, 1992). The social experiences that predicate entry into care represent critical developmental risks for their wellbeing and mental health. Foremost of these is exposure to psychological trauma, emotional deprivation, and other conditions that negate opportunity for secure attachments (Tarren-Sweeney, 2008).

Research has shown that a high percentage of foster care children and adolescents suffer from Post-Traumatic Stress Disorder (PTSD) (Armour & Schwab, 2007), which stems from the various types of abuse they have encountered including, verbal, emotional, physical and sexual abuse. Children whose abuses are compounded by additional types of maltreatment have even higher rates of PTSD (Armour & Schwab, 2007). Ackerman, et al., (1998) found that children who experience both sexual and physical abuse have a higher rate of PTSD (55%) than children either sexually abused (32%) or physically abused (26%). Likewise, Pelcovitz, et al., (2000) found that children who both witnessed domestic violence and were physically abused were three times more likely to suffer from PTSD, five times more likely to have major depression, and four times more likely to have oppositional defiant disorder than children who only reported physical abuse.

Treatment becomes more complicated as the experiences children face are more damaging (Forand, 1999). A recent study of adolescent patients in day and residential treatment facilities found that greater duration of physical abuse predicted more depression, anxiety, and aggression; greater severity of physical abuse predicted more depression and posttraumatic stress disorder; and among physically abused adolescents, concomitant sexual abuse predicted more severe posttraumatic symptoms (Armour & Schwab, 2007).

Because of the abuse and subsequent post traumatic stress, many foster care children become self abusive. In one study (Armour & Schwab, 2007) 80.8% of 26 children engaged in a variety of self abusive behaviors including suicidal threats and suicide attempts. In the same study, self-cutting was done by 26.9%. Also, refusal to follow the medical regime prescribed for physical disorders was a problem for 15.4% (Armour & Schwab, 2007). Other self-harming behaviors included head banging, scratching or stabbing oneself, and swallowing both plastic and pieces of metal. In the study, suicide attempts were made by 68% of the youth. The methods used included "cutting their wrists, tying hair scrunches around their necks, swallowing metal from objects they took apart, and swallowing coins" (Armour & Schwab, 2007, p. 87).

In addition to being at increased risk for a wide display of psychological disorders, studies of foster children also indicate that they are more likely to become involved in delinquent behaviors, demonstrate poorer overall school performance, manifest learning disabilities, and evidence poor interpersonal skills with peers and siblings (Simmel, Barth & Brooks, 2007).

Finally in the Armour and Schwab study (2007) at least "56% of children had disorders that fit into as many as three of four categories inclusive of 1) diagnoses with psychotic features, 2) diagnoses with elevated mood, 3) diagnoses with acting-out behavior, and 4) diagnoses of mild mental retardation and borderline intellectual functioning as well as learning disorders" (p. 86).

Mental Health Interventions in Foster Care

Mental health interventions for foster populations can be understood within four categories: "first, interventions that are not specific to these populations; second, interventions and treatment services designed for these populations; third, interventions directed to caregivers, with a view to maximizing the therapeutic potential of the child's care; and four, therapy-focused models of alternate care" (Tarren-Sweeney, 2008, p. 347-348). However, there are limited and inconclusive findings on the effectiveness of common psychological and pharmacological treatments for foster care populations (Tarren-Sweeney, 2008), and findings for other populations may not generalize to children in foster care. For example Tarren-Sweeney (2008) notes that, "the mechanisms accounting for the characteristic inattention/overactivity of severely deprived children may differ from those that account for other inattention/overactivity, in which case alternative treatments may be warranted" (p. 348). She further notes (2008) that common "treatment modalities are mostly designed for isolated disorders rather than complex bio-psychological phenomena." (p. 348).

Some foster care children and adolescents respond well to medication, while other options, like psychotherapy, sometimes go unexplored; yet Feldman (2004) notes that the

drugs may not be easy on young bodies. Side effects of psychotropic medications range from headaches and weight gain to seizures, liver failure, and even sudden death. After analyzing FDA records on the 12 medications most commonly used by children in residential care, the Westchester Journal News reported that they were "primary suspects in the deaths of at least 71 children nationwide" between 1997 and 2001 (Feldman, 2004, p. 10). Meanwhile, their benefits may be marginal. Feldman also noted that "A 2003 study published in the Journal of the American Medical Association found that 69 percent of children who took the antidepressant Sertraline—the generic ingredient in Zoloft—showed some improvement. But so did 59 percent of those who took a placebo instead" (p. 10).

Another problem is that treatment programs are not meeting the individualized needs of the client. Dore (2008) notes that "pressures from federal and state agency funders and third-party payers on mental health providers to adopt treatment models that appear to have an evidentiary base are intense, leading, at times, to the application of evidence-based models to populations and problems for which they are untested and potentially inappropriate if not harmful" (p. 527).

Although foster care is well documented as a difficult and challenging time for children and adolescents, there is a gap in the literature on empirically validated interventions specifically designed for foster children that address the unique experience and culture of the adolescent and the challenging dynamics of the foster family (Craven & Lee, 2006). Parental involvement in children's mental health care is highly valued by most professionals and the concept of "parents as partners" in treatment planning has

become a focus among children's mental health advocates (Kerker & Morrison-Dore, 2006). Unfortunately, "foster children are unlikely to have an active, committed, and skilled caregiver willing and able to engage in the time-consuming advocacy that is often necessary to receive needed services" (Kerker & Morrison-Dore, 2006, p. 142). Furthermore, foster parents are more reluctant to foster adolescents, restricting the already limited supply of foster caregivers (James, et al., 2008). Research on the parenting skills of foster caregivers has also found that changes in the foster caregiver–child relationship during adolescence are associated with higher rates of placement disruption (Lipscombe, Moyers & Farmer, 2004). This suggests that in child welfare practice, much effort should be directed toward supporting foster children who are transitioning into adolescence in order to prevent placement into more restrictive levels of care. Only one fifth of adopted foster children are 11 years of age and older (U.S. Department of Health and Human Services, 2006), making long-term foster care a primary permanency option (James, et al., 2008).

Craven and Lee (2006) synthesized empirical studies in order to identify and classify therapeutic interventions for foster children. Five of the 18 referenced studies treated one or two specific problems. Three of the interventions used treatment foster care as an overall milieu that involves engaging the foster parent as the therapeutic catalyst. In one study that used a national sampling frame, it was discovered that although over 94% of sampled child welfare agencies assessed all children entering foster care for physical health problems, only 47.8% routinely assessed for mental health problems (Kerker & Morrison-Dore, 2006).

Despite a high prevalence of mental health difficulties, foster children are at an increased risk of not receiving services necessary to address their needs. Foster care children may be particularly vulnerable to not receiving care for their mental health needs because they often lack a person in their life who feels responsible for their well-being. Untreated mental disorders among children in the child welfare system impact not only children's functioning and well-being but also society (Dore, 1999; Landsverk, et al., 1996), as children in foster care with untreated mental health disorders often find themselves homeless or in prisons, jails, institutions, or mental hospitals as adolescents (Kerker & Morrison-Dore, 2006). While working with foster care children and adolescents I have experienced how the foster care system functions and its impact on me as a music therapist.

Personal Context of the Study

I began working as a music therapist with foster care children and adolescents in August 2004. My initial experiences with them were eye opening. They had come from the most severely abusive homes. All of the children and adolescents I worked with were placed in foster homes including treatment foster care, kinship care, and PBC homes. Some of them were transitioning out of hospitals and residential treatment programs. My work not only included providing music psychotherapy in the home, but also coordinating services with other professionals involved with the case. Although my clinical work involved using music therapy interventions, the protocol is similar to Multi-dimensional Treatment, because of the multi-faceted approach, i.e. working directly with foster parents and implementing treatment in the home, school, and community.

The trauma and neglect these children faced was like nothing I have ever experienced before. The majority of the children I worked with had experienced loss of their biological or adoptive families, multiple placements and rejections, and inpatient and residential stays that resulted from acute psychiatric problems. These events typically left them feeling lost, anxious, isolated, and hopeless. The youth then conveyed these feelings of desperation through their behavior. The goals of my work included supporting these children during a time of immense internal conflict by assisting them with the therapeutic support needed to help them stabilize in a safe holding environment- their new foster home.

I had already practiced as a music therapist for eight years. Within that practice I had worked with both children and adults, and with diverse populations including severely physically and mentally disabled children to heart transplant patients. However, I was amazed with the differences in how the youth responded to music therapy as compared to other youth with whom I worked.

While working with some of the very young children I noticed the extremes of how some children welcomed music therapy like they had been stranded in a desert and were finally taking their first drink of water; while, other children would unfathomably use even basic percussive instruments in the most unhealthy or inappropriate manner. For example, these young children, even as young as five, would physically hit themselves repeatedly with the drum stick or even the drum itself, while other non-foster care children would use the instrument appropriately.

I also noticed major differences with adolescents, where there were similarly wide ranges of emotion and connection with music experiences, from absolute joy to complete terror. Additionally, in comparison to most adolescents in mainstream society, I noticed that these youth did not have the resources and equipment to use music as an outlet, outside of my work with them. Unlike mainstream adolescents, who often possess numerous tapes and CDs, and players for them, foster care adolescents often had neither. The same is true for iPods, the relatively new musical companion for most youth. For example, one adolescent who had an iPod, was abruptly moved from one foster home to another, and was unable to take his iPod with him. At the time, he compared this loss of music to being separated from his biological parents.

Working therapeutically with foster care youth is simple yet complex. I have learned that it is not just providing interventions for the child until they are reunified or placed in a stable home; rather it is allowing the youth to express and confront deep issues of abandonment, rejection, and anger, which can be facilitated through music. Also, early abuse has a long-term impact on a youth's ability to form appropriate relationships (Betts, p. 116), while music making and music experiences allow for a safe and healthy relationship. The people and professionals in the lives of these youths come and go, but the music experience will always be there for them. Layman and Hussey (2003) note that:

> Music therapy is often an ideal intervention for foster care and adopted children. It is an inherently non-threatening and inviting medium for these children, for it offers a safe haven in which to explore feelings, behaviors,

> and therapeutic issues related to abuse, neglect, and family disruption. Music therapy can be a powerful therapeutic tool in promoting permanency by helping children establish meaningful relationships, build self-esteem, and address issues of mourning and abandonment. (p. 117)

Need and Significance for the Study

In a review of the literature (see next chapter) the first article that discussed foster care specifically with music therapy is by Layman, Hussey and Laing (2002). The authors described the dynamics and potential implications for music therapist working with foster care children as laying the foundation for future clinical work. There are three books that discuss creative arts therapies with foster care youth. In Betts (2003), Creative Arts Therapies Approaches in Adoption and Foster Care: Contemporary Strategies for Working with Individuals and Families there are two chapters that focus specifically on music therapy. In *Healing the Inner-City Child: Creative Arts Therapies with at Risk Youth*, there are six chapters that deal with music therapy and at risk youth. Two of those chapters focus specifically on foster care youth. The four chapters that do not deal specifically with foster care youth provide appropriate comparisons with inner city at risk youth with foster care youth. A third book called *Music Therapy with Children and their Families* has two chapters that specifically deal with music therapy and foster care. Each chapter and article deal with clinical goals and strategies; however no research studies have been located. Thus, there appears to be more clinically informed understanding of the topic than research data of

any kind. Each of the chapters in the books on music therapy and foster care youth are discussed more fully in the related literature section of this paper.

The use of music therapy could be invaluable to this population. Early life experiences, particularly those that occur in the context of the parent child relationships, are believed to form the child's initial mental representations of self, others, and relationships (Mennen & O'Keefe, 2005). These mental representations are then transferred in other areas of the child's life by which stimuli are interpreted. Music therapy allows for the relationship to develop, between the music and youth, that serves as the foundation for emotional and social development (Mennen & O'Keefe, 2005). Schwartz (2008) notes that, "musical sensitivity in the human race should have disappeared long ago since it serves no discernible purpose in terms of basic existence. Yet, we are still being born with music as part of our makeup" (p. 4).

Perret (2005) notes that musicality is part of our biological nature; present during the first days and months of our lives. Over time, this biological musicality becomes "the expression of our emotions, feelings" (p. 19). He continues by stating that, "musicality is very likely the reflection of what we are about to feel within ourselves, what we are about to become, what is emerging, as if musical expression was a 'fingerprint' of the one who plays or sings; music expression is everyone's birthright" (p. 20-21).

Despite this universal birthright to music, foster care children appear to be lacking in the usual relationship to music that most children have. In my work with them, they do not seem to be attached to certain songs, nor do they have the same emotional connection to music as other adolescents. The biography of their lives typically revolves

around separating from their families to placement disruption. The lack of placement stability essentially leads to a deficit in the opportunities for foster care youth's involvement with musical experiences.

Unfortunately, though the literature on music therapy with foster care children is gradually building, most of it is clinical in nature, with a focus on music therapy methods and techniques. No research is available on the musical lives of foster care children, how they respond to music, what effects music therapy can have, and a host of other topics. Lincoln (2005) notes that "for everyday young people, music is highly significant and is a medium through which they are able to create 'soundtracks' to their lives" (p. 401). This study was aimed at providing foundational research. The purpose of this study was to gain an understanding of the musical biographies of adolescents in foster care and to discern how the musical and personal biographies are related to one another. Subordinate questions were:

1) What musical experiences had these adolescents in foster care had throughout their life span and what meanings had they attached to those experiences?

2) What relationships could be found between the musical and personal biographies?

In this context one's musical biography was the sum total of the experiences in music a person has had and the various kinds of meanings given to them in the past and present. It was assumed that one's musical life is part of one's personal biography, which also includes non musical events, experiences, and meanings.

CHAPTER TWO:

RELATED LITERATURE

Music Therapy and Foster Care

As mentioned previously, no systematic research has been found on music therapy with foster care adolescents. Recently however, several chapters in three different books and one case study focus specifically on using music therapy with foster care youth.

In (Betts, 2003) *Creative Arts Therapies Approaches in Adoption and Foster Care*, there are two chapters. The first chapter, written by Mary Reher is entitled "The Dance of Belonging." The chapter is the author's account of her client's experience in music therapy, particularly through the use of the Bonny Method of Guided Imagery and Music (BMGIM). The client is an aboriginal adoptee and although an adult now, the sessions revolved around her whole life including exploring her early childhood roots. The client was six months old when taken from her biological mother. Her father had been institutionalized due to violent and psychotic behaviors. She was put into 17 homes over the first 11 months of being separated from her family. She was finally adopted when she was six or seven; she referred to this incident as being "stolen" from her mother (p. 44). Although the client's adoptive family was stable and loving, and may have been responsible for preventing further trauma, the effect on her was a "pervasive sense of un-belonging, confusion, and wounding" (p. 57). During her 10 sessions of BMGIM, the

client discovered that "she was able to break through and finally convert her intellectual knowledge into genuine physical, emotional, and intuitive knowing and healing" (p. 58).

Layman and Hussey (2003) in "Music Therapy Issues and Strategies for Working with Adopted and Foster Care Children," provide an introduction to foster care, reunification, and adoption. The authors note that there are three core concerns, which dominate the field of child welfare: safety, permanency, and child well-being, all of which are essential to address in music therapy. The authors conclude that addressing these core areas through music therapy meets the diverse needs and developmental ranges of foster care youth due to the "non-threatening and reinforcing nature of music" (p. 124).

In the next book *Healing the Inner City: Creative Arts Therapist with At Risk Youth* edited by Vanessa Camilleri (2007), all of the chapters discuss using creative arts therapies with inner city youth, and the inner city youth discussed in the book share similar problems with foster care youth. However, one chapter in the book by Diane Austin entitled "Lifesongs: Music Therapy with Adolescents in Foster Care," focuses not only on the problems of inner city youth but also with adolescents in foster care. In her work, Austin notes that the music therapy proved effective in facilitating self-expression and non-violent communication, and in creating a "safe and playful environment" in which the adolescents could grow (p. 94).

Music Therapy with Children and their Families by Amelia Oldfield and Claire Flower (2008) provides two chapters that focus specifically on foster care youth. The first chapter is entitled "Music Therapy after Adoption: The Role of Family Music Therapy in Developing Secure Attachment in Adopted Children" and was written by

Colette Salkeld. Although the chapter focuses on adopted children, the music therapy interventions revolve around the trauma, bereavement, and attachment issues typically associated with foster care children. Also, and more importantly for her work, Salkeld discussed how music therapy and interactive music making "become foundational to the development of their [the adoptive parent] relationship with their adopted son" (pg. 156).

In the next chapter, "A Piece of the Puzzle: Music Therapy with Looked-after Teenagers and their Carers" written by Joy Hasler, the author discusses how music therapy is used with teenagers in the United Kingdom. "Looked after" and "Carers" are terms used for foster care and foster parents respectively in the United Kingdom. In her work, Hasler developed a model for music therapy that includes the foster parents as part of the treatment. She noted that three key issues for foster care youth are bereavement, trauma, and attachment, and that secondary trauma is an issue for the people involved in their lives.

Dvorkin (1991) discusses a case study where she worked with an adolescent diagnosed with borderline personality disorder in an inpatient psychiatric unit. Although the client was hospitalized at the time of the study, she had been in foster care previously. The client also had a history of drug abuse and being sexually abused. At the time of her hospitalization, she had already run away from 30 foster homes. She was referred to music therapy to increase her ability to tolerate feelings of anger and frustration. The music therapy process included connecting her impulses to feelings and regaining control of appropriate expression of her feelings. The music therapist used music experiences

within an object relations approach which allowed the client to resolve her feelings about past emotional injuries and to help her cope better within future relationships.

Music Therapy and Axis I Diagnosis

Each child or adolescent in foster care who receives a therapeutic service, ranging from most restrictive (inpatient or hospitalization) to least restrictive (out patient therapy), receives an Axis I diagnosis from the Diagnostic and Statistical Manual (DSM-IV, 2000). In fact, all managed care companies that specialize in behavioral health insurance require an Axis I diagnosis in order to reimburse for treatment.

Clinical Disorders included in an Axis I diagnosis fall into 14 categories: Anxiety Disorders, Childhood Disorders, Cognitive Disorders, Dissociative Disorders, Eating Disorders, Factitious Disorders, Impulse Control Disorders, Mood Disorders, Psychotic Disorders, Sexual and Gender Identity Disorders, Sleep Disorders, Somatoform Disorders, and Substance-Related Disorders" (Psyweb.com, 2010). Other conditions, known as Adjustment Disorders, may also be a focus of clinical attention include "medication-Induced Movement Disorders, Relational Problems, Problems Related to Abuse or Neglect, Noncompliance with Treatment, Malingering, Adult Antisocial Behavior, Child or Adolescent Antisocial Behavior, Age-Related Cognitive Decline, Bereavement, Academic Problem, Occupational Problem, Identity Problem, Religious or Spiritual Problem, Acculturation Problem, and Phase of Life Problem" (Psyweb.com, 2010).

Unfortunately, a myriad of different terms are used when referring to an Axis I diagnosis, and when reviewing the literature, this can be confusing if not misleading. In

the music therapy literature, general terms rather than specific diagnoses are frequently used to refer to an Axis I disorder. For example, the terms emotional problems, disturbances, or disorders are used to describe a variety of diagnoses related to anxiety, depression, or combinations thereof, while behavioral problems, disturbances or disorders are often used to describe a variety of Axis I diagnoses related to acting out behaviors such as Conduct Disorder, Oppositional Defiant Disorder, or combinations thereof.

The field of music therapy has an extensive history of working with adolescents with behavioral and emotional problems related to Axis I. Music therapists have worked with adolescents through the continuum of most restrictive therapeutic care to least restrictive therapeutic care, from psychiatric hospitals and inpatient treatment to out-patient settings respectively. For the purpose of this review, the music therapy literature on adolescents is organized into four different categories- Research writings that specify Axis I diagnoses, research writings that imply Axis I diagnoses, clinical writings that specify Axis I diagnoses, and clinical writings that imply Axis I diagnoses. Each category is reviewed chronologically.

Research Writings that Specify Axis I Diagnoses

Music therapists have researched adolescent patients in psychiatric or inpatient settings for quite some time. In 1975, Alvin conducted a study with adolescent boys diagnosed with a behavior disorder. She found that when preparing for a concert, the boys who were usually aggressive showed interest and enthusiasm towards music. She also found that music was able to initiate conversation and help create a state of mind in which the boys were ready to reveal their problems.

Within a residential treatment setting, less restrictive than psychiatric inpatient treatment but more restrictive than outpatient, Steele (1975) studied the relationship and the role of the music therapy program with other staff and patients. The researcher noted that music therapy treatment emphasizing behavioral change, rather than musical achievement alone, combined with the high degree of intent in music elicited from students, seemed to appear that the program was a viable tool in therapeutic intervention. Results indicated a high percentage of productive, on task behaviors exhibited by the adolescents with music therapy.

Henderson (1983) conducted a study utilizing experimental and control groups with adolescents who were inpatient/psychiatric clients in music therapy. The primary diagnoses for all participants were adjustment disorders. The results showed that music therapy interventions focusing on mood recognition and awareness enhanced self-esteem and group cohesion. Also, the experimental group improved more on their level of self-esteem than the control group.

Within an out-patient setting, Clendenon-Wallen (1991) completed a pilot study on the use of music therapy to influence the self confidence and self esteem of adolescents who were sexually abused. The researcher noted that all participants showed positive changes in self-confidence as evidenced by increased self rating evaluations. Music therapy was also shown to be beneficial with adolescents who often lack self esteem and the ability to express their feelings.

In 1992, Wooten studied 35 adolescents within a psychiatric facility to determine the effects of listening to heavy metal versus rock music on affect shifts and also to

determine the relationship between music preference and shifts in affect. Short-term fluctuations in mood were measured before and after music listening, and music preferences were assessed during testing. Overall, no significant pre-post differences were found in the affect shifts of the participants. However, when grouped according to music preference, those participants preferring heavy metal music after listening to heavy metal music were found to have significant increases in positive affect regardless of primary diagnosis.

Also, with outpatient clients, Field et al. (1998) examined the frontal EEG in depressed adolescents. The researchers found that depressed adolescents listening to music experienced a significant decrease in stress hormone (Cortisol) levels, and most adolescents shifted toward left frontal EEG activation (associated with positive affect).

Dalton & Krout (2005) studied grief processes through a descriptive analysis of 123 songs written by bereaved adolescents. The participants in the study had received weekly music therapy and grief counseling over a period of 36 months. Lyrical themes within the songs were identified and organized by the researchers into five grief process areas: understanding, feeling, remembering, integrating, and growing. These five grief areas were then compared to the existing theories and models of bereavement (outside of music therapy) and were found to be representative of them. The researchers found that "while participant sample sizes were small, results suggested that the songwriting treatment helped the adolescents improve in their grief processing scores across all grief domains as compared to control participants" (p.137).

Within the school setting, Rickson (2006) compared the impact of instructional and improvisational music therapy approaches on the level of motor impulsivity displayed by adolescent boys who have Attention Deficit Hyperactivity Disorder (ADHD). A combination of a multiple contrasting treatment and an experimental control group design was used. Results indicated that music therapy treatment groups significantly improved accuracy on tasks**,** and teachers reported a significant reduction in Conners' DSM-IV Total and Global Index subscale scores.

While working with female adolescents with eating disorders in an inpatient/ psychiatric setting. Mcferren, et al. (2008) studied what these clients would say about their mothers in music therapy. The results indicated that music therapy is an integral part of inpatient treatment for adolescent females with disordered eating and is a valuable addition to other treatment modalities for adolescents with eating disorders, with song writing being a means of an engaging young people. Results highlighted not only how the dynamics between mother and daughter impact eating disorders but the importance of addressing developmental issues such as individuation.

Research Writings that Imply Axis I Diagnoses

Haines (1989) compared the effects of music therapy and verbal therapy with adolescents in a psychiatric setting diagnosed with a behavioral and/or emotional disorder. She found that those in the music therapy group demonstrated more immediate differences in group dynamics than those participating in verbal therapy. Participants in the music therapy group were more motivated, more willing to work together, and made more healthy choices regarding their interactions.

Within the school setting, Montello and Coons (1998) compared the behavioral effects of active, rhythm-based group music therapy vs. those of passive, listening-based group music therapy on preadolescents and adolescents with emotional, learning, and behavioral disorders. Over the course of the research it became clear that the students with severe attention problems, i.e. attention deficit disorders, were more able to focus and concentrate when the music therapist was able to work with them one-on-one. Those with externalizing problems (under-controlled, aggressive, and acting out) benefited more from active music therapy. The results showed that participants improved significantly after receiving music therapy interventions. The authors recommended choosing a music therapy approach based on personality types and/or clinical diagnoses of participants.

Rickson & Watkins (2003) did a pilot study to investigate whether music therapy is effective in promoting pro-social behaviors in aggressive adolescent boys who have social, emotional, and learning difficulties. Fifteen subjects were randomly assigned to music therapy treatment groups and a waitlist control group. Outcome measures included parent and teacher versions of the Developmental Behavior Checklist. While no definite treatment effects could be detected, results suggest that a music therapy program promoting autonomy and creativity may help adolescents to interact more appropriately with others.

In the only qualitative study found, Gardstrom (2004) examined the meaning of clinical music improvisation with "troubled adolescents" in an out-patient setting. She used a combination of phenomenological and hermeneutic inquiry to analyze the verbal transcripts of participant interviews, as well as Bruscia's (1987) Improvisational

Assessment Profiles (IAPs) in her analysis of the music. The results included a more profound understanding of meaning in the improvisation experiences and products of the participants.

Clinical Writings that Specify Axis I Diagnosis

Only two clinical writings were found on music therapy with Axis I diagnosis; both deal with adolescents with Conduct Disorder. Paul (1982), worked with a 17-year-old male who had been diagnosed with a conduct disorder of the under-socialized aggressive type and was in a psychiatric setting. Guitar instruction, available to him as part of a reward system, was motivation that contributed to his improved behavior and growth in self-esteem. He went on to take part in a music therapy group, and later worked to earn inclusion in a talent show at which he successfully performed.

Kivland (1986) worked with adolescents with conduct disorders in an out-patient setting, and found that music therapy was effective in increasing self-esteem. The author noted that music is viewed positively by teenagers since it is an important focus of adolescent sub-culture. Brooks (1989) adds that adolescents relate extensively to the music of their peer culture and that music is a familiar medium to them. She goes on to say that "music is often the only tool that enhances communication with adolescents" (p. 39).

Wells (1998) maintains that within the multidisciplinary team (inpatient treatment), music therapy is useful in the treatment of adolescents with Axis I diagnoses. She goes on to note that music therapy is helpful in bridging the gap between verbal therapies by "aiding in mastery and sublimation of thoughts and feelings" and helping to

"facilitate ego development through participation in success oriented experiences." (p. 53).

Continuing with music therapy's long history of working with psychiatric patients, Cassity and Cassity (1998) developed a clinical manual that included working with adolescents. The model entitled *Multimodal Psychiatric Music Therapy* is specifically developed for music therapy and music therapists. Assessment, treatment and evaluation are comprehensively covered based on the effective work of numerous music therapists working with psychiatric patients.

Clinical Writings that Imply Axis I Diagnosis

There is a long tradition of music therapy clinicians working with adolescents with what is now known as Axis I Diagnosis. In 1971, Sylwester et al., reported on a 14-year-old female hospitalized with psychiatric needs. Her relationship with her mother was strained. However, the girl spontaneously asked the music therapist to learn to play the guitar, which her mother knew how to play. The therapist included the mother in the weekly sessions, and the music therapy focus served to help the patient better relate to and with her mother.

Barg (1973) used music therapy with behaviorally disturbed adolescents to improve self-concept and attitude toward education, and to reduce maladaptive acting-out behaviors. The guitar was used for group instruction partly because it was a preferred instrument for the patients. While working with the adolescents she noticed a reduction in the acting out behaviors and improvement in self-esteem.

One article discussed the use of music therapy with adolescents within the community. Ragland & Apprey (1974) noted that there was a fine line between adolescents in the depressed community and adolescents in the psychiatric hospital. They used interpretation and discussion of song lyrics as a specific goal while working with 22 member group, while the goals were to improve adjustment to school, community, church, domestic situations and solving problems. The authors noted that music therapy was an effective alternative for "reshaping chaos and furnishing hope in the community" (p.155).

Ficken (1976) described his work with an emotionally troubled adolescent girl. She learned to play the guitar while in the psychiatric hospital. The music therapist worked with her to write a song that she could play and sing. The author noted that having her own song gave her the incentive to practice for longer periods and, not surprisingly, she achieved her goal.

Within the school setting, Milner (1980) completed three case studies with adolescents who were severely emotionally disturbed using music therapy to help them develop self-expression skills. Treatment techniques included the use of color-coded guitars and constantly reinforcing recorded instructions. The guitars were preferred instruments, and proved effective in helping them meet their treatment goals.

Krout and Mason (1988) described the clinical uses of a computer and software system, digital electronic synthesizer, and digital electronic rhythm composer in a school-based music therapy program for behaviorally disordered adolescents. The clinical work emphasized developing targeted social, pre-academic, and academic behaviors or skills.

The electric guitar was a preferred instrument for many students, but most lacked the skills to successfully play rock music (their preferred style) on the guitar. As the students were using computers during the group sessions, digital electric guitar sounds were manipulated via the computer and music performance software to allow students to improvise rock music using the computer mouse. Increases in positive social behavior also allowed students to earn tokens redeemable to play the (traditional) electric guitar during free time.

Salas (1990), in discussing aesthetic experiences in music therapy with institutionalized adolescents with severe emotional impairments, described the important role that the music therapy played in her work. She described the musical relationships that the adolescents had with and through the music as an essential aspect of their therapeutic process.

Also in 1990, Goldstein developed a music therapy assessment for assessing hopelessness in depressed adolescents in foster care. A review of the literature and a pilot study found that the *Songwriting Assessment of Hopelessness* (SAH) when compared with the *Beck Hopelessness Scale* would be sufficient for assessing hopelessness in adolescents.

Within the outpatient setting, Primadei (2004) described his work with a 17-year old male with psychotic traits. The author used music therapy as a means to establish contact and communication, with both himself and the patient. The author reported that the patient's preferred instrument was guitar, stating:

The guitar was the first instrument that Stefano agreed to play, and this

> represented the first step towards our being able to play together. The other instruments in the room, such as the piano or percussion, did not arouse any interest in him, or were completely refused. (http://musictherapyworld.net)

In developing a theoretical model which represents different areas of psychological functions of adolescence that can be supported by engagement in music, Laiho (2004) states "Through promoting the satisfaction of these psychological aims music contributes substantially to adolescent development and mental health."

Tervo (2005), while working with adolescents with psychiatric needs, divided his music therapy work with adolescents into three stages; interest, learning, and improvisation to promote growth and development. He noted that:

> Some adolescents find their inner world safe enough to allow interaction to occur naturally and they are able to express feelings ranging from rage to deep sorrow. To others, this world may be very traumatic and full of loss, disappointment and rage. However, music created together with the music therapist can provide a means to express all of this.
>
> (http://www.voices.no/mainissues/mi40005000169.html)

Dalton (2006) expanded on his study with Krout (2005- see above) to describe the development and implementation of the Grief Song-Writing Process (GSWP) with bereaved adolescents. The project involved three phases. First, a descriptive thematic analysis was completed of 123 songs previously written by bereaved adolescents in individual music therapy sessions. Second, existing grief models were then compared

with these song theme areas, and an integrated grief model was developed which includes five identified grief process areas of understanding, feeling, remembering, integrating, and growing. Third, a systematized GSWP protocol was developed and implemented, during which adolescents created music and wrote original lyrics to songs that focused on each of the five grief process areas. Song-writing using the GSWP proved to be engaging and offered a safe, creative method of addressing the difficult subject matter of a loved one's death. The author notes that surviving the death of a loved one and grieving in healthy, adaptive ways may remain an on-going challenge for bereaved adolescents. However, through music therapy treatments such as the GSWP, adolescents have supportive and creative ways in which to progress through their own "unique journeys of healing."

Music Preferences of Adolescents and Mental Health

Outside of the music therapy literature there are numerous studies related to adolescents and music preference. However, music therapists have a practical and professional interest in understanding music's relationship to the adolescent. Metzger (1986) noted that in a psychiatric setting, adolescents often used their leisure time listening to songs that related to their diagnosis. For example, depressed patients listened to music that made them feel sad.

Doak (2003) in a research study with adolescents in a clinical setting found significant correlations between preferred music and diagnosis ($p<.01$), drug preference and diagnosis ($p<.002$), and diagnosis and reason for using drugs ($p <.02$). Baker and Bor (2008) did a thorough review of the literature on this topic and found three main

conclusions 1) Studies that found a relationship between various genres of music and antisocial behaviors, vulnerability to suicide, and drug use, 2) Studies that rejected music as a causal factor and suggested that music preference is more indicative of emotional vulnerability, and 3) A limited number of studies have that found a relationship between music preference and mental health status. The authors further noted that more research is needed to determine whether music preferences of those with diagnosed mental health issues differ substantially from the general adolescent population.

Summary

In summary, it is clear that adolescents do indeed consciously and actively use music in different interpersonal and social contexts. Musical experiences occur on a variety of different levels of engagement, and the value placed upon the music is dependent on these contexts. This gives some indication of the range of the social functions of music in everyday life, and of the contexts in which these are apparent (North, Hargreaves & Hargreaves, 2004). The question is how does music play a role in the adolescents' life, particularly with adolescents in foster care? The music therapy literature contains a handful of clinical writings on the use of music therapy with foster care children and adolescents, and this provides some evidence that our understanding of this topic is beginning to emerge. Unfortunately, however, no research studies have been found on the musical characteristics of foster care youth, or the efficacy of music therapy in addressing their psychological concerns and needs. The present study was intended to provide a foundation for future research by examining the musical lives of adolescents with foster care experience.

CHAPTER THREE:

METHOD

Design

The study was a qualitative inquiry into the biographical and musical lives of foster care adolescents. Cresswell (1994) notes there are five main types of qualitative research, and one of those types is the biography. More succinctly, this design could be viewed as a biographical inquiry; it was a systematic inquiry into the participant's personal and musical life. Bruscia (1993) notes that:

> Biographical inquiry most often has descriptive objectives…problems and resources in one area or period of life provide the basis for understanding those in other areas or periods, and when woven together these different perspectives provide more holistic and multi-dimensional picture of the client.
> (Bruscia, 1993)

Participants

A sample of 10 participants was selected from clients now enrolled in Bethanna's Mental Health Clinic, where the researcher currently works. Inclusion criteria was: 1) The subject is an adolescent between the ages of 13-18, and 2) The subject is a foster care youth, either currently or in the past, and 3) The subject is willing and able to discuss their lives and musical backgrounds. In addition, any client who volunteered or expressed an interest in participating and met the inclusion criteria was included in the sample. All clients who have been music therapy clients of the researcher were excluded from the study in order to avoid conflict of interest.

Recruitment of participants was based on referrals from staff at Bethanna. I asked each staff member who would like to be involved to provide a list of clients who met the inclusion criteria stated above. After receiving a list of potential participants from clinical staff, I reviewed each participant's referral form. The referral form is required for admission to Bethanna, and is completed by the person referring the child or adolescent, i.e. social worker, foster parent, biological parent, etc. The form requires rating the client on a list of forty-nine presenting problems. The presenting problems list has evolved to include general areas where foster care youth typically have problems. There is also space on the form for the referral source to expound on any presenting problem, including any that may not be listed. The form also provides information on previous foster care, if any. If necessary, information was also gathered from Bethanna's secure database based on when the participant came into foster care and the number of placements. The participant verified if the information was accurate.

After each referral form was reviewed, I selected 10 participants purposively: 1) to maximize heterogeneity in the sample with regard to presenting problems and past experiences, i.e. trauma, abuse, bereavement, etc.; and 2) to create clusters of similar presenting problems and past experiences. After selecting potential participants, I arranged to obtain consent from the participant's legal guardian that also included consent to audiotape, then arranged a meeting with each adolescent to describe the study, and to obtain assent. The study was approved by Temple University's Institutional Review Board (IRB). Participants were not paid.

Procedure

After informed consent and assent, each participant was interviewed by the researcher. All interviews were conducted at Bethanna's Mental Health Clinic in a private office. Every attempt was made to make the time and place for the interview as convenient as possible for each participant. Each participant was interviewed in one of the private rooms of the out-patient clinic for about 30-45 minutes, at a time that did not conflict with any of their other scheduled services. Each interview was recorded and notes were taken during the interview. The recordings of the interview were initially listened to for comparison of my interview notes and to ensure accuracy and clarity with the participants' responses. Additional notes were taken while also listening to the recorded interviews for use in the analysis. Any additional listening occurred as needed so that the transcribed interview remained as authentic as possible to the interview itself.

Before the interview began the purpose of the research and what type of questions they would be asked was explained to each participant. Participants were free to respond how they wished, and were given freedom to answer the questions as they wanted or not at all.

I used a structured interview that I developed to solicit data on the participants' early childhood, pre-adolescence and adolescence (See below). The interview included questions and prompts about their experiences in their biological home, their foster home (s), and the role of music at different periods of their life.

Although the questions and prompts were developed to gather specific information about the participants, I attempted to create a natural flow to the conversation, and also allowed the participants to discuss what was important to them to the extent possible. I used certain prompts to initiate discussion of each topic, and to get the participants to expound on their lives. During the interview, I attempted to maintain an empathic and supportive stance to ensure the comfort and cooperation of each participant.

Materials

Questions for the structured interview were developed based on three music therapy assessments: Bonny (1980), Bruscia (1993), and Katsh and Merle-Fishman (1985). Bonny (1980) developed a questionnaire to assess music experience. The questionnaire includes four areas: practical music experience, music appreciation, music preference, and hearing acuity. Katsh and Merle-Fishman (1985) created a questionnaire for gathering information on an individual's preference on the types of music and musical activities he/she enjoys daily. Bruscia (1993) developed a questionnaire on music preferences and musical activities throughout an individual's life. This questionnaire most matched the style of my structured interview due to specific questions being asked, and its focus on specific periods of a person's life, such as childhood, adolescence, and post adolescence. However, the interview itself was structured within different personal and musical contexts of the participant's life.

The Musical and Personal Biographies of Adolescents with Foster Care Experience

Instructions:

I am interested in learning about your life so far, and particularly about your musical life. So if it's OK with you, I'd like to ask you some questions about these topics. Please free to respond however you wish, and if there is any question you do not want to answer, just let me know, and we can go on to the next.

Age:

Currently in Foster Care: Yes No

Number of Years in Foster Care:

Number of Foster Care Placements:

Before Foster Care:

Do you have any memories of your home life before foster care? What are they?

Did anyone in your family sing or play an instrument?

Do you remember singing or playing an instrument during this time? With anyone? Where?

Do you remember listening to music during this time? With anyone? Where? Live or recorded?

Is there any place that you associate with making or listening to music? Home? School? Church? Anywhere else?

Do you remember how to sing or play any music from this period?

Any favorite pieces of music or recordings from this period?

During Foster Care: Let's talk about your life in foster care now.

What was it like going to foster care the first time?

Do you have any memories of any specific placements? What are they?

Do you remember singing or playing an instrument while you were in any of your placements? Which placement(s)? With anyone? Where?

Do you remember listening to music this time? Which placement? With anyone? Where? Live or recorded?

Is there any place that you associate with making or listening to music? Which placement? Home? School? Church? Anywhere else?

Do you remember how to sing or play any music learned at school, church, or foster care? Which placement? With anyone?

Any favorite pieces of music or recordings from this period?

Any favorite band or singers since being in foster care?

TODAY: Let's talk about your experiences today.

What was it like being placed in your most recent home?

How important is music to you today?

What kinds of music do you like the best?

Any band or singer you like?

Do you sing or play an instrument? With anyone? Where?

How much time do you spend listening to music? With anyone? Where?

Any favorite songs or recordings?

OVERVIEW: Let's talk about anything that we already haven't related to your life and music.

What is the overall experience of being in foster care been like for you?

Is there anything else about music that you would like to talk about?

Data Processing

Data from my notes and the recording of the interview were re-organized and recorded based on the outline of the structured interview. That is, information obtained from each participant was organized according to the specific questions and prompts of the structured interview.

To synthesize the data, I made two comparisons: a within case comparison (comparing responses to different questions within each case); and a cross-case comparison (comparing responses to each question across participants). When transcribing the within case comparison for the results some of the responses of the participant were edited grammatically for sentence structure, but the overall language of the participant was not changed. For example, in the results I would add an omitted pronoun, or word, with brackets so that the analysis of the participants' response was mostly grammatically correct but maintained the "tone" of the participants. For participants who provided favorite songs, the lyrics were reviewed for the within case comparison but not analyzed as an essential part of the study.

Participants' names were changed to protect their identity.

CHAPTER FOUR:

INDIVIDUAL CASES

Steve

Steve is a 17 year old male, currently in foster care; however, his current foster parent is in the process of adopting him. He has been in foster care since he was two years old, and has resided in 10 or 11 placements over the 15 years.

History/Background Information

Steve was referred to the out-patient clinic at 14 years of age to address problems with anger management and the appropriate expression of his feelings. At the time of the referral, he was also receiving Behavioral Health Rehabilitative Services (BHRS), which is a community based service where treatment is provided in the client's home, school, and community. This type of treatment service is typically considered a more restrictive level of care than out-patient.

During his initial evaluation for out-patient services, Steve admitted to having an anger management problem and to lying regularly. There was also reference to him being cruel to animals, but according to the evaluation, Steve minimized the severity of it. As a result of the evaluation, he was diagnosed with an Axis I disorder of Adjustment Disorder with Mixed Disturbance of Emotions and Conduct (309.4). Other presenting problems included the lack of conflict resolution skills, the lack of ability to express his feelings about frequently moving from home to home, and lack of appropriate communication with other family members.

As a part of his initial evaluation, Steve denied any history of violence in his biological family. He never met his father, and his mother had a significant history of substance abuse. Also, his mother had been diagnosed with Bi-Polar Disorder.

Before Foster Care

Steve came into foster care around the age of two. Understandably, he had no or little memory of his life before foster care. To my first question of do you have any memories of your home life before foster care; he responded: "No I was a child, like as a baby." When asked whether anyone in his family sang or played an instrument, he began to discuss his sister, who sings semi-professionally and goes to college for music. Although he had no specific memories of his sister before he was in foster care, he spoke about how at this age, he associated music with his home and his sister. Recalling his sister and his shared music experiences with her appeared to be more significant to him than remembering whether these experiences occurred during his life with his biological family or foster family. He had no memory of any other contact with music and/or music experiences before being in foster care.

During Foster Care

Steve was more readily able to discuss his extensive experience during foster care than he was able to discuss his experience before foster care. When asked what it was like going to foster care the first time, he responded: "Being a child; I was crying, I was with my mom, I remember being here [at the foster care agency]. I had a meeting here in a room and then went to a foster family. My little brother was also here. [It was] hard at

first [going to foster care], because I did not know anyone; after a while I got used to being there." At the time he didn't know that he would be moved.

When asked whether he had any memories of any specific placements, he responded: "I remember a lot of different families. I know most of them loved me or took care of me, [but] some of them didn't, some of them were in it for the money." Upon further inquiry, he noted that "A good memory was when [my brother and I] were living with a foster mother, who had a lot of money and a nice big house. We used to go skiing. She bought us dirt bikes. Another good memory is I got to see my family [biological] a lot. I lived all over Philadelphia."

When I questioned him about his playing an instrument, it elicited a more expanded response. He replied: "I used to play the drums. I was in drum line for the west regional band. I was living with my aunt [kinship care]. I had a good experience with my aunt in that placement, but we had to go to another home. After that, I kind of stopped, I would play a little with my drumsticks, but I was not as good. My aunt would push me to play." Although he had enjoyed playing the drums, he [and his brother] had to move from this placement because his "aunt was getting elderly and could not take care of us anymore." Unfortunately, he did not continue to play actively with a group.

Steve also remembered listening to music. He explained: "I listen to music when upset; it is an escape. I ignore people so that I am not bothered. I like any type of music." His favorites were Hip Hop and Rap. When describing his experience with live music, he said: "I remember going to a gospel concert. It was fun. A social worker took us. I remember her name [said name]. She took us before she went back to college."

When asked, Steve did not associate particular places to making or listening to music, however, he did remember making music when he lived with his aunt. He said "Yeah, I am a little rusty; I used to know how to read music. But since I stopped playing, I don't remember. School taught me that. I was in middle school. I played in a school band, and I played snare. I was learning how to play quad."

His favorite group at this time was B2K, but he did not have any favorite songs or recordings. He did remember listening and hearing many songs because his sister "played a lot of different music and it rubbed off on us."

Although he has had 10-11 placements, either he had no other memories of them or he did not want to talk about his experiences, musical or otherwise. It's important to note that Steve did not choose to move every time his placement was changed. His strongest memory about music was playing drums, which was strongly connected to living with his aunt. Unfortunately, however, once he moved to the next placement, he was never able to follow up with playing drums with another group or playing another instrument.

His Experience Today

Steve is now close to being adopted by his current foster parent. "Being adopted is good. I still get to see my family [biological]. I go to school. I am learning how to drive. [I am] being taught how to be independent." Steve admits that music is very important to him today, because "it doesn't tell you who you are. It gives you a symbol of the type of person you are."

His favorite type of music is still rap, and his favorite rappers are Meek Millz and Young Money. He doesn't play drums anymore, but when asked how often he listens to music, he replied: "I don't know, about 5 hours a day. I listen by myself; I have a zoom (Mp3 player)." He also listens to one of his friends at school who raps. He had no favorite songs.

Overall Experience

He summed up his foster care experience by saying "Being in foster care is like you are on your own even though you have a family. As I was growing up, I felt like I was raising me and that was what gave me the attitude now. It gives you the attitude that you can't trust anybody. I moved around a lot and that is what I always told myself. I was never able to [trust] as a child. As I got older I did not get close to people because I was going to move or leave [them] anyway. I got into fights a lot. I got in trouble a lot when I was younger." His own report of moving frequently from placement to placement and not wanting to always re-adjust seems to fit with his diagnosis of Adjustment Disorder.

Steve's initial entry into foster care was emotionally troubling for him and throughout his life in foster care thereafter, he continued having difficulty adjusting to each family. He remembers crying a lot because he was not prepared for the move and because he didn't know anyone in the new placement, including the foster family. He is brought to the foster care agency by his mother but never returned living with her. He remembered many foster families, and remembers being both loved and not loved by them. Significantly, based on his own account, the families that did not love him were

families that were only in it for the money. His last response about music was "Music helps you get through the day; if you are down or if you are happy. Music gives you a train of thought, it helps you think better."

Interpretive Summary

During foster care, Steve was not given a choice about moving, nor was he adequately prepared for the move or new placement. Therefore he did not understand why he was being moved and where he was going. As a result, Steve responded to so many placements by having a lack of trust in others and an inability to form positive attachments to people.

Steve's only positive transition to a new foster home occurred when it was appropriately explained to him that he was moving to another home because the current foster parent was too elderly to fully take care of him and his brother.

One of the most significant determinants of whether a foster placement was a positive or negative experience was the financial security of the foster family. Steve understood this in terms of whether the foster family could afford to do more than just meet his basic needs. Thus, he associated positive foster care experiences with being involved in recreational activities such as skiing, but not to other growth activities, such as going to school and to different cultural or social events.

Steve reacted to his disappointments with his foster families and placements by adopting a self-defeating way of reacting to life. He admitted in the interview that he "was the one with the attitude, didn't trust anyone, and generally got in trouble." Interestingly, the only foster home, other than his current adoptive home, that is

associated with a positive experience, is in the home where he was also formally and actively involved with music. The foster parent facilitated active involvement with music, which enhanced his sense of trust and provided a positive emotional experience. There appears to be one constant in his foster care experience: Steve moved frequently from one placement to the next, almost yearly—and the reason for his move was always the same—the foster care family could not take care of him appropriately. Unfortunately, every placement affected all aspects of his life, and particularly his involvement in music.

In regards to his musical life, there appears to be two constants: 1) he remembers listening to his biological sister sing and play music, which occurred before coming into foster care at the age of two; and 2) he always listened to music, mostly rap, and he still does.

Steve's involvement in music seemed to be directly linked to whether his experiences with his biological and foster families were positive or negative. Informal and formal involvement in active music making provided a positive experience for him; when he was able to be involved actively with music he, not coincidentally, was able to attach with care givers. While the intensity of his active music involvement lessened as he moved from one placement to another, his music listening increased proportionately. Listening to music (mostly rap) provides an escape for him and allows him to attach to something other than another unstable foster home. He is able to understand music, it is a manageable experience for him, and this helps him to see some meaning in his life.

John

John is a 15 year old male, currently in foster care, but currently in the process of being adopted by his foster family. He has been in foster care since birth, and has been in 6-7 placements over the last 15 years of his life.

History/Background Information

John is a younger sibling of Steve. He was initially referred to the out-patient clinic to address issues of anger management. Like his brother, he was receiving BHRS services. At the time of the intake to the clinic, his presenting problems included: communication conflicts with others, anger/aggression, lack of consistent pro-social peer interaction, and a need to express emotions more appropriately.

During his initial assessment it was noted that he can become very angry, and that at times, his anger leads to yelling, cursing, and property destruction. John also has a history of being "mean" to family pets. In one instance he pulled a cat's tail, and then threw it against a wall, apparently with little empathy or remorse for what he did. He was diagnosed with an Axis I disorder of Adjustment Disorder, with Disturbance of Emotions and Conduct (309.4). He also has a Reading Disorder diagnosis (315.0). His mother has a history of substance abuse and has been diagnosed with Bi-Polar disorder.

Before Foster Care

John came into foster care immediately after he was born. He understandably had no memories of his life before foster care except for his sister who is a professional singer. Like his brother, this memory is blurred between his close relationship with her presently, and his actual experiences with her before foster care. He also had no memories and/or experience with music at this time in his life.

During Foster Care

John was more expressive when discussing his foster care experience. Although he understandably would not have any particular memory of his life before foster care, when asked what it was like going to foster care for the first time, he responded: "First time I stayed with my aunt. I was going to get adopted but she had a stroke/heart attack and she died." When asked whether he had any memories of specific placements, he described his experience of finding his aunt after her heart attack. He remembered that "When she was laying on the ground; I did not know what to do." He also recalled that when he lived with his aunt, he "first learned how to ride a bike and [he] crashed into a pole."

John didn't remember ever singing or playing an instrument in any placement, but he does remember listening to rap music at one placement in particular. "When I lived with a lady, she was ok, but when we got in trouble we had to go to bathroom; we had to pee in a bucket. We left that home when my brother got a welt on his face because the foster parent "whupped" us." He then associated a song with this placement, "I remember this song from Biggie and Tupac, Living *to Die*. This song sticks out because I did not really belong so I did everything so I did not have to stay there. So I got 302'd. I didn't want to stay there. I had scissors in my hand and said I was going to kill myself. I just did not want to stay there." It is interesting that with a simple inquiry into John's music listening, he was able to expound not only on what would be a significant traumatic experience of being physically abused but also on his intent to commit suicide. Upon further discussion, John explained that suicide seemed to be the only way he could

get out of this home. Thoughtfully, he associated his experiences of being physically abused and his suicidal thoughts with a song that he listened to during this tough placement. John also added: "I still listen to *Living to Die* from that tough placement." John didn't remember singing or playing any music but he did have two favorite songs: *Who Shot Ya* by Biggie Smalls and *Window Shopper* by 50 Cent, both considered Rap

John has spent his whole life in foster care. Although he lived with extended family members, such as his aunt, he never lived with his biological parents. His experiences in foster care seemed mostly negative and traumatic. In one placement, his caregiver died and he witnessed this. In another placement, when talking about learning to ride a bike, his memory of this was running into a pole. In another placement, the caregiver was abusive in making him and his brother urinate in a bucket when they were "bad." He disliked this placement so severely that he threatened to harm himself just so he could get hospitalized and subsequently be removed from the home.

His music choices seem to describe his life very poignantly. For example, the chorus of *Living to Die* seems to describe his existential crisis at a very young age. With the other two songs he chose as his favorites while in foster care, *Who Shot Ya* and *Window Shopper,* one is a rap about killing someone; and the other song describes how others are jealous of an artist's current life. John was able to associate all of his favorite songs with a specific placement or foster care in general.

His Experience Today

When asked what it was like being placed in his most recent home, John exclaimed: "It is like heaven, I have everything I never had before. I never knew my dad.

My [caregiver] is the only father figure I ever had, so I call him my dad." John then described how important music is to him today. He said, "[It all] depends on what you listen to. All that killing is not necessary. Music is very important, without music is like where there is no art." John also shared that he was finally at a place he could call home; he had a caregiver that not only took care of him but also was really committed to meeting his needs.

When asked about his favorite types of music, musicians, or groups, he responded that he liked "R & B, Soul, Rap, Hip-Hop, Gospel" and that he didn't like any particular musicians/groups; rather he "listened to everything." John does not play an instrument or sing, but he spends a lot of time listening to music. He added "I listen to music all day. I listen by myself and sometimes with friends, but not my music. With my friends we only listen to hip-hop. I listen to music at school and home." John readily reported that he had two favorite songs. The first, *So Many Girls* by Meek Millz is about girls and knowing so many of them. The other song, *Money to Blow* by Young Money is about having lots of money. Both of these topics are probably concerns of most adolescent males.

During this part of the interview, John remarked that he listened to music with his friends but did not listen to "his own" music with them. He never further clarified, but he seemed to have special moments where he would listen to music that was especially meaningful to him. Perhaps John was too embarrassed to share his own personal music with his friends, or perhaps he just needed to have "his own" music.

At the time of this interview, John is in a more hopeful place. He apparently has a very good relationship with his foster parent who is planning to adopt him. John realizes that this will be a significant change in his life, for the better.

Overall Experience

John began to elaborate further when describing his overall experience in foster care. "You have to really bond with someone in foster care, because you can't trust everyone you live with. You can't let your guard down because they might do something to you. And some people are in it for the money." He coolly added "well, a lot of people."

When I asked him if there is there anything else about music that he would like to add to what he had already said, he hastily retorted "no." Interestingly, John was better able to talk about music within the context of his foster care experiences. Before I could ask him if he would like to discuss anything further, he added: "Music is different now. They used to talk about good stuff, but now they talk about killing, cars, gangs; no one wants to hear that, I know I don't."

John has spent all of his life in foster care. He has been able to visit with his biological family on a regular basis and he is currently in the process of being adopted by his current foster parent. Based on his responses in the interview, throughout his life, he has had no experience with active making music; instead, all of his experiences with music are receptive, essentially only listening. He has shared music experiences with friends but not family members. Also, he listens to music in solitude so that he can listen to "his" music.

His responses during the interview seemed to demonstrate in-depth thinking in that he discussed trust and openly talked about traumatic events in various foster care placements. However, and paradoxically, he noted at the end of the interview that "Music is different now. They used to talk about good stuff, but now they talk about killing, cars, gangs. No one wants to hear that, I know I don't," but the music he currently listens to is of the same genre and has the same content.

Interpretive Summary

John entered foster care at birth. Throughout his life, whether he lived with his biological sister or not, his memories of the past revolved around shared musical experiences with her. Based on his account, these shared musical experiences were brief but positive for him. This strong association with his sister and lack of other memories or associations may be a way that he avoids dealing with memories of his biological family and the emotionally troubling experiences he had with them.

John has no memories of any active and formal musical experiences. His one association between music and foster care was of being abused by a foster parent, which he associates with a rap song that he remembered listening to at the time. In this instance, he did not use the song as an escape, but rather a way for him to express himself, albeit through someone else's words. Expressing emotions appropriately has been difficult for John, especially at this time of life. Unfortunately, he even threatened suicide after the incident. Though this song provided some resolution and relief to his trauma, the lyrics may have also reinforced his dysfunctional behavior of separating

himself from others, and becoming emotionally withdrawn—apparently a pattern that he developed as a result of unhealthy bonds with significant others in his early life.

John trusts music; he derives meaning from listening to music. The problem however is that instead of attaching easily to others in his real life, he attaches to the music and the artists, with which there can only be a superficial or distance emotional attachment. This seems to reinforce his avoidance of and separation from others, and the absence in his life of positive emotional experiences with others. The rap song he associates with his earlier struggles and troubling foster care experiences still weaves through the story of his life. The song is not just an expression, but an implicit description of the meaning he finds in life, and the resulting existential crisis. Music listening then has been used throughout his life as an escape and a way of finding meaning in life; when listening with others, particularly his friends, music is used as an interpersonal connection or a healthy sense of attaching.

Mark

Mark is a 16 year old male. He is currently adopted but spent 12 years in foster care. He detailed his placement history at the initial part of the interview. His first, and longest, foster care placement was between the ages of 4 and 14. His second foster care placement lasted only a couple of months. His last three foster placements lasted two years, then six months, and again two years respectively. His placement history also

included a lengthy stay in a residential treatment facility and two placements in a psychiatric hospital, both intermittent with his five foster care placements.

History/Background Information

Mark was originally referred to the out-patient clinic while residing in the residential treatment facility. At the time of the initial referral, he was placed in a treatment foster home with a definitive plan in place for him to return to his biological mother in a few months. However, about two weeks before he was to be discharged from the facility, his mother relapsed in her drug use. Therefore he was unable to return to her.

His mother has an extensive history of substance abuse and has also been diagnosed with bi-polar disorder. Throughout Mark's life, he has been in and out of foster care due to his mother becoming sober and then subsequently relapsing. At the age of four, he was placed in a shelter and then placed with his paternal grandmother. While living with his grandmother, Mark threatened her with a butter knife and then was removed from her care. He then resided in a series of foster homes until his behavior and mental health issues became so intense that he was placed in a psychiatric hospital. Although the dates are unclear, based on his referral documentation, he has been hospitalized twice because of suicide attempts. For the first attempt, he attempted unsuccessfully to hang himself; for the second, he tried to jump out of a window but was thwarted. He was placed back in the same residential treatment facility shortly after his last psychiatric hospitalization.

At the time of his referral to the out-patient client, Mark was unhappy because he could not return to his biological mother due to her substance abuse. He was also

struggling with myriad symptoms. His numerous presenting problems included: aggression, anger management, bereavement, depressive symptoms, enuresis, emotional abuse, family conflict, fire setting, hyperactivity, impulsivity, oppositional behavior, physical abuse, physical neglect, school suspensions, sleep disturbance, stealing, and a witness of violence. He is diagnosed with two Axis I disorders: Attention Deficit Hyperactivity Disorder (314.01) and Depressive Disorder Not Otherwise Specified (296.30).

Before Foster Care

From the beginning of the interview Mark was eager to talk about his experiences before foster care. When I questioned him about his memories before foster care, he explained "Living with mom was crazy. Mom and dad fought a lot and argued, and fought with my siblings." Without prompting he also added:

> I don't remember living with my aunt. I was taken from her because she couldn't take care of me or my siblings. The State said my mom and then my aunt could not take care of me and [so they] put me into foster care. I am the only one of my siblings who has never been able to return to my mom or aunt. Makes me feel kind of mad, but I am able to deal with it now. I plan to live with my mom after my first year of college.

Mark seems to believe that when he first lived with his Aunt it was not foster care. The majority of children taken from their biological parents and placed with another family, even if the family is related to their biological family, are considered foster care children.

In reexamining his response, it would appear that his initial description of life before foster care was rather confusing for him, if not traumatic.

I followed up with asking him if anyone in his family sang or played an instrument. He remarked, "No, my closest sister is a model, my brother raps, and got a record deal." Mark does remember playing an instrument. When he was between the ages of 6 and 7, he played drums during visits to his biological family. He then added "I used to sneak out while church was going on and I would sneak back into the church and play the drums, and they would just let me play." Subsequently he associated making music from this part of his life with church. He also remembered listening to music during this time in his life; "I listened to Rap music. It is basically what I listened to all my life; with my brothers and sister, in my room and car. And, I watch a lot of music videos." He did not remember how to sing or play any music from this period of his life, and when asked if he had any favorite pieces of music he deadpanned "not really."

Mark told me in the beginning of the interview: "I was taken from my mom at nine months and lived with my aunt." Typically when a child is removed from his biological home by the child welfare system to live in a relative's home, it is considered kinship care. Kinship care is one of the levels of foster care; however Mark does not seem to understand this, as he reported to me that he did not enter foster care until he was four years old. Mark does not have many memories from this part of his life (before four years old). He reported that no one played or sang music in his home, other than his brother rapping, and that he had no active music making experiences except for playing drums in church, which actually did not occur while he lived with his biological family,

but did occur while having visits with them. It appears that he has memories with his biological family, just not when he officially lived with them.

Although memories of his biological family are fuzzy, music did play a role in his life. He mentioned that he always has listened to music. Also, a significant part of his memory is actively playing drums although not in a structured setting such as with a group or lessons at school or other places.

During Foster Care

Based on the initial part of the interview of his life before foster care, I tried to have him focus on more detailed memories of his life in foster care that would differentiate his experiences. With my question of what was it like going to foster care the first time? He responded, "It was good, basically [the foster parent was] an angel. As I started getting older, I got 'badder' in school; from kindergarten up to 4th grade, I would get A's and B's, but from 5th grade, I started failing." He continued:

> I would lose my focus, started hanging out with bad friends. [In the] 1st placement, she [foster parent] would hit me with spoons when I was bad. I started doing bad stuff around the house. I started smoking weed at 12; I had a gun in the house, not loaded, it was a friend's gun. I told her I wanted to leave. [In the] 2nd placement, she was ok, but not a lot of freedom. I didn't like it there. [In the] 3rd placement, [I had] a lot of freedom but kept getting into trouble instead. [For the} 4th placement, I didn't get a lot of freedom [and I] didn't get into a lot of trouble. [She was] strict [so I] asked to be moved out.

I further inquired if he had any other memories of any specific placement. He emphasized, "In RTF, [the staff would] take us on trips, to the swimming pool and to movies. We did a lot of fun stuff. It was not as bad as I thought it was going to be, it was alright."

In regards to singing or playing an instrument in any of his placements, Mark expressed that, "Since I left my first house I haven't played. When I moved into the last placement, I joined a marching band at school and played snare drum and bass drum. I played for 2 ½ years." When I asked him if he still played, he said, "Not since I moved [with my current caregiver] to a new school." When I asked him about his music listening experiences, he replied: "In one placement [I] started to listen to Christian music and going to church. I became more interested in God, and finally became a Christian. I listened to music there in church." He also noted, "I listen to rap and Christian. I mostly listen to rap now." He does believe he remembers how to play the drums still and remarked, "I can play some; if you gave me music I could play some."

When I initially asked if he had any favorite songs he said no, but when I asked about any favorite singers or groups, he mentioned that he liked Kanye West and that his favorite song was *Jesus Walk*.

Mark described how since he has lived in his placement he started to go to church, then became interested in Christian music, and finally became a Christian. Interestingly, when talking about the song he chose as his favorite, he explained that that song was about, "How he [the singer] was a Christian and how he then sold his soul to the devil." However, in further examining the lyrics of the song, rather than representing

a Faustian theme, the lyrics seem to describe the singer's plea to have God help him and not have the Devil "break him down."

He discussed his foster care placements in relative detail, but he did not mention his history of suicide attempts or hospitalizations. Also, there was no mention in his initial referral history that he had a friend's gun in one of his placements. This would have seemed significant since he also mentioned he was smoking marijuana at the same time. Interestingly, he did enjoy his time in a RTF.

In summary of Mark's music experiences during foster placements, he played drums in a school marching band; however, after he moved from that school and placement he no longer played drums. Although he notes he could still read music. He listens to Christian and Rap music but prefers Rap. He did not initially note any favorite music from this time but did note a song when he mentioned a favorite singer.

His Experience Today

I initially asked Mark what it was like being placed in his most recent home. He replied "Good here, not much problems, we all get along. We do what we have to do, so she [caregiver] won't fuss. Good out here, good school." In talking about music, he claimed that music is "Not really that important, I could go without music." He added that he did like, "Rap, hip-hop, R&B, some rock" the best. He expressed that his favorite singer is Kanye West and his favorite band is AC-DC. He further pointed out "I had a CD [of AC-DC] but it broke. I like some heavy metal, like the rhythm."

He currently sings in a choir at the church where his adoptive mother attends. He bemoaned: "I sing in a choir for my adopted mom; I do it 'cause I have to." Although he

remarked that music is not important to him, he did respond that he spends "50% of the time listening to music. [I] don't listen with anyone, chill with myself, out in the garage in the summer time." He added he likes to listen to L'il Wayne's *Watch My Shoes* (which is about the artist and his prowess within the rap world), and *Drop the World* (which is about taking over the world).

Mark is currently adopted, and presumably in his most stable placement, however his discussions of his experience appear contradictory. He notes it is "good" where he lives, but wants to live with his mother when he goes to college. Similarly, with his music experiences, he notes that music is not that important but typically spends half his time (50%) listening to music. He also notes that he sings in a choir but does it because he has to.

Overall Experience

When asked about his overall experience in foster care, Mark summed it up this way: "[I'm] so used to it, when I look back it is not that big a deal now. I am almost 18 and out of it [the foster care system] anyway, they don't have any control of you then." He also noted that for his over all experience with music that he likes "to debate [about] who is the best in rap."

His experiences of foster care, as revealed in referral documentation and his experiences as revealed in this interview, differ greatly. As noted above, there were many contradictions about what was positive and what was negative. Interestingly when reviewing the lyrics to one of the songs he chose as his favorite (*Drop the World* by Kanye West), the lyrics appear to represent his conflicting emotional instability.

Overall, although there is some discrepancy between his actual life and how he describes it, he has always had a relationship to music. The one constant and instrument he associates with music is the drums. At different times during the interview he brought up playing drums, both formally (as in a school band) and informally (sneaking into church to play). He doesn't formally play an instrument now, and his current music experiences revolve around listening to music, mostly rap, and singing in a church choir. It is unfortunate that when he moved to his current home, he changed schools, but did not continue to participate in school music programs. Although he does sing in a choir, he notes he does it because he "has to."

Interpretive Summary

Throughout Mark's numerous placements his personal biography revolves around his mother's inconsistency with providing a stable and healthy relationship with him. His mother is in and out of his life. She receives rehabilitation from her substance abuse, he returns home, she then relapses, and then he is again placed in foster care. He is not given any other option and has no choice in his placements. Rather than having his mother literally reject him again he begins to act out as a feeling of shame, and develops an unhealthy sense of rejecting himself. It would seem easier to reject himself than come to the realization that she is rejecting him. Interestingly, Mark still would like a connection with her, noting that when he goes to college he wants to live with her. In this sense, he can then control if he leaves or stays, which increases his own internal locus of control. This may also be another feeble attempt for him to find the healthy bond that

should have occurred at childhood, rather than coming to terms with the emotional pain he suffered through his experience.

While in foster care, Mark behaved paradoxically. He wanted freedom and independence, but when given them, he became overwhelmed, rejecting, emotionally withdrawn, and suicidal. The paradox for Mark seems to be freedom versus internal control. Interestingly, his most positive placement seemed to a residential facility, where one encounters the most restrictive level of care and an extreme lack of opportunity for independence and freedom. Throughout Mark's experience in foster care, he exhibited symptoms of both homicidal and suicidal ideation, and he showed little capacity for coping with the emotional rejection he experienced while he was with his biological family.

While in foster care, Mark experienced both formal and informal active involvement with music making. Not coincidentally, the active and formal involvement in music making began with a foster care parent who then adopted him. The foster parent then encouraged active and formal involvement with singing in a church choir. The relationship between his placement stability and emotional stability directly correlates with a foster parent who encouraged active and formal involvement in music making. This involvement in music then provided the foundation for a healthier internal locus of control. His drum playing and singing in a choir metaphorically represent the shift from an unhealthy internal locus of control to a healthier one. He needed the external supports to balance out the internal emotional chaos he must have felt.

Listening to music has always been connected to his biological family. He listened to rap music throughout his life with his biological family, and he associates music listening during this time in his life with his biological siblings.

When Mark changed his listening habits for a period from solely listening to rap to then listening to Christian music, not only did his emotional stability improve, but he also experienced a complete change in life style—he became a Christian. Music listening during this period provided Mark more opportunities to make choices and take control. Subsequently, Mark can choose to listen to the music he wants, and now music listening allows him an opportunity to relax. Without developing a sense of his own personal control and independence, Mark would have continued to feel shame, doubt, and general lack of autonomy.

Music played an important role in Mark's life. Mark was unable to handle the stressful circumstances in foster care, and the lack of safety and security that he encountered within his biological family. As a result, he developed abnormal and unhealthy coping mechanisms, involving both suicidal and homicidal ideation. Mark's active and formal involvement with music provided a healthy outlet for coping with his life circumstances, while also relieving the stress and lack of security and safety he experienced.

Martin

Martin is a 17 year old male in foster care. He has been in foster care for the last four years and has had two placements.

History/Background Information

Compared to the other interviewees thus far, Martin came into foster care at a very late age. He was originally referred to the out-patient clinic because he was recently moved into a new home. Martin lived with his father for most of his life, but he died when Martin was 14. He was then sent to live with his paternal aunt in kinship care. While living with his kinship parents, he was moved again to a foster home due to a conflict between the foster parents and biological mother. The current foster parents are not related to him. Martin still wants to live with his kinship parents, but the Philadelphia Department of Human Services (DHS) still has concern with him returning.

In his referral information, DHS noted that his kinship parents continually spoke to Martin negatively about his mother. Because of this, Martin has become more argumentative, and unfortunately this has caused instability in his placement with them. Martin's other presenting problems included being easily frustrated, having conflicts with his kinship parents, and being suspended and expelled from school. This all occurred after being placed with his kinship parents. At the time of his intake, Martin had admitted that his biological father emotionally abused him by calling him names, and that he also physically abused and neglected him. His Axis I diagnosis is Adjustment Disorder Unspecified (309.9).

Martin struggles with anger and resentment over the absence of his mother in his life. He wants to be reunified with her. Nonetheless, Martin continues to be confused by what his kinship parents were telling him about her and also his father's negative comments about her before he died. At this point, Martin has not resolved the idea of living with his mother, given what the paternal side of his family says about her.

Before Foster Care

Martin was quick to discuss his memories about his life before foster care. He first stated that he had "pain and also good memories. Living with dad was always good. He played with me and took me to places." He then added: "Dad abused me and had mental issues . . . [he] hit me with a belt, and he started beating me like I was a grown man. He passed away. [He] never lived with my mom." Later, Martin explained that his Dad had eight other sons that he had never met. He continued: "There is a lot, I can't really explain it." When asked for more information on his pain and his good memories, Martin would not elaborate further.

Martin appears to have a rich experience with music before entering foster care, and he was quite willing to discuss the role of music in his life more fully. Martin began: "My whole family plays an instrument. My uncle plays guitar and drums; he has his own band, and plays jazz. My whole family is into music and art. Dad played sax; he played a whole bunch of stuff." Martin also remembers playing an instrument but responded "I keep those memories in my head, because the memories of playing are very important to me. I tried to play guitar, [but] never fully got into it. My whole family played at my uncle's house."

Listening to music was also important to Martin. "The whole family, aunt and Dad, would take me when my uncle was playing. [We would] listen to all types of music."

Martin's uncle played a significant role in Martin's music experiences. He used to enjoy watching his uncle play. Martin did briefly discuss other family members but he did not add anything further about his association with music and them.

In addition to associating music to his Uncle, Martin associates music with school. When asked about school, he said: "I had my own band; I played drums, played downtown, outside [my] house, just to be doing it, making some noise." It was unclear whether Martin played in the band at school, or if he played outside school with peers from school.

Martin remembers one song from this period; *I Can Say That*, which he wrote. He did not tell me what the song was about. His favorite piece of music from this period is a song by Jay-Z entitled *On to the Next One*. In this song, the artist describes his motivation, successes, and perseverance in the music world, which sounds like what Martin thinks about.

During Foster Care

When I first started talking with Martin about his foster care experience, he did not realize that living with his aunt and uncle was considered foster care. So, with my first question of what was it like going to foster care the first time he responded: "It was strange. [I] didn't know the people I was going to see and the house. I just miss my family; I can't see my family now." He had assumed that foster care began after he moved from his aunt and uncle's home. After I explained to him the difference, he described living with his aunt by saying: "They were good. Me and my cousin would

play games together. The family would come over and we would have parties." He sadly added that there is a "Court order that I can not see my family."

When asked about playing music, Martin said "I would try and play at my uncle's house. I don't play here [his current home]." In regards to listening, he responded "I remember listening to music on CDs, and watching my uncle [play] live. I listen to music in my room or outside at school." After a moment of silence, Martin went on to say: "I can't see my family it hurts so bad."

When asked if there is any placement that he associates with music, Martin blurted out: "I hate being in foster care, I hate being in the system period. I am being seen as a number not a person." Martin then became withdrawn, and seemed upset. He ended this conversation by saying: "I get out of the system next year when I am 18." Martin did not have anything else to add at this point, and I took a moment to let him calm himself a little.

Martin also associates music with church. Just like his other association with music, Martin was involved with church music while living in kinship care but not in his current placement. He indicated that while living in kinship care "I was in the church choir, and sang gospel songs. I remember one song *Never Would Have Made It* about not doing the right stuff." He then mentioned "Church is church, I missed the stuff at my old church, and I don't do any music at this church."

For his favorite song he again stated "*Never Would Have Made It."* A repeating lyric in the song is "I never could have made it without you." Based on the religious context, it would appear that the singer is talking about God; however I wondered if

Martin mentioned this song to talk about someone else in his life. He indicated that his favorite group is Green Day and noted two favorite songs. The first is *21 Guns*, a song about struggles in life; the second is *Travel In Time,* which appears to be a love song. The lyrics to *21 Guns* seem to represent Martin's description of his foster care experience most readily. Interestingly, Martin was the first male participant that did not have a Rap song as his favorite during foster care.

His Experience Today

The tone of the interview changed when Martin began to discuss his present experience in foster care. He was not as withdrawn or upset. Although he had earlier mentioned how he did not like being in foster care, when I asked him about his experiences today, he stated that "It has its ups and downs, it can be good and sometimes [it] can be bad. We go out places; they take me out bowling. When I am here [in the home] there is drama."

He still finds music very important to him. He explained: "A lot of people are influenced by music in so many ways. [Music] teaches me how to change, or [it] can teach [me] how to go the wrong way. It tells both sides of the story." His favorite types of music are Rock and Rap; his favorite group is Fray, which is a rock band. He does not play or sing now, but he does still listen to music. When asked how often he listens, he immediately responded: "A lot, I am music the way I listen to it. [I] listen with friends at school, listen at home with foster family, and listen by myself, [but] no favorite songs."

Overall Experience

When I began asking him about his overall experience in foster care Martin said: “It can get better; in every way.” He did not want to say any more. He ended the conversation with: “I hope I get rich doing music.”

Interpretive Summary

Confusion and conflicting emotions are two themes that emerge within both Martin’s personal and musical biographies. Martin has received a court order to not see his family, and this has affected him very much. Perhaps this is why he does not feel like he is “treated as a person” in foster care, and why he is so eager to turn 18 and “get out of the system.” His confusion lies in that even if Martin was able to make a choice about living with his mother again or staying in foster care, he appears to be unable to make that choice on his own. His conflicting emotion lies in the fact that he is able to express negative experiences and/or memories, but he is unwilling to express positive memories related to his biological family.

Martin’s ability to participate in music drastically changed when he moved from his first placement in kinship care to his current foster care placement. Now he does not play or sing, and he has limited associations with music. This is unfortunate, because Martin’s quality of life and his ability to make and enjoy music are closely intertwined. His experience now, has led to a lack of sustainable psychological/emotional development. This is most clearly evident when Martin discusses his family and being in kinship care.

Any discussion of music quickly turns to statements about how much he misses his family, accompanied by painful facial expressions. On the other hand, even a simple

mention of his music experiences during foster care induced a response on how much he detests the foster care "system." Yet, Martin is conflicted about his experiences in foster care. His description of previous foster care was one of hate and anger, but when discussing his experience today, while still in foster care, he became rather calm and noted that foster care has its ups and downs.

Martin summarized his feelings about music in two ways. The first was, "music tells both sides of the story;" and the second was, "I am music the way I listen to it." While living with his father and then with his aunt and uncle, the one side of the story was that music is essential and very important to his life. The other side of the story is since not living with them; his ability to interact with music has suffered. His conflicting emotions relate to his favorite songs while in foster care since the songs describe the struggles and challenges he encounters. Music is very influential to Martin; it can help him or hurt him.

Jason

Jason is an 18 year old male and currently in foster care. He has been in foster care for 3-4 years and has had two placements.

History/Background Information

Jason was referred to the out-patient clinic by a caseworker from a Residential Treatment Facility (RTF). Although Jason did not regard this as a placement, he was placed in the RTF after he was removed from his biological home due to escalating negative behaviors and an unstable childhood with no reliable primary caregiver. He was

in the RTF for three years, which is a substantial amount of time. At the time of the referral, the plan was for him to move into a treatment foster care home, which would be his first placement and/or "home environment" outside of RTF and his biological home.

He presented with problems both in the foster home and at school. Particularly he refused to follow directions, tested limits, provoked other peers, had problems sleeping, and exhibited both impulsivity and hyper-activity. He also exhibited self-injurious behavior in that he would bite his hand to the point that it would bleed. Neither biological parent adequately provided for Jason, and one or the other abandoned him at various times. At the time of the referral, he was hoping to establish a healthy relationship with his mother. His biological father's whereabouts are unknown.

Throughout his time in outpatient therapy, he has been diagnosed with three Axis I disorders, which include: Oppositional Defiant Disorder (313.81); Attention Deficit Hyperactivity Disorder Not Otherwise Specified (314.9); and finally Attention-Deficit Hyperactivity Disorder Combined Type (314.01).

Before Foster Care

Although Jason has been in foster care for 3-4 years, starting from the age of 14, he initially claimed that he had no memories of his life before foster care other, than that "me and my sister were close." However when asked if anyone in his family played an instrument or sang, he happily replied: "My dad played the guitar and harmonica; he played around the house. [He] used to sing some silly songs, forgot how it goes." He described one song "about an old guy waking up and stuff." Jason then remembered that

his dad would sing to him before he went to bed. He then added, "I have not seen my dad since I have been in foster care, but I talk to him." Jason also sang while his dad played. "I remember a certain song about an old man. [He also] used to sing three blind mice and I used to sing with him. I liked those times when I sang with him."

Jason also remembered listening to music with his sister. He acknowledged that "I used to watch a music channel/video channel with [my] sister. We knew every song that comes on the radio. It was fun listening with her." He also associated listening to music at school. He stated that in his classes "I would hear songs that my sister and I used to sing." He remembered two songs from this period of his life both by Luther Vandross, *Take You Out,* and *Dance with My Father.* He added "My dad used to play them; [I] used to sing these songs, with my dad and sister." *Take You Out,* describes a man's intention for an amorous relationship with a female. However, the other song, *Dance with My Father*, provides a window into Jason's memory of his family and his longing to be with them.

During Foster Care

Jason's brief response to going to foster care for the first time was: "Scary, I didn't know these people." He did have some memories of his initial experience. He remembered "My friends that I lived near. Going to school and hanging out. I remember the dog and cat, her grandkids; they were fun to hang around with, [but] I moved [from this home] because I did not get along with the care giver's son and also her brother."

His only memory of playing an instrument was the guitar in his first placement. He mentioned that he "learned in an after school program and they would let me take the guitar home, [but] I didn't play for anyone." He then related: "[I] still play the guitar a little bit. [I] enjoy playing the guitar; [I] just play with myself." Not coincidentally his only association to making music in any of his placements is "learning to play guitar from school." He also stated: "I remember playing a song and still remember some of it. [I] played this song with a recording of a piano; I remember the beat."

His memories of listening to music at this time of his life are also solitary. "I listened to music alone and watched music channels," he said. Jason did not have any favorite pieces of music but his favorite band was "Three Doors Down." He reported not listening to rap music.

His Experience Today

Jason is still in foster care but plans to leave the foster care system when he is able. When asked about his current experience in foster care, he responded: "Pretty good, I get a lot done and I don't have time to waste; [I] keep going. I don't have much time to get my stuff together." This is in reference to his plan of "leaving the system."

He remarked about music that, "It's alright; I don't have much time to listen to it. The only time I listen to it is in the car." The type of music he listens to now is R & B. His favorite singer is Trey Songz, who falls under the Hip-Hop, R & B, and Rap genres. He emphasized that he likes Trey Songz because "He grabs girls' attention, girls like his songs." He is not actively involved in making music at this time but would like to do so. He admitted: "I want to learn how to play the drums." Interestingly when I asked him

how much time he spent listening to music he specifically answered "about 17 hours." He did not provide any further information on how he dispersed those hours of listening throughout the day, but instead explained that he mostly listens to music in the car: "I listen to it with my child advocate or kids who are with me when I am with my advocate." Jason is the first participant to note that he listens to music with his child advocate, which all adolescents, under the auspice of the Department of Human Services, receive as an attorney.

Jason responded that he had two favorite songs: *On to the Next One* by Jay Z which Jason remarked is "about making money," and *I Wanna Rock* by Snoop Dogg. Jason did not say what the song is about, but based on the lyrics, the song describes the rapper's life. Interestingly, Jason responded earlier in our conversation that he did not listen to Rap music, but both of his favorite songs would be considered under the Rap genre.

His Overall Experience

Overall, Jason initially responded about his experience with foster care by saying "I wish I did not go through foster care." He then sadly stated "I wish that my mom did not do drugs." After prompted to say more, he said: "I am not the only one who goes through this. Depends on where you go. If you want to make it rough, it will be rough. Depends on how you go in there, [how you] are in foster care. If you are nice, they are nice to you. Sometimes foster care is ok. You get to meet a lot of people, but overall you still are thinking that this is not my family and I want to be with my family." He did not

discuss anything further about his overall music experience. When I questioned him about it he simply replied, "Nothing really sticks out to me. I don't really need music."

Interpretive Summary

As compared to other participants Jason has only been in foster care for a brief period of time. He has extensive memories of music listening and singing with his father and sister, and he mentioned many current songs that remind him of the songs he listened to and sang with them before he entered foster care. Interestingly, Jason did not describe any memories of life with his biological family outside of his music experiences.

Jason was removed from his biological home, and instead of immediately being placed in foster care, he was placed directly in a residential treatment facility (RTF). Based on the foster care's level of care system, this type of placement is deemed more restrictive, one restrictive level lower than psychiatric hospitalization. His mental health would have had to be very worrisome to be placed directly in RTF; yet, he made no mention of any problematic behaviors or any negative experiences with his biological family that would have warranted direct placement in the RTF. This raises questions about whether he has repressed or denied painful aspects of his past, or whether he has not worked through them adequately in therapy.

Jason's last statement regarding his overall experience, "I don't really need music," does not seem to fit with his biography. Before he was in foster care, he had significant memories of the role of music in his life, both actively and passively. He was able to discuss his interaction with his family through music. However, now perhaps music only serves to remind him of not being able to be with them. For example, the

music he listens to now is very different from the music he listened to before foster care. In fact, at one point he stated he does not listen to rap, but when responding about his current listening habits he noted only two artists, both rappers. His foster care experience is associated with active and formal involvement with music making in school.

Fred

Fred is a 15 year old male who spent four years in foster care. He has had 3 placements, however his last foster care parent recently adopted him.

History/Background Information

Fred was referred to the out-patient clinic while he was placed in an inpatient psychiatric hospital. He was being discharged and would be moved to a treatment foster care placement. He was hospitalized for both homicidal and suicidal behavior while already living in a foster home. His referral documents revealed that he did threaten his brother with a knife; however the suicidal behavior was reported as just high risk behavior—he climbed out an adjacent window to get to his locked bedroom.

Fred's presenting problems included poor anger management, inappropriate aggression, oppositional behavior, and impulsivity. Both of his parents have a history of substance abuse and have consistently not met their goals for reunifying with Fred. His parents also have a history of domestic violence. During one incident Fred's father was arrested. Fred was originally placed in foster care while his father was incarcerated and his mother was unable to meet her children's basic daily needs. Also, the family's housing was deemed unsuitable by Philadelphia's Department of Human Services. Fred

has six sisters and two brothers, but after being hospitalized he was separated from them and has never lived with them again.

At his intake with the out-patient clinic, Fred was diagnosed with two Axis I disorders; Oppositional Defiant Disorder (313.81), and Attention Deficit Hyperactivity Disorder Combined Type (314.01).

Before Foster Care

Fred was immediately engaged in the interview. With my first question of what his memories of life were like before foster care he easily responded: "I stayed out as long as I wanted, did whatever I wanted, [I] didn't come home. Having fun, not doing anything bad, parents did not make me do anything. Did whatever we wanted as long as we went to school." He then subtly added, "My parents are alcoholics, they fought." Fred understood why he was originally placed in foster care: "It was scary the reason I came into foster care." [I] saw my dad go to jail for domestic violence." Interestingly Fred used the term "domestic violence," which is a common term in the mental health and legal systems, but not a term commonly used so far by any of the participants.

Fred did not have much relationship with music before foster care. He does not remember anyone singing or playing an instrument, and he never sang or played. He does not associate any place with making or listening to music. He reported that he "listened to rap a lot, [but] did not listen with anyone." He then explained: "[I] usually listened to it in my room, by myself." He clarified that at this point in his life he never listened to music live, but only "listened to CD's." He did have two favorite artists from this time; Eminem and 50 Cent. His favorite song is entitled *Mockingbird*, which Fred

described as: “[It’s] about [the artist] losing [someone]; his girlfriend was a drug addict.” A brief review of the song matches his description; the singer describes the process of “losing” his daughter to the biological mother (girlfriend), who is a drug addict.

During Foster Care

Fred described his life in foster care calmly. Yet he said: [It was] “sad having to leave my family and leaving my sisters. I see my mom sometimes and then my sisters.” He did not mention anything about seeing his brothers or father, who at the time of the interview was released from prison.

Fred had fresh memories of specific placements, which he described in detail for the interview. In the first placement, he lived with an “old lady.” He softly said, “I was really bad, [she] couldn’t handle us. I was destructive and didn’t listen. When I had rules I stayed acting out.” In his second placement, the “caregiver used to blame us for stuff and make us hold up phone books and pots of water [as punishment].” He clearly remembered “being punished and being blamed for something her son did.” Fred then related that the caregiver showed “favoritism” towards her biological son. Fred continued by saying “I got moved [from this home] and got sent away [hospitalized] for trying to stab my brother.” Describing this incident, he stated: “I just stopped it and didn’t do anything [stab his brother].” However he did further clarify that “we kept fighting and then instead of fighting I got a knife.” Fred stayed in the hospital for about four months before going to his third placement, where he seems much happier. He explains: “Since I am here [current home and final placement] it is like 10 times better.” Perhaps, not coincidentally, as mentioned previously, this current caregiver, which is his

final foster care placement, has adopted him. It is also in this last placement where Fred started to become actively involved in making music.

Fred explained: "In school I started playing drums. "[I] played drums for two semesters; I liked it, it was fun." However when his caregiver found a new home, Fred had to change schools, and he "just stopped playing." Although Fred seems most comfortable in his final placement, his memories of listening to music stem from his first and likely most stressful placement. He remembers "listening to music with my brothers in the car or chilling, hanging out in my room sometimes." He then revealed that his older brother ran away with his younger brother at the placement he did not like. He explained: "That's why I worry about them." He also added that "My new born sister went there too, and I have not seen them since I got sent away [hospitalized]." He revealed that his "older brother is still not found, will never be found." Up to this point in the interview Fred consistently used the term "sent away" in referring to his experience of being hospitalized. It seems significant that the one connection with his biological biography and foster care biography relates to both Fred and his father being "sent away" for domestic violence; the father going to jail and Fred being placed in a psychiatric hospital for attempting to stab his brother.

Fred described three associations he had between music and foster care. In his current home, he and his adopted parents played a music listening game. He associates playing the drums with school, and he associates singing with church, where he was a member of the choir. He added: "I like it; all my friends are in it." The only songs he remembers playing or listening are those he learned by singing in the choir at church.

Fred responded that his favorite pieces of music include "Some rock, a lot of rap." He added "I keep it on my iPod." His favorite artists are L'il Wayne, Meek Millz, Lincoln Park and Slip Knot, which he told me is an Irish band. Fred remarked about Meek Millz that he "raps about how his life was, violent not necessarily positive." He noted that he has no favorite songs from this period of his life in foster care.

His Experience Today

Fred was excited to talk about his most recent home, in which he is currently adopted. He said, "[It's] way better than everywhere; [I'm] doing good here not getting into trouble. She takes care of me. I like it." Fred has "a lot of fun, a lot of land to play on." I asked him what he likes to play and he responded, "I like football and ice hockey."

Fred commented that music is not that important to him, "I don't need it, but listen to it to waste some time." Although music listening was not important to him, it seems active music making is. He continued with "I sing in church choir. I like that it is fun, we sing gospel songs." He subtly explained that he gets to "make jokes" with his friends. Significantly, Fred also revealed that "The choir has given me a more positive kind of reaction and stuff, a different outlook, and positive actions." Essentially, Fred doing well and not getting into trouble connects with the adopted caregiver taking care of him and also "encouraging" him to be involved in the church choir.

Fred admitted that he still likes Rock, Rap, and Hip-Hop, but he does not have any favorite songs. Although it he originally noted that music is not that important to him, he did say that he listens to music about "five times a week." "[I] listen to it at night

when we [other foster and adopted children in the home] are chilling. I sometimes listen to it and go to sleep." He then reiterated that he had "no favorite songs."

Overall Experience

Fred expressed contentment with being in his current home. He has been more active in music making since being in foster care, mostly with his current adoptive parent, who initially was his foster parent. He connected "doing well" with "being taken care of." He still openly expresses concern for his family, particularly his brother and sisters, but at this point he assumes they are well. The difference musically from before foster care and now is that Fred not only listens to music more, but has been more actively involved in making music in the home, school, and church.

Interpretive Summary

When Fred was describing his foster care experiences and the role of music in his life, he commented twice that he had no favorite songs. However, earlier in the interview Fred had mentioned that one of his favorite songs before he entered foster care is called *Mockingbird*. When examining the lyrics, there is a particular section of the song that seems to match Fred's description of his experience.

Throughout Fred's foster care, he exhibited signs of both homicidal ideation and suicidal ideation. He apparently did not have the positive coping skills needed to deal with the emotional rejection of being separated from his biological family. His negative acting out behaviors and his emotional instability with foster parents led directly to more frequent changes in placement. Unfortunately, some foster care placements continued to

induce feelings of rejection and instability because of the abuse and conflicts he encountered at the hand of the foster family's biological children.

While in foster care Fred had both formal and active involvement with music making. Not coincidentally, this level of involvement began with a foster care parent who eventually adopted him. That foster parent encouraged Fred to sing in the church choir. Fred's emotional stability seemed directly linked to his placement stability, which directly related to having a foster parent who encouraged active and formal involvement in music making. Like another participant, (Mark) this involvement in music provided Fred the foundation for a developing a healthier internal locus of control. His drum playing in school and then singing in a church choir metaphorically represent the shift from an unhealthy state of well being to a healthier one. He needed the external supports to balance the internal emotional chaos he must have felt.

Mary

Mary is a 16 year old female who entered foster care as a baby. She spent about three years in foster care and was adopted around the age of four. She has been adopted for 12 years. During her time in foster care, she had two placements. The second placement foster family eventually adopted her.

History/Background Information

Mary was referred to the out-patient clinic by her adopted parents when she was 14 years old. The parents had concerns about Mary's inability to focus and her thought content. At the time they also noted that she was having difficulty with her school work. This difficulty with school work was beginning to manifest at home in that Mary was

becoming increasingly angry, and this led to conflict within the adopted family. The family noted she was disrespectful, anxious, and began to physically act out by throwing or breaking things. At the intake, she presented as having anger management problems, distractibility, family conflict, low frustration tolerance, and poor decision-making skills.

Mary reported that although she has lived with her current family for 12 years, she is still "close" with the family in her first foster care placement. Within her current adopted family, she has a good relationship with her adoptive brother and father, and she wished that she and her adoptive mother were closer. She would like to spend more time with her adoptive mother, but she feels that her mother does not want to spend more time with her.

Mary's biological parents had their rights terminated before she was adopted. She currently does not have contact with any biological family members. There is no known history of family violence and/or substance abuse. There is also no reported history of trauma. Interestingly at the same time the family was having concerns over her behaviors, Mary revealed in her intake assessment that she had "issues" with being adopted. At the intake, she was diagnosed with an Axis I disorder of Attention Deficit Hyperactivity Disorder, Predominantly Inattentive Type (314.00). The therapist that currently works with her recommended her for this research due to her extreme pleasure in participating in music activities.

Before Foster Care

Mary initially noted that she did not remember very much about her parents. As she remarked at the beginning of her interview, "I was put into foster care out of the

hospital, as a baby." She continued: "I lived with my dad for 3 months and was then put back into foster care. My dad tried to get me back but he couldn't." At this point it was not clear if this was her own memory or something she had been told. As she continued to describe her life before foster care, Mary acknowledged that her dad, "didn't have a stable job and he smoked cigarettes and weed," and that her "mom did a lot of drugs." She poignantly stated that her "mom was in and out of jail while pregnant with me." When describing her initial placement experience, Mary briefly discussed living with her "Nana," with whom she is still close. Nana told Mary that if her mother had not gone to jail when she did, Mary would have been born a "crack baby."

Mary's memories of music before foster care are sparse. When asked if she remembers any family member playing an instrument, she responded: "I really don't know [any of my] siblings, but I know I have them." She does not remember singing, playing, or even listening to music. Perhaps this is why she does not associate any place or person with making music, and she does not remember any specific songs or favorite pieces of music.

During Foster Care

Mary spent little time in her life with her biological parents. She was placed with two different families while in foster care. She remembered that she lived with the first family "about three years, and moved from their home because they felt they were too old to adopt." Yet, according to Mary, this family was willing to wait if "no one adopted me."

When asked about her first foster home, she explained: “That is the only home I knew, so I consider that my biological home.” Though she spent most of her life in the second home, Mary had two specific memories of her first foster care placement.

The first memory was about another boy in the home, who left home when he was around seven years old, even though he was adopted by that home. She was not able to remember the reasons why he left but she does remember being “upset” that he left. Her second memory was about the child welfare professionals working with the family. She was apparently confused by them: “People would come in the house, like the social worker, [and] I would not understand why. I didn’t know what her purpose was. I didn’t understand what was going on.” Having child welfare professionals in the home is not uncommon and in fact is required in both foster care and adoption. However, Mary was confused because she believed that her foster parents were her real parents, in spite of the fact that they were Caucasian, and her biological father was African-American. At the same time, she instinctively realized the discrepancy: “I knew my dad when he would come and visit, I knew who he was but it was still kind of confusing.” Mary is still very close to this first family.

When asked about her involvement in music during this first placement, Mary reported that she did not play an instrument, but she was actively involved in singing. She thinks of herself as “a singer.” She indicated, “I used to sing with my foster mom [from her first placement], she cannot really sing, but she tries.” Mary seems to have a talent for singing, particularly for Gospel music. She remembers that her foster mother “would play a lot of gospel music” and she was able to “just pick it up.” She remembers

listening to music quite often, noting that she listened to Gospel music "at church and on the radio." albeit in a car or at home. Not surprisingly then, she associates music making and listening to both church and home. She still remembers singing Sunday School songs, particularly the very popular *Jesus Loves Me.* She also remembers her first foster mother singing to her every night another popular Sunday School Song, *The B-I-B-L-E*. She did not have any favorite group or singers while in foster care, but she said that her one foster sister had a band which sang Gospel and Soft Rock music. Mary remarked that she liked "to listen to them."

Mary has had an interesting placement history because she was adopted at a young age. She sees her first foster family as her biological family because she lived with them since birth. Although she would see her real biological father, she met her biological mother only once. This first foster family had an impact on her musically. She was heavily influenced by Gospel music through both active and receptive music experiences. Her memories and associations from this period of her life stem from that influence.

Her Experiences Today

Mary has lived with her current adopted family for about 12 years. She expressed that "I like it; it is just like a normal house. They are my family now." Though this family has not had the same musical impact on her as her first family, Mary acknowledged that music is still very important to her. She explained: "It [music] is like a coping mechanism to me; I can always go to it." She indicated that music has always

been a part of her life since she was a baby. She also added: "Music helps keep me out of trouble."

Her favorite types of music are R & B and Gospel. Her favorite singers include Yolanda Adams (Gospel), Mariah Carey (R & B/Rock), and Alicia Keys (R & B), who is her idol. At this point, she interjected that her dad (adopted father) "now sings a lot." Mary added: "I sing at home and [I] sing in school in voice class." Mary also listens to music frequently. "[I listen] most of my day, sometimes in the car. Most time I have an MP3 and listen to it." She had two favorite songs: 1) *Trouble Don't Last Always*, which deals with when there is trouble, "you have to deal with it" and, 2) *Like You'll Never See Me Again,* which she remarked is a "love song." She did not remember who sings those songs.

Her Overall Experience

Mary was forthright in discussing her overall experience of being in foster care and then adopted. Although most of her life has been spent in foster care and with her adopted family, she began by talking about her biological parents: "When I am 18, I am going to get in contact with my mom and dad. I have to see if my mom is ok or still alive." She then started to describe what her initial experience in foster care was like: "It was hard, really hard. First you get taken away from mom." Mary continued: "I saw her once but she was high, and I was little. She did not even remember that she was meeting me that day [when] she signed over parental rights." Mary also recalled when her biological father gave up his parental rights: "My dad was fighting to get me back, but they made him sign over his parental rights." At the time, Mary remembered him saying

that he would have "to go away." She then confessed: "You think it is [going to be] just for a couple of years, but not to come back ever again?"

Earlier in our interview Mary had noted that she did not initially know that her biological parents were really her parents, because she had only known her other first foster "parents" since birth. However, there appears to be a deep connection still to her biological parents: "At first I did not even know who it [parents] was, but you always know who your real parents are." She dejectedly added, "It is a closed adoption, you can't get in contact with [your] parents until 18."

Mary has had consistent care throughout her life, and fortunately has not had to move to several different foster care placements. Music has also been consistent in her life. She explained: "If I did not have music I would probably be depressed a lot. My nana said that if I did not have music, I would have probably been in a lot of trouble. She said that music was one of the things that kept me safe." Mary clearly values music a great deal: "Music is my life; it is the only thing I can turn to. Where there is no one else you can go to I can always go to music." She closed by saying: "When you put your headphones to your ears, you can just turn off the world."

Interpretive Summary

Mary was removed from her biological home as a baby. She has memories now of her biological parents, but it is unclear if these memories are really her memories or if they are what her foster and adoptive parents told her. She would have had only one foster care placement if the foster family was not deemed too elderly to adopt her. She has not experienced the same amount of trauma or neglect that other participants have,

but she still has to confront the grief and loss of not being able to see her biological parents. Although she has never spent any real time with them, there still seems to be a strong emotional connection to them. Understandably, she had no music memories or associations while living with biological family.

Mary seems to be exhibiting some racial and cultural confusion. She mentioned that she is only now realizing that although her foster and adoptive families are Caucasian, she is African American. For an adolescent trying to form her identity, this confusion could be a very important issue to resolve.

When other participants were adopted after being in foster care, their emotional well-being typically improved. It seems that Mary's initially did as well, but once she realized what it meant to be adopted—that she cannot see her biological parents again until she is 18, her behaviors deteriorated. Mary harbors anger and resentment toward her adoptive mother which may be displaced emotions, as it was her biological mother who abandoned her. Although, Mary's anger and resentment may also stem from a belief that her biological mother did not abandon her, but that the adoptive mother has "kept" Mary from her biological mother.

Mary has been heavily influenced by music and frequently listens to it. She has also experienced both formal and informal involvement with music and both active and receptive involvement with singing. She has been encouraged to be involved with music by her foster parents from an early age, and she has positive memories of musical interactions with her foster parents. Mary is the only participant who reported that a foster mother sang to her before going to bed, such as a lullaby. Mary may use music to

fill the emotional void resulting from the loss of her parents as an adopted youth. Music plays a role in her life in several ways: it is a coping mechanism, a help, an escape and perhaps even a way to hide out from owning and expressing her feelings toward her adopted mother.

Michelle

Michelle is a 13 year old female who is currently in foster care. She has been in foster care for nine years, and has had 13 placements, including both group homes and foster homes. At the time of her referral to the out-patient clinic, she was in a group home for children. Significantly, Michelle had changed her first name.

History/Background Information

Michelle was referred to the out-patient clinic with the main presenting problems of lying and stealing. Based on the clinic's assessment, her lying leaned towards the pathological side in its frequency and lack of remorse. Also, her stealing tended to be more impulsive and self-centered than need-based. Although there were no substantiated reports, it also appeared that Michelle had a history of sexual abuse, and exhibited problematic sexually inappropriate behaviors at a very young age.

At the time of her referral to the clinic (2008), her records indicated that Michelle had only been in four foster homes; yet, at the time of this interview (2010), she has had a total of 13 placements, indicating that she would have been placed in nine different placements within the last two years.

Michelle was first placed in foster care at age seven. It is unclear why she was placed, but based on the limited history at the time; the reason was that both her parents

were sent to prison on embezzlement charges. But, as Michelle's biography unfolded during our interview, she revealed that she was sent to foster care because her mother had abandoned her and her siblings. Both of Michelle's biological parents have a history of substance abuse and addiction. There also is a high probability that they both had other undiagnosed mental health issues.

Michelle's mother was placed in and out of jail on a couple of different occasions, due to welfare fraud. At one period in her life, her mother's whereabouts were unknown and Michelle stayed in a stable foster home for three years. Her mother then came back into her life, and Michelle returned home to live with her. Unfortunately, her mother abandoned her and her siblings again in less than a year, and Michelle was again placed in foster care. Even while living together, Michelle's mother had a history of abandoning her children for several days at a time. Michelle noted at her initial assessment that she would like her mother to take advantage of the help she can receive, and at the same time was upset that her mother had not "tried to get us back."

Michelle has been diagnosed with an Axis I disorder of Attention Deficit Disorder Inattentive Type (314.00) and a Rule Out (R/O) of Sexual Abuse of Child. At the time of our interview, this diagnosis had not changed. Her parent's rights have been terminated, and her social worker from Children and Youth Services is her legal guardian.

Before Foster Care

Before living in the Philadelphia area, Michelle remembered living in Boston. She also remembered her grandmother and father, and she had specific memories of playing "hide and seek with siblings." She also noted that her parents had separated, and

that there was a history of domestic violence between her parents. After some prompting, she also recalled that, "mom did not have a job and we lived in an abandon house for a couple of months." When I asked if she had any other memories, she simply responded "that is basically it."

Michelle did not remember anyone in her family singing or playing an instrument, but commented that her father was an artist. "He did music but I don't know what kind he did." She had no recollection of him singing or playing an instrument, but she does remember singing along with the radio with her family, and particularly Brittany Spears' songs. Her dad told her that she "could sing all the songs by her." She does not remember playing an instrument at this time in her life.

Michelle does remember listening to music, particularly listening to the radio in the car. Interestingly, she also had a specific memory of listening to music during a particular New Years Eve, but upon further inquiry, she noted that there was "no special reason." She does not remember how to sing or play any song from this period in her life, even though she did remark earlier that she could sing all of Brittany Spears' songs. Her favorite song is by Brittany spears, and is entitled *Oops, I Did it Again*. This, as the love song describes, is the artist's attempt of explaining why she keeps breaking her lover's heart, and that doing so was "not that innocent."

The place she most associates with music is in the car listening to the radio. This seems significant because her family moved frequently, and therefore being in the car could have been the one constant in her life. If so, then associating music listening with her family and the car radio makes sense to her.

During Foster Care

Michelle explained that "it was pretty weird" when going to foster care for the first time: "I was with a single mom and she was a different race than I was. [It was] a whole different lifestyle and I lived with her for four years and that was actually kind of surprising." Michelle continued talking about her first placement experience: "When we [her siblings and child welfare professionals] first arrived at her [the foster mom's] house, she wasn't there so we waited a couple of minutes and no one knew what was going on." Evidently the foster mom did not know or realize that Michelle and her siblings were moving into her home. As Michelle noted: "The foster parent was shocked because she wasn't expecting it."

Explaining why her foster mother was shocked, Michelle recounted what happened when she was living with her biological mother: "Mom had a boyfriend and she took off one day; she said she was going to a doctor's appointment. She was missing for three days and we couldn't find her; so mom's boyfriend decided he was not going to take care of us; so he took us and my siblings to the Department of Human Services." Then Michelle explained that, even though she was not expecting to see children at her door with child welfare professionals, "the foster mother still took us in." During Michelle's initial intake with the out-patient clinic, it was presumed that Michelle was first placed in foster care because her mother had been placed in jail. But, based on what Michelle recounted this was not what really happened.

Michelle had specific memories of her first two placements. She emphasized that in her first placement, her "sister was really bad and my foster mother couldn't

handle her so we all had to move." It is common practice in foster care work that when children have to move, the agency does not want to split up the siblings, so they all move together. Michelle's other memory was of another disconcerting experience in her second placement. She started by explaining that her first foster mother and second foster mother did not like each other. Then she said: "My first foster mother wanted to take me out for my birthday, but we were late coming back because there was traffic and everything. So my second foster mother told me to lie and say that my first foster mother was beating us." Whenever there is an allegation of abuse, child welfare professionals must complete an investigation. In this case, the abuse was not substantiated and as Michelle explained "The truth and everything came out."

After sharing these first two memories, Michelle did not want to discuss her experiences with any other placements. It is difficult to know what she experienced in her later placements, as there is no other mention in her records of why she was removed from so many different placements.

Regarding her musical life during foster care, Michelle's revealed, "I played the violin. I was good but I forget how to play." She played in the school band and received lessons from the school. She stopped playing after she had to move from this home and her new school did not offer violin lessons. She never formally sang and did not play any other instruments in any other placements. She did state that she "would like to play an instrument some day again." Her memories of listening to music while in foster care also stem from her first foster home.

Michelle related that her first foster mother "was a real fan of gospel music." She "wasn't into anything else and she was in a church choir." She remembers listening to her foster mother sing in the church choir, and like her experience with her biological parents, "listening to music on the radio in the car." Michelle has never been to a live concert. Although, she did not formally sing, she did state that she remembers singing gospel songs in the home.

Apparently, her first foster mother had a significant influence on Michelle's favorite music. The favorite singers she mentioned were Byron Cage, Mary Mary, and Kiki Sheard, all gospel singers. Her favorite songs from this period include Mary Mary's *Yesterday* and *Heaven,* and Kiki Sheard's *Why Me*. She also mentioned another favorite song entitled *A Sinner's Prayer*, which was recorded by several artists, including Eric Clapton and Deitrick Haddon.

The song that seems to match Michelle's description of her initial experiences in foster care is Mary Mary's *Yesterday*. *Yesterday* is a song about having internal or emotional pain and then letting go of it. *Heaven* as the song suggests is about the artist striving to live her life in order to go to heaven. Along a similar Christian theme, *Why Me* is the artist's contemplation of Jesus dying on the cross and wondering why Jesus would still love someone like her. *A Sinner's Prayer* describes the artist's thankfulness that God "hears a sinner's prayer."

Her Experiences Today

Michelle still currently lives in a foster home and when asked what her experience is like today she expressed, "It has been different, it really changed my life."

When asked for clarification, she responded, “I enjoy being in my current foster home. I don’t see my parents at all, but live with all my siblings.”

Music is still important to Michelle today. When originally asked how important music was, she responded “I guess it is important,” but then added: “If I could never listen to music again I would think my life would just end.” She listens to Gospel music occasionally now, “like on Sundays and stuff,” but she listens more to Hip-Hop, R & B, and Rap music. Her favorite singers include Rihanna, Beyonce, Lady Gaga, and Ne-yo. She also had at least one favorite song by each of her favorite singers. For Rihannna, it was *Please Don’t Stop the Music* which denotes that if the music stops, the budding love relationship the artist has with the person she is dancing with, will also stop. Beyonce’s *Halo* describes a woman who is guarded about having a relationship, but realizes her defenses have been lessened since falling for a lover. The lyrics for Lady Gaga’s *Just Dance* are difficult to understand; they seem to be a metaphor about a woman who falls for a man at a dance club and “can't see straight anymore.” She realizes, however, that by just dancing it is “gonna be ok.” If the lyrics are taken literally, they suggest that the woman might be intoxicated and that dancing will lessen the effects of drugs or alcohol.

Michelle had two favorite songs by Ne-yo. The first titled *Miss Independent* and the second titled *Mad*. Although *Miss Independent* is a song about a loving relationship between a male and female, what is different is that the artist Ne-yo is a male and offers an alternative perspective about the relationship he enjoys with an “independent” woman. *Mad* describes the prototypical “existential” meaning derived

from the verbal "fights" couples have but still do not want to go to bed angry. There does not seem to be any link between Michelle's favorite songs and her experience in foster care today. The songs she chose seem to express the typical common angst and pleasures of loving relationships.

Michelle still does not formally sing or play an instrument; nevertheless, she still "sings in the shower." She also sings with her siblings when a song comes on the radio and at church services. When asked how often she listens to music, she impossibly stated, "probably 24 hours a day." She clarified by remarking, "I sneak my iPod in school and listen. I usually listen by myself. Sometimes at lunch I will give one ear piece to a friend and then we will start singing."

Her Overall Experience

When asked about her overall experience in foster care, Michelle nonchalantly stated, "After awhile, you get used to it." She then seemed to become more introspective and added, "It really takes some of your privileges away. You don't have freedom like regular kids, like cell phones, stuff like that." She did not further clarify "stuff like that" but described foster care as "stressful." Her final thoughts on music were that when she is under pressure, she listens to music to calm down.

Interpretive Summary

Michelle seemed to find it easy describing various significant experiences in her life, both with her biological parents and in the different foster homes. Her descriptions

were mostly narrative rather than brief responses. On the other hand, what she shared about her biography included only a small number of her placements. She discussed openly her first and second placements, but made no mention of her other 11 placements, including the group home she was in when she first started psychotherapy with the out-patient clinic, and her current foster home placement. Even when asked about her present experiences in foster care, she was more reflective about her past and much less specific about the present. In the end, it is difficult to be certain about the accuracy of her recollections, not only because she did not have or provide factual information, but also because of the inadequate documentation in her records by the child welfare professionals responsible for her care.

She had a very unstable life with her biological family, one in which she moved frequently and was abandoned regularly by her parents. Perhaps this is why she did not have many memories of her life with her biological parents. Frequently moving has also characterized her life in foster care, and here again, she only provided memories of 2 of the 11 placements. Her entire life seems to be literally about moving, and metaphorically about moving on and forgetting.

Michelle's music biography seems sparse based on what she reported in the interview. She was actively and formally involved with music making at school until she moved to another placement. She did not become involved with music again but would like to do so now. Her favorite singers and favorite style of music while in foster care are associated only with her first foster placement, not any of the others. She has no involvement in active music-making, but she listens to music frequently and values

music. Her favorite songs and artists are also popular with her peer group. The role of music in her life is to both relax and escape.

Sophia

Sophia is a 16 year old female who has been adopted by her last foster parents. She was placed in foster care when only four weeks old, and then adopted at age nine. Before she was adopted she had been in four different foster homes, including her current home, within those nine years. Her first foster home was technically a kinship care home, living with her Grandmother and biological father. She changed her last name to her adopted parents' last name, and like another participant, she also changed her first name.

History/Background Information

Sophia was referred to the out-patient clinic by her adoptive mother just before the adoption process was complete. Sophia was nine years old at the time. Her main presenting problems included being physically aggressive with objects and people, and having problems with coping skills and anger management. Before coming to her current clinic, she was seen for out-patient therapy at another agency. She has been attending out-patient therapy since 2002.

Her placement history is replete with both physical and sexual abuse. Sophia lived with her biological mother for only the first four weeks of her life. She was removed from her mother by DHS due to the mother's drug addiction and inability to take appropriate care of Sophia. Her mother immediately agreed to have her parental rights terminated.

Sophia's first placement was with her paternal grandmother, where her father also lived. While living with her grandmother, her aunt (unable to clarify if paternal or maternal) physically abused her by throwing her down a set of stairs. Also, her biological father was arrested for sexually molesting her at the age of two while she lived with him and the grandmother. She was removed from this home because the grandmother refused to follow child welfare directives to keep the father away from the home, even after the abuse.

In her next foster care placement, she was sexually abused again, this time by her biological brother who was living with her at the time. She was removed again and then placed in another foster home. In this home, she was physically abused by the foster mother and also forced to stand in a corner for inappropriate extended periods of time as a form of discipline.

Sophia experienced abuse throughout her foster care history except for her fourth and last placement. She also suffers from Sickle Cell Anemia, and has already received treatment for Gonorrhea.

Sophia was first diagnosed with two Axis I disorders: Attention Deficit Hyperactivity Disorder (314.01) and Post Traumatic Stress Disorder (309.81). She is still diagnosed with both.

Before Foster Care

Sophia remembers living with her grandmother. Though this placement was technically defined as kinship care, Sophia considered it as before foster care. She did

not have a lot of memories from this period. She reported only one: going to Taco Bell after school, where her grandmother worked.

Understandably, she was "not sure" if anyone in her family sang or played an instrument. She does not remember singing or playing an instrument. When asked if she remembered listening to music at this time in her life, she stated: "My grandma would sometimes sing *Rock-a-bye Baby*, then she would tell me to shut up and stop crying." Surprisingly Sophia then said: "I think it was funny. I was not sure if she was being serious." She did not have any other memories of music experiences during this part of her life.

During Foster Care

When Sophia first entered foster care after living with her grandmother, she explained why: "I moved from grand moms because my father abused me. He lived in the home." Regarding her first placement, Sophia thought "it was awesome." She further explained: "I did whatever I wanted; at least the lady [foster parent] let me do whatever I wanted." Going even further, she said: "She treated me like one of her own." Despite these fond memories of her foster parent, Sophia related that "the lady gave me away and put me into another home."

Sophia made it clear that she did not like her second (next) placement. She believed that she was a scapegoat; "I was kind of a target." She had been accused by the foster parent of abusing an older child in the home while Sophia was only four and the other child, a male, was nine years old. The foster parent made her "stand in a corner"

and beat her "with a brush." Sophia blamed herself for being moved out of this home: "I moved because she couldn't handle me."

In her third placement, Sophia remembered having an older foster care sister, whom she liked. Unfortunately, the foster parent had a severe seizure and was unable to take care of Sophia, so she had to move once again.

In her fourth placement, Sophia met her last foster parents, the ones who eventually adopted her. They met at a foster care agency "picnic." She remembered that her current adoptive father asked her to go swimming with the other children. She stated, "I liked him right away."

In Sophia's initial intake with the out-patient clinic, the assessment noted as one of her "strengths" that she could play the piano. In fact, the adoptive mother remarked that Sophia would come home from school and play everyday. Strangely however, when I asked her if she remembered singing or playing an instrument, she responded "I wanted to learn how to play the piano so bad, but didn't learn to play or sing." Sophia may not remember playing or perhaps believed that my question related to formal training with the piano, i.e. lessons.

The places she associated most with music were home and church. When at home, she said "I always turned on the radio." As for church, she remembered that she only was permitted to listen to "Christian music" Grudgingly, she added, "I hated church." This changed as she become older. Now she enjoys church because she has joined a youth group and as a result, she has "found some good music now." She also remembered singing and dancing with her friends with a particular song entitled *Tootsie*

Role. She also remembers a song titled *I Wanna Know* (the song title is actually *I Wanna Know Your Name*) and she made sure that I spelled wanna "correctly" and not "want to." She added there are many songs she still remembers, "I have them on my computer and MP3."

Her favorite type of music is R & B. Her favorite artists and corresponding songs are Keith Sweat's *I Wanna Know Your Name*; Aaliyah's *Rock the Boat;* Monica (she had no favorite song from her); and Michael Jackson's *Man In the Mirror*.

Her Experiences Today

Sophia has lived in her current home for about 10 years, first as a foster home, and now as an adoptive home. Her experience has been, "Ok, it is fun. It is better than being somewhere else." She emphasized that she likes her home, "[It is a] nice big house, nice big yard."

Music is important to her in the home. She explained that "My parents take my iPod and phone away for punishment and they know I can not take it. It upsets me, but it works, it really works." She added that music is like her "second life" and "is what I wanted to do when I was older." Now she does not want to do music anymore as a career, but wants to become a Cosmetologist. Nevertheless, she added: "I am still going to sing in church and everywhere else."

Her favorite types of music include R&B, Hip-Hop, Pop, Rap, Christian music, and Christmas music. She listed Trey Songz, Usher, Chris Brown, Rihana, Beyonce, Jay-Z, Justin Beiber, Monica, R. Kelly, Plies, Meek Millz, and L'il Wayne, as her favorite musicians. Notwithstanding her previous statements about lack of involvement in music,

Sophia claimed: "[I] write songs and I play the piano." She then added "I did play the drums and I sing. I am going to get started back on it." Her intriguing response to how often she listens to music was, "All day—not one minute of the day that I don't. I don't like people irritating me, they talk too much." She also had a comprehensive list of favorite songs and artists: *Back Out* by Chris Brown; *On Top* and *It Would Be You* by Trey Songz; *Baby* by Justin Bieber; *Jam* by Michael Jackson; *Birthday Sex* by Jeremiah; *Let's Get Married* by Jagged edge; and *Miss Independent* by Ne-yo. As a brief overall analysis of the songs she chose, the main themes include love, the dynamics of relationships, and sex (i.e., *Back Out*, *On Top*, *Baby*, *Birthday Sex*, and *Rock the Boat*). Although *Jam* appears to have some sexual overtones, it also represents the artist's frustration with the world and the problems that need to be changed.

Overall Experience

Considering the amount of trauma Sophia had during foster care, I was shocked to hear her summarize her overall experience like this: "I thought it was fun." She continued and clarified: "I lived with crazy people, normal people, and so-so people. I just got to see how different families work and got treated differently. I got to see where I really belonged. Got to see whether I was truly loved by a family, or…" Her voice then faded away and she did not finish the sentence. She still loves music and overall it has been important to her. She reiterated, "I wanted to be a musician like when I was older." Her dream included being "the next Alicia Keys, 'cause she inspires me. That is probably why I play the piano" She did not list Alicia Keys as a favorite artist but evidently

Sophia still plays the piano because she remarked, “I play a song by her on the piano. It is important to me.”

Interpretive Summary

Since she was placed in foster care around birth, Sophia had a brief time with her biological family, and then was placed in four different foster homes, with her last foster care placement adopting her. While in foster care, particularly with her first two placements she encountered severe sexual and physical abuse.

Sophia has an informal association to music both actively (playing the piano) and receptively (listening to music). Although she has not had any formal lessons in singing or playing, it appears that she sings and plays enough to be quite proficient, even writing songs. However, the contradictions not only between her responses during the interview, but between her intake information and responses are troubling. She was unable to describe significant experiences related specifically to music, but was able to provide an extensive list of artists and songs she liked.

Sophia’s answers to the interview questions appeared superficial. It also seems significant that of the extensive list of favorite songs and artists she mentioned that are important to her today, she did not include Alicia Keys. However, at the end of the interview, she expressed how important this artist’s music was to her. In fact, Sophia named her as the only artist whose songs she knows how to play. The significance perhaps lies in that fact that although the artist is not listed as a favorite, she is still very special to Sophia. It seems then that based on the interview Sophia’s responses were

avoidant, which would fit her diagnosis of PTSD. Throughout her time in therapy, she has not dealt appropriately with the trauma she encountered early in her life.

Sophia mentioned Michael Jackson as a favorite a couple of times during the interview. Most of the songs deal with themes of love, sex, and relationships. However, Michael Jackson's *Man in the Mirror* seems to be a more representative metaphor for her.

Elizabeth

Elizabeth is a 17 year old female who is currently in foster care. She has been in foster care for five years and, by her account, has had eight different placements within that time.

History/Background Information

Elizabeth was referred to the out-patient clinic by her foster care social worker to be psychiatrically evaluated. Also, the initial evaluation would assist the treatment team with determining her level of placement, i.e. treatment foster care, residential treatment, etc., and ongoing treatment needs. Her presenting problems included: lying; stealing; behavioral problems in school; probable promiscuity including involvement with older men; running away; defiance; resistance to treatment; cutting classes; intermittent difficulty with sleep; fear of eating in front of others; threatening others (both adults and peers); aggression toward peers at school; and instability in her living situation. Her behaviors resulted in being removed from her most recent foster home and hence the need for the psychiatric evaluation.

When Elizabeth was 12, her father was shot and killed. It appears that her father had a history of violence in that he was shot on two other occasions. Also, her father physically abused her, particularly when so requested by her mother. At the time of her intake evaluation, it was noted that her mother was a substance abuser. There is no information on when her mother started using controlled substances and why her father was arrested. It is also unclear as to why she originally came into foster care, but based on the above information, there is a high likelihood that it was due to both neglect and abuse. Also, Elizabeth noted that she had been in foster care for five years, which is the amount of time her father has been deceased, but it is unknown whether her father was living when she first entered foster care.

When Elizabeth first entered foster care, she attended a different out-patient clinic than the one she attends currently. Her current out-patient clinic, although requested, did not receive any treatment documents from the first clinic; therefore there are some gaps and discrepancies in the information available about her and her family. Her first out-patient clinic diagnosed her with Axis I disorders of Adjustment Disorder Not Otherwise Specified (309.9) and Cyclothymic Disorder (301.13). However, she seemed more appropriately diagnosed by the agency, where this research occurred, with an Axis I Conduct Disorder, Childhood Onset (312.81).

Before Foster Care

Elizabeth lived with both her mother and father before foster care. She mentioned that when her father died, is when she entered foster care. Although, there is a history of her father physically abusing her, when discussing her father she remarked, “I

had a good time with my dad." She had few memories except for "going out and vacations." She still sees her mother but her mother is "not stable; she needs her own house." She declined to discuss any more about her experiences before foster care.

She did not sing or play an instrument while living with her parents. She did have a cousin who played the violin and she noted that "I saw him a lot." She does not remember singing or playing an instrument with anyone, but she emphasized that "I was always listening to music." She really enjoyed music at this time in her life and she listened to music through various media including the radio, CD's and television music channels. She also went to several live concerts.

When I asked her about what places, if any, she associated with making music, she used music as a verb stating, "I have friends that music." She added that they make up raps. She sang informally and named the artists songs she used to sing including Mary J. Blige, Cisco, Usher, Michael Jackson, and DMX. Her favorite songs are *Rainy Days* by Mary J. Blige and *Confessions* and *Let It Burn* by Usher. Interestingly when first discussing her favorite songs, she stated "My dad used to always listen to a song and it got on my nerves—*Lord, Give Me a Sign."* She did not know the artist of the song. Based on a Google search, the artist is probably DMX, who was mentioned as one of her favorite artists. This Christian based song describes the artists plea to God for guidance, hence the name; *Lord, Give Me a Sign*. *Rainy Days* seems to be about finding one's way through life's struggles. Usher's *Confessions* deals with the need or want to confess something, but during the brief song the artist never really confesses anything specific. Interestingly, Usher's *Let It Burn* is also a confession of sorts. Here the artist is letting his

significant other know that he wants to end the relationship. "Let it burn" is the metaphor for a Dear John Letter. In all likelihood, each song connects with Elizabeth in some way, but the lyrics of her favorite songs and the interview data did not reveal what those connections might be.

During Foster Care

Elizabeth was eager to discuss her experience about being in foster care for the first time. In her case she eventually lived with her Aunt, which is specifically called kinship care. She expressed that "I was mad because my dad just died and like days later I went into foster care." The story as she describes it was that she was staying at her Aunt's house until her Father's funeral. The Department of Human Services (DHS) planned to move her to kinship care permanently, but DHS did not come to the home tell her, but came to her school. DHS tried to take her from the school but she would not go. Her Aunt finally came to the school and then she felt comfortable leaving school and going home with her. Understandably, Elizabeth did not know why DHS came to the school to take her to her Aunt's home.

When asked if she had memories of any specific placements, she responded: "I hate them all and terrorized them; and I did bad things to them; and they made me mad. When they made me mad, I used to mess their stuff up and take their stuff and leave the house." Later in this part of the interview, she admitted: "I did a lot of crazy stuff in every place I have been in." I prompted her about any specific instances with a particular placement. She first stated, "At one place I was at, this man choked me." I asked her who the man was and she responded, "The foster mother's boyfriend." She continued,

"and once he choked me I started being real mean, stayed out all the time. Then I moved out to another home." In the next home she indicated that the home was fine, and that she liked the other children in the home; however, she did not have any other memories that were of any importance. She then bragged, "One time, I was at this lady's house, [foster parent] I took her cell phone and hid it and she said if someone found it she said she was going to buy a cell phone." Then she laughed, "So, I found it and then she gave me a phone." Finally at another placement, which she did not describe clearly, she told the story of how "This lady [foster parent] was a Christian and I am Muslim. They [foster parents] prayed for me and my baby but I don't have a baby. They were real confused." She clarified that the foster parents thought she was pregnant due to Elizabeth admitting to being sexually promiscuous and likely tricking the foster parents into thinking she was pregnant. However, Elizabeth thought differently, she stated the reason the foster parents were concerned is because they "wanted that money." Elizabeth knew that in the foster care system foster parents not only get paid for being foster parents, but if a foster child has a baby, they also receive state funding for the baby as long as the baby is in the home.

Elizabeth had a general music class in school, but did not sing or play an instrument formally: "I had music class in school but never took any lessons. I was not interested, I did other things." She did not clarify what the "other things" might be or associate any particular place with making or listening to music. However, she did report listening to music in every placement, and she listened "in the car, in the house, on the computer, iPod, music video channels, and MP3 players."

Elizabeth remembers singing along with songs on the radio and with friends. [We] put a radio/song on and everyone listens to it and sings together." Her favorite song is by Yolanda Adams titled *Open My Heart*. "It makes me sad. It is like a sad song." Interestingly, the song is not only a plea for guidance, which would seem hopeful, but the overtone is a Christian song based on the usage of the word "Lord." Her favorite singer is Alicia Keys, and her favorite group is the Jonas Brothers.

Her Experience Today

Being in foster care has not been a pleasant experience for Elizabeth. She moaned, "It's bad, I have been in better, but I can deal with it for the time being." But she also noted that "there is always something worse." She mentioned several reasons why she does not like being in foster care, including not liking the "ceiling leaks," running out of everyday items like "toothpaste," not "getting what I need," being too crowded in the home, needing "more space," and not liking her "bed on the floor." She plans to only be in foster care while she is in high school.

Music is still important to her, as she exclaimed "really important. I relate to music." She relates to music through her emotions "depending on what mood I am in." She clarified, "If I am in a happy mood, but if a depressing song comes on, I will try and turn it off." She then generalized her experience, "Everyone is in different moods at different times." She further added, "I can listen to music all day; mainly by myself, because I am everywhere by myself." Her favorite types of music include "slow jams," Rap, Hip-Hop, R & B, "jazzy songs", and "some rock songs, but not all of them." Her favorite artists include Nicki Minaj, Trina, Lady Gaga, Trey Songz, Usher, L'il Wayne,

Jay-Z, and Drake. Currently, she does not formally sing or play an instrument but sings informally with her friends. Her favorite songs include *We Make 'Em Say* by Meek Millz, *That's My Attitude* by Trina, *Little Freak* by Minaj and Usher (she noted that she particularly likes the video), and two Lady Gaga songs *Paparazzi* and *Bad Romance*. Each of these songs, based on a brief analysis seems to be the kinds favored by a typical adolescent in that the songs discuss love, relationships, sex, and money.

Overall Experience

Elizabeth resolved herself to talk more about her experience in foster care, she responded, "First, I thought it was going to be bad, but after awhile, because I got older, I got better with a lot of things. She added, "I was 13 when I came into care and I did not know why." She described the child welfare system and professionals, rather than her foster parents as the "better" part of her foster care experience. "It is not so bad, and it pays off. They help you find an apartment if you go to a program; they pay you to go to programs, they help you with grants."

Her final responses on music are that she really enjoys it and "has a passion for music." She expressed that there is a song for every "emotion that I go through." She succinctly stated, "I don't know what my life would be without music. I would be miserable without music."

Interpretive Summary

Elizabeth was expressive, if not audacious, throughout the interview. She was forthright in discussing her experiences and in recognizing that her negative experiences were her responsibility as well. Music is very important to her; it appears to provide

more stability in her life than her foster parents can provide. She links her own identity to the emotions and moods of her favorite songs. She mainly interacts with music informally listening alone and at times with her friends.

Elizabeth's history is similar to other participants in regards to the abuse and neglect she encountered. She wants to live with her mother, rather than be in foster care, but her mother is unable to take care of her due to her substance abuse. She mentioned good experiences with her biological family but only briefly. Although she lived with her biological parents until the age of 12 she declined talking about them. She offered only one musical association with her biological family: her dad used to sing the same song to her frequently. Typically, her memories associated with music before foster care revolved around her passive involvement with music listening.

Foster care appears to be a brief stay over until she can be on her own. She has not had much success with being stable in any placement and her behaviors have typically led to her removals. Some of her behaviors may be seen as typical rebellious adolescent behavior, but consistent with her diagnosis of conduct disorder, she seems to enjoy causing problems. Fortunately, she has decided to stay in foster care so that she can finish high school. While in foster care music listening is used to not only calm her moods but to match her moods. At times, music listening is used to even "put sound" to her mood because she is limited in her ability to express her feelings.

Elizabeth chose a song that she associated with her life before foster care. The song, which reminds her of her father, appears to intertwine with her own life. Some of her behaviors, despite being the result of a conduct related disorder, stem from not being

able to appropriately grieve over the loss of her father and being traumatized and unable to adjust to being abruptly removed to a foster home immediately after her father died. This song, *Lord Give Me A Sign,* perhaps expresses her feelings where her own language can not.

CHAPTER FIVE:

CROSS CASE COMPARISON

The purpose of this chapter is twofold: 1) to compare the personal biographies of the participants at the different life periods discussed in the interview: before foster care, during foster care, present placement experience, and overall experience; and 2) to compare the musical biographies of the participants' lives through the same life periods. In the next chapter, the relationship between the personal and musical biographies of these adolescents will be analyzed to identify any themes or patterns.

The Personal Biographies of Adolescents with Foster Care Experience

Ten adolescents participated in the study; six males and four females. The ages of the males ranged from 15 to18 and the females from 13 to 17. Two participants were in foster care, but in the adoption process; four participants were still in foster care; and four were already adopted. The number of years in foster care ranged from 4 to 15 years. Three participants were placed in foster care at birth, or shortly thereafter. Six participants entered foster care age four or younger, while the other four participants entered foster care at age 11 or older. Thus, the history of foster care for these ten participants varied widely.

Mental Health of Parents

A question posed by the present data was the extent to which these participants, all of whom were receiving psychotherapy within the out-patient clinic where the research occurred, tended to have parents with mental health issues. Four participants

had parents with diagnosed mental health issues; five participants either did not know if their parents had mental health issues or had no records indicating such; one participant did not have a parent with a diagnosed mental health issue and came into care because his father died. In this group, there did not seem to be any relationship between a biological parent having a mental health diagnosis and the diagnosis of the participant. Diagnoses of the participants included various forms of Adjustment Disorder, various forms of Attention Deficit Hyperactivity Disorder, Post Traumatic Stress Disorder, Cyclothymia, Oppositional Defiant Disorder, Conduct Disorder, Sexual Abuse of Child, and Reading Disorder. Six participants had either more than one disorder, or his/her disorder had been changed during their time in psychotherapy. The research literature shows a connection between parent mental health problems and their children's mental health problems, regardless of whether the parent has been officially diagnosed.

Radke-Yarrow and Klimes-Dougan (2002), found that parental mental health problems are known to suggest risk "to offspring for a number of negative outcomes including depression, anxiety, and behavioral problems" (p. 155). Other researchers have noted that mood disorders, substance use disorders, and antisocial behavior have been found to have a genetic component (Arseneault, et al., 2003; Merikangas, et al., 1998; & Sullivan et al. 2000). Also, parental psychopathology may lead to poor outcomes with clinical populations through poor treatment adherence. For example, in a longitudinal study of suicidal adolescents, "family dysfunction and less involved fathers were linked with less follow-through with recommended psychotherapy, and mothers' self-reported hostility was associated with less follow-through with recommended

pharmacotherapy" (King et al. 1997, p. 1441). Similarly, parental psychopathology impacts the risk of suicide with adolescents.

King et al. (1997) found that "adolescents were almost twice as likely to make a suicide attempt if they had at least one biological parent with mental health problems" (p. 1440). Other cross-sectional and longitudinal studies have found associations between adolescent suicidal behavior and a family history of suicidal behavior, parent–child discord, and family dysfunction (Brinkman-Sull, et al., 2000; Spirito, et al., 2003; & Wagner 1997).

Number of Placements

The number of previous placements of these 10 participants varied widely. Four out of the ten participants are still in foster care, and of the remaining six participants, two were in the process of being adopted. Of the four participants in foster care and not currently in the adoption process, two participants had had only two placements, while the other two had 8 and 13 placements respectively. Of the six participants already adopted or in the adoption process, the number of previous placements ranged from 2 to 11. Within this group of participants, the number of previous placements did not seem to affect whether they would ultimately be adopted.

At the time of this research, no study was found that examined specifically whether the number of placements had any causal link to whether a foster child was adopted or not. Although there is limited research on adolescent adoption as a whole, studies have examined the predictors of adoption and the risks associated with adoption disruption. One might expect that during adolescence, independence from caregivers and

oppositional behaviors are likely to increase; however, research findings are unclear on whether behavioral issues preclude adoption (Leathers, et al., 2010). Leathers, et al. (2010) note that youth who enter care as adolescents are more likely to have entered care due to behavioral problems and difficulties with their parents. The researchers suggest that their permanency outcomes, such as adoption, might be different from those of adolescents who enter care prior to their teenage years. Of the participants who entered foster care at an older age, only one participant was placed for his behaviors. However, even for that participant this related research may not be relevant because he was initially placed in a RTF. For the other participants who entered foster care at a later age, the reasons for initial placement included the biological parent dying and abuse/neglect, not behavioral problems.

Age of Initial Placement

As for the potential effect of age of initial placement on the likelihood for adoption, five of the six participants who were either adopted or in the process were initially placed into foster care before the age of four; the one exception was the participant who first entered care at age 11, but was already adopted. Conversely, of the four participants not adopted, three of them entered foster care after the age of 12, but again, the notable exception was the participant who was not adopted but entered foster care at age four. It seems plausible that children placed in foster care earlier in life may have a better chance of adoption than those placed later. Although, the present findings are inconclusive, research on adoption seems consistent with these findings.

Research suggests that the child's age when removed from the parent's home and child's current age are predictive of adoption; children who were removed at an older age are less likely to be adopted than other children (Festinger, 2002; Snowden, Leon, & Sieracki, 2008). Leathers, Falconnier, & Spielfogel (2010) after exploring associations between youth characteristics, relationships with foster and biological families, and placement outcomes among young adolescents not placed in kinship foster care found in the analysis of their research that that predictors of adoption included younger age at time of placement, foster care adoptive placement as opposed to placement with a new family, and sibling placement as opposed to non-sibling placement.

Tarren-Sweeney (2008) found that "key predictors of mental health and wellbeing identified from risk studies of children in care include older age at entry into care, placement instability, and perceived placement insecurity" (p. 346). He also found that "younger age at entry into family-type (i.e. foster and kinship) care appears to be protective for subsequent mental health, while early placement in residential care is harmful" (p. 346.)

Adolescent's Diagnosis

Another question that emerged from the present study was the relationship between an adolescent's diagnosis and the number of previous placements. Do certain diagnoses predispose adolescents to multiple placements? And conversely, do multiple placements predispose adolescents to certain diagnoses? Four of the ten participants had been diagnosed with adjustment disorders. According to the DSM IV TR (2000), Adjustment Disorder is a "maladaptive reaction of a person to identifiable psychosocial

pressures, with its reaction response emerging within three months after the initiation of the stressors" (p. 679). One of the psychosocial pressures and stressors leading to an adjustment disorder, according to the DSM, can be "moving from one place to another" (p. 679). This suggests that multiple placements in foster care might contribute to a diagnosis of Adjustment Disorder; however, in the present study, the four participants who had adjustment disorders had experienced from two to eleven previous placements; whereas the six participants who did not have an adjustment disorder diagnosis had experienced two to thirteen placements. Thus, no consistent pattern was found in the present study linking diagnosis to number of placements. Unfortunately, no other studies were found in the research literature that even examine the question of whether diagnosis is a predictor of multiple placements.

On the other hand, there is some evidence that multiple placements may be implicated in an adolescent's diagnosis. Hussey and Guo (2005) found that the number of previous "out-of-home placements was positively associated with increased levels of psychiatric symptomatology and served as the most robust predictor for modeling treatment response trajectories across problem domains" (p. 485).

A related set of questions raised by the present research is whether behavioral problems predict out-of-home placements and whether out-of-home placements predict subsequent behavior problems (Aarons, et al., 2010). In Aarons, et al. (2010) analysis of behavior problems related to placement change, the researchers found that four variables have consistently been linked to a greater number of placements. They are: "higher levels of behavioral or emotional problems, older age of the child, extended stays in care,

and placement type (e.g., children in kinship care tend to experience fewer placement changes compared to children in group home or residential care)" (p. 71). Fewer studies have attempted to examine whether placement changes cause behavior problems, or those studies have had inconsistent findings (Aarons, et al., 2010).

The Effects of Previous Trauma

Another question that arose was the effect that previous trauma might have on the adolescent's experience of foster care. While only one participant had an actual diagnosis of Post Traumatic Stress Disorder (PTSD), many of the other participants had experienced considerable trauma as children. The Mayo Clinic's online website (2010) defines Post-traumatic stress disorder (PTSD) as "a type of anxiety disorder that's triggered by a traumatic event." A traumatic event is viewed as an occurrence "that causes intense fear, helplessness or horror" (Mayo Clinic, 2010); it would seem then that more of the participants should share this diagnosis. Other research supports this as well.

Milburn, Lynch, and Jackson (2008) found in an early intervention study for children in foster care that "at least mild Post Traumatic Stress Disorder (PTSD) symptoms were reported by 86% of children and adolescents aged between 7 and 17 years" (p. 34). The researchers also note that "entry into care is a time of crisis in a child and family's life and represents a fundamental breakdown in the family's capacity to protect the child from harm" (Milburn, et. al., 2008. p. 34).

Often overlooked indicators of trauma are attention deficit disorders. Tarren-Sweeny (2008) points out that "various research findings demonstrate that children in care have complex symptomatology that is not well captured by present classifications of

mental disorders" (p. 348). In the case of ADHD diagnoses, there should be a question as to whether a child's problems with focus, inattention, and hyper-activity, which were common presenting problems with these participants, are symptomatic of ADHD or may have a more etiological base in early trauma.

Another trauma related to multiple placements is abuse. Spencer (2010) found that abused children were more likely than non-abused children to not only have a diagnosis of emotional disturbance at entry into foster care, but that abused children had higher rates of placement disruption than non-abused children.

Memories Prior to Foster Care

Memories of life before foster care were sparse in this group of adolescents. This is understandable for three of the participants, who were removed from their home at birth or shortly thereafter. Any memories they might have had were probably not real memories but more beliefs they developed over the years, based largely on what they were told by others. As for participants not removed from their biological homes at birth, they still had very few memories of living with their biological families.

Memories tended to be mostly negative in this group. When a participant had a memory, it was most often unpleasant or painful. Often these memories included witnessing domestic violence and substance abuse, being physically abused, needing more parental guidance, and being neglected. Even with participants who had a pleasant memory, each one compared that memory with an unpleasant memory or experience. For example Martin and Fred said there was "pain and good memories." Michelle and Elizabeth claimed that they enjoyed being with their biological families, yet Michelle was

abandoned and neglected throughout her life by her biological family; Elizabeth was physically abused by her father, and witnessed a significant amount of domestic violence. Interestingly, both Jason and Michelle were removed from their biological homes at a relatively late age (pre-adolescent and adolescent), which would lead one to believe that they would have more biographical memories. Instead, they had very limited memories or did not want to discuss those memories.

The paucity of memories held by the present participants, and the predominance of negative associations, might be explained in terms of the various painful ordeals that they experienced when removed from their biological home and placed in foster care. These include: 1) Parents with substance abuse or addiction problems, 2) Death of a parent, 3) Court order, 4) Neglect, 5) The child's behaviors precipitated the movement, 6) Abandonment by parent(s), 7) Domestic violence, 8) Incarceration, and 9) Physical, sexual, and/or emotional abuse. The majority of the participants had more than one reason for being in care, with the most common being substance abuse by parent, neglect, and abuse.

Reasons for Being Moved to Another Placement

Strikingly, the foster care history of these adolescents entailed moving and living in multiple placements, including inpatient psychiatric hospitals, residential treatment facilities, and group homes. Participants were moved to a different placement for eight different reasons, based on both their responses during the interview and their history/background information.

The first reason, and not in any particular order of significance, was the participant's own negative or acting out behaviors. The foster parent was ill-equipped or unable to handle the participant's behaviors. For example, one participant mentioned he had a gun and smoked "weed;" another participant admitted that he was destructive and "just did not listen."

Closely related, the second reason was the severe acting out behaviors of their siblings living in the same home. When children are placed in foster care with their siblings, the stability of the placement for all the siblings is dependent upon the behaviors of each sibling. When one acts out, the other siblings often suffer the consequences.

The third reason was the participant had intent, whether real or fabricated, to seriously harm self or others in order to be moved to another home. For example Steve stated, "I said I was going to kill myself, but I did not mean it. I just did not want to stay there." Fred also mentioned that he had a knife and was going to stab his brother, but really, he just wanted to get out of his current placement.

The fourth reason was that there was conflict between the foster family and the biological family. Although each child's case is different, when parental rights are not terminated, biological mothers and fathers still have access to their children and can visit them. These visits can easily cause conflicts.

The fifth reason, which applied to four different participants, was because there was conflict between the foster child, the siblings of the foster child, and the biological and foster children of the foster parents. Linares et al. (2007) studied placement movement and sibling relationships in foster care, and concluded that "…little is

understood about the aspects of sibling relationships that may enhance or diminish child functioning after children enter foster care. The available data suggest that sibling conflict is likely to be high among foster children" (p.737).

The sixth reason was the foster parent's inability to continually care for the child, because of poor health, age, or other reasons. When the foster parent is loving, this can be a particularly painful move for the child.

The seventh reason was the death of a foster parent. At times, the foster child is removed to allow for the family to grieve, or because the foster parent was a single parent and therefore no one else in the home was able to take care of the child.

The eighth and final reason was that the foster parent physically, sexually, or emotionally abused the child/adolescent. This unfortunately occurred with six of the 10 participants in this study.

Responses to Moving to Another Placement

Like the lack of memories before foster care (when living with their biological parents), the participants also had little or no specific memories of different placements during foster care. It is unclear whether this lack of memories in foster care is the result of avoidance, repression, or just an unwillingness to discuss them. Linked to this lack of memories may be the child's confusion when moved from one home to another. Two closely related themes that emerged from the participants responses in this regard were: 1) the participant was not prepared for the move; and 2) the participant did not understand why they were being moved.

In regard to a lack of preparation, all of the participants reported at least one time when they did not know they would be moved. Often, they had no choice of where they were going, and they were not given the opportunity to meet the new family before moving. Michelle's situation is a case in point: DHS took her and her siblings to a foster home and the foster parent did not even realize they were coming. This type of situation clearly could be deflating and painful for her, as well as for any other children who may encounter similar situations. Also, a lack of preparation occurs when a foster parent suddenly dies and the child is moved. This happened with two participants.

In regard to a lack of understanding, the reasons why DHS moves foster children may seem clear now, based on the reasons for placement movements described above; however, the children themselves are not always informed of the reasons(s). Often the participants did not even know beforehand that were they being moved, and then they were not informed why they were moving from the current placement as well as where and why they would be placed instead. In fact, two participants reported being worried that they would not be able to see their previous foster family again. No clear explanation to the child/adolescent was given. Noteworthy is that the participants expressed these feelings of confusion not only when being moved between foster placements but also when being moved from their biological home to foster care. Unfortunately, this theme of "not understanding what was happening" permeated the overall experience these participants had while in foster care.

Relationships with Foster Family

The foster child's lack of understanding often results from an unhealthy relationship with the foster family and lack of a clear role within that family. The participants described their experience as "lonely" and not being able "to trust." One participant distinctly stated "you can't trust anyone." Many participants also reported that they did not attach to their foster families because they did not want to get close to them for fear of being moved again.

This loneliness and lack of trust supports the foster child into thinking they are their own parent. One participant mentioned "I felt like I was raising me." The idea of a foster care child being his/her "own parent" is not uncommon in the foster care system. There is a term associated with this that child welfare professionals employ called "parentification." Jurkovic (1997) developed a model of parentification, and more specifically destructive parentification. Jurkovic (1997) describes this as "a family environment featuring an imbalance among family members' roles and behaviors, a lack of boundaries between family subsystems, and an excessive level of caretaking (emotional and/or instrumental) by a child to maintain the family system" (p. 237). Although, most of the participants had an overall perspective of "taking care of themselves," they still reported that having access to their biological family was very important.

There are positive relationships with the foster family that occur, particularly when not only are the adolescent's physical needs met, but when emotional or social needs are met. For example, adolescents thrived when a foster parent encouraged involvement in formal music activities and other social activities. Also, the participants

as a whole generally felt comfortable and had less acting out behaviors when they were able to receive "special" gifts or "go places." This type of extra attention to the adolescents overall well being seems to compare well with Maslow's hierarchy of needs, in that when the physiological and safety needs are met, a person's capacity for overall health improves. In this research, the adolescents' placement stability generally increased when more than basic physiological needs were met.

Relationships with Biological Family

There are two types of adoptions: closed and open. The family law center states that "A closed adoption means that there is no contact whatsoever between the birthparents and the adoptive parents and child after the adoption takes place. In fact, there may be no contact before the adoption" (family.findlaw.com, 2010). An open adoption occurs when "all the parties to an adoption meet and often remain in each other's lives" (family.findlaw.com, 2010). Six participants in this study were either adopted or at the end of the process of being adopted; those with a closed adoption could not see their biological families until after they turned eighteen; those with an open adoption could have access to them before turning of age. The six participants who were adopted or in process recognized that being adopted was "good" and that it provided them with the stability they needed. Nevertheless, they all still wanted to have access to their biological families, either after they turned eighteen or on a regular basis before turning eighteen. The four participants who were not adopted were older, and therefore were waiting to turn eighteen so that they could "get out of the system."

Of the five participants, who were able to have access to their biological families while in foster care; either from regular contact or arranged visits, each one enjoyed that opportunity and anticipated their visits with family members. Five of the participants had no access. Interestingly, nearly every participant reported that when they turned eighteen and became legally independent, they wanted to re-connect with their family, especially if they were unable to do when they were in foster care. For the two participants who visited with their family regularly, they both planned to continue that connection even after being adopted. For the participants who entered foster care at birth, each planned to have some contact. For example, they said: "I want to get out and be with [my] sister;" "I want to find my mother;" and "I plan to live with my mom after my first year of college." The other participants made similar statements even if they had lived with their biological family: "Can't wait to get out of system and be with my family;" "I will go and see my brother, I know where he is;" and "I will live on my own, but want to connect with [my] mother." The experience of the participants with having relationships with not only biological families but with foster families provides a unique perspective for comparison.

Positive and Negative Qualities of Foster Parents

Whether describing relationships with their biological or foster parents, participants identified many of the desired qualities for being a foster parent. According to the participants, foster parents should: 1) be loving; 2) be committed to taking care of their foster children; 3) be willing to meet more than just the basic needs and recognize the child's need for play and recreation; 4) encourage active involvement with music; 5) be a surrogate and positive parental figure; 6), be able to bond and promote trust with

their foster children; 7) allow foster children the appropriate amount of freedom and independence; and 8) Impart the foster child with level of responsibility.

Conversely, there are also several characteristics of an inferior foster parent, as described by participants: foster parents who enjoy foster care for purely financial benefit; the use of severe corporal punishment; foster parents that are physically abusive to their foster children; foster parents that promote fear and/or a lack of safety in the home; foster parents that lack appropriate boundaries and discourage freedom and independence; and foster parents who have conflicts with the child's biological family.

The Musical Biographies of Adolescents with Foster Care Experience

Musical Memories Before Foster Care

Participants described music as having various levels of significance in their lives before foster care. One indicator seems to be how vivid their musical memories were. On a continuum from least to most significant, some participants had no memories or music experiences; some had vague associations with music and a family member, such as a sibling who sings or raps; some had experiences of singing and listening to music with family members; some had extensive memories of not only a family member playing an instrument, but also singing and listening to music with family members. Only one participant played an instrument while living with his biological family. Every member of his family played an instrument. Notwithstanding this strong beginning in musical engagement, his later experiences in foster care deleteriously affected his relationship with music. With two participants, it was unclear how important music was

to them during this period. They both recalled having family member sing to them (e.g., lullabies); however, one of these participants associated this music experience with a negative memory.

Formal and Informal Involvement in Music

Another indication of the value of music was whether the participant was formally or informally involved with making music. Examples of formal involvement included taking music lessons, playing an instrument in a school band, or singing in a church choir, all of which required taking some level of responsibility with regard to their learning and participation in music. Informal involvement consisted of general music making or listening to music at home or in an unstructured environment. Examples included: listening to music alone or with friends, singing along with the radio, again alone or with friends, and at times just trying to play an instrument without a group or taking lessons.

Before foster care only one participant formally played an instrument, in that he took lessons and played with a group. For the other participants who had spent time living with their biological families, each of them only had informal music involvement in that they listened to music, both live and recorded. Six of the participants associated a music experience with their life before foster care. The associations were typically related to listening to the radio in the car or at home and singing along with their siblings. The remaining four had been removed at birth or shortly thereafter, which would lead to no association. Remarkably, one of the participants removed at birth associated music

with a family member. However, this is most likely attributed to that he had regular access to his biological family while in foster care.

During foster care, the participant's formal involvement in music tended to expand over their involvement before foster care. Eight participants formally played an instrument in school or took lessons, (e.g., drums, guitar, piano and violin), and/or sang in a church choir; and informally they also listened to music. The other two participants only informally listened to music.

Moving from one placement to another seemed to have an adverse effect on how actively involved the participants were in music during their foster care years. Often, their active involvement in the previous placement lessened in the next placement. After the move, the participants that were active in formally studying music in school or privately, did not maintain this active involvement, due to changing schools or the lack of support and encouragement from the new foster parent.

Informal involvement in music during foster care tended to consist primarily of listening to music when alone. At times when participants did listen to music with others, it was usually with friends or in the car listening to the radio. No participant reported that they listened to music with their foster parent(s).

The media of choice for listening was the MP3 player, iPod, or the radio; only two participants mentioned listening to CDs. Nine of the ten participants reported that they never listening to live music, and had never attended a live concert. Only one participant had experienced live music and attended concerts; unfortunately, this changed when he was moved to the next placement.

When participants listened to music they used it as a psychological resource rather than merely a leisure time activity. They used music listening:

- To calm themselves: They would purposively choose music just to relax or "chill," albeit by themselves or with others.
- As an escape: Participants used music listening to get away from the stressors and difficulties they faced regularly, and sometimes from the people that caused them distress. These adolescents reported finding a place of solitude and then listening to music by themselves. This alone listening seemed to meet a metaphorical and literal need of the adolescents for their own space, away from others.
- As a distraction: Music listening helped divert their attention away from their mental turmoil or worries; and sometimes, by also being an obstacle to appropriately attending or focusing.
- As a way to forget the past: They used music to help them forget in that there is an intention to neglect or banish their thoughts, mostly to forget past experiences and perhaps even to avoid dealing with them.
- As a catalyst for socialization and identity formation: Listening to music with friends provided these adolescents with an opportunity to discuss and debate life issues, and thereby compare one's own perspective to those of others. This in turn helped them to find themselves and shape their own identity, musical as well as personal. A similar effect occurs when adolescents sing or play in musical groups.

It is interesting to find that research on adolescents who never had foster care experience have the same listening habits, and use music in the same ways as adolescents who have had foster care experience. For example, Gantz, Gartenberg, Pearson, and Shiller (1978) note that adolescents listened to music for relieving tension, distracting themselves from worries, and relieving boredom. Similar findings are reviewed by Zillmann and Gan (1997). Other researchers have found that "Music is an important source for social comparison and self-appraisal against which adolescents measure their appearance, behavior, or overall sense of self" (Kistler, et al., 2010, p. 617). The use of music as a form of socialization or identity finding seems to be common with adolescents regardless if they have foster care experience or not. Arnett (1995) found the most common uses of music from a media standpoint were "entertainment, identity formation, high sensation, coping, and youth culture identification" (p. 521). Adolescents use music to debate and consider the meaning and significance of music with each other (Steele & Brown, 1995). Other research results suggest that "similarity in music preferences is related to friendship formation, and not to friendship discontinuation" (Selfhout, 2009, p. 95).

A significant trend found in this study was that active involvement in music, whether formal or informal, tended to be associated with a positive foster care placement. For Steve, he felt most comfortable in the foster home where he played drums in school and with an outside drum group. Mark also played drums in school and is currently adopted by the foster parent who encouraged the involvement. Also, he currently sings in a church choir which was encouraged by this adoptive parent and he is happy with being

adopted and living in this home. Jason learned guitar in school and although he does not live in that foster home, he associates it with a good experience. Fred's experience is similar to Mark's in that he was encouraged to get involved in both playing a drum in school and singing in a church choir by the foster parent who has currently adopted him. Mary was adopted at an early age by the same family who once were her foster parents. She has always been encouraged to be involved with music in what would seem like a positive placement. Similarly, Sophia has been adopted for some time and is continually encouraged to be actively involved with music; in what would also be likely her most positive placement.

Currently, the participants' music experiences do not differ much from previous experiences in foster care in that their involvement with music revolves solely around listening. Two participants still had a formal involvement with singing in a church choir. While one participant noted that she still composes music and plays the piano informally. Unfortunately, active involvement in music lessons lessened as the adolescents moved from placement to placement, and as they grew older.

This movement away from active music involvement is unfortunate, because it potentially impacts other areas of life as well. It would seem important that the development and maintaining of healthy and self-efficient behaviors would be important in preventing and intervening with the struggles that adolescents face not only behaviorally and emotionally, but educationally as well. A recent study by Root-Wilson (2010) investigated the relationship between early adolescents' participation in school music programs with behavioral and emotional functioning. Her results suggested that:

Students involved in music programming significantly differed in relation to their

> health behaviors, with music students reporting higher levels of health-enhancing behaviors than non-music students. Further, gender, as well as length and breadth of music participation did not appear to contribute to the significant differences in health-enhancing behavior scores. (Root-Wilson, 2010, p. 3342)

Another study found that there is a "robust relationship between music participation and achievement—a relationship that emerges particularly when music participation is conceptualized and measured broadly" (Southgate and Roscigno, 2009, p. 18). Particularly important for this population is that North, et al. (2000) note that music involvement can "reduce the incidence of delinquent behaviors" (p. 255).

Musical Preferences

During foster care, it was interesting to examine whether the adolescents had a favorite song or artist. Five participants did have a favorite song while five did not. For participants who did have a favorite song, the music they liked then was similar to the music they like today. Favorite types of music while in foster care were Hip-Hop, Rap, and R & B. Two participants shared a favorite artist; Alicia Keys.

While they did not have as many favorite artists previously in foster care, the participants reported that they now have many favorite artists and/or groups. Meek Millz, Young Money, Trey Songz, Rihanna, Beyonce, L'il Wayne, Jay-Z, and Lady Gaga were all shared as favorites by two or more participants. All ten participants stated that they listen to music frequently. Most participants had two favorite songs, whereas one

participant had seven favorites, and three participants had none. Overall, their favorite artists and songs are what are considered "top 40", which is common with their peer groups.

In describing their current style preferences, participants still favor Hip-Hop, Rap, and R & B, with the radio and MP3 players the main media used to listen to music. McFerran-Skewes (2003) states that "within most naturally-formed adolescent groups, there is a tendency toward a particular genre of music that the group identifies with" (p. 3). Although this group of participants was not "naturally-formed," this research seems to have similar findings in that as a "group," the participants had similar favorite genres of music.

Two themes emerged when analyzing the favorite songs of participants during their foster care. The first theme was that the song voiced or matched their experience in foster care. Although participants were not always able to verbally articulate what they experienced in foster care, they often revealed their experiences through their choice of favorite songs. For example, John's existential crisis was voiced in his chosen song through the lyrics of "*Why am I dying to live, if I'm just living to die*?" Mark's song described his emotional stability through the lyrics of "*Hate in my heart, love in my mind. You keep the sunshine, save me the rain*." Martin was less verbal about his past, but the lyrics from the song he chose poignantly described his angst about being separate from his family, both physically and musically. Jason's song stemmed from the time he lived with his biological family; the song matched his verbal description of what it was like for him when living with his father. Similarly, Fred's song described the relationship, or the

lack thereof, he had with his father. Michelle's song depicted her feelings about having numerous placements with the lyrics of "*Either I'm going to trust you or I may as well walk away*." Elizabeth's song voiced her need for guidance, a need she also had during foster care.

The second theme is that the song voiced a request or plea for help or change. For example, John's song in describing his existential crisis also had a plea: "*Why am I trying to give, when no one gives me a try*?" Jason voiced his yearning to be with his father again: "*If I could get another chance, another walk, another dance with him*." Michelle's song pleaded for some relief from her woes in foster care: "*I've had so many ups and downs, don't know how much more I can take*." Sophia asked for change with her song; "*I'm starting with the man in the mirror, I'm asking him to change his ways*." Finally, Elizabeth's song for guidance was through a request for help "*I really need to talk to you Lord, since the last time we talked the walk has been hard*."

Summary

Three aspects of foster care appear to have influenced these adolescents' relationship to music across the three time periods. They are:

- Placement history. This may include the initial age of foster care placement, the number and types of placements, the adolescent's feelings about the placement, the reasons for being moved, and how the move took place.
- Relationships with Biological Family: This may include whether members of the family served as musical models, musical partners, positive or negative

reinforcers, and/or facilitators. Or, did the family use music to enhance their parenting role?

- Relationships with Foster Care Family. This may include whether members of the family served as musical models, musical partners, positive or negative reinforcers, and/or facilitators. Or, did the family use music to enhance their parenting role?

Aspects of their relationship to music that seem to have been influenced by foster care across the three time periods were:

- The intensity of their relationship to music, as evidenced by: 1) the amount of time they spent on a daily basis listening to or making music, and 2) whether they regarded their musical experiences as positive, neutral, or negative.
- The nature of their involvement in music. This includes whether they formally or informally involved as previously defined.
- Their reasons for becoming involved in music. What psychological, social, or cultural needs did they seek to address through music?
- Their listening habits. This includes how, when, where, and with whom they listen to music.
- Music Preferences. This includes their favorite styles of music, songs, and artists.

CHAPTER SIX:

CONCLUSIONS AND IMPLICATIONS

The purpose of this chapter is to draw conclusions from the integration of data presented in the previous chapter on the personal and musical biographies of adolescents. Two main questions are addressed: 1) How can foster care influence an adolescents relationship to music? And 2) How can music influence an adolescent's foster care experience? Following these conclusions, limitations of the study are examined, and implications are drawn for music therapy practice, research, and theory.

How Foster Care Can Influence An Adolescent's Relationship to Music

Placement History

The placement history of the participants varied widely. Placement movement tended to lessen the participant's active involvement in music-making with a group or receiving lessons. On the other hand, placement movement did not seem to lessen the participant's access to music and music listening habits. Interestingly, those foster homes where music involvement was encouraged tended to be more stable placements for the participants than those that did not.

Relationship with Biological Family

Typically, if the participant had a music relationship with a biological family member before foster care, this music relationship ceased when the participant entered foster care. Every participant that had some type of music involvement (e.g., singing, playing, listening) with a biological family member, lost that relationship to music upon

being placed in foster care. And those participants who continued to have contact with their biological family did not report any attempts to resume their earlier relationship to music with a family member.

When a participant was able to share music listening preferences with their biological family, these preferences tended not to change when he or she was placed in foster care. In all likelihood, this happened because participants' preferences were shared not only by the biological family, but also by the participant's peer age group.

Relationship with Foster Care Family

Participants who had positive music experiences in a foster home at an early age (i.e., pre-adolescence) tended to have music preferences that were similar to their foster parents. However, as the participant entered adolescence their listening preferences were shared more by their peer group than their foster parents.

Participants generally had a positive relationship with their foster family when involvement with music was encouraged. Participants generally enjoyed and felt more comfortable in foster homes that encouraged music involvement; however there did not seem to be any pattern of whether the music involvement led to less or more placements or led ultimately to adoption.

How Music Can Influence
An Adolescent's Foster Care Experience

Intensity of the Relationship to Music

Listening to music alone tended to increase in frequency and importance when the participant did not have a positive relationship or healthy attachment with the foster

parent. Music seemed to function in these cases as an attachment object—the adolescent attached to their favorite music when he or she did not trust or felt unsafe with the foster parent. Music for these participants became an escape or a way to separate from the daily struggles or lack of connection with the foster family. Interestingly, when participants shared a positive attachment with their foster family, listening to music alone tended to continue at the same level of frequency and importance. With these participants, music was a way to relax or just "chill," not an escape.

Nature of Involvement in Music

The nature of a participant's involvement in music varied according to whether it was formal and/or informal and active and/or passive. Formal, active involvement in music (e.g., participating in school or group music, or taking lessons) seemed to be associated with a positive or healthy relationship with the foster family. Formal and passive involvement in music (e.g., listening to music in church or at concerts) did not seem to have any influence, unless the involvement was encouraged by the foster family.

Informal, active involvement with music (e.g., singing with friends) did not seem to influence the participant's relationship with the foster family, nor did informal passive involvement (e.g., listening to music alone or with friends). While in foster care, participants tended to listen to music alone, when they did listen with others, it was generally with their friends or with other peers in the home.

Formal or informal musical involvement does not seem to show any relation to number of placements. However, formal and active music involvement was adversely effected by placement changes. Participants tended to lessen and/or cease formal and

active involvement with music when moved to a new home; particularly, if that new home did not encourage music involvement. Also, formal or informal musical involvement had no influence on the relationship between the foster care family and the biological family. No participant mentioned any experience that revolved around a shared music experience between the two families.

Reasons for Involvement in Music

Participants involved themselves in active music-making during foster care when they were encouraged to do so by their family, or when it helped to connect them socially to their peers. Participants tended to listen to music for personal, psychological reasons, often to cope with the trauma, grief, and loss they continued to encounter throughout their lives. Participants used music listening as a psychological resource in five ways; to calm themselves, as an escape, as a distraction, as a way to forget the past, and as a catalyst for socialization and identity formation. For this reason, they preferred listening to songs that voiced or matched their life experience, or to songs that voiced a request or plea for help or change. Possibly not different than adolescents without foster care experience, music seems to help these adolescents express what they had difficulty expressing verbally.

Listening Habits

The music listening habits of these participants remained consistent throughout foster care and with each new placement. These listening habits included: how often they listened to music, the types of music they preferred, when they listened to music, and

where they listened to music. Throughout foster care participant's typical media of choice for listening was the MP3 player, iPod, or the radio.

Music listening habits did not seem to affect the stability of a participant's foster care placement or his/her personal experiences of living in a particular foster home. This makes some sense, as their music listening tended to be a very private activity, unrelated to where they lived.

The listening habits of these participants do not seem to be different than adolescents who have not had foster care experience. Interestingly, these participants tended to listen less in solitude and more with others when they lived in a home with other foster children of similar age or when they lived with a foster family who had their own children of a similar age. Thus, music listening seemed to help the participants to relate and connect with others through their shared listening habits and preferences.

Music Preferences

Like their music listening habits, the music preferences of these participants seemed to remain essentially the same throughout their various foster care placements. Throughout foster care, favorite types of music were Hip-Hop, Rap and R & B. The participants' favorite artists were Meek Millz, Young Money, Trey Songz, Rihanna, Beyonce, L'il Wayne, Jay-Z, and Lady Gaga. Their preferences and favorite artists seem similar to adolescents who share similar urban backgrounds and who have not had foster care experience.

The music preferences of these participants also did not seem to influence the stability of their placements or their experiences within the foster care environment. For

example, two participants preferred gospel music, which was the preferred music of the foster parents they lived with at the time; however these participants were still placed in other homes. Also, for the other participants who mostly enjoyed Hip-Hop, Rap, and R & B throughout foster care, their preferences for music did not seem to have any relationship on whether they were placed in another home or not.

Limitations of the Study

A major limitation for this study was the small number of participants. The initial plan was to do a pilot study with two to four participants, and then to recruit 10 more participants for the study itself. This did not occur because a total of only 10 participants were available. There were two reasons for this. First, in recruiting for participants the therapists working in the out-patient clinic did not feel enough of their adolescent clients were stable or emotionally ready for the research. Second, some participants were recruited but then were unable to participate in the study. In fact, one participant was placed in a psychiatric hospital the day before I had planned to interview her.

The conclusions of this study are therefore not generalizable to the adolescent population with foster care experience. Nevertheless, these conclusions point to a number of issues that need to be addressed in music therapy practice, research, and theory.

Another limitation was that the data were gathered through only one interview, lasting about one hour. Additional rich data may have been gathered by doing another interview later in which the adolescent was given an opportunity to listen to and discuss

the meaning of songs they recalled from their past. Unfortunately, this was not possible to do at this facility.

Recommendations for Music Therapy Practice

Selecting Music for Adolescents in Foster Care

Based on the present study, two criteria should be used in selecting music to use in music therapy with adolescents in foster care. The first is to select music according to their preferences for music styles, songs, and artists. These preferences seemed to be shared by their peer age group, regardless of whether the adolescents have had foster care experience. Music preferences include the genres of Hip-Hop, Rap and R & B and songs from favorite artists like Meek Millz, Young Money, Trey Songz, Rihanna, Beyonce, L'il Wayne, Jay-Z, and Lady Gaga.

The second criterion is lyric content. A theme that emerged from the analysis of song lyrics chosen by the adolescents in this study was that music helps them to examine and express the paradoxes and conflicts that characterize their lives. The adolescents recognized that music has the ability to express both sorrow and joy, sometimes at the same moment and within the same experience. The favorite songs of these adolescents deal not only with the common themes of love, sex, and relationship problems, but also with the paradoxes and conflicts around these themes that pervade their daily life.

Other clinicians and researchers have noted similar patterns with adolescents in general, but obviously not with the same biographical experiences. McFerran, Roberts, and O'Grady (2010) found that, when confronted with loss, adolescents can confront the "paradoxical elements of grieving" through musical activity, and that teenagers can find

opportunities in music to experience "both freedom and control, altruism and empathy" (p. 546). North, Hargreaves, and O'Neill (2000) suggest that music is important to adolescents, because it allows them "to satisfy their emotional needs" (p. 255). McFerran-Skewes (2005) research showed that adolescents "choose music that reflects their life experience" (p. 546).

Although the adolescents in this study have probably encountered more trauma, hardship, grief, and loss than adolescents who have had no foster care experience, the use of music to express their inmost feelings does not seem to be any different for them. Whether their favorite songs were metaphorical or literal representations of their life experiences, these adolescents seemed to have a clear understanding of the difference between reality and their imagined "good life." Issues of relationships, loss, death, and betrayal frequently found in their preferred music are the very issues that teenagers are confronted with in their lives (McFerran-Skewes, 2005).

Music Therapy Can Help Identity Development

Another finding of this study was that music helps adolescents with foster care experience to develop their personal identities. Ruud (2009) writes that music and identity "seems to be a fruitful combination" for music therapy (p. 37). He continues by stating that "identity is constructed through the narratives we will tell ourselves in relations to musical events and experiences in different contexts" (p. 40). Therefore, involvement in music through an adolescent's life may serve in the development of the self and identity (Ruud, 2009, p.50). Ruud (2009) also notes that "Identity may serve as a bridging concept between music therapy and the role of music in everyday life for the

individual" (p. 38). As Ruud (1998) initially wrote on music therapy and identity "A more specific grasp of how music helps to construe a sense of identity is an important tool for perceiving and understanding clinical events" (p. 37).

In this study, identity is very closely related to music choice and preferences. Five participants remarked in some manner or form that music was their "life." Four participants described their favorite music as a metaphor for their identity. They explained: It's a "symbol of the type of person you are;" and "I am music the way I listen to it." Music appears to help define them within a world where personal identity is lost. Ruud (2009) remarks that music serves an important role in the "narration of identity throughout life" (p. 38). Research by North, Hargreaves and O'Neill (2000) found that music is important to adolescents, because it allows them "to portray an 'image' to the outside world" (p. 255). Music preference is then "not as much a reflection of identity as a way of *performing* ourselves, our identities" (Ruud, 1998, p. 31).

Other research has shown that group identity is also implicated in music choice. Adolescents value the music of their peer group and tend to devalue the music of "other" groups (Bakagiannis and Tarrant, 2006). Also, "preferences for music sometimes predict to a large extent" preferences for other "non-musical activities and attitudes" based on the adolescent's identification with society and media in general (Rudd, 2009, p. 46). This recent stream of research and theoretical writings is adding further to the specific research on social identity theory and its relationship to musical behaviors (Bakagiannis and Tarrant, 2006).

The Use of Group

Participants shared similar personal biographies and musical biographies within this study. It would seem that adolescents with foster care experience would then represent a specific clinical population or group. The participants seemed to enjoy the relationships and musical connections they made while listening to music with peers. Music therapy in a group context would not only help adolescents feel comfortable with peers with similar backgrounds but would allow for engagement and open communication through the use of the group's shared musical preferences.

Based on their work with adolescents McFerran, et al., (2010) found that "music therapy promotes a useful balance between fun and emotional engagement for teenagers, particularly when it takes place within the safety of a closed group that promotes respect and confidentiality" (p. 546).

McFerran, et al. (2010) further report that adolescents find "expressing their grief-related emotions valuable but struggle to find a forum where this is viable" (p. 546). There is a transition for all adolescents to make in the process of self-discovery or identity (McFerran-Skewes, 2003). "This process does not occur in isolation, but rather through a comparison of who they consider themselves to be in contrast to the feedback they receive from others" (McFerran-Skewes, 2003, p. 3). Music therapists have been trained in interventions within the medium of music "as well as to work verbally with its meaning after the music is ended" (Gold, et. al., 2007, p. 585). Music therapy's ability to use "non-verbal communication is perfectly matched to those who have difficulty in expressing themselves in words—whether for cognitive, psychological or safety reasons" (McFerran-Skewes, 2003, p. 3). Group music therapy would be not only

beneficial, but perhaps warranted as a necessary treatment recommendation for any adolescent with foster care experience.

This study has also encouraged me to look at my own music therapy practice in working with adolescents in foster care. Much of my work has been individually based music therapy. However, I have learned that incorporating the use of group music therapy into my own practice would be useful and beneficial, particularly for this population. I plan to incorporate more song discussion and song writing within an adolescent music therapy group. This would allow for the adolescents to communicate personal experiences with others who share not only their personal biographies but shared musical preferences. The adolescents in this study enjoyed the relationships and musical connections they made while listening to music with peers. It would only seem natural then to shift my own practice in incorporating more group work.

Early Intervention Through Music

In this study, there did not appear to be any conclusive findings on how music involvement related to placement movement. However, formal and active musical involvement typically provided a stable and positive experience within a foster home. It would seem then that early intervention through music might limit the amount of placements since participants who lived within a foster home that they generally enjoyed typically had less acting out behaviors.

The incidence of mental health issues and behavior problems in foster care adolescents, both at the time of entering foster care and subsequently, attests to the need for early intervention (Milburn, et al., 2008). Examples of early intervention programs

specifically targeting children in foster care show some promising results. One assessment program that researched the relationship between infant and caregiver showed "an increased rate of adoption or permanency planning and a substantial reduction (53–68%) in reoccurrence of maltreatment" as a result of early intervention (Zeanah, et al., 2001, p. 214). Perry, et al. (2000) found through early intervention programs that there was a "reduction in placement breakdown, staff and carers' increased sensitivity to trauma and attachment difficulties, fewer days in care and more rapid decision making within the system" (hjttp://www.bcm.tmc.edu/cta/cccc_paper.htm). Price, et al. (2008) found that interventions for children in foster care "moderated the effects of prior foster placements on permanent placements with biological parents, with children in the control group more likely to experience a failed permanent placement than children in the intervention group" (p. 73). There is a clear indication that early intervention in itself is effective for children in care. Simmel, Barth, & Brooks (2007) state that "with the ensuing increase in adoptions of foster youth, avenues for early and consistent intervention to alleviate foster youths' behavioral impairments are needed" (p. 346).

There is evidence from correlations between brain responses and the age of onset music involvement that "musical experience early in life has a more profound effect than musical experience later in life" (Trainor, 2005, p. 262). Rudd (2009) states that "continuity and stability are maintained in life" through engagement in music (p. 47). Therefore, not only are early intervention programs important for children in foster care but music therapy in particular would have a greater effect. "This early process of reciprocal sound making is at the core of healthy, nurturing relationships and provides the

foundation for a lifetime of satisfying communication with others" (Katsh & Merle-Fishman, 1998, p. 8). Fortunately the practice of music therapy for early intervention or early development has been developed more fully by Elizabeth Schwartz in her book titled *Music, therapy, and early childhood: A developmental approach*.

Psycho-education As Treatment Intervention

Since working with children and adolescents in foster care I have begun implementing psycho-education as way to engage the foster parent, to reduce potential clinical risks, and to provide strategies for reducing negative behaviors. One of the goals in using psycho-education is to normalize both the client and foster parents responses to disruptive experiences and to reinforce accurate cognitions about those experiences (Cohen, Mannarino, & Deblinger, p. 59). The adolescents in this study experienced severe anxiety and/or symptoms of post traumatic stress. They feel like their thoughts and emotions are out of control and they can typically feel confused and upset about their experiences. Psycho-education helps them to recognize the symptoms and prepare for problems that arise. The findings of this study have prompted me to provide further psycho-education on the value of music in encouraging positive attachments with adolescents and their foster parents. As a music therapist, I encourage musical discussion and involvement with the family. However, based on the current research, I am able to provide authentic psycho-education on the advantages of involvement with music.

As a treatment intervention, this study has shown that formal and active involvement in music was associated with a positive or healthy relationship with the foster family. The adolescents participated in active music-making during foster care

when they were encouraged to do so by their family, which normally lead to a stable placement. It appears from this research that placement movement then has a negative impact on active music making. Importantly, adolescents tend to listen to music for personal and psychological reasons. Hence, psycho-education on music involvement may enhance not only the treatment but the relationship between the adolescent and foster parent.

Recommendations for Music Therapy Research

There are three recommendations for future research based on the current study. First, adolescents with foster care experience should be studied in their own environment instead of an office environment; second, the current study should be extended to more fully examine the musical biographies of adolescents with foster care experience; and third, further inquiry into the specific relationship, if any, between placement, movement, stability and the adolescents relationship to music.

"Very few studies have investigated people's experiences of music in naturalistic, everyday circumstances" (North, et al., 2004, p. 41). North, et al. (2004) completed an exploratory study to understand "who people listen with, what they listen to (and what their emotional responses to this music are), when they listen, where they listen, and why they listen" (p. 41). Their findings suggest that adolescents listen to music primarily on their own; however, in this study the participants not only listened to music privately but with others. Observing the adolescents in their environments and examining the role of music in their lives may provide more information on both their foster care experiences and their relationship to music. The current research provides a foundation for

understanding the musical biographies of adolescents with foster care experience, but perhaps a more naturalistic study would provide more day to day understanding of the role music plays in their everyday life.

The current study examined the personal and musical biographies of adolescents with foster experience. There have been no previous studies that have focused on their personal lives from their point of view, or on their musical biographies, as described by them. Thus, more phenomenological research seems warranted, and especially on the psychological needs addressed by their preferred music.

Such research could focus specifically on song choice throughout their life span, focusing specifically on what adolescents find most meaningful and valuable about the music they like. The research could have the adolescents choose songs based on different stages of life, for example, birth, as a toddler, to pre teen, etc. Although the participants would not need to necessarily choose a song they remember from that part of their life, but could choose a song that reminds them of that stage of life. This kind of "song biography" is particularly useful for client populations where there is less available research, practice or theoretical information. A more thorough understanding of the musical biographies from this specific population would be useful in further understanding their mental health needs.

Finally, the number of placements each participant had varied widely. In interviewing these participants, and then analyzing their responses, it was not possible to determine whether music habits/involvement affected placement movement or placement stability. A key research question that needs to be answered is: Are there fewer or more

foster care placements, depending on whether the foster families encouraged active music involvement?

Recommendations for Music Therapy Theory

In doing the bibliographic research for this study, and when examining the data to find relationships between psychiatric diagnosis and the life experience of these foster care adolescents, I found that there is one area in theory that seems significant not only for the field of foster care, but also for music therapists—attachment theory. Attachment theory is just starting to gain prominence in clinical practice and research with foster care children. Similarly, music therapists may benefit from understanding attachment theories as part of practice with foster care children.

In foster care, research indicates that "maltreated children are likely to have mental representations of self characterized by a devalued sense of self, a mistrust of others, a tendency toward negative attribution bias, hostility, and a wariness of close relationships" (Mennen, & O'Keefe, 2005, p. 581). Unfortunately, theoretical research on the attachment behavior of children in foster care and music therapy is limited and needs to be increased to provide a clearer understanding of how maltreatment, separation from parents, and placement in foster care may influence attachment, and how foster children's attachments affect their long-term adjustment. Meenen and O'Keefe (2005) note that "The existing research is sparse and has focused on only several areas: the effect of children's attachment on outcome; attachment to foster parents and birth families; the effect of age at placement on attachment; and the qualities in foster parents that encourage good attachments" (p. 582). These findings can be further understood in terms

of “cumulative adversity and attachment” theories (Tarren-Sweeney, 2008). Significantly, no study has looked at the relationship to music and attachment within the foster care setting. As a foundation, this study found that active and formal music involvement is associated with a positive foster care placement. Therefore, perhaps a more theoretical understanding of attachment theory can lead to not only music therapy theory, but enhanced research and practice.

Tarren-Sweeney (2008) state that “even one traumatic event may have developmental consequences for children at large. The impact of individual events is tempered among children exposed to chronic and multiple adversities” (p. 346). Age at entry into care also has significance in terms of attachment quality, and related emotional and neurological development. It is known that emotional deprivation and abuse in early childhood may lead to development of disorganized or disordered attachments (Tarren-Sweeney, 2008). “Experiences that affect attachment include the repeated loss of significant care givers and a pattern of serial care given by unfamiliar adults (such as temporary foster carers, or friends of birth parents)” (Tarren-Sweeney, 2008, pp. 346-347). Attachment theory would predict that the therapeutic potential of alternate care should vary according to the characteristics of children's attachment systems at entry into care (Schofield, 2002; Bowlby, 1998). More recently, however, researchers have become interested in factors across the life span that can lead to changes in attachment (Mennen & O'Keefe, 2005). Meenen and O’Keefe (2005) state that “One’s internal working model has been found to change when an individual is able to make sense of a previous attachment pattern, for example, through psychotherapy” (p. 581).

In summary, it is hoped that this research provides further use for music therapy not only with adolescents with foster care experience but with foster children in general. Recommendations have been presented for practice, research, and theory in music therapy. The adolescent's musical life is part of their personal biography, which also includes non musical events, experiences, and meanings. Music is a valuable resource for adolescents, whether he/she has foster care experience or not, and the role music plays in their life is integral to meaning making, particularly in the process of therapeutic change or growth. As the research shows, adolescents with foster care experience use music consciously and actively in their everyday lives, similar to ways that adolescents with no foster care experience do. As the research also shows, the difference is that adolescents with foster care experience have vastly different personal biographies, which is pertinent in understanding their mental health needs.

REFERENCES

Aarons, G. A., James, S., Monn, A. R., Raghavan, R., Wells, R. S., & Leslie, L. K. (2010). Behavior problems and placement change in a national child welfare sample: A prospective study. *Journal of the American Academy of Child and Adolescent Psychiatry*, *49* (1), 70-80.

Ackerman, D., Newton, J.E.O., McPherson, W.B., Jones, J.G., & Dykman, R.A. (1998). Prevalence of post traumatic stress disorder and other psychiatric diagnoses in three groups of abused children (sexual, physical, and both). *Child Abuse and Neglect, 22,* 759-774.

Ainsworth (1969). Object relations, dependency and attachment: A theoretical review of the mother-infant relationship. *Child Development, 40*, 969-1025.

Allard, P. (2006). Research to action: Informing policy makers about the needs of mothers and children at risk of separation. *Women and Criminal Justice, 12* (2/3), 27-42.

Alvin, J. (1975). *Music therapy*. New York: Basic Books, Inc.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental Disorders* (4th ed., text rev.). Washington, DC: Author.

Armour, M. P., & Schwab, J. (2007). Characteristics of difficult-to-place youth in state custody: A profile of the exceptional care pilot project population. *Child Welfare, 86* (3), 71-96.

Arnett, J. J. (1995). Adolescents' uses of media for self-socialization. *Journal of Youth and Adolescence*, *24* (5), 519-533.

Austin, D. (2007). Lifesongs: Music therapy with adolescents in foster care. In V.A. Camilleri (Ed.), *Healing the Inner City Child: Creative Arts Therapies with At-risk youth* (pp. 92-103). London & Philadelphia: Jessica Kingsley Publishers.

Bakagiannis, S. & Tarrant, M. (2006). Can music bring people together? Effects of shared musical preference on intergroup bias in adolescence. *Scandinavian Journal of Psychology*, *47*, 129–136.

Baker, F. & Bor, W. (2008). Can music preference indicate mental health status in young people? *Australasian Psychiatry, 16* (4), 284 – 288.

Barg, M. (1973). The effect of group guitar instruction on self-concept, attitude, toward education, and maladaptive acting out of adolescent hospitalized psychiatric patients. Unpublished master's thesis, University of Kansas.

Betts, D. J. (Ed.). (2003). *Creative arts therapies approaches in adoption and foster care: Contemporary strategies for working with individuals and families*. Springfield, Il: Charles C. Thomas Publishers.

Bonny, H. (1980). *GIM therapy: Past, present and future implications*. Salina, KS: Bonny Foundation.

Bowlby J. (1998). *A secure base: Clinical applications of attachment theory*. London: Routledge.

Brinkman-Sull, D. C., Overholser, J. C., & Silverman, E. (2000). Risk of future suicide attempts in adolescent psychiatric inpatients at 18-month follow-up. *Suicide and Life-Threatening Behavior*, *30* (4), 327–340.

Brooks, D.M. (1989). Music therapy enhances treatment with adolescents. *Music Therapy Perspectives, 6*, 37-39.

Bruscia, K. E. (1987). *Improvisation models of music therapy*. Springfield, IL: Charles C. Thomas Publisher.

Bruscia, K. E. (1993). Client assessment in music therapy. Unpublished manuscript.

Burns, B. J., Goldman, S. K., Faw, L., & Burchard, J. (1998). The wraparound evidence base. In B. J. Burns & S. K. Goldman (Eds.), *Systems of care: Promising practices in children's mental health: Vol. IV. Promising practice in wraparound for children with serious emotional disturbance and their families* (pp. 77–100). Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

Camilleri, V. (Ed.). (2007). *Healing the inner city child: Creative arts therapies with at-risk youth*. London: Jessica Kingsley Publishers.

Cassity, M. D & Cassity, J. E. (1998). *Multimodal psychiatric music therapy for adults, adolescents, and children: A clinical manual* St. Louis, MO: MMB Music, Inc.

Clendenon-Wallen, J. (1991). The use of music therapy to influence the self confidence and self esteem of adolescents who are sexually abused. *Music Therapy Perspectives, 9*, 73-85.

Cohen, J., Mannarino, A. & Deblinger, E. (2006). *Treating Trauma and Traumatic Grief in children and adolescents.* New York: The Guilford Press.

Craven, P. A. & and Lee, R. E. (2006). Therapeutic interventions for foster children: A systematic research synthesis. *Research on Social Work Practice,16*, 287-304.

Cresswell, J.W. (1994). *Research design: Qualitative and quantitative approaches*. Thousand Oaks, CA: Sage Publications.

Dalton, T.A. (2006). The grief song-writing process with bereaved adolescents: An integrated grief model and music therapy protocol. *Music Therapy Perspectives, 24* (2), 94-107.

Dalton, T. A., & Krout, R. E. (2005). Development of the grief process scale through music therapy songwriting with bereaved adolescents. *The Arts in Psychotherapy*, *32*, 131–143.

Doak, B. A. (2003). Relationships between adolescent psychiatric diagnoses, music preferences, and drug preferences. *Music Therapy Perspectives, 21* (2), 69-76.

Dore, M. M. (1999). Emotionally and behaviorally disturbed children in the child welfare system: Points of preventive intervention. *Children & Youth Services Review, 21* (1), 7–29.

Dore, M. M. (2008). Book Review: *Burns, B. J., & Hoagwood, K. (2002). Community Treatment for Youth: Evidence-Based Interventions for Severe Emotional and Behavioral Disorders. Research on Social Work Practice, 18*, 526-527.

Dozier, M., Peloso, E. Lindhiem, O., Gordon, K. M., Manni, M., Sepulveda, S., Ackerman, J., Berrnier, A., & Levine, S. (2006). Developing evidence-based interventions for foster children: An example of a randomized clinical trial with infants and toddlers. *Journal of Social Issues,62* (4), 767-785.

Dvorkin, J. M. (1991). Individual music therapy for an adolescent with borderline personality disorder: An object relations approach. In K. E. Bruscia (Ed.). *Case Studies in Music Therapy.* Phoenixville, PA: Barcelona Publishers.

Family Law Center (2010). Open vs. closed adoption. http://family.findlaw.com/adoption/adoption-types/open-adoption comparison.html

Feldman, C. (2004). Prescription for trouble: Foster children are far more likely to be prescribed psychiatric drugs than kids in the general population. Have the doctors been scribbling too fast? *City Limits, 29* (7), 10.

Festinger, T. (2002). After adoption: Dissolution or permanence? *Child Welfare*, 81 (3), 515-533.

Ficken, T. (1976). The use of songwriting in a psychiatric setting. *Journal of Music Therapy, 13* (4), 163–172.

Field, T., Martinez, A., Nawrocki, T., Pickens, J., Fox, N. A., & Schanberg, S. (1998). Music shifts frontal EEG in depressed adolescents. *Adolescence, 33* (129), 109–116.

Forand, A. (1999). Residential treatment and diagnosis: How stable is the label? *Residential Treatment for Children and Youth, 16,* 57-60.

Gantz, W., Gartenberg, H. M., Pearson, M. L., & Shiller, S. O. (1978). Gratifications and expectations associated with pop music among adolescents. *Popular Music and*

Society, *6*, 81–89.

Gardstrom, S. (2004). An investigation of meaning in clinical music improvisation with trouble adolescents. In B. Abrams (Ed.), *Qualitative inquiries in music therapy: A monograph series*. Gilsum, NH: Barcelona Publishers.

Garland, A. F., Landsverk, J. L., Hough, R. L., & Ellis-MacLeod, E. (1996). Type of maltreatment as a predictor of mental health service use for children in foster care. *Child Abuse & Neglect, 20,* 675–688.

Gold, C., Voracek, M. & Wigram, T. (2004). Effects of music therapy for children and adolescents with psychopathology: A meta-analysis. *Journal of Child Psychology and Psychiatry*, *45* (6), 1054–1063.

Gold, C., Wigram, T. and Voracek, M. (2007). Predictors of change in music therapy with children and adolescents: The role of therapeutic techniques. *Psychology and Psychotherapy: Theory, Research and Practice*, *80*, 577–589.

Goldstein, S. L. (1990). A songwriting assessment for hopelessness in depressed adolescents: A review of the literature and a pilot study. *The Arts in Psychotherapy*, *17* (2), 117–124.

Goncik, R.S., & Gold, M. (1991). Fragile attachments: Expressive arts therapy with children in foster care. *The Arts in Psychotherapy,18* (5), 433-440.

Haines, J. H. (1989). The effects of music therapy on self-esteem of emotionally-disturbed adolescents. *Music Therapy, 8* (1), 78-91.

Halfon, N., Berkowitz, G., & Klee, L. (1992). Children in foster care in California: An examination of Medicaid reimbursed health services utilization. *Pediatrics, 89,* 1230–1237.

Halperin, R. & Harris, J. L. (2004). Parental rights of incarcerated mothers with children in foster care: A policy vacuum. *Feminist Studies, 30* (2), 339-352.

Hasler, J. (2008). A Piece of the puzzle: Music therapy with looked after teenagers and their carers. In A.Oldfield & C. Flower (Eds.), *Music Therapy with Children and their Families* (pp. 159-176). London & Philadelphia: Jessica Kingsley Publishers.

Henderson, S. M. (1983). Effects of a music therapy program upon awareness of mood in music, group cohesion, and self-esteem among hospitalized adolescent patients. *Journal of Music Therapy, 20*, 14-20.

Hussey, D. L., & Guo, S. (2005). Characteristics and trajectories of treatment foster care youth. *Child Welfare, 84* (4), 485-506.

James, S., Landsverk, J., Leslie, L. K., Slymen, D. J., & Zhang, J. (2008). Entry into restrictive care settings: Placements or last resort? *Families in Society*, *89* (3), 348-359.

Jurkovic, G. J. (1997). *The plight of the parentified child.* New York: Brunner Mazel Inc.

Katsh, S., & Merle-Fishman, C. (1998). *The music within you*. Gilsum, NH: Barcelona

Publishers.

Kerker, B. D, & Morrison-Dore, M. (2006). Mental health needs and treatment of foster Youth: Barriers and opportunities. *American Journal of Orthopsychiatry, 76* (1), 138–147.

King, C. A., Hovey, J. D., Brand, E., & Ghaziuddin, N. (1997). Prediction of positive outcomes for adolescent psychiatric inpatients. *Journal of the American Academy of Child & Adolescent Psychiatry*, *36* (10), 1434–1442.

Kistler, M., Rodgers, K. B., Power, T., Austin, E. W., & Hill, L. G. (2010). Adolescents and music media: Toward an involvement-mediational model of consumption and self-concept. *Journal of Research on Adolescence*, *20*, 616–630.

Kivland, M. J. (1986). The use of music to increase self esteem in a conduct disorder adolescent. *Journal of Music Therapy, 23* (1), 25-29.

Krout, R., & Mason, M. (1988). Using computer and electronic music resources in clinical music therapy with behaviorally disordered students, 12 to 18 years old. *Music Therapy Perspectives, 5*, 114–118.

Landsverk, J., Davis, I., Ganger, W., Newton, R., & Johnson, I. (1996). Impact of child psychosocial functioning on reunification from out-of home placement. *Children & Youth Services Review, 18,* 447–462.

Laiho, S. (2004). The psychological functions of music in adolescence. *Nordic Journal of Music Therapy*, *13* (1), 47-63.

Lane, K. (2004). Grounding mother and child in their intrinsic relational unit: An

analysis of motherhood and the parent-child relationship within the child welfare system. *Women's Rights Law Reporter, 25* (2/3), 145-166.

Layman. D. & Hussey, D. (2003). Music therapy issues and strategies for working with adopted and foster care children. In D. Betts (Ed.), *Creative arts therapies approaches in adoption and foster care: contemporary strategies for working with individuals and families* (pp. 114-130). Springfield, Il: Charles C. Thomas Publishers.

Layman. D., Hussey, D., & Laing, S. (2002). Foster care trends in the United States: Ramifications for music therapists. *Music Therapy Perspectives, 20* (1), 38–46.

Leathers, S. J., Falconnier, L., & Spielfogel, J. E. (2010). Predicting family reunification, adoption, and subsidized guardianship among adolescents in foster care. *American Journal of Orthopsychiatry*, *80*, 422–431.

Linares, L. O., Li, M., Shrout, P. E., Brody, G. H., & Pettit, G. S. (2007). Placement shift, sibling relationship quality, and child outcomes in foster care: A controlled study. *Journal of Family Psychology*, *21* (4), 736-743.

Lincoln, S. (2005). Feeling the noise: Teenagers, bedrooms and music. *Leisure Studies*, *24* (4), 399-414.

Lipscombe, J., Moyers, S., & Farmer, E. (2004). What changes in 'parenting' approaches occur over the course of adolescent foster care placements? *Child & Family Social Work, 9*, 347–357.

Lubrano, A. (2008, September 11). Report on DHS hits return rate: Children discharged

from foster care are "highly likely" to reenter. But there is success for those placed with relatives. *Philadelphia Inquirer*, p. B01.

Mayo Clinic (2010). Post-traumatic stress disorder (PTSD). http://www.mayoclinic.com/health/post-traumatic-stress-disorder/DS00246

McBeath, B. & Meezan, W. (2008). Market-based disparities in foster care service provision. *Research on Social Work Practice, 18* (1), 27-41.

McFerran-Skewes, K. (2003). Contemplating the nature of adolescent group improvisation. *Voices: A World Forum for Music Therapy, 3*, 3.

McFerran, K., Baker, F., Kildea, C., Patton, G. & Sawyer, S. M. (2008). Avoiding conflict: What do adolescents with disordered eating say about their mothers in music therapy? *British Journal of Music Therapy, 22 (1)*, 16-23.

McFerran, K., Roberts, M. & O'Grady, L. (2010). Music therapy with bereaved teenagers: A mixed methods perspective. *Death Studies*, *34* (6), 541-565.

McMillen, J. C., Scott, L. D., Zima, B. T., Ollie, M. T., Munson, M. R., & Spitznagel, E. (2004). Use of mental health services among older youths in foster care. *Psychiatric Services, 55*, 811–817.

Mennen, F. E., & O'Keefe, M. (2005). Informed decisions in child welfare: The use of attachment theory. *Children and Youth Services Review, 27* (6), 577-593.

Metzger, L. K. (1986). The selection of music for therapeutic use with adolescents and young adults in a psychiatric facility. *Music Therapy Perspectives, 3*, 20-24.

Milburn, N. L., Lynch, M. & Jackson, J. (2008). Early identification of mental health needs for children in care: A therapeutic assessment programme for statutory

clients of child protection. *Clinical Child Psychology and Psychiatry, 13* (1), 31-47.

Milner, E. W. (1980). Music as the least restrictive environment of the severely emotionally disturbed (ERIC Document Reproduction Service No. ED201131)

Montello, L. & Coons, E. E. (1998). Effects of active versus passive group music therapy on preadolescents with emotional, learning, and behavioral disorders. *Journal of Music Therapy, 35* (1), 49-67.

North, A. C. Hargreaves, D. J, & Hargreaves, J. J. (2004). Uses of music in everyday life. *Music Perception*, *22* (1), 41–77.

North, A. C., Hargreaves, D. J., & O'Neill, S. A. (2000). The importance of music to adolescents. *British Journal of Educational Psychology*, *70* (2), 255-272.

Oldfield, A. (2008). Working in partnership and supporting parents: Music therapy for pre-school children and their parents at a child development centre. In A. Oldfield & C. Flower (Eds.), *Music Therapy with Children and their Families* (pp. 19-36). London & Philadelphia: Jessica Kingsley Publishers.

Paul, D. W. (1982). Music therapy for handicapped children: Emotionally disturbed. In W. B. Lathom & C. T. Eagle (Eds.), *Music therapy for handicapped children*. Washington, DC: National Association for Music Therapy.

Pelcovitz, D., Kaplan, S. J., DeRosa, R. R., Mandel F. S., & Salzinger, S. (2000). Psychiatric disorders in adolescents exposed to domestic violence and physical violence. *American journal of Orthopsychiatry, 70,* 360-369.

Perret, D. (2005). *Roots of musicality: Music therapy and personal development.* London and Philadelphia: Jessica Kingsley Publishers.

Perry, B. D., Conrad, D. J., Dobson, C., Schick, S., & Runyan, D. (2000). The children's crisis care centre model: A proactive, multidimensional child and family assessment process. Downloaded from hjttp://www.bcm.tmc.edu/cta/cccc_paper.htm

Price, J. M., Chamberlain, P., Landsverk, J., Reid, J. B., Leve, L. D., & Laurent, H. (2008). Effects of a foster parent training intervention on placement changes of children in foster care. *Child Maltreatment*, *13* (1), 64-75.

Primadei, A. (2004). The use of the guitar in clinical improvisation. *Music Therapy Today.* Retrieved May 30, 2009 from http://musictherapyworld.net

Psyweb.com (2010). Axis I clinical disorders, most V-codes, and conditions that need clinical attention. http://psyweb.com/Mdisord/DSM_IV/jsp/Axis_I.jsp

Radke-Yarrow, M., & Klimes-Dougan, B. (2002). *Parental depression and offspring disorders: A developmental perspective.* Washington DC: American Psychological Association.

Ragland, Z. & Apprey, M. (1974). Community music therapy with adolescents. *Journal of Music Therapy, 11* (3), 147-155.

Reher, M. (2003). The dance of belonging: An exploration of identity through the Bonny Method of Guided Imagery and Music. In D. Betts (Ed.), *Creative arts therapies approaches in adoption and foster care: Contemporary strategies for working*

with individuals and families (pp. 41-61). Springfield, Il: Charles C. Thomas Publishers.

Rickson, D. J. (2006). Instructional and improvisational models of music therapy with adolescents who have Attention Deficit Hyperactivity Disorder (ADHD): A comparison of the effects on motor impulsivity. *Journal of Music Therapy, 43* (1), 39-62.

Rickson, D. J. & Watkins, W. G. (2003). Music therapy to promote prosocial behaviors in aggressive adolescent boys: A pilot study. *Journal of Music Therapy, 40,* 283 301.

Root-Wilson, K. A. (2010). The effect of music education on early adolescents' adaptive skills, health-enhancing behaviors, and self-efficacy. Dissertation Abstracts International Section A: Humanities and Social Sciences (0419-4209) (978-1-109-37091-1) Vol.70; p.3342.

Rudd, E. (1998). *Music therapy: Improvisation, communication, and culture*. Gilsum, NH: Barcelona Publishers.

Rudd, E. (2010). *Music therapy: A perspective from the humanities*. Gilsum, NH: Barcelona Publishers.

Salas, J. (1990). Aesthetic experience in music therapy. *Music Therapy, 9* (1), 1–15.

Salkeld, C. (2008). Music therapy after adoption: The role of family music therapy in developing secure attachment in adopted children. In A. Oldfield & C. Flower (Eds.), *Music Therapy with Children and their Families* (pp. 19-36). London & Philadelphia: Jessica Kingsley Publishers.

Schofield G. (2002). The significance of a secure base: A psychosocial model of long-term foster care. *Child Family Social Work*, *7*, 259–272.

Schwartz, E. (2008). *Music, therapy, and early childhood: A developmental approach*. Gilsum, NH: Barcelona Publishers.

Selfhout, M. H. W. (2009). The role of music preferences in early adolescents' friendship formation and stability. *Journal of Adolescence*, *32* (1), 95-107.

Sieracki, J. H., Leon, S. C., Miller, S. A., & Lyons, J. S. (2008). Individual and provider effects on mental health outcomes in child welfare: A three level growth curve approach. *Children and Youth Services Review, 30*, 800–808.

Simmel, C., Barth, R. P., & Brooks. D. (2007). Adopted foster youths' psychosocial functioning: A longitudinal perspective. *Child & Family Social Work, 12* (4), 336-348.

Snowden, J., Leon, S., & Sieracki, J. (2008). Predictors of children in foster care being adopted: A classification tree analysis. *Children and Youth Services Review*, *30*, 1318–1327.

Steele, A. L. (1975). Three year study of a music therapy program in a residential treatment center. *Journal of Music Therapy, 12* (2), 67-83.

Steele, J. R. & Brown, J. D. (1995). Adolescent room culture: Studying media in the context of everyday life. *Journal of Youth and Adolescence*, *24* (5), 551-576.

Southgate, D.E, & Roscigno, V.J. (2009). The impact of music on child and adolescent development. *Social Science Quarterly*, *90* (1), 4-21.

Spencer, C. M. (2010). Abused children placed in foster care: A prospective case-control study of quality and number of placements. Dissertation Abstracts International: Section B: The Sciences and Engineering (0419-4217).

Spirito, A., Valeri, S., Boergers, J., & Donaldson, D. (2003). Predictors of continued suicidal behavior in adolescents following a suicide attempt. *Journal of Clinical Child and Adolescent Psychology*, *32* (2), 284–289.

Steele, J. R. & Brown, J. D. (1995). Adolescent room culture: Studying media in the context of everyday life. *Journal of Youth and Adolescence*, *24* (5), 551-576.

Sullivan, P. F., Neale, M. C., & Kendler, K. S. (2000). Genetic epidemiology of major depression: Review and meta-analysis. *American Journal of Psychiatry*, *157* (10), 1552–1562.

Sylwester, K., Barg, M., Frueh, H., Baker, K. A., Patrick, F. D., & Shaffer, S. (1971). Music therapy in a decentralized hospital. *Journal of Music Therapy, 8* (2), 53-67.

Tarren-Sweeney, M. (2008). The mental health of children in out-of-home care. *Child and Adolescent Psychiatry, 21* (4), 345–349.

Tervo, J. (2005). Music therapy with adolescents. *Voices: A world forum for music therapy*. Retrieved May 30, 2009, from http://www.voices.no/mainissues/mi40005000169.html

Trainor, L. J. (2005). Are there critical periods for musical development? *Developmental Psychobiology, 46*, 262–278.

US Department of Health and Human Services (2008). Children's bureau. http://www.acf.hhs.gov/programs/cb/index.htm

Wagner, B. M. (1997). Family risk factors for child and adolescent suicidal behavior. *Psychological Bulletin*, *121* (2), 246–298.

Wells, N. F. (1998). An individual music therapy assessment procedure for emotionally disturbed young adolescents. *The Arts in Psychotherapy*, 15 (1), 47-54.

Wooten, M. A. (1992). The effects of heavy metal music on affects shifts of adolescents in an inpatient psychiatric setting. *Music Therapy Perspectives, 10* (2), 93-98.

Zeanah, C. H., Larrieu, J. A., Heller, S. S., Valliere, J., Hinshaw-Fuselier, S., Aoki, Y., & Drilling, M. (2001). Evaluation of a preventative intervention for maltreated infants and toddlers in foster care. *Journal of the American Academy of Child and Adolescent Psychiatry*, *40* (2), 214–221.

Zeltin, A., Weinberg, L., & Kimm, C. (2004). Improving education outcomes for children in foster care: Intervention by an education liaison. *Journal of Education for Students Placed at Risk, 9* (4), 421-429.

Zillman, D., & Gan, S. L. (1997). Musical taste in adolescence. In D. J. Hargreaves & A. C. North (Eds.), *The Social Psychology of Music.* Oxford: Oxford University Press.

TEMPLE UNIVERSITY®
Office for Human Subjects Protections
Institutional Review Board
Medical Intervention Committees A1 & A2
Social and Behavioral Committee B
3400 North Broad Street
Philadelphia, Pennsylvania 19140
Phone:215.707.3390 Fax:215.707.8387
e-mail: richard.throm@temple.edu

Research Review Committee B

Certification of Approval for a Project Involving Human Subjects

Protocol Number:	**12679**
PI:	**BRUSCIA, KENNETH**
Approved On:	20-Nov-2009
Review Date:	21-Dec-2009
Committee:	B BEHAVIORAL AND SOCIAL SCIENCES
Department:	MUSIC-THERAPY (2207)
Project Title:	The Musical and Personal Biographies of Adolescents with Foster Care Experience

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In accordance with the policy of the Department of Health and Human Services on protection of human subjects in research, it is hereby certified that protocol number 12679, having received preliminary review and approval by the department of MUSIC-THERAPY (2207) was subsequently reviewed by the Institutional Review Board in its present form and approved on 20-Nov-2009 with respect to the rights and welfare of the subjects involved; appropriateness and adequacy of the methods used to obtain informed consent; and risks to the individual and potential benefits of the project.

In conforming with the criteria set forth in the DHHS regulations for the protection of human research subjects, and in exercise of the power granted to the Committee, and subject to execution of the consent form(s), if required, and such other requirements as the Committee may have ordered, such orders, if any, being stated hereon or appended hereto.

It is understood that it is the investigator's responsibility to notify the Committee immediately of any untoward results of this study to permit review of the matter. In such case, the investigator should call Richard Throm at 707-8757.

ZEBULON KENDRICK, Ph.D.
CHAIRMAN, IRB

TEMPLE UNIVERSITY®
Office for Human Subjects Protections
Institutional Review Board
Medical Intervention Committees A1 & A2
Social and Behavioral Committee B
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MEMORANDUM

To: **BRUSCIA, KENNETH**
MUSIC-THERAPY (2207)

From: Richard C. Throm
Institutional Review Board

Date: 21-Dec-2009

Re: Subpart D Status for IRB Protocol:
12679: The Musical and Personal Biographies of Adolescents with Foster Care Experience

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Addendum to the IRB Approval Certificate – append to certificate
CFR Subpart D: Additional Protections for Children Involved as Subjects in Research

Federal regulations classify permissible research involving minors into four categories, based on degree of risk and type of prospective benefit. These categories are described in relation to "minimal risk".

Minimal risk is defined as "the probability and magnitude of harm or discomfort anticipated in the **research** are not greater in and of themselves from those ordinarily encountered in daily life of during the performance of routine physical or psychological examination or tests.

Greater than minimal risk is a term used in defining Category 2 [45 CFR 46.405] and Category 3 [35 CFR 46.406]. The regulations do not provide any further definition or clarification of this term except for specifying "a minor increase over minimal risk" in regards to Category 3 only. Therefore, the protocol application should clearly describe the study risks so the IRB, in consultation with the investigator's assessment, make an appropriate determination for category of approval.

Operative Definitions.
(a) Children are persons who have not attained the legal age for consent to treatments or procedures involved in the research, under the applicable law of the jurisdiction in which the research will be conducted.
(b) Assent means a child's affirmative agreement to participate in research. Mere failure to object should not, absent affirmative agreement, be construed as assent.
(c) Permission means the agreement of parent(s) or guardian to the participation of their child or ward in research.
(d) Parent means a child's biological or adoptive parent.
(e) Guardian means an individual who is authorized under applicable State or local law to consent on behalf of a child to general medical care.

This protocol was reviewed and approved under category:
Research Category 1: Not greater than minimal risk
Requires:
1. Permission from ONE parent/legal guardian
2. Assent of minor (if child is 7 years of age or older (18)

Boyer College
of Music and Dance
TEMPLE UNIVERSITY

Department of Music Education and Therapy
110 Presser Hall
2001 North 13 Street
Philadelphia, Pennsylvania 19122

phone 215-204-8310
fax 215-204-1982
web www.temple.edu/boyer

Study Title: The Musical and Personal Biographies of Adolescents with Foster Care Experience

Principal Investigator: Dr. Kenneth Bruscia
Department: Music Education and Therapy
Phone: 215-204-8314
Email: kbruscia@temple.edu

Student Investigator's Name: Michael L. Zanders, LPC, MT-BC
Department: Music Therapy Education and Therapy
Phone: 215-568-2435
Email: mzanders@bethanna.org

Purpose of study: Your son or daughter is invited to participate, as a volunteer, in a study which examines the musical and personal biographies of adolescents with foster care experience. Your child has been asked to participate in this study because he or she has experience with foster care. We hope to learn how music has played a role in the biography of your son or daughter's life. 20 Participants will be used in the study. This study is undertaken as dissertation research at Temple University.

As a participant in this study, your son or daughter will be interviewed for about 45 minutes to an hour. Each interview will occur at Bethanna's mental health clinic, to ensure confidentiality and privacy, and at a time that is convenient for him or her.

Your child is not required to bring anything or have anything prepared prior to the interview. During the interview your child will be asked questions about his/her musical and personal life. Though not anticipated as necessary, the researcher may have to contact your child one more time, to clarify responses or to ask him or her to elaborate on a specific question or area.

There are no expected physical discomforts or risks associated with the interview. Although unlikely, if unpleasant emotional reactions to the interview occur, I, the student researcher, will work with your son or daughter until these reactions are resolved in some way. I am a Licensed Professional Counselor and a Board Certified Music Therapist and therefore qualified to deal with such situations.

Benefits of this study will include your child being able to "tell" his/her story. Also, it is hoped that this study will provide meaningful information to not only the field of music therapy, but also to other professionals who work within the child welfare system.

Initials: _____ **Date:** _____

Information you need to know before you give consent:

I understand that my child's participation in this study is completely voluntary. He or she may withdraw at any time without consequence or prejudice, and may decide to answer all, some or none of the interview questions. I also understand that I may withdraw my son or daughter from the study at any time. My child's participation is in no way connected to the services my child's receives at Bethanna, and that my decision for my child to participate, not participate, or withdraw will in no way affect child's program at Bethanna.

I understand that any information that is obtained in connection with this study and that can be identified with my child will remain confidential. All study materials will be identified with a code. The document containing the child's name and code number will be kept in a locked file cabinet in the researcher's office. Only the researcher will have access to this information, and it will be destroyed at the end of the study. The results of this study will be submitted for publication; data will be presented in aggregate form, and no individual results will be presented.

I understand that there may be benefits to my child's participation in this study: He or she may: 1) gain a greater awareness of personal and music experiences, and 2) gain a greater appreciation for the role of music in his or her life. In addition, I also understand that there may be risks to my child's participation in this study, although these are very unlikely. He/she may experience some distress or discomfort in revealing life issues or sharing musical experiences. If this occurs, I understand that the studenet researcher will talk to my child and provide support until he or she feels better.

I understand that my child's participation in this study does not constitute routine therapy, and it is not meant to substitute for such therapy.

I understand that the information being gathered is for research purposes only. When the results of the study are published, my child's name or any identifying information will never be mentioned. All individual results will be held in the strictest of confidence.

If I have questions:

I understand that I am encouraged by the investigators to ask questions at any time, and that my questioning will be given prompt and full answers. I understand that I may refuse to have my child's participate further in this project until my questions are answered to my satisfaction.

I understand that questions about my rights as a research subject may be directed to:

Mr. Richard Throm,
Program Manager & Coordinator
for the Institutional Review Board (IRB)
Temple University, Health Sciences Center
Office of the Vice President for Research
3400 North Broad Street
Philadelphia, PA 19140
215-707-8757

Initials: _____ Date: _____

Confidentiality statement:

I understand that all documents and information pertaining to the research study will be kept confidential in accordance with all applicable federal, state, and local laws and regulations. I understand that medical records and data generated by the study may be reviewed by Temple University's Institutional Review Board and the Office for Human Research Protections (OHRP) to assure proper conduct of the study and compliance with federal regulations. I understand that the results of this study may be published. If any data are published, neither my child nor I will be identified by name.

I understand that my participation and my child's participation is entirely voluntary, and that refusal to participate will involve no penalty or loss of benefits to me at Bethanna. I may discontinue my participation at any time without penalty or loss of benefits.

I understand that I will receive no compensation for this study.

This study has been explained to me, I have read the consent form and I agree to participate. I have been given a copy of this consent form.

Study Title: The musical and personal biographies of adolescents with foster care experience.

_____

Signature of Legal Guardian Date

_____

Signature of Investigator Date

Temple University IRB protocol #: _____

Participant's name: _____ ID#: _____

TEMPLE UNIVERSITY
IRB (COMMITTEE B) APPROVAL

NOV 2 0 2009

VALID FOR NO MORE
THAN ONE YEAR

Boyer College
of Music and Dance
TEMPLE UNIVERSITY

Department of Music Education and Therapy
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Philadelphia, Pennsylvania 19122

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web www.temple.edu/boyer

Consent
Permission to Audiotape

Study Title: The Musical and Personal Biographies of Adolescents with Foster Care Experience

Principal Investigator: Professor Kenneth Bruscia, Ph.D.
Investigator's Name: Michael L. Zanders, MMT, MT-BC, LPC
1212 Wood St., Philadelphia, PA 19107
Email: mzanders@bethanna.org
Phone: 215-568-2453 x461

Subject: _____ _____ Date: _____
Log #: _____

I give **Michael L. Zanders** permission to audiotape my child _____.
This audiotape will be used only for the following purpose:

___ RESEARCH

This audiotape will be used as a part of a dissertation research project at Temple University. The study will take place at Bethanna I have already given written consent for my son's/daughter's participation in this research project. At no time will my son's/daughter's name be used.

WHEN WILL MY CHILD BE AUDIO-TAPED?

I agree for my son's/daughter's to be audio-taped during the time period: September 1st, 2009 to May 31st, 2010

HOW LONG WILL THE TAPES BE USED?

I give my permission for these tapes to be used from: September 1st, 2009 to May 31st, 2010.

Initials: _____ Date: _____

I understand that all information about my son/daughter will be kept in the strictest confidence. Recordings collected from audio-tape will be kept destroyed immediately following use.

WHAT IF I CHANGE MY MIND?

I understand that I can withdraw my permission at any time. Upon my request, the audiotape(s) will no longer be used. This will not affect my care or relationship with Bethanna in any way.

OTHER

I understand that my son/daughter and I will not be paid for being audio-taped or for the use of the audiotapes.

FOR FURTHER INFORMATION

If I want more information about the audio-tape(s), or if I have questions or concerns at any time, I can contact:

Investigator's Name: Michael L. Zanders
Department: Music Education & Therapy Department
Institution: Temple University
Street Address: 1212 Wood St.
City: Philadelphia State: PA
Zip Code: 19107
Phone: 215-568-2435x461
Email: mzanders@bethnna.org

This form will be placed in my child's records and a copy will be kept by the person named above. A copy will be given to me.

Please print:
Parent or Guardian's Name:
Date:
Address:
Phone:
Relationship to Participant:

Study Title: The Musical and Personal Biographies of Adolescents with Foster Care Experience

Parent/Guardian Signature Date

Investigator Signature Date

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fax 215-204-1982
web www.temple.edu/boyer

Assent for Adolescent's Participation in Research
Confidential
Study Title: The Musical and Personal Biographies of Adolescents with Foster Care Experience

Principal Investigator: Professor Kenneth Bruscia, Ph.D.
Investigator's Name: Michael L. Zanders, LPC, MT-BC
Department: Music Education & Therapy Department
Phone: 215-204-8314
Emails: kbruscia@temple.edu: mzanders@bethanna.org

Purpose of the Study: This study examines the biography of your life as it relates to your foster care experience and musical experiences. It is believed that music is ever present in our lives and it provides various ways of importance with everyday life experiences. In this study, you are encouraged to be a collaborator and ask questions or provide answers to questions that may have not been originally asked. The purpose of this qualitative study is to gain an understanding of the musical biographies of adolescents in foster care and to discern how the musical and personal biographies relate to one another. In this context one's musical biography is the sum total of the experiences in music a person has had and the various kinds of meanings given to them in the past and present. It is assumed that one's musical life is part of one's personal biography, which also includes non musical events, experiences, and meanings.

What the Study Involves: You will be asked to participate in on interview session for about 45 minutes to an hour. Each interview will focus on your musical and personal experiences. Each interview will take place at Bethanna's mental health clinic. Though not anticipated as necessary, you may be contacted one more time, to clarify responses or asked to expound on a specific question or area.

Information you need to know before you give assent: I understand that my participation in this study is completely voluntary.

I understand that I am free to withdraw from the study at any time without consequence or prejudice. My participation in the study is in no way connected to my participation in therapy at Bethanna, and my decision to participate , not participate, or withdraw will no way affect further participation in therapy at Bethanna.

I understand that any information about me will be kept in the strictest confidence. All information that is obtained in connection with this study and that can be identified with you and/or your child will remain confidential. All results will be identified with a code. The document containing your name and code number will be kept in a locked file cabinet in the researcher's office.

Initials: _____ Date: _____

Only the researcher will have access to this information, and it will be destroyed at the end of the study; if you are interested in having a copy of the interview, please notify the researcher during the interview. The results of this study will be submitted for publication; data will be presented in aggregate form, and no individual results will be presented.

I understand that there may be benefits to my participation in this study: 1) I may gain a greater awareness of my personal and musical experiences, 2) I may feel relieved to tell someone the story of my experiences and 3) I may gain a greater appreciation for the role of music in my life.

I understand that there may be risks to my participation in this study, although these are very unlikely. I may experience some distress or discomfort in revealing life issues or sharing musical experiences. If this occurs, I understand that the researcher will talk to me and support me until I feel better.

I understand that my participation in this study does not constitute routine therapy, and it is not meant to substitute for such therapy.

I understand that the information being gathered is for research purposes only. When the results of the study are published, my name will never be mentioned. All individual results will be held in the strictest of confidence.

If I have questions: I understand that I am encouraged by the investigators to ask questions at any time, and that my questioning will be given prompt and full answers. I understand that I may refuse my child's participation further in this project until my questions are answered to my satisfaction.

I understand that questions about my rights as a research subject may be directed to: Mr. Richard Throm,
Program Manager & Coordinator for the Institutional Review Board (IRB)
Temple University, Health Sciences Center
Office of the Vice President for Research
3400 North Broad Street
Philadelphia, PA 19140
215-707-8757

If I have further questions or concerns I can contact the researcher at:

Michael L. Zanders, LPC, MT-BC
Temple University, Department of Music Education and Therapy
Phone: 215-568-2435
Email: mzanders@bethanna.org

Study Title:
The musical and personal biographies of adolescents with foster care experience.

Signature of Participant _____ Date _____

Signature of Investigator _____ Date _____

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Assent
Permission to Audiotape

Study Title: The Musical and Personal Biographies of Adolescents with Foster Care Experience

Principal Investigator: Professor Kenneth Bruscia, Ph.D.
Investigator's Name: Michael L. Zanders, MMT, MT-BC, LPC
1212 Wood St., Philadelphia, PA 19107
Email: mzanders@bethanna.org
Phone: 215-568-2453 x461

Subject: _____ Date: _____
Log #: _____

We are asking for your permission to audio-tape your interview. This interview is part of the research project in which you have agreed to participate. The audio-tapes tapes will be used to help us remember important details of our conversation. At no point will anybody other than the names listed above have access to these tapes. The audio-tapes will be destroyed immediately following completion of the study.

You can change your mind at any time and tell us not to audio-tape you anymore. You can also tell us if you do not want us to use the audio-tapes in our research. This will not have any negative consequences for you. You will still be treated in the same manner at Bethanna and you will be eligible to participate in all services offered.

This form will be placed in a locked file cabinet and a copy will be given to me.

I give **Michael L. Zanders** permission to audiotape _____. This audiotape will be used only for the following purpose:

___ RESEARCH

This audiotape will be used as a part of a dissertation research project at Temple University. At no time will my name be used.

Initials: _____ Date: _____

WHEN WILL I BE AUDIO-TAPED?
I agree to be audio-taped during the time period: September 1st, 2009 to May 31st, 2010

HOW LONG WILL THE TAPES BE USED?
I give my permission for these tapes to be used from: September 1st, 2009 to May 31st, 2010.

WHAT IF I CHANGE MY MIND?
I understand that I can withdraw my permission at any time. Upon my request, the audiotape(s) will no longer be used. This will not affect my care or relationship with Bethanna in any way.

OTHER
I understand that I will not be paid for being audio-taped or for the use of the audiotapes.

FOR FURTHER INFORMATION
If I want more information about the audio-tape(s), or if I have questions or concerns at any time, I can contact:
Investigator's Name: Michael L. Zanders
Department: Music Education & Therapy Department
Institution: Temple University
Street Address: 1212 Wood St.
City: Philadelphia State: PA_Zip Code: 19107
Phone: 215-568-2435x461
Email: mzanders@bethnna.org

This form will be placed in my records and a copy will be kept by the person named above. A copy will be given to me.

Please print:
Parent or Guardian's Name:
Date:
Address:
Phone:
Relationship to Participant:

Study Title:
The musical and personal biographies of adolescents with foster care experience.

Participants Signature Date

Researcher's Signature Date