

THE EFFECTS OF LYRIC ANALYSIS AND SONGWRITING MUSIC THERAPY  
TECHNIQUES ON SELF-ESTEEM AND COPING SKILLS AMONG HOMELESS  
ADOLESCENTS

BY

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## Abstract

Homelessness is a troubling epidemic affecting a wide range of individuals, including youth and adolescents. The reasons for homelessness as well as manifestations of the condition are perpetuated by a cycle of abuse, delinquency, mental illness, and risky survival behaviors. This study aimed to break this cycle among homeless adolescents in a transitional living facility by promoting self-esteem, coping skills, and empowerment through songwriting and lyric analysis music therapy techniques. A total of six subjects, ages 19-21, participated in an eight-week treatment program. Subjects served as their own control and sessions alternated between music therapy interventions and talk-based interventions each week. Outcome measures included the Rosenberg Self-Esteem Scale (RSES), attendance rates, a qualitative survey, and notes and observations kept by the researcher. Quantitative results indicated a significant increase in RSES scores before and after both the musical and non-musical treatment sessions ( $p < 0.20$ ). Differences between each treatment, however, were not marginal enough to be statistically significant, suggesting that the efficacy of each treatment was comparable. The music therapy sessions consistently yielded higher attendance rates, implying that more participants were interested in the music-based interventions than the talk-based activities. Qualitative responses were overwhelmingly positive, with participants noting an appreciation to be able to express themselves and relieve stress. Subjects also expressed themes of struggle, perseverance, and empowerment in their group song. Although this study was limited by the transience of the homeless population, small sample size, and lack of multiple quantitative measures, attendance rates, RSES scores, and qualitative responses and observations warrant future music therapy research with this population.

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## CHAPTER I

### Introduction

#### *Introduction to Population*

Homelessness knows no boundaries. It is a growing condition affecting young, old, and adolescent populations across the globe. In America, economic struggles have led to a decrease in average income and an increase in budget and job cuts across the nation. Vulnerable populations like the homeless are one of the most affected groups and are predicted to remain so as deep poverty levels continue to rise (National Alliance to End Homelessness, 2011a). According to point-in-time counts collected across homeless communities, the National Alliance to End Homelessness (2011b) estimates that there are upwards of 640,000 people who experience homelessness on a nightly basis in the United States. Within this collective number of homeless individuals exist many diverse subsets including families, youth, veterans, and chronically homeless adults (National Alliance to End Homelessness, 2011b).

In examining the issue of homelessness, it is imperative to become familiar with the commonly used terms and associated issues that define and distinguish each demographic group. In an effort to isolate characteristics of the homeless population, one study identified and discussed three major subgroups: adults, families, and adolescents. Researchers concluded that individual adults experiencing homelessness were primarily male and without children, families were mostly comprised of young women with children under the age of ten, and adolescents were lacking the supervision of a parent or caregiver (Haber & Toro, 2004).

Within the homeless youth demographic group there are other, more specific terms used as additional qualifiers that often pertain to one's reason for becoming homeless. The word "runaway" is used to describe someone who has left his or her home without parental knowledge

or permission. A “throwaway” on the other hand, has been forced out of his or her home, often due to behavioral or familial dysfunction. Sometimes youth and adolescents become homeless subsequent to foster care and are then referred to as “systems youth.” In addition, individuals who have been homeless for some period of time are lumped into the “street youth” category. The term “street youth” is often associated with risky sexual and drug-seeking behaviors that can yield higher levels of personal disruption and turmoil (Haber & Toro, 2004; Toro, Lesperance, & Braciszewski, 2011). The many negative connotations associated with these labels and terms make homeless youth a highly vulnerable population that is depicted by unstable histories and unhealthy behaviors.

In addition to being one of the most at-risk populations, homeless adolescents are also one of the most difficult groups to understand. Adolescence can be fraught with longing for social acceptance, personal meaning, and identity. When homelessness is introduced during this delicate time of development, adolescents are forced to find other, sometimes unhealthy, support systems and coping mechanisms. Street families are formed to fill the void of parental and familial supports. Street brands, hairstyles, and music are used to express personal style and identity. Drug or sexual transactions form a street economy and give adolescents a sense of belonging within the homeless hierarchy (Oliviera & Burke, 2009). This unique culture of homeless adolescents challenges treatment providers to cater to this population’s need for social support, self-exploration, identity formation, and personal health. In addressing these issues, it can often be helpful to examine each adolescent’s history in search of underlying reasons why he or she is homeless.

### *Reasons for Homelessness*

Many adolescents resort to a life of homelessness when they no longer feel safe in their home environment, often because of persistent physical, sexual, or emotional abuse. In examining 372 homeless and runaway adolescents, Tyler and Cauce (2002) found that half of those individuals had experienced physical abuse and one-third had endured sexual abuse, often by multiple perpetrators over a span of several years. For women and sexual minority groups, the rates of abuse are even greater (Tyler & Beal, 2010; Tyler & Cauce, 2002). The National Alliance to End Homelessness (2010) cites domestic violence as one of the most common causes of immediate homelessness for women and families.

The repercussions of physical and sexual abuse can be seen acutely as well as chronically over the victim's lifespan. Sexual trauma in youth has been shown to influence future sexual practices (Johnson, Rew, & Sternglanz, 2006) and often serves as a predictor for continued abuse and victimization throughout adulthood (Hudson et al., 2010). Experiencing trauma during the critical identity-forming years of adolescence can severely impair one's self-esteem and fuel reliance on unhealthy coping mechanisms.

During times of self-discovery and personal struggle, the family unit can serve as a foundation of strength, support, and guidance. When there is instability in this structural foundation, however, risky behaviors and a search for alternative sources of shelter and support may result. Thompson and Pillai (2006) found familial dysfunction, specifically feelings of neglect and mistrust of parents, to be one of the strongest determinants of runaway behaviors among adolescents. Families that lack at least one biological parent, demonstrate poor management skills, and/or participate in drug and substance abuse are also at a highly increased risk of becoming homeless (Bearsley-Smith, Bond, Littlefield, & Thomas, 2008). Additionally,

dysfunctional family behaviors and dynamics are often passed down through generations, yielding continued early parenthood, welfare, and runaway recidivism among adolescents and young adults (Crimswell, 1998; Thompson & Pillai, 2006).

As a result of fractured home lives, many youth find themselves entered into foster care at a young age. Once they have achieved a legal age of majority, however, they are forced to exit the system, often lacking the independent life skills necessary to secure shelter or a sustainable form of income (Fowler, Toro, & Miles, 2009). It is during this time of transition when many adolescents find themselves homeless. Two studies targeted groups of foster care alumni and found that approximately twenty percent of surveyed individuals experienced chronic homelessness upon exiting the system (Fowler, Toro, & Miles, 2009; White et al., 2011). White et al. (2011) posed further investigation into this demographic group and discovered increased incidences of Post Traumatic Stress Disorder (PTSD), depression, and anxiety. These results illustrate a disturbing correlation between homeless individuals who have been in and out of foster care and the prevalence of mental illness.

Mental illness has long-been identified as one of the major causes of homelessness, and the adolescent population is no exception. Merscham, Van Leeuwen, and McGuire (2009) examined 182 homeless youth and discovered high levels of bipolar mood disorder (26.9 percent), schizophrenia (21.4 percent), depression (20.3 percent), and PTSD (8.2 percent). These conditions are frequently seen in conjunction with some type of trauma or substance abuse (Merscham, Van Leeuwen, & McGuire, 2009), which can make it difficult to determine whether the mental illness manifested before becoming homeless, or as a result of co-existing traumatic conditions (Haber & Toro, 2004). Despite the origin of the illness, mental health issues among

the homeless adolescent population make these individuals more vulnerable and likely to engage in negative externalizing behaviors.

### *Manifestations of Homelessness*

Adolescents often turn to illegal or unhealthy substances and behaviors in an attempt to cope with the many issues surrounding the origin of their homelessness. Drugs such as cocaine, methylphenidate, heroin, opiates, benzodiazepines, and even Risperidone can be easily accessed and abused on the streets to remedy symptoms of mental illness, attention deficit hyperactivity disorder (ADHD), anxiety, and depression (Oliviera & Burke, 2009). While substance abuse disorders typically do not appear until late adolescence or early adulthood in the general population, homeless individuals often encounter these types of issues in their early childhood years (Haber & Toro, 2004). Homeless adolescents may be particularly prone to drug and alcohol abuse because of their susceptibility to peer pressure and desire to uphold the expectations of the street culture.

In addition to consuming drugs and alcohol, some homeless adolescents sell illegal substances in order to sustain themselves financially. The income brought in by these survival tactics is frequently used to support the adolescent's own drug habits as well as provide him or her with adequate food (Oliviera & Burke, 2009). Sexual behaviors are another way homeless adolescents earn money on the street. Commercial sexual exploitation, also referred to as "domestic minor sex trafficking," occurs whenever a minor is forcibly coerced into a sex act such as stripping, pornography, or prostitution. The term "survival sex" specifically describes the use of sex in exchange for basic needs like food, shelter, or clothing. Homeless youth, as well as gay, lesbian, bisexual, and transgender sexual minority groups within this population, are at increased risks of engaging in these types of behaviors to avoid other forms of abuse and

sustain their basic needs for survival (National Alliance to End Homelessness, 2009). As a result, these individuals are more likely to suffer from chronic illnesses and infections like HIV/AIDS (National Alliance to End Homelessness, 2006). Engaging in negative externalizing behaviors can significantly affect homeless adolescent's mental well-being in addition to physical health.

While some individuals identify mental illness as a contributing source of their homelessness, others find that a life of transience on the street introduces or exacerbates existing feelings of anxiety, depression, and suicidality. These mental issues are often correlated with some of the negative externalizing sexual behaviors previously discussed (Rohde, Noell, Ochs, & Seeley, 2001). Trauma and victimization on the streets can lead to decreased self-esteem, lower perceived quality of life, and manifestations of PTSD (Haber & Toro, 2004). These symptoms of psychological distress can also fuel thoughts of self-harm and suicide (Cleverly & Kidd, 2011). The internal indicators of adolescent homelessness, along with the other common external activities these individuals use to cope and survive, make this growing issue a difficult one to examine and fully address.

### *Recommended Treatments*

Due to the wide range of associated causes and resulting issues of homelessness, effective treatments can differ in their overall goals and approaches. Based on their review of current research literature with this population, Karabanow and Clement (2004) categorized widely used interventions as either individual, family, mentorship, peer-based, or experiential. Within each of these approaches, services were catered to address individuals' basic needs, medical issues, cognitive coping abilities, mental well-being, and/or functional life and career-building skills. Engaging the adolescent and providing him or her with personal support and empowerment was

shown to be essential in yielding positive outcomes (French & Reardon, 2003; Karabanow & Clement, 2004).

Many treatment approaches also focus on the transitional part of homelessness, aiming to equip adolescents with the skills and healthy thinking patterns necessary to become self-sustaining members of society. In an effort to do this, community partnerships are frequently formed to provide holistic services and a network of supports (Miller, et al., 2007). Cognitive-behavioral approaches have also been successful in decreasing instances of depression and substance abuse and increasing self-efficacy in homeless youth. These interventions address individual's negative thinking patterns and aid in the identification of other, healthier forms of cognition and coping (Altena, Brilleslijper-Kater, & Wolf, 2010). Whether a treatment approach is aimed at alleviating physical pain or persistent illnesses, introducing healthy coping mechanisms, or building positive social supports, the research indicates that treatment within a supportive, personal context has the greatest chance of success.

While there is little to no literature on the efficacy of music therapy with homeless populations, there are many different music therapy approaches that have been used to successfully address issues of trauma, abuse, addiction, depression, and self-esteem. The Bonny Method of Guided Imagery and Music (BMGIM) is one such approach, developed by Helen Bonny in the 1970's. BMGIM falls under the psychotherapeutic realm of music therapy and combines both humanistic and transpersonal psychological concepts to guide the client to self-awareness and perception. The music serves as the mode for self-expression and specific musical elements such as timbre, rhythm, tone, and form provide structure and comfort as the client explores latent feelings and issues. BMGIM involves progressive muscle relaxation, music listening, and verbal review stages. The therapist serves as a supportive guide throughout

the process and monitors the client's emotional and physical stability (Burns & Woolrich, 2008). This technique aims to elicit emotions and memories and has been effective in addressing tension, stress, anxiety, and depression (Burns & Woolrich, 2008; Lin, et al., 2010).

Other music therapy techniques focus on the behavioral aspects of treatment. Interventions are formulated to assess, track, and modify behaviors. The inherent motivational qualities of music make it an effective medium through which to change negative behaviors and reinforce positive ones. Cognitive-behavioral techniques such as prompting, fading, modeling, and reinforcement are naturally incorporated into musical interventions and assist with behavior and cognition changes. This pairing of behavioral and musical techniques allows music therapists to uniquely address a variety of negative issues associated with substance abuse, depression and anxiety, and trauma (Standley, Johnson, Robb, Brownell, & Kim, 2008) while increasing clients' engagement levels and willingness to participate in treatment and recovery (Dingle, Gleadhill, & Baker, 2008).

Lyric analysis and songwriting are two effective interventions that capitalize on both psychotherapeutic and cognitive behavioral music therapy tenets (Choi, Lee, & Lim, 2009; Hatcher, 2007; Silverman, 2009, 2010; Tamplin, 2006). Through the process of lyric analysis, music therapists guide clients through an analysis of relevant and accessible lyrics in an effort to evoke thoughts and feelings. This process often leads to therapeutic self-expression as well as social interaction and network building. Songwriting also serves as an expressive outlet whereby clients can explore underlying issues and emotions. The music therapist provides a flexible structure to the songwriting process so clients feel safe sharing their ideas but are also free to take more control of the creative process if they choose to. Songwriting procedures allow clients to identify maladaptive behaviors, make a conscious shift toward healthier thought patterns and

behaviors, and express this positive change in a musical and aesthetically reinforcing way (Gfeller & Thaut, 2008). Songwriting and lyric analysis techniques are viable options when addressing a variety of negative internalizing and externalizing behaviors and conditions associated with adolescent homelessness.

### *Summary and Purpose*

Homelessness is on the rise, and with its growth yields increased numbers of at-risk adolescents and youth living on the street. Many homeless adolescents come from unstable, abusive homes that have stripped them of any sense of dignity or self-worth. This lack of self-esteem makes it difficult for these individuals to develop feelings of empowerment and resilience to their situations, often leading them down a path of risky and unhealthy behaviors. While music therapy has been shown to effectively address the issues of trauma, abuse, and depression in other treatment contexts, very little research has been done with the homeless population. This study has been formulated to test the efficacy of songwriting and lyric analysis music therapy techniques in increasing levels of self-esteem and positive coping strategies in homeless adolescents.

## CHAPTER II

### Review of Literature

While the existence of negative externalizing and internalizing behaviors has been made apparent, additional literature will be reviewed to more clearly illustrate the scope of these issues and how they interact with one another in the lives of homeless adolescents. In addition, current treatments, both musical and non-musical, will be identified and analyzed in regards to efficacy among homeless populations. Specific musical interventions will be suggested for use in this study and self-esteem, coping, and retention will be supported as accurate measures of empowerment and motivation to make healthy, positive life changes.

#### *Sexual Victimization and Survival Behaviors*

A large number of homeless individuals have been exposed to sexual, physical, or emotional abuse at some point in their lives (Tyler & Beal, 2010; Tyler & Cauce, 2002). These types of experiences can put them at risk of developing unhealthy sexual coping mechanisms as a means of survival in adolescence and young adulthood. Tyler and Beal (2010) examined these coping mechanisms among a group of 127 homeless young adults over a period of one year. They identified several unhealthy survival strategies that emerged from this group, including panhandling, deviant peer relationships, and survival sex. The researchers used bivariate correlations to analyze associations between sexual victimization and survival sex behaviors. These analyses unveiled significant relationships between sexual victimization experiences and instances of selling sex ( $r = .41$ ) or trading sex with friends ( $r = .33$ ). Additionally, regression models predicted increased risks of sexual victimization for individuals who had ever resorted to prostitution or sexual bartering for money, food, or shelter (Tyler & Beal, 2010). These findings

suggest a strong relationship between homeless adolescents' previous sexual victimization experiences and likelihood of continued victimization in the future.

Noell, Rohde, Seely, and Ochs (2001) reiterate the existence of a relationship between past and future sexual practices of homeless individuals. These researchers narrowed their focus to homeless female adolescents and ascertained data from 216 individuals who were, on average, 17.7 years old. Participants were surveyed three times over a six-month period and completed both interview assessments of childhood sexual abuse and blood and urine tests for sexually transmitted infections (STI). Results indicated that 37.9 percent of surveyed individuals had experienced some type of sexual abuse throughout childhood. One hundred percent of participants reported that they had recently suffered some type of sexual coercion with approximately 39 percent of those respondents experiencing physical force as a coercing factor. In addition, 77 percent of participants admitted to recent sexual intercourse, 15.4 percent were positive for an STI at the initial survey period, and an additional 10.6 percent tested positive for STI's by the end of the six-month treatment period (Noell, Rohde, Seeley, & Ochs, 2001). The results of sexual deviant behaviors as a response to previous sexual or physical victimization pose significant risks for the sexual, mental, and physical health of homeless adolescents, female and male alike (Walls & Bell, 2010).

Whether an individual participates in unhealthy sexual behaviors as a means of financial survival, or he or she is simply seeking social connection and acceptance, many homeless adolescents are unaware of the severe physical health risks associated with unsafe sexual practices. Given the relationship between sexual abuse and future sexual practices, many researchers have identified additional risks resulting from this correlation. Two studies discovered that homeless adolescents who had been sexually abused were also less likely to

partake in self-care measures or utilize positive social supports when making decisions about sexual behaviors (Johnson, Rew, & Sternglanz, 2006; Rew, Grady, Whittaker, & Bowman, 2008). The duration of homelessness has also been identified as a contributing factor to the adolescent's likelihood of participating in risky sexual acts. Rew, Grady, Whittaker, and Bowman (2008) found that homeless adolescent males' social resources decreased the longer they were homeless and both males and females demonstrated fewer safe-sex practices despite an increased knowledge of HIV/AIDS.

Even when adolescents are knowledgeable about STI's and other health hazards associated with survival sex behaviors, they often continue to put themselves at risk. Booth, Zhang, and Kwiatkowski (1999) investigated the sexual risk behaviors of 244 street youth and came to this same conclusion. Participants with increased knowledge of sexual health risks reported more occurrences of risky sexual acts. Additionally, participants who perceived a lower risk of HIV infection exhibited higher instances of illegal drug use. These findings suggest that knowledge and perceived likelihood of HIV and AIDS are not independent protective factors within the homeless adolescent population (Booth, Zhang, & Kwiatkowski, 1999).

Taylor-Seehafer et al. (2007) looked to measures of social support and connectedness in an effort to make sense of the confounding relationships between knowledge, self-perceived risks, duration of homelessness, and risky drug and sexual behaviors. Analyses revealed that the longer an individual was homeless, the more social connectedness he or she experienced. While this social connectedness was correlated with social supports, it also yielded lower levels of self-efficacy in regards to safe sex practices. Researchers hypothesized that this finding may be due to the powerful impact of the street family, specifically its influence on homeless adolescents' knowledge and standards of self-concept and health practices (Taylor-Seehafer et al., 2007).

Despite the importance of social attachment and connectedness, its existence among homeless adolescents, in addition to education and perceived risks alone, can prove to be counter-productive in preventing risky survival sex behaviors.

### *Delinquency*

Shelter is one of the most basic human needs to survival. When an individual is deprived of this amenity, he or she can be driven to partake in illegal behaviors to stay alive and cope with his or her situation. Ferguson, Bender, Thompson, Xie, and Pollio (2011) examined a variety of survival behaviors among homeless adolescents and young adults in four U.S. cities. Of their 196 participants, 52.6 percent reported recently using one or more survival behaviors. The three most commonly used survival strategies were panhandling (36.2 percent), dealing drugs (22.4 percent), and stealing (14.8 percent). In addition to the mere existence of these illegal survival behaviors, researchers discovered that individuals who had experienced physical victimization, had changed locations frequently, were unemployed, relied heavily on peer supports, or suffered from some type of drug addiction were more likely to resort to illegal methods of street-survival (Ferguson, Bender, Thompson, Xie, & Pollio, 2011). Substance use in particular has been identified, not just as a precursor to delinquent acts, but also as a resulting externalizing behavior among homeless adolescents. This strong correlation between substance abuse and delinquency suggests that adolescents who engage in delinquent acts are more likely to use alcohol and drugs and less likely to understand the implications of these types of behaviors (Paradise & Cauce, 2003).

### *Substance Abuse*

The use of drugs and alcohol is a growing problem among adolescents. Homeless adolescents often come from unstable homes and have histories of abuse and victimization that

can further increase their chances of developing a substance abuse problem. Dietz (2007) sought to identify predictors of substance abuse among homeless populations in the United States. Based on previous research findings, this study was formulated around several hypotheses regarding demographics, socio economic status, and those factors' effects on the likelihood of a homeless individual reporting a substance abuse problem. Results indicated that having a current mental or infectious disease increased the likelihood of reporting a substance use problem. Participants who identified a current drug or alcohol problem, however, were shown to be less likely to report their addiction (Dietz, 2007). Given the prevalence of cigarette, alcohol, and illegal substance use among teenagers, especially those who have been in and out of foster care (Thompson & Hasin, 2011), these findings warrant a growing concern for homeless adolescents and suggest that treatment will continue to be avoided until a more pressing mental or physical issue manifests.

Abusing drugs and alcohol can also lead to other unsafe means of survival among the homeless adolescent population. In looking at street youth groups in several cities across the United States, Ferguson, Jun, Bender, Thompson, and Pollio (2010) discovered significant relationships between length of homelessness, drug addiction and abuse, and levels of transience. Participants who had endured longer periods of homelessness were more likely to move from place to place each month. Those who were dependent upon drugs and those who abused drugs, however, were 73 percent and 76 percent less likely to experience these high levels of transience (Ferguson, Jun, Bender, Thompson, & Pollio, 2010). While this finding may indicate more stable locations for homeless adolescents using drugs and alcohol, it does not denote added safety. Rhule-Louie, Bowen, Baer, and Peterson (2008) found that youth who partook in injection drug use stayed in a smaller range of places, but chose riskier forms of shelter such as

squats, non-abandoned vehicles, and the street. These dangerous sources of refuge can lead to increased vulnerability for homeless adolescents with substance abuse dependencies.

Substance use creates implications for homeless individual's physical safety and amplifies one's risk of psychological distress as well. Long-term use of specific drugs like alcohol, cocaine, heroin, and amphetamines has been shown to positively correlate with symptoms of depression, irritability, anxiety, and somatic agitation (Rhule-Louie, Bowen, Baer, & Peterson, 2008). Using alcohol and other drugs can also decrease homeless individuals' chances of seeking out treatment at drop-in shelters or centers. Bantchevska et al. (2011) recruited 82 substance-using homeless youth, tracked their attendance at a University drop-in shelter, and compared those rates with other demographic data. Results suggested that homeless youth who used alcohol more frequently were less likely to attend treatment than those who spent fewer days consuming alcohol (Bantchevska et al, 2011). These studies illustrate the growing existence of substance abuse among homeless adolescents and, similarly, a growing need to identify and address the resulting physical, depressive, and safety issues within this population.

### *Mental Illness*

Negative externalizing behaviors are often linked to internal sources of trauma and pain. The prevalence of physical, sexual, and psychological abuse among homeless individuals can yield serious mental health issues, including posttraumatic stress disorder (PTSD). One study looked specifically at 239 homeless men in urban, rural, and suburban shelters. Reported experiences of trauma proved to be strong indicators of current mental health problems among participants (Kim, Ford, Howard, & Bradford, 2010). Another study examined the rates of homelessness and PTSD-related psychological disorders among young adult foster care alumni (ages 19-25). Not only did researchers reveal disturbingly high rates of homelessness among this

group, but they also found significantly higher rates of PTSD-related symptoms among the alumni as compared to the general population (White et al., 2011).

Bender, Ferguson, Thompson, Komlo, and Pollio (2010) reiterated these findings with groups of homeless youth. Researchers used quantitative and qualitative interview assessments to collect data regarding participant demographics, substance use and mental health diagnoses, self-esteem and self-efficacy, and manifestations of PTSD. Out of the 147 youth participants, 83 (57 percent) had experienced some type of traumatic event in their lives. Twenty-four percent of participants also met criteria for PTSD, as indicated by the Mini International Neuropsychiatry Interview (MINI). Participants within this PTSD group experienced greater transience, alcohol addiction, and manic symptoms while ranking lower on self-efficacy measures (Bender, Ferguson, Thompson, Komlo, & Pollio, 2010). PTSD is just one of several mental health issues that require attention in the treatment of homeless individuals.

Episodes of trauma and abuse can also lead to increased depressive symptoms, placing homeless adolescents and adults at risk of harmful externalizing behaviors and suicidal ideation. In an attempt to capture this intertwined relationship between negative internalizing and externalizing actions, Yoder, Longley, Whitbeck, and Hoyt (2008) used factor analyses to assess data gathered from 428 homeless adolescents. Results supported a positive intercorrelation between suicidal ideation and attempts (suicidality), depressive episodes and PTSD (internalizing disorders), and drug and alcohol abuse (externalizing conduct disorders) (Yoder, Longley, Whitbeck, & Hoyt, 2008). A similar study with homeless youth also found high incidences of mental illness in conjunction with substance abuse and trauma. Specific associations were discovered between participants' drug of choice and diagnosis, diagnosis and trauma history, and trauma history and suicidal ideation (Merschman, Van Leeuwen, &

McGuire, 2009). This interconnected web of issues continues to ensnare homeless adolescents and add to the complex nature of treating this population.

Due to the overwhelming knowledge of co-existing mental disorders among homeless adolescents, some researchers have begun to narrow their focus toward indicators of effective interventions and services. Cleverley and Kidd (2011) recognized the growing mortality rates of homeless adolescents resulting from various mental illnesses. In response, they facilitated a study measuring the suicidality, psychological distress, self-esteem, and resilience of 47 homeless youth living without a fixed address or staying in a homeless shelter. Results showed a strong link between perceived resilience and empowerment as well as lower psychological distress and suicidal ideation. Similarly, the longer an individual had been homeless, the greater his or her psychological distress levels were and the lower his or her perceived resilience was. Not surprisingly, participants with higher levels of psychological distress were also at a greater risk of suicidal thoughts and ideations (Cleverley & Kidd, 2011). When combating suicidality and depressive disorders, it is important for homeless individuals to be instilled with a strong sense of self-worth, social support, and positive coping mechanisms.

#### *Vulnerability and Resistance to Treatment*

Adolescence can be filled with confusion, turmoil, and difficult personal struggles. Based on the added instability and risks associated with living on the street, homeless adolescents are one of the most vulnerable populations. Dorsen (2010) completed a concept analysis of homeless adolescents' vulnerability and its manifestations in activities and deficiencies. The literature showed a prevalence of risk-taking activities including substance abuse, survival sex, and violence as well as deficiencies in family support, adult role models, access to health services, basic food and water, and vocational training. These factors accounted for homeless

adolescents' erosion of mental and physical health as well as deflated self-esteem and empowerment (Dorsen, 2010). Racism, classism, sexism, and homophobia were also identified as antecedents to homelessness and vulnerability among adolescents (Dorsen, 2010; Milburn et al., 2010).

Even when homeless adolescents recognize their need for mental health services, they are often hesitant to pursue treatment. Sometimes the issue is as simple as not knowing where to go to receive care. Solorio, Milburn, Andersen, Trifskin, and Rodriguez (2006) analyzed 688 adolescent homeless individuals and found that among those who experienced emotional distress and perceived a need for mental health services, 57 percent of those individuals reported not knowing which service to access or where to go to receive that service. Other times, homeless adolescents resist treatment because of negative past experiences or discrimination from service providers. Ensign and Panke (2002) looked at a small group of homeless female adolescents and conducted both focus groups and individual interviews to ascertain feedback regarding their experiences with health professionals. Many of the adolescents described these interactions as disrespectful and condescending. They felt that they were being judged and labeled as "deviant" because of their homelessness. As a result, many participants reported mistrust of doctors and a hesitancy to open up about their mental and physical issues (Ensign & Panke, 2002). Based on these responses, providing a safe, supportive treatment environment could potentially improve outcomes for homeless populations who experience habitual judgment and discrimination.

### *Non-Musical Treatments*

The prevalence of abuse, mental illness, unhealthy social supports, and risky coping mechanisms makes the treatment of homeless individuals both a necessity and a real challenge. Day centers and homeless shelters are two widely used services that aim to address the basic,

immediate needs of homeless individuals in crisis. Thompson, Pollio, Constantine, Reid, and Nebbitt (2002) conducted intake and six-week follow-up interviews with 421 homeless youth utilizing runaway or homeless shelter services. All of the six outcome variables showed improvement post-treatment period. These changes were reflected by participants' increased self-esteem, perceived support, and employment opportunities, as well as decreased sexual activity, time on the run, and school reprimands (Thompson, Pollio, Constantine, Reid, & Nebbitt, 2002). In an attempt to maximize on these positive outcomes, Miller et al. (2007) evaluated the collaboration between a University and community homeless services. This alliance ultimately strengthened the project's outcomes, allowed for direct input from homeless individuals, and sparked inventive ideas for future program development (Miller et al., 2007).

While most homeless shelters and drop-in centers are geared toward client empowerment and health, some focus specifically on transitional life skills. One study evaluated the efficacy of one such transitional program called Walkabout. Upon enrolling in this program, homeless youth were provided room and board for one year and asked to adhere to the rules, curfews, and house chores outlined in their contract. During the initial phase, clients met with social workers and collaborated to develop specific educational, financial, and employment-driven goals to work toward throughout their stay. As clients developed their personal goals throughout the middle stage of the program, a variety of supportive services were available to fund study materials, testing supplies, scholarship applications, and skills workshops. Finally, clients were phased out of the program and guided toward continuing education opportunities, potential relocation, housing, and job placement (Giffords, Alonso, & Bell, 2007).

Researchers tracked two case studies of individuals who had completed the Walkabout Program. One individual had an unstable family history and had dropped out of high school

following his struggles with Bi-Polar and Borderline Personality disorders, ADHD, and depression. By the end of his time at the Walkabout Program, he had acquired cooking skills, time and money management abilities, and was applying to a local University. Another client came from a similarly dysfunctional family and while he still experienced some emotional resentment post-treatment, he was able to cease his gang involvement, acquire full-time employment, and sustain himself independently (Giffords, Alonso, & Bell, 2007). These types of anecdotal evidence stress the importance of integrating proactive education into the treatment protocols of homeless shelters and drop-in programs.

Living on the street without sufficient food, water, or shelter can create serious acute and long-term health problems. Some aftercare programs work to address these health issues by offering critical medical services to homeless individuals who would otherwise have limited or no access to care. Gundlapalli et al. (2005) examined benefits of a multidisciplinary approach to acute care for homeless individuals. Researchers targeted one respite program that offered shelter-based services, emergency housing, tuberculosis care, and nursing home amenities. The program was funded by a non-profit organization and over the course of four years, served 1,686 patients. Medical professionals were often responsible for transferring these individuals to the aftercare program and as a result, did not have to deal with the confounding issues of treating uninsured homeless individuals. In addition, the multi-care program successfully addressed the unique acute and long-term needs of the homeless population, transferring them to other shelter-based programs once treatment was complete (Gundlapelli, 2005).

Homeless adolescents possess unique traits that can further complicate the treatment of their acute needs. In a review of current services for homeless youth, Slesnick, Dashora, Letcher, Erdem, and Serovich (2009) found that many interventions aimed toward the prevention

and treatment of sexual and physical health did not significantly improve the homeless individuals' long-term risk outcomes. While there is a great need for general medical services within this population, there are low rates of facility use. Sometimes this is because homeless youth are unaware of how or where to access these types of services. Other times it is because homeless youth have negative connotations with medical professionals and anticipate patronizing interactions when asked to present identification or sources of payment for health services (Karabanow & Clement, 2004). Adolescents might also avoid medical treatment because they are developmentally unable to grasp the severity of some of their issues, or because they simply lack the motivation to make a healthy change (Rew, Fouladi, Land, & Wong, 2007). While acute medical services and health education are earnest attempts to improve the lives of homeless individuals, these studies reiterate the need for individualized treatments that address and support the specific needs of each subset group in the homeless population.

Due to the increased vulnerability of homeless adolescents, peer relationships and networking can be powerful positive and negative coping mechanisms for these individuals. Karabanow and Clement (2004) reviewed the literature and found that peer-based interventions were often more appealing to homeless adolescents because of the common mistrust they have for other adult treatment providers. Establishing peer relationships was shown to increase the efficacy of drug abuse interventions, improve social skills, heighten self-esteem, and develop academic abilities (Karabanow & Clement, 2004). Homeless adolescents also establish peer networks in an attempt to aid in their survival on the streets. Peers provide them with street knowledge as well as tips and strategies for obtaining basic needs. These social support systems are typical of all adolescent populations and are seen specifically in homeless groups in the

United States and other countries across the world (Thompson, Kim, McManus, Flynn, & Kim, 2007).

While peer groups within the adolescent homeless culture enable their safety and survival, they can also perpetuate additional unhealthy externalizing behaviors. Drug abuse, delinquency, and risky sexual activities are taught and reinforced by peers. This deviant activity can easily lead to fractured relationships, disputes, and victimization among homeless adolescent groups (Rice, Milburn, & Monro, 2011; Thompson, Kim, McManus, Flynn, & Kim, 2007). Rice, Milburn, and Monro (2011) evaluated social networking technology as a tool to potentially minimize interactions with negative peers and maximize healthy home-based relationships. Researchers interviewed 136 homeless adolescents and found that 50 percent of those individuals communicated with a parent and 75 percent communicated with a home-based peer through some type of social network (cell phone, texts, internet). These contacts were often non-substance users and served as positive social supports for the homeless adolescents (Rice, Milburn, & Monro, 2011). These findings suggest that treatments that capitalize on the power of peer groups among homeless adolescents have the potential to create healthy social support systems that encourage positive behavior changes.

In order to create these positive behaviors changes, it is often necessary to break the cycle of unhealthy thought processes and cognitive rationalization. Therapy and counseling are two services that work to address these psychological issues in homeless youth and adolescents. These types of services can be administered through individual or group sessions. In a review of literature on current treatments with homeless adolescents, Karabanow and Clement (2004) noted several instances of success using individual counseling with homeless youth, specifically in decreasing substance abuse and risky sexual behaviors. Altena, Brilleslijper-Kater, and Wolf

(2010) also reported on the efficacy of individualized cognitive behavioral therapy with homeless and runaway youth. Researchers completed a systematic review of current interventions with this population, including cognitive-behavioral approaches, case management, motivational interventions, peer-based interventions, vocational training, independent living, and supportive housing programs. Among these treatment modalities, cognitive-behavioral interventions yielded greater social stability and self-efficacy as well as decreased depression and substance abuse (Altena, Brilleslijper-Kater, & Wolf, 2010). Similar therapy and counseling techniques can be used within peer and family groups.

Since many homeless adolescents' issues stem from unhealthy and sometimes abusive family histories, incorporating other family members into the treatment process can improve the rate and quality of recovery for the adolescent. Reconciling with family members who have previously endured or even facilitated acts of abuse can decrease homeless adolescents' feelings of hopelessness, suicidal ideation, and overall negativity (Karabanow & Clement, 2004). Tischler, Karim, Rustall, Gregory, and Vostanis (2004) used quantitative and qualitative interview measures to assess psychosocial characteristics of 49 homeless families. Utilizing family support services allowed parents to improve self-perceptions of their living environment and obtain feelings of support from multi-disciplinary service providers (Tischler, Karim, Rustall, Gregory, & Vostanis, 2004). These feelings of support are of particular importance to homeless adolescents as well. When transitioning from homelessness, it is integral for adolescents to be able to recognize their personal value, adopt new attitudes and behaviors, and rely on positive sources of encouragement. (Lindsey, Kurts, Jarvis, Williams, & Nackerud, 2000). Cognitive-behavioral treatments, individualized or group-based, can embrace the unique

issues and characteristics of this age group, guiding individuals to discover their own personal value and instilling them with the power to create positive changes in their lives.

### *Music Therapy and Substance Abuse*

In addition to the more traditional types of interventions, music therapy can serve as a creative and supportive treatment modality for homeless populations and their associated issues of substance abuse, depression, and trauma. Music has the ability to evoke a wide range of positive emotions and can potentially replace other negative activities from which homeless individuals seek these emotions. One study looked at the effects of music therapy when added to cognitive behavioral techniques used in substance abuse treatment groups. Researchers found that adding musical elements to treatment improved levels of enjoyment and motivation to attend sessions. In addition, music therapy appealed to a wider range of individuals, regardless of age or drug of choice (Dingle, Gleadhill, & Baker, 2008). Baker, Gleadhill, and Dingle (2007) used a similar cognitive-behavioral framework to guide their music therapy interventions with clients with substance-abuse disorders. Music therapy sessions were conducted once a week for seven weeks and included lyrics analysis, songwriting, improvisation, and music listening interventions aimed toward eliciting communication, problem solving skills, emotional regulation, and self-esteem. Post-session questionnaires revealed a strikingly positive response from participants, with 83.4 percent rating sessions as enjoyable. In addition, positive feelings such as “happy” were cited most frequently by participants in regards to emotions they experienced throughout the treatment period (Baker, Gleadhill, & Dingle, 2007).

Incorporating elements of movement and rhythm can also aid in engaging individuals with substance abuse issues. Cevalco, Kennedy, and Generally (2005) employed movement-to-music, rhythm activities, and competitive games in sessions with ten females in an outpatient

substance abuse treatment program. Four sessions were dedicated to each music therapy intervention and data regarding depression, stress, and anxiety were obtained before and after each session. Results showed an overall decrease in negative internalizing conditions and increased instances of collaboration, problem solving, and communication that arose from each music therapy intervention (Cevasco, Kennedy, & Generally, 2005). Substance abuse can also yield a wide-range of associated problems and behaviors that differ in treatment priority and threat levels to health. Music therapy approaches such as songwriting, improvisation, lyric analysis, and instrument playing can be modified and adapted to address these confounding issues as they come up within the recovery process. Issues of rapport, self-esteem, identity, and mood regulation can be addressed and potentially improved through the use of music therapy techniques within a harm-reduction model (Ghetti, 2004).

### *Music Therapy and Depression*

Music has the ability to evoke strong personal feelings and emotions. Music therapists can utilize this unique characteristic of music by creating personal listening experiences that elicit positive emotions and facilitate alternative coping strategies. Koeslch, Offermanns, and Franzke (2010) used songs from a wide variety of musical styles, each categorized as “happy” by a music psychologist, to facilitate a music listening and instrument playing session with individuals suffering from an affective disorder. Participants chose different percussive and barred instruments to play throughout each song and rated their emotions following each session. Results indicated decreased feelings of depression, anxiety, and fatigue and increased feelings of vigor for the music-making group (Koeslch, Offermanns, & Franzke, 2010). A different study examined the physiological effects of music listening in addition to self-rated depression scores. Chan, Chan, Mok, and Tse (2009) collected depression level variables as well as blood pressure,

heart rates, and respiratory rates for elderly patients suffering from depressive symptoms in a community setting. These measures were obtained again following a thirty-minute Western classical, Western jazz, Chinese classical, or Asian classical music listening intervention. After one month, post-treatment measures indicated statistically significant decreases in each quantitative physiological measure of depressive symptoms (Chan, Chan, Mok, & Tse, 2009).

Adding verbal cues during music listening experiences can evoke positive imagery and potentially enhance music therapy treatments for individuals experiencing depression and anxiety. Guided imagery and music therapy (GIM) has been shown to elicit peaceful images of nature and positive past experiences as well as promote relaxation, both mentally and physically (Chou & Lin, 2006). The Bonny Method of Guided Imagery (BMGIM) is another commonly used music therapy technique for individuals experiencing symptoms of depression. Lin and her associates (2010) interviewed five patients with depression who completed eight individual BMGIM sessions in a medical setting. Several themes emerged from these interviews including mind and body relaxation, self-awareness and inspiration, and personal transformation and acceptance. Patients also made positive statements regarding BMGIM's ability to break down mental barriers to recovery and enable future healing (Lin, Hsu, Chang, Hsu, Chou, & Crawford, 2010).

Depression is a multi-faceted illness that sometimes requires multiple, complimentary methods of treatment. Music therapy techniques are suited to this type of collaborative approach and have been effective in conjunction with both cognitive behavioral and psychotherapeutic techniques (Castillo-Perez, Gomez-Perez, Velasco, Perez-Campos, & Mayoral, 2010; Hendricks & Bradley, 2005; Kerr, Walsh, & Marshall, 2001). One study used self-rated inventories to measure internalizing symptoms among individuals with low- and medium-grade depression. A

total of 79 patients participated in the study with 41 undergoing Classical and Baroque music listening interventions and 38 undergoing psychotherapeutic group therapy. Overall, the music therapy group reported significantly lower ratings of depression than the group receiving psychotherapy alone (Castillo-Perez, Gomez-Perez, Velasco, Perez-Campos, & Mayoral, 2010). Kerr, Walsh, and Marshall (2001) came across similar findings when comparing the efficacy of cognitive-behavioral techniques alone with the efficacy of cognitive-behavioral techniques in conjunction with music therapy. Both treatment groups aimed to reframe negative thinking patterns of individuals with depression, but anxiety and depression inventory measures identified the music therapy group as being more successful in actually reducing anxiety and promoting affect modification and positive imagery coping techniques (Kerr, Walsh, & Marshall, 2001). These findings advocate for the addition of music to cognitive-behavioral techniques with depressed adults as well as adolescents, as these individuals are often motivated by music and use it as a medium for self-exploration and identity (Hendricks & Bradley, 2005).

### *Music Therapy and Trauma*

The prevalence of trauma among homeless youth implies an urgent need for safe, supportive interventions. Music therapy incorporates the comforting qualities of music to confront traumatic experiences and reconcile persistent negative emotions and psychological discomfort. Hussey, Reed, Layman, and Pasioli (2008) recommend music therapy to invoke social reciprocity between the traumatized child and the therapist. Simple drumming patterns or melodies can be learned to establish initial trust and engagement. Collaborative songs with accompaniment encourage the client to attend to social cues and develop an awareness of others. Finally, call and response songwriting and instrumental compositions teach appropriate social reciprocity, equipping the child with social supports and skills to expand their support network in

the future (Hussey, Reed, Layman, & Pasiali, 2008). Feelings of connectedness and social support have also been yielded from music therapy interventions used with soldiers with PTSD. In one study, group drumming allowed patients to safely access traumatic memories, express anger and anxiety, and regain a sense of control and composure (Bensimon, Amir, & Wolf, 2007).

Sexual abuse is a common origin of trauma among homeless children and can elicit unpredictable episodes of fear and re-traumatization. The adaptability of musical elements makes music therapy an appealing form of treatment for these types of traumatized individuals. In a long-term case study, Robarts (2006) described the transformative effects of music therapy on a sexually abused child. This child, originally very emotionally disturbed, self-harming, and dissociating, was able to regain control over her impulsive outbursts, communicate effectively with others, enjoy appropriate interactions with peers, and maintain attention and focus during school activities as a result of music therapy. Strehlow (2009) described similar results in her music therapy work with an eight-year-old girl who had been sexually abused. Throughout the treatment period, music served as a safe way to re-enact and perceive the traumatic experience, to identify and experiment with new and healthy relationships, and to participate in a pleasurable, non-sexual form of coping and enjoyment (Strehlow, 2009).

As previously mentioned, music is a flexible treatment resource and can quickly be adapted to accommodate the changing client behaviors stemming from sexual abuse and trauma. Improvisation utilizes these musical qualities and has been an efficacious music therapy treatment for traumatized individuals. Amir (2004) reflects on a case study with a 32-year-old sexually abused woman undergoing improvisational music therapy. Qualitative descriptions of this experience reveal progressive stages of healing through improvisation. At the beginning of

the treatment period, the client only played classical compositions and pieces that she was comfortable with. As sessions progressed, she began to improvise and explore inner emotions, images, and memories by making riskier musical decisions. The culmination of this process was illustrated by the client's rich and tonal compositions, reflecting personal growth and inner peace (Amir, 2004). Improvisation can help describe, process, and alleviate symptoms of trauma through complex melodies, musical tension and resolution, phrasing, and even transitions of silence or sustained tones (Sutton & Baker, 2009).

### *Songwriting and Lyric Analysis*

The literature suggests that homeless adolescents respond positively to interventions that are personalized and administered in a supportive environment. Lyric analysis and songwriting are two powerful ways that music therapy can address the unique, personal needs of these individuals while providing them with positive social supports. Several studies have looked specifically at the effects of lyric analysis versus traditional verbal therapy with individuals experiencing withdrawal symptoms in a detoxification unit. Silverman (2009) used the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) to assess participants' eagerness to adhere to treatment as well as readiness and motivation to make positive behavior changes. Post-test measures revealed that these scores were, on average, slightly higher for the lyric analysis (experimental) group as compared to the talk therapy (control) group (Silverman, 2009). In a more recent study, the researcher used the same lyric analysis techniques to assess the physiological manifestations of withdrawal. Once again his results favored the music therapy treatment group and illustrated somewhat less severe withdrawal symptoms for individuals post-lyric analysis treatment as compared to post-verbal therapy assessments (Silverman, 2010).

In addition to analyzing song lyrics, creating a new, original song can also be an empowering way to address a wide range of needs. The Song Collage Technique (SCT) is one approach that music therapists can take when incorporating songwriting into their sessions. This technique draws words and phrases from existing songs to serve as a beginning structure. Next, the client and music therapist work together to fill in original lyrics to complete and personalize each musical phrase. Case studies have illustrated the efficacy of SCT with individuals with a variety of cognitive deficits resulting from neurological dysfunction, damage, and trauma (Tamplin, 2006). Hatcher (2007) described her experience using songwriting techniques with an individual living with HIV/AIDS and struggling with street drug addiction. Throughout the treatment process, the client musically explored the intense emotions surrounding his complex trauma experiences as well as his separation from and anger toward society. The music therapist then guided him through the songwriting process, allowing him to find closure with those negative experiences and take on new, healthy societal roles and behaviors (Hatcher, 2007).

Songwriting has been shown to have powerful effects in one-on-one therapeutic sessions but can also yield equally impactful behavior changes in group music therapy settings. Choi, Lee, and Lim (2009) tracked levels of depression, anxiety, and social support among 26 adults at an in-patient psychiatric facility. Participants attended a total of fifteen 60-minute music therapy sessions, each organized by treatment stages. In the first few sessions, interventions were geared toward establishing rapport, relaxing, and music-making. The second and third phases grew more intensive and focused on music listening and songwriting to promote self-esteem, imagery, confidence, cooperation, and collaboration. Each participant completed depression, anxiety, and relationship inventories before and after the treatment period. In comparing pre- and post-treatment scores among the experimental group, in addition to cross comparisons with a control

group receiving no additional therapies, all dependent measures for the patients receiving music therapy improved significantly (Choi, Lee, & Lim, 2009). These findings suggest that songwriting interventions can aid in alleviating symptoms of depression and anxiety in addition to promoting self-efficacy and group relationships. These positive indicators for songwriting and lyric analysis warrant the need for further research that investigates the efficacy of these treatments with other vulnerable populations.

### *Summary and Purpose Statement*

Homeless adolescents face daily struggles ranging from basic survival needs to complex manifestations of abuse, addiction, and trauma. Although limited research has been done with this critical population, treatments that are dedicated to instilling values of self-esteem, resilience, and positive coping strategies seem to be the most effective (French & Reardon, 2003; Karabanow & Clement, 2004). Healthy coping mechanisms are critical for adolescents, especially when they are faced with the excessive external and internal stressors associated with homelessness. Despite its importance, coping is a concept that is difficult to measure and assess using quantitative measures (Garcia, 2010). Self-esteem and empowerment are skills that correlate with coping and are also integral in creating change among homeless populations. Swick (2009) suggests that empowering homeless parents and their children can yield a greater depth of positive resources and social supports in addition to strengthening the family unit and potentially breaking the cycle of life on the street. Acquiring these types of educational, social, and financial resources can also lead to decreased risky behaviors among homeless adolescents (Milburn, Liang, Lee, & Rotheram-Borus, 2009). Self-esteem and empowerment are imperative coping strategies for homeless adolescents and can serve as quantitative indicators for positive behavior change and adaptation to and from the homeless environment.

Many homeless adolescents are not equipped with the tools necessary to create positive change in their lives. In the search for self-worth and acceptance they can become involved in negative peer groups, develop substance addictions, and experience serious depressive symptoms (Oliviera & Burke, 2009). Incorporating group music therapy interventions into the treatment of these vulnerable individuals has been shown to yield positive effects on mood, anxiety, peer relationships, and self-esteem (Faulkner, 2011; Kenny & Faunce, 2004). Songwriting and lyric analysis are two other musical interventions that have been efficacious in eliciting positive coping skills among at-risk youth, adolescents, and adults (Choi, Lee, & Lim, 2009; Hatcher, 2007; Silverman, 2009, 2010; Tamplin, 2006). The purpose of this study was to determine the effect of group lyric analysis and songwriting on homeless adolescents' self-esteem, coping skills, and retention over an eight-session music therapy treatment period. The following research questions were addressed:

1. Among homeless adolescents, do song writing and lyric analysis yield greater self-esteem outcomes than talk-based therapy groups?
2. Do homeless adolescents identify more positive coping strategies and treatment benefits with songwriting and lyric analysis or talk-based interventions?
3. Are songwriting and lyric analysis effective in retaining homeless adolescent participants from session to session, over an eight-session treatment period?

## CHAPTER III

### Methodology

#### *Participants*

Participants included homeless adolescents, ages 18-21, who were currently utilizing residential services at a transitional housing facility in a large Northwestern city. The ten-bed facility was specifically designed for homeless individuals who are lesbian, gay, bisexual, transgender, or questioning (LGBTQ) and also included a number of heterosexual “allies.” The majority of these individuals were homeless because they had been kicked out or had run away from their families after opening up about their sexual orientation. Residents were allowed for stay for up to two years and were educated in independent living skills as well as empowerment and self-esteem.

Due to the small number of individuals at the housing facility, subjects served as their own control and attended each of the eight sessions. The experimental sessions focused on songwriting and lyric analysis while the control sessions focused on more talk-based therapeutic interventions. All participants had not had any music therapy before and were not concurrently participating in other music therapy or talk groups throughout the treatment period.

Prior to the treatment period, the researcher attended a community meeting at the residential facility. All house residents were required to attend this weekly meeting. The researcher took 15 minutes to explain the project and allowed individuals to ask specific questions. After the meeting, residents were asked to sign up, if interested, and fill out the necessary initial paperwork. Due to the transient nature of this population, N did not remain consistent from session to session, however, participant retention was monitored and tracked throughout the treatment period. To encourage retention, a flyer promoting the 8-week program

was posted on an activities board and staff at the facility reminded residents of upcoming sessions each week.

### *Consent*

All participation was voluntary and was not compensated in any monetary form. Since all residents were 18 and older, they were each asked to sign a consent form before participating in any sessions. This consent form contained a brief overview of the treatment protocol, explained any potential risks, and guaranteed the confidentiality of any personal information obtained from the participants (see Appendix A for consent forms).

### *Environment*

Each session included a small group of two to four participants, plus one volunteer, and was held in a community room within the residential facility. This room was re-arranged as necessary to create enough space for movement and instrument playing, while still maintaining an intimate group atmosphere. Similarly, chairs and couches were arranged in a small circle and spaced close enough to encourage social support and cohesiveness but not so close that participants were unable to maintain physical comfort and independence. All furniture and props were returned to their original places following each session.

### *Materials*

Upon consenting to participate in the study, each subject completed a short intake questionnaire (see Appendix B for data collection tools). This questionnaire asked each participant's name, age, how long he or she had lived at the transitional living facility, what originally brought him or her to the facility, and any specific musical preferences or experiences he or she might have had. In addition, each participant was assigned a number that ensured that no personal information would be linked with a specific name or location. Session attendance

was tracked using a data chart (see Appendix B for data collection tools). This chart allowed the researcher to easily track and organize information from each participant over the treatment period. The researcher provided the Rosenberg Self-Esteem Scale (RSES) data sheets that were used as measurement tools at the beginning and end of each session (see Appendix B for data collection tools). During the final session, a short-answer qualitative questionnaire was also used to assess subjects' overall reactions to the music therapy and talk-based groups, special preferences or skills they acquired, and additional coping mechanisms they may have attained throughout the treatment period (see Appendix B for data collection tools). The researcher kept brief notes following each treatment session so notable, qualitative observations could be made in addition to each participant's quantitative scores.

During the control and experimental groups, participants were given a pencil and paper to write down any thoughts, ideas, or lyrics during the group discussions and activities. In addition, a white board was available to write down session themes, lyrics, and suggestions or reactions from the group throughout the music therapy and talk-based interventions. During the control group sessions, the researcher used written prompts to guide each activity and group discussion. Magazines, crayons, markers, scissors, glue, and paper were also provided for the variety activities scheduled for each session.

For the experimental group sessions, song lyrics were given to each participant during the lyric analysis interventions to more easily allow for specific references to words or phrases during group discussions. The researcher provided instruments for the songwriting interventions. These included hand drums, djembes, a cajon, rhythm sticks, egg shakers, agogo bells, a cabasa, an electric keyboard, and an acoustic guitar. This variety of musical instruments was provided to allow participants to develop musical preferences and personally express

themselves while enhancing the overall aesthetic experience. Participants who owned personal instruments were also permitted to bring those to use during the songwriting interventions. A MacBook Pro computer was used to record the groups' songwriting selections and improvisational jam sessions using Garageband.

### *Procedures*

The researcher led each experimental and control group throughout the treatment period. She completed a background check, volunteer orientation class, and signed all volunteer forms required by the facility. Staff members were allowed to observe throughout the experimental and/or control group sessions and provided behavioral support and feedback when necessary.

The entire treatment period consisted of eight sessions, each lasting approximately 60 minutes. The experimental group received the music therapy treatment, which primarily used lyric analysis and songwriting techniques. The control group participated in talk and game-based interventions, stemming from cognitive-behavioral techniques. All sessions had a specific theme that focused on one of the components of self-esteem and empowerment. Treatments alternated between experimental and control each session. Figure 1 illustrates the overall treatment format.

The music therapy sessions followed the same general format, beginning with an introductory drumming intervention, leading to song sharing and lyric analysis, following-up with songwriting and instrumental improvisation, and ending with a short group assessment of progress throughout the session. The talk-based groups also maintained a consistent structure, beginning with a question or task to initiate participant interaction, leading to different games, activities, and journaling to spark conversation regarding the session theme, and ending with a verbal recap and closure (see Appendix C for intervention procedures).

<p><u>Session 1 – Experimental</u></p> <p>Theme: Identity</p> <ul style="list-style-type: none"> <li>- Drum intervention</li> <li>- “New Deep” live performance</li> <li>- Lyric analysis and group discussion</li> <li>- Begin songwriting               <ul style="list-style-type: none"> <li>- Choose instruments</li> <li>- Identify genre</li> <li>- Create verse 1</li> </ul> </li> <li>- Practice</li> <li>- Group Jam</li> <li>- Closing discussion</li> </ul>	<p><u>Session 2 – Control</u></p> <p>Theme: Self-Evaluation</p> <ul style="list-style-type: none"> <li>- Ice breaker question/activity               <ul style="list-style-type: none"> <li>- “If you could be animal, what would you be and why?”</li> </ul> </li> <li>- Journal/group discussion</li> <li>- Group game               <ul style="list-style-type: none"> <li>- What I Believe</li> </ul> </li> <li>- Group discussion related to activity and session theme</li> <li>- Closing discussion</li> </ul>	<p><u>Session 3 - Experimental</u></p> <p>Theme: Self-Confirmation</p> <ul style="list-style-type: none"> <li>- Drum intervention</li> <li>- “Stronger” live performance</li> <li>- Lyric analysis and group discussion</li> <li>- Songwriting               <ul style="list-style-type: none"> <li>- Create chorus and instrumental bridge</li> </ul> </li> <li>- Practice</li> <li>- Group Jam</li> <li>- Closing discussion</li> </ul>	<p><u>Session 4 - Control</u></p> <p>Theme: Forgiveness</p> <ul style="list-style-type: none"> <li>- Ice breaker question/activity               <ul style="list-style-type: none"> <li>- Steps to Forgiveness</li> </ul> </li> <li>- Journal/group discussion</li> <li>- Group game               <ul style="list-style-type: none"> <li>- Forgiveness Collage</li> </ul> </li> <li>- Group discussion related to activity and session theme</li> <li>- Closing discussion</li> </ul>
<p><u>Session 5 - Experimental</u></p> <p>Theme: Happiness</p> <ul style="list-style-type: none"> <li>- Drum intervention</li> <li>- “Happier” live performance</li> <li>- Lyric analysis and group discussion</li> <li>- Songwriting               <ul style="list-style-type: none"> <li>- Create verse 2</li> </ul> </li> <li>- Practice</li> <li>- Group Jam</li> <li>- Closing discussion</li> </ul>	<p><u>Session 6 - Control</u></p> <p>Theme: Gratitude</p> <ul style="list-style-type: none"> <li>- Ice breaker question/activity               <ul style="list-style-type: none"> <li>- List of Gratitude</li> </ul> </li> <li>- Journal/group discussion</li> <li>- Group game               <ul style="list-style-type: none"> <li>- Thank You Card</li> </ul> </li> <li>- Group discussion related to activity and session theme</li> <li>- Closing discussion</li> </ul>	<p><u>Session 7 – Experimental</u></p> <p>Theme: Empowerment</p> <ul style="list-style-type: none"> <li>- Drum intervention</li> <li>- “Do It Now” live performance</li> <li>- Lyric analysis and group discussion</li> <li>- Practice and record entire song using Garageband</li> <li>- Group Jam</li> <li>- Closing discussion</li> </ul>	<p><u>Session 8 - Control</u></p> <p>Theme: Resolution</p> <ul style="list-style-type: none"> <li>- Ice breaker question/activity               <ul style="list-style-type: none"> <li>- Fill out final questionnaire</li> </ul> </li> <li>- Journal/group discussion related to questionnaire responses and individual experiences throughout treatment</li> <li>- Closing discussion</li> </ul>

*Figure 1.* Treatment outline.

The experimental sessions focused on the themes of personal identity, self-confirmation, happiness, and empowerment. Upon entering the session, participants were asked to sign-in on the attendance sheet. Participants completed the RSES form both before and after treatment. Each music therapy session began with a drumming intervention, designed to prompt group participation and verbalizations (see Appendix C for intervention procedures). The researcher then performed a live song that was chosen based on subjects’ musical preferences as well as the session’s theme and purpose. Each participant was given a copy of the lyrics and was encouraged to write down their thoughts and reactions as the song was played. Participants were

also allowed to play or sing along with the live performance if they so desired. Following the performance, the researcher led the group in a discussion about the lyrics, prompting with verbal thoughts and questions as necessary. Once the discussion had reached a natural close, the researcher guided participants through the songwriting process. Over the course of the four treatment sessions, subjects came up with a musical genre, chose instruments, and composed lyrics and instrumentation for their original song. The researcher was available for musical suggestions, guidance, and encouragement, but primarily served as the impetus for participants to take control of the songwriting process. Once the song was completed, the group recorded and burned their original composition onto a CD using Garageband. At the end of each music therapy session, participants were given an opportunity to improvise a “group jam” using instruments and/or vocalizations. The researcher also led a short closing discussion about the individual and group progress made throughout the session.

The control sessions focused on themes of self-evaluation, forgiveness, gratitude, and resolution. As in the experimental sessions, participants signed-in on the attendance sheet and completed the RSES form before and after treatment. These talk-based sessions began with a question or task posed by the researcher. This directive was related to the session theme and prompted participants to journal a response or reaction. Once all subjects were finished writing, the researcher began a group discussion about the opening activity. Once the discussion came to a close, the researcher facilitated an additional activity to prompt further conversation (see Appendix C for intervention procedures). Participants were asked to share their reactions to these interventions and were given verbal prompts when necessary. Due to the traumatic nature of life on the street, the researcher, as well as staff at the facility, was ready to appropriately address or redirect any resurfacing manifestations of previous traumatic events, emotions, or

behaviors that arose during these group discussions. During the last control session, participants were asked to complete the final RSES form as well as a qualitative questionnaire regarding their personal experiences, preferences, and growth throughout the entire treatment period.

Participants who felt comfortable were given an opportunity to share these responses with the group and identify how their experience throughout the treatment period might affect their lives post-treatment.

### *Outcome Variables*

Each session was designed to yield outcomes in self-esteem levels, identification of positive coping strategies, and participant retention throughout the treatment period. Self-esteem was measured using the Rosenberg Self-Esteem Scale (RSES) which has ten statements related to self-worth and acceptance. Participants rated each statement on a four-point scale, marking strongly agree, agree, disagree, or strongly disagree. Total scores ranged from 10-40 with higher scores indicating higher levels of self-esteem (Rosenberg, 1965). Since coping is a difficult concept to measure quantitatively (Garcia, 2009), a qualitative, short-answer survey was administered to assess this skill. Narrative observations made by the researcher after each session also served as qualitative data regarding participants' acquisition of coping skills and personal growth. All participants were assigned a number before participating in their first session. These numbers allowed the researcher to track the frequency and duration of participant attendance from session to session, yielding indications of participant retention and motivation to attend treatment.

### *Data Analysis*

Participant attendance for both groups was tracked and illustrated using a frequency graph. RSES scores from each group were obtained before and after each session, averaged by group,

and compared using t-tests. These results were displayed in a table format to illustrate changes throughout the treatment period as well as specific differences between the experimental and control groups. Due to the transient nature of the population, small N, and treatment design, the alpha level for statistical significance was set at  $p < 0.20$ . This decision was justified based on the lack of statistical power this study resulted in. Qualitative responses regarding positive coping mechanisms and reactions to the musical and game-based treatments were categorized by the researcher according to each question and synthesized in a discussion format. Any surfacing trends regarding score changes, short-answer responses, and attendance rates, both between groups and over time, were discussed as well.

## CHAPTER IV

### Results

#### *Demographics*

A total of six participants (N = 6), four males and two females, took part in the study over the course of the treatment period. All participants read and signed the consent form and completed an intake questionnaire. Due to the transient nature of this population, only three participants successfully completed the qualitative survey at the end of treatment, plus one staff volunteer. The other participants were unable to complete this survey because they were no longer living at the transitional living facility at the time the survey was administered. These participants had either been asked to leave the facility due to behavioral issues, had chosen to leave the facility for unknown reasons, or had moved on to a more stable, independent living environment.

Participants' ages ranged from 19-21. No participant had lived at the facility for over a year and length of stay for each individual varied from one month to nine months. When asked why they moved into the transitional living facility, 50 percent of participants said it was because they needed help or needed to move, 33 percent said it was because they were homeless, and the remaining participant did not write in a response. Participants listed a wide assortment of preferred music, with the most popular genres being pop, classical, and rock. While musical experience was not required to participate in the study, all participants noted that they had some level of previous experience with musical instruments including piano, voice, tuba, drums, guitar, ukulele, cello, bass, and flute.

### Quantitative Data

Attendance rates varied each session. Figure 2 tracks the trend of participation levels across the entire treatment period. Some individuals only attended one or two sessions while

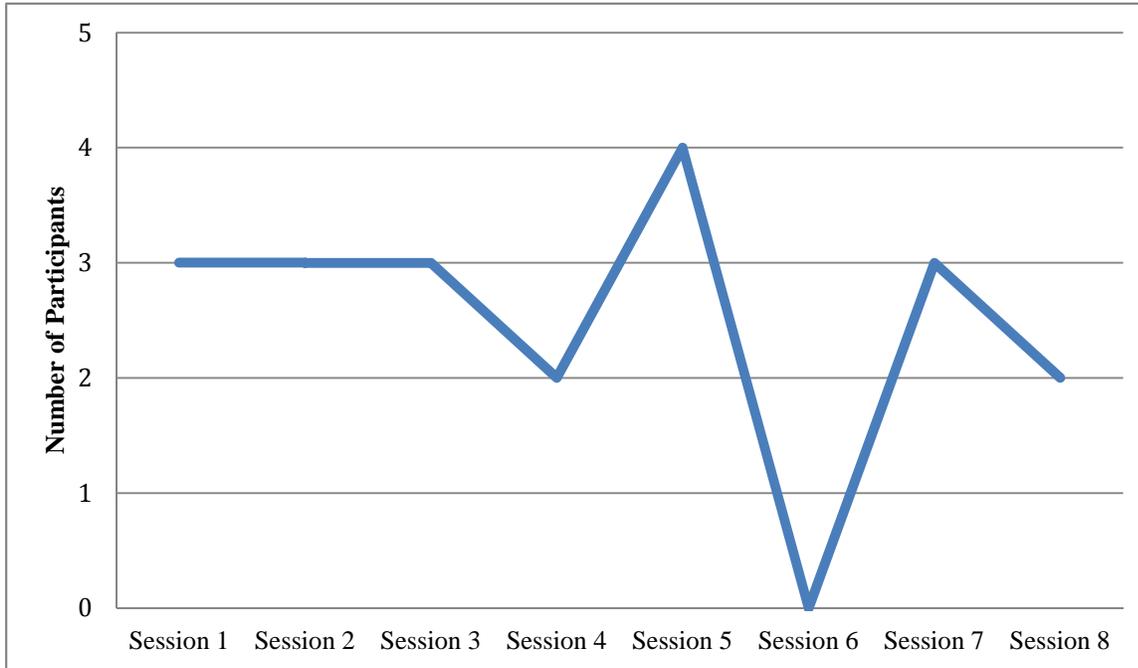


Figure 2. Session attendance rates across entire treatment period (both control and experimental groups).

others were present for the majority of the treatment period. The experimental sessions yielded higher, more consistent attendance rates than the control group sessions. Figure 3 illustrates these differences in attendance rates between the two groups. No participants were present for the sixth session, however, the treatment schedule continued as planned. One staff volunteer was present for all sessions and participated in each intervention to appropriately encourage and enhance group participation. This staff member's verbal and written contributions were not included in the results.

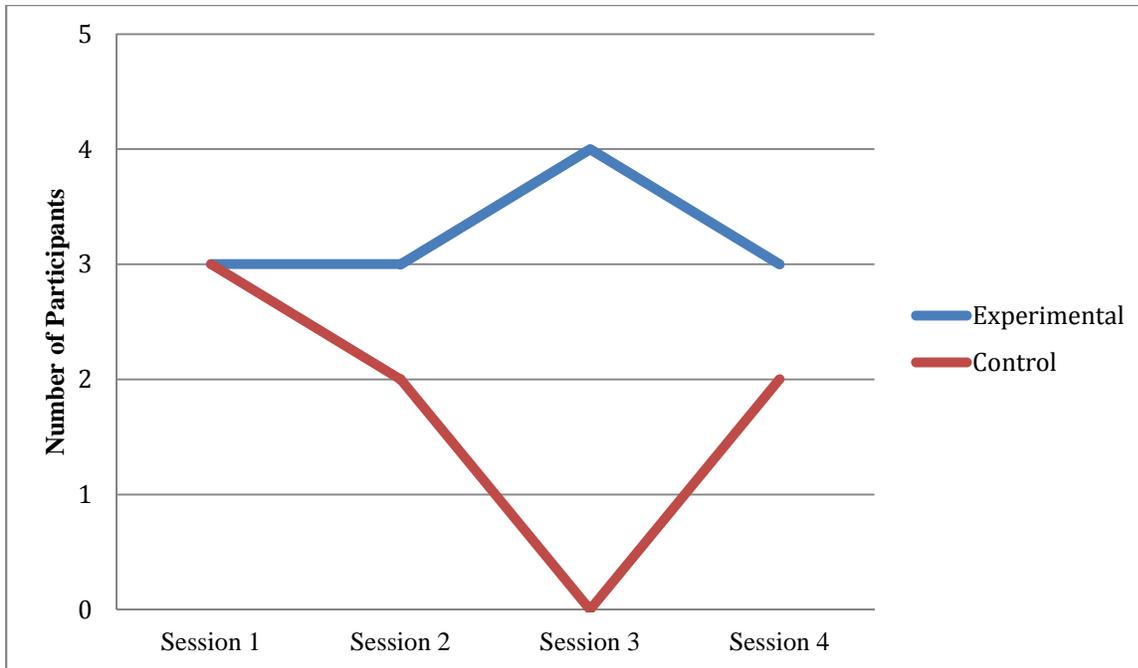


Figure 3. Comparison of experimental and control group attendance rates.

Paired t-tests were used to illustrate any significant changes from pre- to post-treatment RSES scores within each group (see Appendix D for treatment outcomes). Both groups experienced positive score increases following the treatment interventions. The experimental sessions yielded an averaged 1.38-point increase ( $t(12) = 1.73, p = 0.11$ ) while the control sessions' scores increased by an average of 1.71 points ( $t(6) = 2.30, p = 0.06$ ). These marginal increases in self-esteem scores before and after treatment were found to be statistically significant at the 0.20 alpha level. In addition to assessing the impact of each treatment on RSES scores, an independent t-test was used to determine if the difference in score changes between the experimental and control groups was significant. Results indicated a comparable increase in self-esteem scores for both groups and no statistically significant differences between the impact of one treatment intervention over the other ( $t(18) = 0.26, p = 0.80$ ).

### *Qualitative Data*

Three participants and the staff volunteer completed the final questionnaire, providing qualitative information regarding general reactions, experiences, and preferences for different treatment interventions. When asked to provide an overall reaction to the project, participants' responses were all positive, but varied in content. Examples included, "I could release a lot of stress," "a relaxing experience," "being able to collaborate and express myself musically," and "getting to know my roommates better." One participant stated that he enjoyed the "free-style jam sessions" the most, another participant stated that he preferred the "discussion-based activities," and the third participant listed both as being beneficial to him. All participants justified their responses, citing the value of being able to express themselves. When asked if they learned anything about themselves throughout the treatment period, participant responses ranged from "not really," to new knowledge about the treatment of instruments, to an acknowledgment of brash behaviors that can arise from social interactions. All participants said they would choose to participate in another music therapy group, if given the opportunity.

In addition to the qualitative survey, session notes regarding participants' comments and behaviors also served as an assessment of individual progress and personal changes throughout the treatment period. The majority of these observations were made about participants one and three, since they were each present for seven out of the eight total sessions. Participants four and six were each present for two sessions, which also allowed the researcher to make some general observations regarding their behavioral changes over a short period of time.

Participant one provided the most written and verbal feedback throughout each treatment session. During the first session, he was extremely participatory and provided a lot of musical input to the songwriting process. He started to take on a dominating role and sometimes made it

difficult for other group members to voice their opinions. As sessions progressed, he began opening up to the researcher about different personal things happening in his life. During the second session, he disclosed that he had experienced an awful day but had found solace in a comforting song. When participating in verbal discussions, participant one began to disclose aspects about his family's dynamic and how the constant turmoil at home made him feel like he had to fight for attention or recognition. These realizations were accompanied by behavioral changes seen in later sessions. He started to allow other group members to take the lead and seemed more open to collaboration and compromise. During the last session, he told the researcher that the music therapy project had allowed him to see that he could be "more brash and rushed than [he'd] like to be." He also stated that the experience helped keep him grounded as challenging events transpired over the eight-week treatment period.

Participant three also displayed personal growth throughout the research project. During the first couple of sessions, he was extremely quiet and reserved. He needed a lot of prompting to participate in verbal conversations and was hesitant to share his musical experience with the group. During the third session, however, this participant brought his own personal cello and electric bass to accompany the songwriting intervention. He started to share more verbally and exhibited joking behaviors with the researcher and his peers. The staff volunteer made an observation that participant three normally did not seek out interactions with others in the living facility, but had recently agreed to partake in social events and outings that he normally avoided or declined. Toward the middle of the treatment period, this participant also initiated conversations with the researcher about music and said that he had begun cello lessons and was thinking about joining a choir.

While participants four and six were not present for the majority of sessions, they each displayed small aspects of personal growth in the time that they participated. Participant four seemed hesitant to take part in the project at all, but quickly became a leader during verbal discussions. He took a lot of time to formulate his thoughts and gave many thoughtful observations about himself and other group members. Participant six was also hesitant to partake in the music session, but agreed to try it because he was feeling frustrated and needed some emotional release. While he was not particularly engaged during the songwriting process, he opened up during the improvisational jam sessions. His RSES scores increased for both sessions he attended and made a dramatic leap from session five to session seven.

## CHAPTER V

### Discussion

The purpose of this study was to determine the effect of group lyric analysis and songwriting on homeless adolescents' self-esteem, coping skills, and retention over an eight-session music therapy treatment period. Quantitative and qualitative assessments were used to identify differences between the effects of non-musical, talk-based interventions and music therapy interventions on each outcome measure. Additional observations were also noted based on individual participants' comments and behavioral changes from session to session.

#### *Statistical Interpretation*

Based on the quantitative measures used, the music therapy and control treatments both had statistically significant effects on participants' self-esteem scores. Statistical changes noted after the music therapy interventions, however, were not significantly different than changes associated with the control interventions. Pre- to post-test scores stayed the same or increased for each participant, each session, excluding participant three in session three. This was the session during which participant three contributed his personal musical instruments with the group and exposed musical abilities that he had not been comfortable sharing in previous sessions. Throughout the songwriting intervention he was verbally critical of his performance, which may have influenced his decrease in RSES scores upon session completion.

While the statistical power of these findings is very low, it is safe to assert that RSES scores experienced marginal changes as a result of the treatment interventions, significantly affecting participants' self-esteem levels in both the musical and non-musical sessions. That being said, it is difficult to assert that the changes in participants' self-esteem levels are comprehensively quantified in the resulting data. Self-esteem and coping skills are personal

attributes that vary from individual to individual, making it difficult to quantify into statistical numbers (Garcia, 2010). In addition, some participants were more thoughtful and meticulous about filling out the RSES than others. Participant one, for example, yielded consistently high RSES scores, both before and after each treatment. By session three, he began scoring 40 points, the maximum score, consistently on the pre- and post-test measures. While it is possible that these scores were truly reflective of his self-esteem levels, it could also be that he was no longer interested in taking the time to really evaluate how he was feeling during each distribution of the survey.

Session attendance rates illustrated higher overall retention for the music therapy groups. While this suggests that the music therapy treatments may have been more appealing or beneficial for participants, responses in group discussions as well as the qualitative survey indicate that each participant varied in their preference and overall response to the different treatments. The transient nature of this population and adolescents in general may have also contributed to the differences in session attendance. For example, during session six, no participants were present for treatment. The staff volunteer informed the researcher that this was because one participant was engaging in a social activity with other house members and another participant had to be at a job that he had begun that week. These reasons, in addition to unknown reasons for other absences throughout the treatment period, make it difficult to conclude that the lack of participants present was directly related to a lack of interest or perceived benefit of one particular session over another.

Perhaps the most telling indications of treatment efficacy and acquisition of coping skills and self-esteem were found in the qualitative responses given by the participants in both verbal discussion and written form. All participants who completed the final survey indicated that they

had an overall positive experience throughout the treatment period. Several participants made statements to the researcher, both during and outside of the treatment sessions, regarding personal struggles they were currently facing and how they were dealing with them. Participants one and three made the most concerted effort to be at each session and both apologized to the researcher for being absent for session six. While it was not required that they be at any sessions, this independently initiated gesture suggested that these participants had taken on a sense of responsibility and obligation to be present for each part of the research project.

Coping skills and personal growth were also witnessed throughout the songwriting process. While the researcher provided some light prompting, participants were responsible for the majority of the instrumentation and lyrical construction for their original song. The lyrics encompassed themes of feeling alone, personal struggle, perseverance, and empowerment (see Appendix E for group songwriting lyrics). The instrumentation complimented these themes, taking on a major key with some minor chords interspersed throughout the chord progression. The vocals, acoustic guitar, cello, drums, and auxiliary percussion provided a diverse but overall mellow tone to the song as well. Throughout the songwriting process and jam sessions, participants frequently made statements regarding their musical progress. Several participants said they were impressed with the sound they had created and felt encouraged to continue practicing and “jamming” with the other group members.

Based on these qualitative observations, it could be suggested that French and Reardon (2003) and Karabanow and Clement (2004) were correct in asserting that instilling self-esteem and empowerment in a supportive environment yields the most positive results for at-risk adolescents, regardless of the specific intervention. It could also be suggested that participants’ overall positive responses to the research study were due to the combination of both the musical

and non-musical interventions. In the qualitative survey, all participants expressed an appreciation for opportunities to be able to express themselves throughout each treatment session. While the avenues for this kind of expression differed between the experimental and control groups, they were all similarly designed to yield outcomes in self-esteem and empowerment. It could be that giving at-risk adolescents this variety of approaches to self-expression makes their overall treatment experience more positive and beneficial.

### *Limitations*

The biggest limitation to this study is the size of the sample. With only six total participants, it is difficult to generalize any notable findings to the homeless adolescent population as a whole. Participants also served as their own control, which limits the researcher's ability to clearly distinguish differences between the efficacies of each treatment intervention. In addition, there were no participants who were able to be at every session consistently. This adds supplementary variability when trying to interpret the group's quantitative and qualitative results.

The demographics of the participant sample also present a challenge when trying to generalize findings to the greater adolescent homeless population. At the transitional living facility from which participants were sampled, all residents were required to be at least 18 years old. Although individuals in this age range are frequently included under the "adolescent" or "street youth" umbrella (Haber & Toro, 2004; Toro, Lesperance, & Braciszewski, 2011), this study discounted younger homeless adolescents that could be placed in the same category. Many participants were also on the path toward stability in their lives and were not quite as volatile as other homeless youth still living on the street and seeking shelter. While these qualities allowed participants to demonstrate higher verbal processing skills and an openness to new interventions

and experiences, homeless adolescents who do not have their basic needs met may not have illustrated the same responses to treatment.

Finally, the transient and fleeting nature of homeless youth and adolescents in general make it difficult to stabilize the data yielded from the study. As mentioned previously, no individuals were able to participate consistently in every treatment session. While some made more of an effort to attend sessions regularly, others dropped in and out of sessions as their schedule and mood allowed. Some participants took more time with the RSES questionnaire while others seemed to memorize each statement and put the same score each time. In addition, not all adolescents who took part in at least one treatment session were able to complete the final, qualitative questionnaire. This lack of data and variability in questionnaire completion styles makes it difficult to standardize findings and accurately generalize results.

#### *Suggestions for Future Research*

Although quantitative tests did not illustrate any statistically significant differences between the impacts of one treatment group over another, RSES score increases and qualitative results and observations indicate an overall positive response to both the musical and non-musical interventions. Participants articulated an appreciation for self-expression outlets and made observations about personal growth and self-discovery throughout the treatment process. These, along with behavioral changes noted by the staff volunteer and researcher, warrant further investigation into the efficacy of music therapy treatments with the homeless adolescent population.

Participants who completed the final questionnaire indicated preferences for the music group, the non-music group, and both groups. Future researchers might want to capitalize on a variety of approaches, combining music therapy techniques with other, cognitive-behavioral,

journaling, or game-based techniques. This eclectic approach might better cater to the varying needs of adolescents and give individuals an opportunity to express themselves through a wider range of creative outlets.

Researchers might also want to consider the transient nature of the homeless population and work to stabilize a small group for an extended period time. Drop-in facilities and shelters are more difficult settings to do this in than a transitional living facility with a group of live-in residents. Considering alternative research designs might also be beneficial when trying to capture a greater number of participants and results to generalize to the greater population. For example, researchers can create a one-session treatment design with quantitative and or/qualitative measures assessed before and after treatment. Researchers can provide services over a long period of time to incorporate a growing number of different participants as they transition in and out of the shelter. A different group of participants can be utilized for control data, using the same outcome measures, and compared once the appropriate number of control and experimental group participants has been attained. While it would be ideal to formulate long-term treatment objectives for a large number of group participants, the homeless adolescent population does not lend itself easily to this type of consistency.

Due to the difficulty of stabilizing a large group within the homeless population, case studies may also be beneficial in assessing more in-depth, qualitative responses to a variety of music therapy techniques. Several participants in this study verbalized a desire to continue musical development, both personally and within a small group setting. One participant told the researcher he was planning on pursuing private cello lessons to further develop his skills. Another participant was the primary voice during the songwriting process and seemed to benefit from lyrical expression and vocalization. Providing these types of individuals with specialized

music therapy treatments may allow researchers to gather long-term qualitative observations. In addition, specific interventions such as musical development and songwriting techniques may foster functional, non-musical skills like self-esteem, self-expression, empowerment, and autonomy.

While the statistical findings from this study do not yield enough power to make any broad conclusions regarding music therapy interventions with homeless adolescents, they do shed some light on the needs of these types of individuals. For both the musical and non-musical interventions, all RSES scores except one either remained the same or increased from pre- to post-test measures. In addition, qualitative observations and survey results illustrated a need for self-expression, both musically and non-musically. Participants seemed to benefit the most from a supportive environment that created safe ways for them to share past experiences, explore new outlets for expression, and examine personal changes for the future. Due to the overall positive response to this study and a lack of comprehensive music therapy research with homeless adolescents, further research with this population is both warranted and encouraged.

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## APPENDICES

## APPENDIX A

### Consent Forms

## ADULT INFORMED CONSENT STATEMENT

“The Effects of Lyric Analysis and Songwriting Music Therapy Techniques on Self-Esteem and Coping Skills Among Homeless Adolescents”

### INTRODUCTION

The Department of Music Education and Music Therapy at the University of Kansas supports the practice of protection for human subjects participating in research. The following information is provided for you to decide whether you wish to participate in the present study. You may refuse to sign this form and not participate in this study. You should be aware that even if you agree to participate, you are free to withdraw at any time. If you do withdraw from this study, it will not affect your relationship with this unit, the services it may provide to you, or the University of Kansas.

### PURPOSE OF THE STUDY

This study aims to assess the efficacy of music therapy techniques in working with homeless adolescents. Lyric analysis and songwriting interventions will be compared with more recreational, game-based interventions to see which sessions yield higher self-esteem scores, more consistent participant attendance, and more frequent testimonies of empowerment and healthy coping skills as a result of treatment.

### PROCEDURES

You will be asked to attend as many sessions as you are willing and able to be a part of over the course of the treatment period. Sessions will either be held twice a week for 4 weeks, or once a week for 8 weeks. One session will be music-based and will involve song sharing, lyric analysis and discussion, and songwriting interventions. By the end the treatment period, you will have created an original song with your peers that will be recorded and transferred to a CD for you to keep. The other session will be fueled by interactive games that encourage group cohesion, interaction, and creativity. These activities games will also allow for group discussion and verbal reflection.

Before and after each session, you will be asked to complete the Rosenberg Self-Esteem Scale (RSES) form. This assessment tool contains 10 statements that you will rank as either strongly disagree, disagree, agree, or strongly agree. Following the final sessions of treatment, you will also be asked to complete a short-answer survey that asks about your overall reactions to this experience, what you learned, what you liked, and what you disliked.

### AUDIO/VIDEO RECORDINGS

Audio recordings will be used throughout the experimental group sessions. These recordings are required for the research procedures and will include each group songwriting rehearsal, instrumental improvisation, and the final performance of the group’s original song. Throughout the treatment period, each recording will be stored in Garageband on the researcher’s computer.

Only the researcher will have access to these audio files. Upon completion of treatment, the researcher will burn the group improvisations and final performance onto a CD for each participant. These CD's will be distributed on the final day of treatment and all remaining audio files will subsequently be deleted from the researcher's computer.

The group's song lyrics may be transcribed by the researcher and used throughout the research paper to illustrate significant findings or results. No names or other identifying information will be used in conjunction with these song lyrics.

If you are not comfortable participating in the audio recordings, you may request that the recording process cease and withdraw from the study at any time.

## RISKS

There are no foreseen health or physical risks resulting from participation in this study.

## BENEFITS

There are many inherent benefits that you can gain from participating in this study. You will be able to enjoy a unique and personal musical experience, explore different musical instruments, interact with your peers, express experiences and feelings in a safe and creative way, learn about yourself and others, and gain a sense of empowerment. Your participation in this study will also benefit the music therapy community and provide helpful data that can lead to more effective musical interventions in the future.

## PAYMENT TO PARTICIPANTS

Participants will not be paid for their involvement in this study.

## PARTICIPANT CONFIDENTIALITY

Your name will not be associated in any publication or presentation with the information collected about you or with the research findings from this study. Instead, the researchers will use a study number rather than your name.

## REFUSAL TO SIGN CONSENT AND AUTHORIZATION

You are not required to sign this Consent and Authorization form and you may refuse to do so without affecting your right to any services you are receiving or may receive from the University of Kansas or to participate in any programs or events of the University of Kansas. However, if you refuse to sign, you cannot participate in this study.

## CANCELLING THIS CONSENT AND AUTHORIZATION

You may withdraw your consent to participate in this study at any time. If you cancel permission to use your information, the researchers will stop collecting additional information

about you. However, the research team may use and disclose information that was gathered before they received your cancellation, as described above.

### QUESTIONS ABOUT PARTICIPATION

Questions about procedures should be directed to the researchers listed at the end of this consent form.

### PARTICIPANT CERTIFICATION:

I have read this Consent and Authorization form. I have had the opportunity to ask, and I have received answers to, any questions I had regarding the study. I understand that if I have any additional questions about my rights as a research participant, I may call (785) 864-7429 or (785) 864-7385, write the Human Subjects Committee Lawrence Campus (HSCL), University of Kansas, 2385 Irving Hill Road, Lawrence, Kansas 66045-7568, or email irb@ku.edu.

I agree to take part in this study as a research participant. By my signature I affirm that I am at least 18 years old and that I have received a copy of this Consent and Authorization form.

---

Type/Print Participant's Name

---

Date

---

Participant's Signature

### Researcher Contact Information

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APPENDIX B  
Data Collection Tools

Intake Questionnaire

Participant # \_\_\_\_\_

Name: \_\_\_\_\_

Age: \_\_\_\_\_

How long have you lived at the ISIS house? \_\_\_\_\_

What made you decide to come to the ISIS house?

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What is your favorite musical genre (rap, alternative, classical, etc.)?

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List some of your favorite musicians and/or songs.

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Do you play any musical instruments?

If yes, which instrument(s)? If no, is there an instrument you would like to try?

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Participant # \_\_\_\_\_

**Rosenberg Self-Esteem Scale** (Rosenberg, 1965)

The scale is a ten-item Likert scale with items answered on a four-point scale – from strongly agree to strongly disagree. The original sample for which the scale was developed consisted of 5,024 High School Juniors and Seniors from 10 randomly selected schools in New York State.

Instructions: Below is a list of statements dealing with your general feelings about yourself. If you strongly agree, circle **SA**. If you agree with the statement, circle **A**. If you disagree, circle **D**. If you strongly disagree, circle **SD**.

- |     |  |    |   |   |    |
|-----|--|----|---|---|----|
| 1.  | On the whole, I am satisfied with myself.                                  | SA | A | D | SD |
| 2.* | At times, I think I am no good at all.                                     | SA | A | D | SD |
| 3.  | I feel that I have a number of good qualities.                             | SA | A | D | SD |
| 4.  | I am able to do things as well as most other people.                       | SA | A | D | SD |
| 5.* | I feel I do not have much to be proud of.                                  | SA | A | D | SD |
| 6.* | I certainly feel useless at times.   | SA | A | D | SD |
| 7.  | I feel that I'm a person of worth, at least on an equal plane with others. | SA | A | D | SD |
| 8.* | I wish I could have more respect for myself.                               | SA | A | D | SD |
| 9.* | All in all, I am inclined to feel that I am a failure.                     | SA | A | D | SD |
| 10. | I take a positive attitude toward myself.                                  | SA | A | D | SD |

Scoring: SA=4, A=3, D=2, SD=1. Items with an asterisk are reverse scored, that is, SA=1, A=2, D=3, SD=4. Sum the scores for the 10 items. The higher the score, the higher the self-esteem.

(Note: Asterisks and scoring information is for the researcher only and was not included on the form participants completed.)

Final Survey

1. What is your overall reaction to this project?

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2. Which sessions did you enjoy most, songwriting, discussion-based activities, or both? Why?

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3. Did you learn anything from this experience? (Ex. about yourself, others, musical skills, coping skills, etc.)

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4. If you had the opportunity, would you choose to participate in another music therapy group in the future? Why or why not?

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## APPENDIX C

### Intervention Procedures

## *Procedures*

### Introductory Drum Circle for the Music Therapy Group

Total Length: 7-10 minutes

Materials Needed: Variety of drums, chairs arranged in a close circle, mallets

1. The MT will allow participants to choose a drum from the instruments provided. Mallets will be distributed for those drums requiring them.
2. The MT will ask participants to arrange their chairs in a close circle.
3. The MT will teach participants the short, 4-beat, rhythmic phrase.
4. Participants playing drums will play the first 3 beats and participants with the auxiliary percussion instruments (shakers, sticks, agogo bells, etc.) will finish with 2 eighth notes, the second ending on beat 4.
5. This will be practiced with the MT modeling each part.
6. The MT will then allow participants to add syncopated rhythms for the first 3 beats if they feel comfortable.
7. Once this has been practiced, the MT will add the verbal 2-phrase chant. The first phrase prompts clients to say their name and the second allows them to answer a question. (This question will remain simple and will change each session.)
  - a. Ex. "What kind of music do you like?" Response: "My name is Susie, and I like rap."
8. Each participant will have a chance to fill-in the 2-phrase chant and the group will repeat his/her answer.
  - a. Ex. "Your name is Susie, and you like rap."
9. As more participants are added, previous responses are also repeated so the chant grows in a layering fashion.
10. This will continue until the final client has led the verbal chant and the group repeats all participants' answers.

## *Procedures*

Same Letter, Different Name

Total Length: 7-10 minutes

Materials Needed: Paper, pencils, envelope with each letter of the alphabet in it

1. Each participant will be asked to write down the names of each group member, include himself/herself.
2. Participants will then be asked to choose one letter from the envelope.
3. Using positive descriptive words that start with the chosen letter, participants will write down an appropriate adjective for each group member.
  - a. Ex. “Hard-working Sam;” “Honest John”
4. Once all group members are finished writing, the MT will ask them to share what they wrote down for each person
5. The MT will facilitate a discussion about the responses, using verbal prompts when necessary
  - a. How do you feel about the words people chose to describe you?
  - b. Did you find it difficult to think of adjectives for other group members?
  - c. Is it easy or hard to think of descriptions for other people? For yourself?
  - d. Etc.
6. After each participant has had a chance to share his or her reactions, this process can be repeated with new letters.
7. This process will continue until it is time to move on to the next intervention.

This activity was taken from:

Jones, Alanna. (1998). *104 Activities That Build: Self-Esteem, Teamwork, Communication, Anger Management, Self-Discovery, Coping Skills*. Richland, WA: Rec Room Publishing.

## *Procedures*

### What I Believe

Total Length: 20-25 minutes

Materials Needed: Pencils, paper, whiteboard and markers

1. The MT will have the following names displayed on the white board:
  - a. Mother
  - b. Father
  - c. Siblings
  - d. Friends
  - e. Teachers
  - f. Others
2. Participants will be asked to write down how each person/group of people contributed to what they think/previously thought of themselves.
3. Once participants are finished writing, the MT will facilitate a discussion using verbal prompts. For example:
  - a. Which messages still dominate your self-image today?
  - b. Which messages support and which ones detract from your happiness?
  - c. Which messages are truth and which are beliefs?
  - d. Which messages do you want to change?
4. Participants will then be asked to write down a new set of thoughts and beliefs about themselves that they choose to accept to enhance their self-esteem and confidence.
5. The MT will ask participants to share their new list with the group if they are comfortable.
6. The discussion will continue until the MT leads it to a natural close.

This activity was taken from:

Reeve, S. & Breiner, J. (2009). *What I believe worksheet* (Self Esteem Building Activities, Lessons, Exercises & Tips). Retrieved from <http://www.self-esteem-experts.com/support-files/self-esteem-worksheet-1.pdf>.

## *Procedures*

### Forgiveness Recipe and Collage

Total Length: 30-35 minutes

Materials Needed: Pencils, paper, crayons, scissors, markers, glue, and magazines

1. Following a discussion about the definition of forgiveness, the MT will ask participants to think about the steps you must complete in order to forgive someone.
2. MT will hand out paper and pencils to each individual and ask them to come up with a step-by-step “recipe” for forgiveness.
3. MT will provide verbal prompts if participants are having trouble coming up with concrete steps to take:
  - a. Is there a length of time required to reach forgiveness?
  - b. Does forgiveness occur naturally or is it a conscious choice?
  - c. How will you know when your recipe is finished? What changes for you?
4. Participants who feel comfortable sharing will be asked to present their “recipe for forgiveness” to the group.
5. MT will facilitate a discussion about each recipe and ask group members which recipe would work for them.
6. After the discussion comes to a close, the MT will hand out magazines, scissors, crayons, markers, and glue for participants to create a collage describing their views on forgiveness.
7. Individuals will be asked to draw or cut out images representing the feelings surrounding a hurtful event as well as the path to forgiveness.
8. MT will provide suggestions if necessary and allow participants to present their collages once they are complete.

## *Procedures*

### Thank You Card

Total Length: 30-35 minutes

Materials Needed: Pencils, paper, crayons, and markers

1. MT will ask participants to write down at least 10 things that they are thankful for and include a description for why they are thankful for each of their choices.
2. MT will go around and ask each participant to share some or all of his or her list.
3. MT will lead discussion about each individual's response:
  - a. Did anyone list the same things? Did they include the same reasons for their gratitude?
  - b. Did any choices surprise you?
  - c. If you had to prioritize your choices, which one would be first? last? why?
4. Once the discussion comes to a close, the MT will ask participants to write a thank you note to one person or thing from their list.
5. Participants will be given papers and pencils as well as other materials to decorate their letters.
6. Once all letters are complete, the MT will ask individuals to share if they feel comfortable.
7. MT will then initiate a discussion about the groups' reactions to the activity:
  - a. How does it make you feel to openly express your gratitude?
  - b. Do you usually take time to give thanks? Will you make more time now?
  - c. Will you send your thank you card? Why or why not?
8. This will continue until the discussion comes to a natural close or the MT guides the group to closure.

## APPENDIX D

### Treatment Outcomes

Table 1

*RSES Scores Across the Treatment Period*

Session	Treatment	N	<u>Pre</u> M(SD)	<u>Post</u> M(SD)
1	Experimental	3	25.00(5.10)	28.33(4.11)
2	Control	3	32.67(4.78)	35.33(4.64)
3	Experimental	3	31.00(5.66)	30.00(7.26)
4	Control	2	32.50(7.50)	33.00(7.00)
5	Experimental	4	29.75(6.87)	31.25(6.22)
6	Control	0	N/A	N/A
7	Experimental	3	32.67(5.44)	34.67(3.77)
8	Control	2	34.00(6.00)	35.50(4.50)

Table 2

*Paired t-tests for Pre- and Post-Test Scores of the Control and Experimental Groups*

Groups	N	Pre	Post	Paired t-test	
		M(SD)	M(SD)	t(df)	p
Experimental	13	29.62(6.76)	31.08(6.26)	1.73(12)	0.11
Control	7	33.00(6.53)	34.71(5.94)	2.30(6)	0.06

Table 3

*Independent t-test Comparing Mean Differences Between Experimental and Control Groups*

<u>Experimental</u>		<u>Control</u>		<u>Independent t-test</u>	
N	M(SD)	N	M(SD)	t(df)	p
13	1.38(3.04)	7	1.71(1.98)	0.26(18)	0.80

APPENDIX E

Group Songwriting Lyrics

“Higher Than the Sky”

Verse 1:     Falling in the middle of the road, felt like falling out of the sky  
              Everybody stares at me and I just don’t know why  
              Finally got up, held my head up high  
              Just kept on walking, left my worries far behind

(Instrumental bridge)

Chorus:     It’s time to fly, higher than the sky  
              Who cares about wasting time?

Verse 2:     Open your eyes to the road before you, see what possibilities lie  
              Turn your head away from those who ignore you, draw from the strength inside

Chorus:     It’s time to fly, higher than the sky  
              Who cares about wasting time?

(Instrumental/vocal improvisation until end)