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## The Use of Music Therapy to Influence the Self-Confidence and Hostility of Adolescents Who are Sexually Abused

Joy Clendenon-Wallen

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THE USE OF MUSIC THERAPY TO INFLUENCE THE SELF-CONFIDENCE  
AND HOSTILITY OF ADOLESCENTS WHO ARE SEXUALLY ABUSED

by

Joy Clendenon-Wallen

A Thesis  
Submitted to the  
Faculty of The Graduate College  
in partial fulfillment of the  
requirements for the  
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School of Music

Western Michigan University  
Kalamazoo, Michigan  
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# THE USE OF MUSIC THERAPY TO INFLUENCE THE SELF-CONFIDENCE AND HOSTILITY OF ADOLESCENTS WHO ARE SEXUALLY ABUSED

Joy Clendenon-Wallen, M.M.

Western Michigan University, 1993

The purpose of this study was to determine whether music therapy would be an effective therapeutic medium for reducing hostility and increasing the self-confidence of sexually abused adolescents. The study utilized an experimental and control group which is unique in the sexual abuse literature. Most studies are descriptive or quasi-experimental in nature. Some of the subjects increased their self-confidence and decreased their hostility although no statistical significance was achieved for either group. This study describes the treatment problems of sexually abused adolescents and offers examples of non-confrontational and goal directed treatment strategies which can be achieved through music therapy. Music therapy appears to be an effective therapeutic medium for use with adolescents since it is an important part of the adolescent peer culture. Music evokes feelings and facilitates the expression of feelings and disclosure which is important in the treatment of sexual abuse.

## ACKNOWLEDGEMENTS

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Joy Clendenon-Wallen

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**Clendenon-Wallen, Joy, M.M.**

**Western Michigan University, 1993**

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## CHAPTER I

### INTRODUCTION

#### Background of the Problem

There has recently been a great deal of concern among professional mental health workers regarding the increase of sexual abuse and its consequences upon the emotional and psychological health of the survivors.

#### The Prevalence of Sexual Abuse

Many researchers believe that sexual abuse is far more prevalent than is even reflected in current statistics. O'Brien (1986) states that "for each victim known, nine remain hidden from authorities" (p. ix). It appears that sexual abuse is the best kept secret (Rush, 1980). Finkelhor (1986) reports that most cases of sexual abuse do not come to the attention of child welfare workers or professionals because of the nature of the problem. The secrecy and shame, the legal sanctions against it, and the young age and dependent status of its victims inhibits and discourages voluntary reporting (p. 18). Russell (1983) states that if the findings of her prevalence study in San Francisco are indicative of the prevalence in other areas, then "over one-quarter of the population of female children has experienced sexual abuse before the age of 14, and well over one-third have had such an experience by the age of 18 years" (p. 35). Her study also confirms the fact that only a small percentage of cases ever get reported to the police (2% of intrafamilial and 6% of extrafamilial child sexual abuse cases). Bradshaw (1988) states that it is estimated that there are currently 60 million

survivors of sexual violence. The literature reflects mainly the sexual abuse of females yet many males are survivors of sexual abuse also.

### The Definitions of Sexual Abuse

The definitions of what constitutes child sexual abuse differ considerably in the literature. Russell (1983) describes some of the problems. Many researchers use a narrower definition which may not include exhibitionism and/or other experiences which may not involve actual contact or attempted contact such as a sexual proposition which is not acted upon. Researchers differ on the age that determines the criterion for sexual abuse. Some states' laws mandate that the child must be under 13 years of age while many researchers define the age as any child under the age of 17 (Finkelhor, 1979). The National Center on Child Abuse and Neglect (1981) has established the age at 18.

Downer (1984) provides the following definitions.

**Child sexual abuse** is defined as contact or interaction between a child and an adult or older person when the child is being used for the sexual stimulation of the perpetrator or another person. "Child" refers to a boy or girl under 18 years of age. The perpetrator need not be an adult, as long as the perpetrator is significantly older than the victim and/or in a position of power over the victim. Child sexual abuse includes a wide range of sexual activity ranging from "non-violent", non-touching offenses such as exposure, to offenses that do involve physical contact, and sometimes the use of violence or physical force, such as fondling, oral/genital contact, vaginal and anal stimulation and penetration, incest, and exploitation of children through pornography and prostitution.

**Incest** is defined as any sexual contact between family members in which an adult or older person seeks or gains sexual gratification through the child. This activity may include fondling, manual or oral manipulation of the genitals, or intercourse. Family members include mothers, fathers, grandparents, aunts, uncles, brothers, sisters, cousins, adoptive and step relations. (p. 8).

Bradshaw (1988) divides sexual abuse into the following categories:

**1. Physical Sexual Abuse** - This involves hands on touching in a sexual way. The range of abusive behaviors that are sexual include sexualized hugging or kissing; any kind of sexual touching or fondling; oral and anal sex; masturbation of the victim or forcing the victim to masturbate the offender; sexual intercourse.

**2. Overt Sexual Abuse** - This involves voyeurism, exhibitionism. This can be outside or inside the home. Parents often sexually abuse children through voyeurism and exhibitionism. This criteria for in-home voyeurism or exhibitionism is whether the parent is being sexually stimulated. Sometimes the parent may be so out of touch with their own sexuality that they are not aware of how sexual they are being. The child almost always has a kind of "icky" feeling about it.

### **3. Covert Sexual Abuse**

**(a) Verbal** - This involves inappropriate sexual talking: Dad or any significant male calling women "whores" or "cunts" or objectified sexual names; or Mom or any other significant female deprecating men in a sexual way. It also involves parents or caretakers having to know about every detail of one's private sexual life, asking questions about a child's sexual physiology or questioning for minute details about dates. An overt kind of sexual abuse occurs when Mom or Dad talk about sex in front of the children when the age level of the children is inappropriate. It also occurs when Mom or Dad make sexual remarks about the sexual parts of the children's bodies (jokes about the size of their penises, breasts, or buttocks).

**(b) Boundary Violation** - This involves children witnessing parents in sexual behavior. They may walk in on it frequently because parents don't provide closed or locked doors. It also involves the children being allowed no privacy. They are walked in on while in the bathroom. They are not taught to lock doors or given permission to lock doors. Parents need to model appropriate nudity and need to be clothed appropriately after a certain age. Mom and Dad need to be careful about walking around nude with young children. If Mom is not being stimulated sexually, the nudity is not sexual abuse. She simply is acting in a dysfunctional way. She is not setting sexual boundaries. The use of enemas at an early age can also be abusive in a way that leads to sexual dysfunction. The enemas can be a body boundary violation.

**4. Emotional Sexual Abuse** - Emotional sexual abuse results from cross-generational bonding. It is very common for one or both parents in a dysfunctional family to bond inappropriately with one of their children. The parents in effect use the children to meet their emotional needs. This relationship can easily become sexualized or romanticized. The daughter may become Daddy's "Little Princess" or the son may become Mom's "Little Man". In both cases the child is being abandoned. The parents are getting their needs met at the



expense of the child's needs. The child needs a parent not a spouse. Sometimes both parents bond with a child and the child tries to take care of both parent's feelings. When a parent has a relationship with a child which is more important than the relationship with their own spouse then this is emotional sexual abuse. (pp. 48, 49, 50)

### The Purpose of the Research

The first purpose of this study is to determine if the use of music therapy activities in an adolescent support group of adolescent survivors of sexual abuse will significantly increase the self-confidence and lower the hostility level of the subjects. Low Self-Confidence and high levels of hostility are two of the most negative effects of sexual abuse seen by this experimenter in adolescents who have been sexually abused. There is a need to develop ways to deal with the hostility seen in this population as this factor may keep many from receiving the treatment they need. Ellenson (1989) states the existence of rage and its attendant hostility in survivors is deeply repugnant and painfully lowers self-esteem. This study also seeks to determine if there is in fact a correlation between self-confidence (self-esteem) and hostility in adolescent survivors.

### Assumptions

The Adjective Checklist (Gough and Heilbruh, 1983) is assumed to be reliable and valid. Reliability coefficients for the various scales show wide variation (.34 to .95); however, median values in the mid 70's attest to generally adequate reliabilities for most of the scales (Mitchell, 1985). In reviewing the manual (Mitchell, 1985) though, one will not find a specific section dedicated to the analysis of the validity of the ACL (p. 52).

Although the lack of validity appears to be a weakness in the test, Mitchell believes that the test is of greatest utility to researchers and theoreticians interested in

the self-concept rather than to clinicians using it as a personality measure, as it was originally designed. The use of the self-confidence core from the ACL for this study will therefore provide an estimate of self-concept by measuring self-confidence. A person with the behavior of poor self-confidence would be expected to have a poor self-concept. Branden (1969) believes that self-esteem is the integrated sum of self-confidence (competence) and self-respect (worthiness). Therefore, by measuring self-confidence, one could obtain an assessment of a subject's self-concept or self-esteem.

The Buss-Durkee Hostility Inventory (Buss and Durkee, 1957) will be used to gather pre- and post-test data on the clients' hostility levels. Although this experimenter found no reliability or validity information for this instrument, it has been used as an instrument with this population (Salter, 1988).

## CHAPTER II

### REVIEW OF RELATED LITERATURE

#### Socioeconomic and Ethnic Groups

Survivors of sexual abuse come from all socioeconomic and ethnic groups (Cohen and Phelps, 1985). "A significant percentage of the perpetrators of sexual abuse of children, as opposed to those who commit physical abuse, are well-educated, often professionals and business executives, people least suspected of such crimes" (p. 266). Lew (1988) states that incest is found all over the world and is not limited to any one particular segment of society. Incest is found in all racial and ethnic groups and it exists in some of the "nicest" families, including wealthy, poor, and middle class families. It has been reported that three fourths of all reported cases of sexual abuse involve stepfather-stepdaughter incest (Kempe and Kempe, 1984). Most researchers and clinicians make a distinction and refer to sexual abuse as either intrafamilial or extrafamilial.

#### The Sexual Abuse of Males

Kempe and Kempe (1984) report that the sexual abuse of boys may be as widespread as that of females but more often goes unreported. Boys who have been molested additionally fear being stigmatized as homosexuals and generally do not report their victimization to anyone. A sexually abused male may experience gender identity and believe that he is gay. Lew (1988) states that there is very little clinical information in print regarding the sexual abuse of males. Through his work he has discovered that males experience the same effects as the female survivors that he has

treated in therapy although there are some problems that are specific to male survivors.

Males who have been sexually abused experience demasculinization because our society perpetuates the myth that males are not supposed to be victims. A man feels that if men are not supposed to be victims and he is a victim then he must not be a man. Lew states that another problem which is specific to the male survivor is confusion between power and abuse. Unfortunately this confusion leads many male survivors to become offenders themselves. The survivor may believe that the only way that he can masculinize or empower himself is to victimize another person. This may explain why many males who have been sexually abused go on to victimize others while most female survivors continue in the role of victim. Women are more likely to get help for the treatment of sexual abuse as evidenced by their ability to disclose their sexual abuse and the availability of treatment centers. Men who are survivors and the survivors who become perpetrators of sexual abuse are less likely to receive help as evidenced by the lack of treatment facilities and their failure to disclose their own sexual abuse (See Chapter IV for descriptions of the treatment that is currently available for offenders).

Unfortunately, Lew found no male survivor groups or treatment centers which offered treatment for male survivors after searching extensively throughout the Massachusetts and New England area. Men appear less likely to admit their sexual abuse even though the sexual abuse of males is pervasive in our society.

In conclusion, it seems that sexual abuse will continue until society changes and the men who have been sexually abused are able to come forward for treatment.

## Diagnosis of the Sexually Abused

### Posttraumatic Stress Disorder

The diagnosis of Post-traumatic Stress Disorder in DSM III-R (APA, 1987), came about as the result of the recognized effects of trauma that the Vietnam Veterans experienced. Eventually, this diagnosis became the primary diagnosis of survivors of sexual abuse because of the similarity of the symptoms.

The diagnosis of Post-traumatic Stress Disorder (PTSD) requires that the following must be present:

An aversive event has transpired, of sufficient severity that it would evoke significant psychological disturbance in almost anyone.

The event is frequently re-experienced via nightmares, intrusive thoughts, or flashbacks (sudden sensory memories that seem immediately real even though the event is long past).

The individual experiences a "numbing of general responsiveness" to, or avoidance of, current events in his or her world.

There are "persistent symptoms of increased arousal," such as sleep disturbance, heightened startle response, or poor concentration. Also included in this domain is "physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event" (American Psychiatric Association, 1987, pp. 250-251).

Blume (1990) states that the diagnosis of PTSD recognizes that emotional problems can be predictable problems of external events. In addition, the author states that the diagnosis is not entirely accurate in describing the post-incest experience and fails "to acknowledge the admirable survival spirit and inevitability of the emotional and behavioral consequences it describes" (p.78). The author presents a very important point that is not mentioned often in the literature on sexual abuse. Individuals suffering from PTSD are often times misdiagnosed as psychotic or schizophrenic.

When a person reacts to trauma by hearing or seeing images evoked by the trauma, many psychiatrists hear only the 'craziness' and miss the meaning of what the person is doing - the meaning of the hallucination, the meaning of the panic or hysteria. In relation to incest, this misdiagnosis occurs because psychiatrists tend to overvalue 'symptoms' and undervalue life, to overemphasize 'chemistry' and underplay human feelings. At the same time, they are unwilling to acknowledge sexual abuse of children. (p. 79).

The author states that these attitudes reinforce the blame of the trauma survivor. Blume (1990) agrees with many other clinicians that the diagnosis of PTSD fails to describe the entire post-incest experience. However, the author believes that the diagnosis is "the best available psychiatric framework for understanding the affects of this trauma" (p. 80). Blume (1990) prefers to refer to the disorder as Post-Incest Syndrome.

In support of the diagnosis of PTSD for victims of sexual abuse, Horowitz (1976) developed a treatment model based on the Freudian concept of "urge to completion." According to Horowitz, the survivor of sexual abuse alternates between denial and intrusion until the trauma is resolved through cognitive completion and is a part of conscious experience. Horowitz stated that "they cannot remember and they cannot 'not' remember" (p. 83). "Cannot remember" was categorized by Horowitz as denial. Inability to remember as emotional constriction, numbness, inability to evaluate stimuli, forgetting, and selective amnesia are all symptoms of "cannot remember." "Cannot not remember" is described as symptoms such as flashbacks, hyper-vigilance, common night fears, and inability to concentrate. These symptoms are all considered intrusive. The initial period after shock was labeled by Horowitz as "outcry." Haugaard and Reppucci (1989) in describing Horowitz's theory state that the painful nature of the memories causes the person to attempt to reduce their occurrence by withdrawing from the world, especially those parts of the world that might evoke the memories. "The attempt to

shield oneself from the memories reduce the chance of the mind to work through them, and, consequently, their cyclical intrusion into one's life continues" (p. 95).

Horowitz (1976) developed a treatment plan based on the symptoms of denial and intrusion. For example, if a client experienced numbness as a symptom of denial, catharsis would be encouraged through encouraging emotional relationships. If a client experienced intrusive symptoms such as rage or fear, the treatment would include support and suppression or desensitization. Horowitz states that both intrusion and denial help the person to resolve the trauma.

Cole and Barney (1987) have developed a group treatment model which takes into account the traumatic nature and sequelae of abuse experiences. They stress that caution must be used in promoting disclosure of the trauma in order to not precipitate or exacerbate post-traumatic stress symptoms. The authors describe symptoms of post-traumatic stress which cluster into a stress response syndrome and which cycles in two major phases. The person "experiences phases of denial (over-controlling defenses) which alternate with phases of an intrusive nature (under-controlling defenses)" (p.602). Denial phases may include amnesia, forgetfulness, minimizing, dissociation, fatigue, headaches and selective inattention. Intrusive phase symptoms might include hypervigilance, unbidden repetitive thoughts and imagery, hallucinations, confusion, waves of intense emotion, tremors, sweating, and nightmares. The person oscillates between these two phases. Between the extremes of these phases a "therapeutic window" can be imaged in the mind. This is the band of more moderate distress where post-traumatic symptoms are present but manageable. The authors use the therapeutic window as a guide in the timing and pacing of interventions. The symptoms will increase in severity as they approach the extreme of one phase or the other which impedes the resolution process. Therefore, the therapeutic window is the zone where resolution can proceed. Reintegration of

the material and affect is the primary task. Reworking the meaning of the incest is the final step. Key themes must be processed before cognitive and affective mastery can take place. The therapist must closely monitor the "dosage" of intensity and duration so that it is of therapeutically manageable proportions. The clients learn what their "triggers" are and how these triggers have precipitated movement out of their own therapeutic window (Either into the over-controlled or denial stage or the out of control or intrusive phases). "Triggers" could be sounds, odors, touch, movies, visits from family members and etc. Clendenon-Wallen (1991) describes music functioning as a "trigger" with adolescents who have been sexually abused. For example, the song "I Want Your Sex" by George Michaels was used in a session which dealt with sexual issues. When the subject heard the song she flooded with affect and was crying hysterically. She was finally able to tell the group that this song had been playing on the radio when she was raped. It is important that persons who have been sexually abused become aware of the "triggers" and develop ways to cope with them.

When the person who has been sexually abused experiences intensely powerful and frightening emotions, a technique called "grounding" can be used (Cole and Barney, 1987). This technique involves teaching the person how to keep in touch with the immediate reality and to develop grounding strategies. An example given by the authors is to have the persons repeat to themselves their age and to state that they are not a child anymore.

Ellenson (1989) describes the disruptive energy of rage and its reactive companion of horror in those who have been sexually abused. To understand the survivor, "one must understand her rage, the defenses she brings to bear against it, and the meaning of her resultant symptoms" (p. 596). He states that the manifestations of horror and rage are the hallucinations which are common to



survivors. Hallucinations experienced by survivors include auditory, visual, tactile, kinesthetic, and psychic hallucinations. "From an object-relations perspective, the process of projection may be thought of as one in which an attribute of the self is detached from the self-representation and reassigned (intrapsychically) to another object or symbol" (p. 590). Rage is detached from the self-representation and reassigned to an external entity or disembodied force. Situational factors which tend to elicit or increase hallucinations are described and the author explores the reasons why survivors defend so heavily against rage. The treatment of survivors falls into two broad phases: (1) remembering and (2) mastering. Memories are repressed to defend against the affects associated with them, especially rage. During the remembering phase symptoms usually intensify and multiply with grief and horror being the chief affects. Rage is still largely out of consciousness, and the person will continue to experience hallucinations, phobias, and nightmares. In the mastering phase "the clinician must shift attention from symptoms as memories to symptoms as representations of affects, which the survivor fears and must master" (p. 595). The rage must be accepted and group members are encouraged to provide support with empathetic acceptance of rage. The author states that "future theory development in the field of sexual abuse needs to attend to the immensity of horror and rage in survivors and to the impact of these cataclysmic affects upon the ego from a psycho dynamic standpoint " (p. 596).

### The Multiple Personality

Saltman and Solomon (1982) presented case studies of multiple personality after incest and a review of literature which suggests a high incidence of incest among persons with multiple personalities. DSM-III-R (APA, 1987) describes multiple personality as "the existence within the individual of two or more distinct

personalities, each of which is dominant at a particular time. Each personality is a fully integrated and complex unit with unique memories, behavior patterns, and social relationships that determine the nature of the individual's act when that personality is dominant" (p. 257). Saltman and Solomon (1982) describe transitional phenomena which may occur leading into a dissociative episode. "These phenomena include: feelings of unreality, depersonalization, shaking, trembling of the extremities, twitching of the eyelids, nausea, and histrionic, convulsive-like fits. These behaviors result in an immobilized state in some lasting from seconds to hours. The patient is unresponsive to external contact but may be verbal or appear conscious. There then follows a distinct change in personality" (p. 1128).

Blume (1990) reported that an "overwhelming majority of people who have multiple personalities were victims of particularly sadistic, relentless physical or sexual abuse in childhood, which usually involved confinement" (p. 86). The author questioned the existence of multiple-personality disorder until she began working with survivors of sexual abuse and noted the "inventiveness of the cognitive resources that incest survivors create in childhood--the totality of their denial, the functional purpose of splitting--demonstrate that such altered states of consciousness are possible. Someone can indeed split off parts of herself and not be aware of those parts" (pp. 86-87). The fact that many survivors who have absolutely no awareness of incest history, are divided from themselves, and then at some point begin to remember, supports the fact that multiple-personality disorder does exist (p. 87). Blume (1980) states that treatment will often require hypnosis, developing an alliance with one personality and the unlocking of memory through art, music, movement, or mutual support groups (p. 88).

### Borderline Personality Disorder

Childhood sexual abuse often plays a role in the history of borderline personality disorder (DSM-III-R, 1987, pp. 346-347). Everstine and Everstine (1989) explain the importance of differentiating between the true masochistic or manipulative borderline client and the sexually abused person who exhibits borderline characteristics. "The emotional dynamics of the self-destructive or acting-out behavior of the borderline or masochistic person are quite different from those of a person who suffers unresolved sexual trauma" (p. 154). The authors state that many survivors of sexual abuse have been misdiagnosed as having borderline personality disorder. Acting-out behavior by those who have suffered sexual trauma as children may be a reflection of their trying to express the unspeakable by their behavior (p. 154). Patten, Gatz, Jones, and Thomas (1989) address this issue. They question the extensive use of the diagnosis of borderline personality in light of the estimates that as many as "35% of borderline patients have experienced incestuous sexual abuse" (p. 197).

### Schizophrenia

Blume (1990) describes the fact that mental hospitals are full of incest survivors, many who are not schizophrenic and who do not require such serious institutionalization. These people have been incarcerated by family or psychiatrists who misunderstand post-incest syndrome (p. 85). The author describes the symptoms of mild hallucinations that are related to experiences that the incest survivors have had. These hallucinations are related to the shattering of boundaries represented by the abuse which leaves a survivor no privacy or personal space (p.86).

### Traumagenic Dynamics

Finklehor and Browne (1988) saw the need to develop a clear model that would specify how and why sexual abuse might result in the traumas described in the PTSD diagnosis so that the model could be used in research and treatment. Their model postulates that the experience of sexual abuse can be analyzed in terms of four trauma causing factors. The researchers titled these factors as "traumagenic dynamics" and divided them into four categories: traumatic sexualization, stigmatization, betrayal, and powerlessness. They noted that these dynamics are found in other types of trauma not specific to sexual abuse, but the conjunction of all four of these dynamics in one set of circumstances is what makes the trauma of sexual abuse unique and different from either childhood physical abuse or the divorce of a child's parent. The researchers state that when these dynamics are present the child's cognitive and emotional orientation to the world is altered. These dynamics create trauma which distorts a child's self-concept, world view, and affective capacities. The dynamic of stigmatization distorts children's sense of value and worth. The dynamic of powerlessness distorts the children's sense of their ability to control their lives (p. 62) When survivors of sexual abuse try to cope with the world through these distortions, either as a child or later as an adult, then they experience all of the problems associated with sexual abuse. Traumatic Sexualization refers to a process in which the child's sexual feelings and sexual attitudes are shaped in a developmentally inappropriate and interpersonally dysfunctional way as a result of the sexual abuse. These children emerge from their experience with inappropriate repertoires of sexual experience, with confusions and misconceptions about their sexual self-concepts, and with unusual associations related to sexual activities (p. 63)

Betrayal refers to the dynamic where children discover that someone upon whom they were vitally dependent has caused them harm. The degree of betrayal a child experiences is related to how tricked the child feels. If the child experienced the initial contact as nurturing or loving then he/she may experience more of a sense of betrayal when it is realized what really happened. If the child was suspicious from the beginning then the feeling of betrayal would be less. Betrayal is also related to the family's response following disclosure. The child who is disbelieved, blamed, or ostracized will experience a greater sense of betrayal than the child who is supported (p. 64).

Powerlessness, the dynamic of rendering the victim powerless, refers to the process wherein the child's will, desires, and sense of efficacy are continually contravened. Many aspects of the sexual abuse experience contribute to this dynamic because the child's territory and body space are repeatedly invaded against the child's will. The manipulation and coercion that the offender imposes as a part of the abuse process exacerbates this dynamic. Powerlessness is reinforced when the child sees that his/her attempts to halt the abuse is futile. The feeling of powerlessness is increased when the child feels fear, when there are attempts to make others understand or believe that the sexual abuse is occurring, or when the child realizes that conditions of dependency have the child trapped in the situation (p. 64).

Stigmatization refers to the negative connotations such as badness, shame, and guilt that are communicated to the child about the experiences and are then incorporated into the child's self-image. These negative meanings are communicated by the abuser who may blame the child, or who may denigrate the child. Pressure for secrecy from the offender may convey powerful messages of shame and guilt. Stigmatization is also reinforced by attitudes that the child who has been sexually abused infers or hears from others in the family or from the community.

Stigmatization may also come from the child's knowledge or sense that sexual abuse is deviant or taboo. Other factors may cause the child to be stigmatized such as how persons in the environment impute negative characteristics to the child such as having loose morals or spoiled goods.

Clearly, being able to view the main sources of trauma to the survivor of sexual abuse in clusters of injurious influences with a common theme can help organize and categorize our understanding of the effects of sexual abuse.

### The Family Dynamics of Incest

There are certain family dynamics that have been identified as leading to the sexual abuse of a child within the family. Waterman and MacFarlane (1986) identified three theoretical formulations about these dynamics. Each of these theoretical formulations has a different focus for the explanation of the sexual abuse, although they all share some combination of factors which is present in most cases. The author identifies the theoretical formulations as sociological, psycho dynamic, and family systems.

Looking at the sociological explanations for incest, there are factors such as socioeconomic class, poverty, overcrowded living conditions, and social or geographic isolation which could be implicated as reasons for incest. It is commonly accepted in the current sexual abuse literature that incest has no socioeconomic barriers and that it is equally represented in all social classes (Cohen and Phelps, 1985; Lew, 1988). One factor that is fairly consistent is that most incestuous families tend to be socially, psychologically or physically isolated. High stress seems to increase the risk for sexual abuse, and stressful life events in the life of the father or step-father usually precede the onset of the incest. Finklehor (1980) found that the most significant factor in the possibility of incest occurring was that a stepfather was

involved. This may mean that men perceive that molestation by stepfathers is less taboo than with natural fathers.

The psycho dynamic formulations look at factors such as the particular traits of those involved, historical events, or underlying personality dynamics that are attributed to those involved in the incestuous relationship. A common finding is that the fathers are domineering and authoritarian in relating to the family. Generally speaking, the father is rigid, moralistic, and demands complete obedience. The father appears to have poor impulse control. He may function very well in the community and appear well adjusted to those outside the family. Alcoholism or overuse of alcohol often characterizes the father, although many offenders are often extremely religious, prominent figures in churches, and are not alcohol users. The fathers who do use alcohol do so in order to cope with their anxiety. The alcohol also functions to lower inhibitions which helps to facilitate the sexual abuse. Waterman and MacFarlane (1986) state that contrary to popular opinion, the father does not have an unusually high sexual drive or a tendency to want deviant sexual activities. There does appear to be an exception to this, and that is when the offender is a sexual addict.

The common findings of the mothers in incestuous families where the father is the perpetrator is that the mothers are frequently emotionally or physically ill, absent, or disabled. The mother tends to be dependent, passive, and she most always feels powerless in her life. Very often, the mother was herself sexually abused as a child. Waterman and MacFarlane (1986) describes the mother as frigid, nonsexual, or repressive in her feelings and attitudes about sex. Because the mother is passive and dependent she may not move to protect her child and may even side with the offender when the incest is disclosed for fear of losing his support and protection. Some clinicians and researchers find that the mother consciously or

unconsciously sets her child up for the sexual abuse in order to free herself from her husband's sexual demands.

When looking at the child's psychodynamics, girls who have fewer friends are those more likely to be sexually abused. The oldest daughter has been found to be at the greatest risk to be sexually abused. The victims are probably more passive and dependent than their peers and therefore comply more to the demands of the sexualized relationship with the father.

When examining the family systems formulations, Waterman and MacFarlane (1986) have identified two approaches. These are the common relationship dynamics and secondly, the family patterns in incestuous families. The two main areas that have been found to be consistently dysfunctional in incestuous families are the power and sexual relationships. Power is distributed very unequally. Either the father is dominant and authoritarian with a dependent and ineffectual mother or the opposite with a dominant and authoritarian mother and a dependent and ineffectual father. Sometimes when the father is the powerful authoritarian he will be violent to other family members in order to ensure power. The sexually abused daughter may enjoy a special position of immunity within the family.

Sexually, the marital relationship generally has troubles as the wife often is not interested in sex and rejects the husband sexually. The husband may be unusually sexually demanding or the wife may be ill, disabled or absent. Another explanation may be that the mother, most often being a survivor of sexual abuse herself, may never have felt sex as a pleasurable and loving experience. For whatever the reason, the husband is sometimes sexually frustrated. When the family is isolated, the chance of the father visiting a prostitute or developing an extra-marital affair is not likely, and therefore he may turn to his daughter.



The mother/daughter relationship in an incestuous family is often characterized by a role reversal. The mother either overtly or covertly will turn over the household tasks to the oldest daughter. This usually means that the daughter will be responsible for the cleaning, cooking, and the care of any younger children. The daughter does not feel close to the mother. Once the family roles become blurred, the daughter eventually takes over other activities of the mother's role such as providing comfort and sex for the father.

The father/daughter relationship becomes sexualized. The daughter is often starved for affection since she may not receive any from the mother, and the father is affectionate only in a sexual way. The child who has been sexually abused will most likely relate to others in a sexualized way which evokes affection and attention because this is the only way she has learned to gain nurturance in the past. This behavior often leads the survivor to sexual promiscuity with male peers.

### Types of Offenders

Salter (1988) reports that there are basically two types of offenders who sexually abuse children. The first type of offenders convert their problems into inappropriate sexual behavior. They are "unable to solve nonsexual problems, or even to tolerate certain feeling states (most often anger or depression) without relying on sexual behavior as an escape" (p. 45-46). Sexual behavior refers to sexual acting out. The second type of offender repetitively molests children. These offenders have a deviant arousal system and are sexually attracted to children. While the first type of offender molests when under stress, the second type of offender molests regularly regardless of life's circumstances. Groth (1982) divided these offenders into two groups which he identified as either regressed or fixated pedophiles. The regressed pedophiles are primarily sexually attracted to those of their own age, and their sexual

involvements with children are more impulsive and occur when they are under stress. Their offense is often alcohol related. The fixated pedophiles are usually single, have little sexual contact with those of their own age, and they generally prefer the company of children to adults. They do not usually have a history of alcohol or drug abuse and are described as having characterological immaturity and inadequate personalities. Offenders can be not only fathers or stepfathers but may also include mothers, older siblings, uncles, grandfathers or close family friends.

## CHAPTER III

### THE EFFECTS OF SEXUAL ABUSE

#### The Most Frequent Effects

The literature is filled with lists of the negative effects and the problems experienced by those who are sexually abused. Lew (1988) proposed a question to a group of male incest survivors who were attending a weekend retreat. The question was, "In what ways does the childhood sexual abuse continue to affect your adult life?" The group of male survivors responded to the question and put together a list of 62 current effects. Unfortunately, very little research has been conducted in the field of sexual abuse, therefore it has proved very difficult to acquire researched based information of the effects of sexual abuse. Schlesinger (1982), in his search for research studies in the field of sexual abuse found only nineteen research studies published between 1977 and 1982. Although there have been many publications on sexual abuse since that time, there still continues to be very few research studies being conducted. The following negative effects are those which are mentioned most frequently in the literature.

#### Self-Esteem

There are many books that have been written about self-esteem yet most authors fail to define self-esteem. Apparently, they believe that most people know what self-esteem is and therefore it does not warrant an explanation or definition. Brooks and Dalby (1990) have a simple explanation which states that self-esteem is a way of feeling about yourself. If you accept and like yourself as you are, you are

said to have self-esteem. If you do not accept and like yourself, you are said to have low self-esteem. Another more complicated definition by the authors states that "Self-esteem is appreciating my own worth and importance and having the character to be accountable for myself and to act responsibly towards others" (p.3). McKay and Fanning (1987) say that self-esteem is essential for psychological survival and that without some measure of self-worth, life can be enormously painful, with many basic needs going unmet. Branden (1969) believes that self-esteem is the integrated sum of self-confidence (competence) and self-respect (worthiness).

Disturbed self-esteem, inability to trust and depression are chronic problems in persons who have experienced sexual abuse (Blitstein and Michel, 1979). Sexual abuse is devastating to a survivor's self-esteem, a fact commonly cited in the literature (de Young, 1982; Fromuth, 1986; Brown, 1979; Tabor, 1984; Verleur, Hughes, Dobkin de Rios, 1986; Maltz and Holman, 1987). Feelings of worthlessness result in a lack of competence in the tasks of everyday life. A person who has been sexually abused experiences a decrease in self confidence, and if the survivor is a small child, he/she may never develop self-confidence. In a study conducted by DeFrancis (1969), 58% of the survivors expressed feelings of inferiority or lack of self-worth as a result of being victimized.

Clinical observations found in the literature generally support these findings, yet, in the Tufts study (1984), no evidence was found that sexually abused children in any age group had consistently lower self-esteem than a normal population of children (p. 184). In the Tufts Study (1984), positive self-esteem was measured by the Piers-Harris Children's Self-Concept Scale (ages 7-18) or the Purdue Self-Concept Scale for pre-school children (ages 3-6). The findings in this study were inconsistent with many clinical observations in the literature. The researchers believe that there are two competing explanations for this finding. One explanation may be that sexual

experiences do not have as pervasive an impact on the child's sense of self as we might have believed. The alternative hypothesis emphasizes the significant shortcoming of research which relies on the person's self-reports. Those who have been sexually abused may have some incentive for presenting themselves in a more favorable light. It is relatively easy to choose the more socially desired response on self-concept measures. Children may be prone to "fake good" in order to not feel blamed for the sexual abuse or to try to appear less damaged in order to avoid disruption of their families (p. 184). Bagley and Ramsey (1985) found that 19% of the children who were sexually abused in their random sample scored in the "very poor" category on the Coopersmith Self-Esteem Inventory whereas only 5% of the control group scored in this category. In addition, only 9% of the sexually abused children demonstrated "very good" levels of self-esteem as compared to 20% of the control group falling into this category.

O'Brien (1987) extensively evaluated and treated sixty female survivors of incest and their families over a three year period. He identified various developmental tasks of adolescent development which are all compromised by the incest experience. Establishment of a positive sense of self is one of these crucial tasks which is most seriously compromised. The survivors in his study saw themselves as damaged goods. He reports that it is important when talking about these feelings associated with the concept of damaged goods to distinguish between the feelings the person has of being damaged by the sexual experience and also the feelings the person has which relate to the idea that there was something wrong with them well before the incest occurred in order for them to have been the one chosen to be the victim. The author states, "This sense of evil and being doomed because of one's innate defectiveness is a crucial issue because the victim never gets a sense of being all right, and her sense of inner self is crippled by the experience" (p 87).

Orr and Downes (1985) assessed the self-concept and psychological profile associated with sexual abuse in 20 adolescent female survivors. The instrument used was the Offer Self-Image Questionnaire. The sexually abused adolescents' scores on the self-concept test were compared against the scores of a group of adolescent females seen in the emergency room of the hospital who were not sexually abused. No treatment was performed. The sexually abused adolescents were found to have specific problems in self-concept as measured by the instrument although statistical significance was not achieved. The specific problems related to sexual feelings, family relationships, and ability to master the environment. The authors state that because their findings are so similar to those problems reported among adults who have been sexually abused that it is unlikely that the findings were due to chance.

Verleur et al, (1986) conducted a research study to determine if low self-esteem exhibited by adolescent female incest survivors could be modified with female-headed group psychotherapy intervention. The Coopersmith Self-Esteem Inventory was used to measure self-esteem. The authors also measured changes in sexual awareness of the incest survivors after they received training about human sexuality. The study was unique because an experimental and control group were used. The authors stated that there are very few studies in the field of sexual abuse which utilize experimental and control groups. The female adolescent incest survivors participated in a six month therapy program and the data were collected and compared against female incest survivors who were not involved in a therapy program. The results of the study showed a significant increase in the self-esteem of both the experimental and control groups. The authors attribute this phenomenon to the fact that the services provided at the residential treatment facility focus on personalized attention and that it was not unanticipated that both groups' self-esteem would be enhanced.

Blume (1990) theorizes that low self-esteem is a result of feeling soiled and spoiled. Because the sexual abuse occurred in childhood, when self-esteem and identity are still developing, "these feelings weave their way into the very fabric of her being" (p. 113). Feeling dirty therefore, becomes a part of the survivor's character rather than a response to an event that happened.

Tabor (1984) compared the psychological adjustment of sexually abused adolescent females who presented for an intake interview only and the other group who continued in group treatment. Psychological adjustment as defined by self-concept was measured by the Tennessee Self Concept Scale. In addition, locus of control was measured by the Nowicki-Strickland Internal-External Scale for Children. The results supported the contention that incest survivors demonstrated more negative self-concepts and external locus of control than did normative populations.

Cavaiola and Schiff (1989) conducted a research study which compared the self-concept of a group of physically or sexually abused chemically dependent adolescents against a group of nonabused chemically dependent adolescents and a group of nonabused, nonchemically dependent adolescents. The Tennessee Self-Concept Scale was administered to all subjects. "The abused, chemically dependent adolescents were found to demonstrate significantly lower self-esteem on all subscales when analyzed against these two comparison groups" (p. 327). The authors concluded that abuse, whether it be physical, sexual, or incestuous, has a long-lasting impact on self-esteem.

Neubauer (1989) measured self-concept (Tennessee Self-Concept Scale) and substance useage in four groups of adolescent girls. Fifty-eight percent of the girls in treatment for substance abuse reported sexual abuse in their history. The non-sexually abused girls (living in the community) scored the highest on self-concept. The sexually abused girls (living in the community) scored next highest. The non-

sexually abused substance abusers (treatment facility) scored next lowest, and finally the sexually abused substance abusers (treatment facility) scored the lowest on self-concept. Substance abuse was strongly correlated with self-concept in the sexually abused and non-sexually abused samples. In addition, severity of abuse and secrecy were shown to have a strong impact on self-concept in the sexually abused sample. For example, a subject who had experienced intercourse would have scored lower on the Tennessee Self-Concept Scale than a subject who had experienced fondling. A subject who had been threatened to secrecy would have scored less on the Tennessee Self-Concept Scale than a subject who was not threatened or coerced to secrecy by the offender. Severity of abuse and secrecy did not seem to have a relationship with substance usage.

Walsh (1986) measured the self-concept and sex-role orientation of adult female incest survivors who were involved in therapy. In addition, the study examined the resultant impairment produced by the molestation variables associated with the molest. Thirty-four control non-incest subjects were compared with thirty experimental incest subjects in the nationwide study. The Tennessee Self-Concept Scale was used to measure self-concept. The women with an incest history showed poor self-concepts as evidenced by diminished scores on the Total Positive Score and all subscale scores.

### Body Image

Another important task of adolescent development that sexual abuse disrupts is the consolidation of body image. O'Brien (1987) states that "One very important aspect of body image is the concept of owning one's body and the assumption of the responsible use of that body" (p. 89). This is damaged in the incest experience. The author reported from his study that the adolescent girl becomes aware that she is not



in control of her body, she has lost her power, and her body is not her own. As a result, her body image becomes fragmented.

Clark and Delson (1981) reported that the sexually abused girls in their study appeared to have poor body images. A therapeutic goal was to foster physical nurturing in non-threatening, non-sexual ways and to have them experience their bodies as capable of giving them pleasure without fear, violence, embarrassment, or sexual arousal.

Movement educators such as Cratty and Martin (1969) state that achieving competency in motor tasks can cause a person's body image and self-image to improve. Improving physical skills in a concrete way may help increase the ability to function at higher cognitive levels. This would lead us to believe that activities such as aerobics, sports, and dance and movement activities might be beneficial in improving body image for those who have been sexually abused.

### Sexuality

Maltz and Holman (1987) have discovered through research that sexuality is also significantly affected by the negative experience of sexual abuse. These problems with sexuality could include gender identity, types of sexual expression pursued and sexual preference. Sexual difficulties also encompass both extremes of the frequency continuum ranging from later avoidance of men and sexual activity to promiscuity and/or prostitution (Fromuth, 1986). Finklehor (1986) states that the effects on sexuality is the area in the long term effects of sexual abuse which receives the most attention in the empirical literature. "Almost all clinically based studies show later sexual problems among child sexual abuse victims, particularly among the victims of incest" (p. 159). Meiselman (1978) found a very high percentage of incest survivors reporting problems with sexual adjustment. Eighty-seven percent of her

subjects were classified as having had a serious problem with sexual adjustment compared to only 20% of the non-victim, women in therapy, control group. Courtois (1979) found that 80% of the incest survivors in her study reported an inability to relax and enjoy sex, an avoidance or abstinence from sex, or conversely, a compulsive desire for sex.

Langmade (1983) conducted a study with a group of women who had been incest survivors. The subjects were more sexually anxious, experienced more sexual guilt, and reported greater sexual dissatisfaction than did the control group of non-sexually abused women. If a child's sexual abuse lasts for a long time or the issues are unaddressed for years, many problems develop, such as depression, guilt, a sense of powerlessness and poor self-esteem. "These problems often lead to self-destructive activities such as alcohol and drug abuse, suicide attempts, and sexual relationships in which the woman continues to be victimized" (Maltz and Holman, 1987, p. 41).

### Drug and Alcohol Abuse

There is some empirical evidence that supports the claim that there is a connection between childhood sexual abuse and later substance abuse. McIntyre and Livingston (1984) state that past sexual abuse among alcoholic women appears to be disproportionately high. The authors stated that surveys conducted among Minnesota alcohol treatment centers show that 40% to 50% of the clients have been sexually abused. They have observed that alcohol helps to numb repressed feelings such as anger, fear, guilt, and shame, which survivors of sexual abuse experience. Therefore, sober sex often leads to emotional turmoil for these women. The authors explain further problems which sober sex may entail. Many of these women fear their first sexual experience while sober since many have never had sex without

drinking. Many of these women lack sexual decision making skills and assertiveness, and many may never have learned how to set limits or take control of lovemaking for their own pleasure.

Cavaola and Schiff (1989) state that "While alcohol and drugs may play a self-enhancing role in chemical dependency, it appears that for the abused chemically dependent adolescent, the self-enhancement or self-medicating role of these chemicals is short-lived. In these adolescents the chemical dependence is the first layer of defense; it must be removed before an attempt can be made to work through the repetitive trauma of abuse" (p. 333).

Skorina and Kovach (1986) believe that addressing the issues of sexual abuse is vital to the recovery process of alcoholism, especially if the person has been diagnosed Posttraumatic Stress Disorder (PTSD), delayed (DSM III Dx 309.81). "Although all alcoholics develop compulsive behaviors, incest victims seen in treatment for alcoholism often develop more extreme compulsive behaviors to cope with PTSD symptoms. If alcohol use abates, it is likely that other compulsive behaviors such as compulsive eating, gambling or sexual acting out might emerge to defend against the PTSD symptoms" (p. 19). In addition to a self-help group such as AA, therapy or counseling for the sexual abuse is very important. Along with these negative affects of sexual abuse, clinicians are seeing an association between sexual abuse and eating disorders such as obesity, anorexia and bulimia

### Eating Disorders

Sloan and Leichner (1986) state that the association between sexually traumatized individuals and eating disorders appears striking. They state that although sexual conflict has long been recognized in the pathogenesis of eating disorders, actual instances of sexual trauma or incest have been neglected in the

literature. In their study, a parallel is drawn between the psychological problems experienced by survivors of childhood sexual abuse and anorexia and/or bulimia. From the five case studies presented, the authors reported that their cases ascribed a crucial role to their previous sexual experience. Their conclusions were that the symptoms of eating disorders may permit the avoidance of painful memories and negative feelings associated with sexuality, or permit the avoidance of sexuality itself in all its manifestations (impulses, sexual activity, menstruation, adult sexual characteristics and adult sex-hormone levels).

The authors provide a concrete description of a client who dissociated herself mentally during a rape. Later, by identifying herself with her mind, and viewing her body as a foreign container of her "bad" sexual feelings, she attempted to make her body gradually disappear by starving herself. "Prior sexual abuse or incest may provide an explanation for some of the observed symptomology of eating disorders in many patients" (p. 659). The authors stress the importance of the use of therapy techniques which can unearth possible sexual abuse and provide therapy which will incorporate sexual abuse treatment into the treatment plan. Oppenheimer, Howells, Palmer, and Chaloner (1985) found that two thirds of 78 eating disordered patients reported adverse sexual experiences.

### Guilt and Shame

Guilt and shame are often experienced by those who have been sexually abused (DeFrancis, 1969; deYoung, 1982), yet, very few clinical studies have been conducted to assess the negative effect on survivors.

Bradshaw (1988) has coined the term "toxic shame" as being the most significant detrimental effect of sexual abuse (p. 50). Bradshaw differentiates between healthy shame and toxic shame. He describes normal shame as the emotion

which gives us permission to be human, helps keep us in our boundaries, shows us our limits, and is the psychological foundation of humility. Bradshaw states that sexual abuse generates intense and crippling shame and more often than not results in a splitting of the self (p. 21). Bradshaw explains that when a person is sexually abused, shame is transformed into a state of being, and the shame takes over the person's whole identity. When a person has shame as an identity then the person believes that his or her being is flawed. Once shame is transformed into a person's identity then it becomes toxic and dehumanizing (p. vii). The person will create a false self when he/she realizes that the true self is defective or flawed, and the person ceases to exist psychologically when he/she becomes a false self.

### Hostility or Aggression

Hostility is commonly referred to as feeling or showing enmity or ill will. Antagonistic is a word that is often used to refer to a hostile person. Aggression refers to hostile or destructive behavior or actions. It is clear that the meanings of these two words are closely related. Hostility is often the by-product of frustration and the high stress levels that frustration can produce.

Although infrequently mentioned in the literature, some authors (Kline, 1977; De Young, 1982; Mannarino and Cohen, 1986) cite hostility or aggression as a characteristic of those who have been sexually abused. Kline (1977) states that anger, hostility and fear of the consequences of sexual abuse, especially in adolescents, may prompt delinquent, hostile, and/or aggressive behavior toward both people and property (p. 21). Waterman and MacFarlane (1986) states that the daughter develops resentment towards the mother for not protecting her when incest has occurred within the family, and the daughter will most often develop hostile feelings towards the mother. Slater (1988) conducted a research study utilizing the

Theme Creation Test for Youths (TCTY), (Gallagher and Slater, 1982) in an attempt to develop a better means to identify and provide early intervention with sexually abused children. The TCTY is a projective instrument which utilizes storytelling and figures.

The two groups consisted of 18 sexually abused seriously emotionally disturbed children and 18 seriously emotionally disturbed children with no history of sexual abuse. The researcher decided that certain behavioral signs which are frequently mentioned in the literature on sexual abuse would be examined during the testing session, and hostility was one of the behavioral signs which she chose. The sexually abused children demonstrated hostility more frequently than did the nonsexually abused children although no statistical significance was found between the two groups for hostility. The majority of the children in the study were ages 5-7. It is the experience of this experimenter when working with children who have been sexually abused that few of the young children display hostile behavior. It is when the survivors approach puberty and adolescence that the hostile behavior develops. The reason for this could be that when the child is young he/she does not understand the sexual abuse and may even experience it as pleasurable. As the child becomes older and begins to cognitively understand that the sexual abuse was wrong, the child then begins to develop anger. Hostility is likely the behavior that is the result of that anger. Peters (1976) describes a case where there was a delayed development of hostility, and this case provides interesting insight into the long delayed effects of incest. He reported a case history where two daughters, aged three and six, were molested by their father and appeared to have been unharmed by the incest as children. Both girls became schizophrenic as adults, and the circumstances associated with their breakdowns suggested a link with the unresolved sexual abuse trauma. The younger girl developed a postpartum psychosis with the delusion that her father

was the father of her newborn child. The oldest daughter suffered an acute psychosis during her first serious relationship with a man and remained hostile to men as a group even while in remission.

DeFrancis (1969) conducted a study utilizing 250 families that were randomly selected from 628 families wherein sexual abuse had taken place. Hostile-aggressive behavior was identified in 143 of the 263 children involved in the study (55% of the total). The aggressiveness was directed towards the parents, and the hostility was shown in destructive behavior either at home or at school. Of the 143 children whose behavior was hostile, there was a clear indication that for 11% (16 cases), hostile behavior had not existed prior to the sexual offense. For the remaining 79 cases it was determined that the hostile behavior pre-dated the offense, but it could not be determined whether the hostile behavior became aggravated following the offense (p. 161).

In one of the most important studies in the field of sexual abuse (The Tufts Study, 1984), the aim of the research project was to systematically evaluate the signs of emotional distress relating to sexual abuse. The children's affective states were assessed using the Gottschalk-Gleser Content Analysis Scales that tap anxiety and hostility (p. 165). The measures were derived from 5-minute speech samples which were elicited from the child by the standard open ended request to tell a story about himself or herself. The level of anxiety and hostility expressed by the child was assessed through 5 scales: Total Anxiety, Hostility Directed Outward, (i.e., direct expression of hostile wishes or acts toward others), Hostility Directed Inward (i.e., self-blame, despair, and suicidal ideation), Ambivalent Hostility, (i.e., thoughts or fears of others harming the self); and Total Hostility (i.e., a sum of the three dimensions of hostility). Only 11 percent of the 7-13 year old group exhibited high levels of anxiety and 17 percent showed substantial self-directed hostility (Hostility

directed inward). However, 35 percent expressed high levels of anger towards others (Hostility Directed Outward) and 41 percent expressed concerns about harm from others (Ambivalent Hostility). On both of these dimensions, as well as Total Hostility, the sexually abused school-age children demonstrated higher scores than normative populations (p. 174).

In the 14-18 year old age group, the most prevalent stressful feelings among the adolescents were fears of being harmed (Ambivalent Hostility, 36% elevated) and overt anger (Hostility Directed Outward, 23% elevated). Only on Total Hostility did the adolescents have significantly higher scores than the normative population. In the pre-school group (ages 4-6) hostility levels were substantially elevated in 20-25% of the sample, but the group as a whole did not differ from children in the general population (p. 170). The researchers offer several conclusions for the findings in this study. In contrast to the low levels of serious emotional disturbances found in pre-school children (low hostility levels), severe psychological difficulties appeared to be quite frequent in the 7-13 year old school age group (high hostility levels).

The researchers hypothesize that the older children are more cognizant of the meaning of the sexual approaches, and this may explain the fact that they expressed more overt anger (Hostility Directed Outward) and fear of being harmed (Ambivalent Hostility). It would follow that the older adolescents who are at a higher level of cognitive development and are more likely to have been abused for longer periods of time ought to have responded more intensely to the sexual abuse. It was therefore surprising to the researchers that so few of the adolescent victims in this study exhibited severe psychopathology or high levels of hostility. In fact, the adolescents fell predominantly into the anxious, inhibited category. The researchers speculate that the survivors who began treatment in adolescence were similar to the anxious, school aged children when they were initially abused. In contrast, the children who



responded to sexual abuse during their earlier childhood with aggressive behavior might have been unlikely to reach a clinic such as the one where the study was conducted. The tendency for them to act upon their feelings might have led them to run away or to be placed in treatment settings for delinquent children before reaching adolescence.

The child who responds to sexual abuse at age 8 or 9 through destructive, acting out behaviors and receives no clinical intervention at that time may become the teenager who turns to prostitution, becomes a sexual abuser of children, or perpetrator of other illegal behavior (p. 184). The researchers believe that the findings from this study demonstrate how particularly important early intervention is to younger children who have been sexually abused, before their distress leads to more severe problems.

Meiselman (1978) conducted a study which took three years in order to gather the data on 58 incest survivors. Most of the information on the subjects gathered from this project was through interviewing and information given to the researcher from therapists working in the same facility. The intake reports of daughters who were survivors of incest and control patients were read and patient complaints were enumerated into categories. Twenty-four percent of the incest group reported hostility while 18 % of the control group reported hostility.

The author stated that most of the daughters felt that they had been victims of an all-powerful man who had "used them" sexually and betrayed them by failing to maintain his parental role, and that these feelings were responsible for kindling the hostility that some of them expressed towards men as a group (p. 216). In this study 60% of the incest survivors disliked their mothers, and 40% continued to experience strong negative feelings towards their fathers. Herman (1981) noted that the rage of the incest survivors in her study was often directed towards the mother, and she

observed that the survivors seemed to regard all women, including themselves, with contempt. In de Young's (1982) sample 79% of the survivors experienced predominantly hostile feelings towards their mothers, and 52% experienced hostile feelings towards their abusers.

Gordon (1955) suggests that sexual acting out or promiscuity that is often seen in survivors of sexual abuse is the result of hostility towards the parents. In Meiselman's study (1978), one of the subjects was a prostitute whose prostitution was not motivated by financial need but by a need for personal abasement and an expression of extreme hostility towards men. The author carefully points out that this case is an exception since most survivors who develop an extreme hatred for men usually avoid them altogether (pp. 233-234). In this study 64% compared to 40% of the control group, complained of having conflict with their husbands or fear of their husbands or sex partners, and 39% of the sample had never married. This supports the finding of Courtois (1979). In this study 79% of the sexually abused subjects experienced moderate or severe problems in relating to men, and 40% of the them had never married. It is apparent that the hostility which many survivors experience has an impact on their interpersonal relations.

Everstine and Everstine (1989) cite anger and hostility as one of the key symptoms of sexual abuse. "Children are rarely able to express their anger toward their assailant, and as a result it is often displaced onto others. However, in some cases (usually those that involve extrafamilial abuse) the child does find an opportunity to release his or her anger toward the abuser" (p. 17). The authors describe a case study of an adolescent survivor age 16 1/2 whose sexual abuse began at the age of 2 or 3. The client was argumentative and disruptive in her school classes, had used drugs extensively since grammar school, and in addition was an alcohol abuser. "She had a reputation for possessing an explosive temper, and she

had been thrown out of school several times for fighting" (p. 81). The client's mother reported tantrums and oppositional behavior began when she was about three years old. When the sexual abuse was disclosed, the client responded with some hostility towards her parents. When the client began therapy, she was angry and suspicious. The authors describe the client as using her anger to protect herself from experiencing other emotions.

Cohen (1983) states that the majority of cases of sexual abuse are disclosed by the daughter after she has left home and that the motive for the disclosure at this particular time is revenge and hostility towards the parents.

Bergart (1986) describes group therapy in depth with survivors of incest. She describes the hostility that survivors display during the various stages of group development. During the initial stage of group development, "Some women are so obsessed with hostile fantasies that they experience themselves as powerful, evil monsters; others split off their impulses and are intensely disturbed by occasional violent scenes flashing before their eyes" (p. 271). Members play out their fear of hostile feelings toward parental figures in later group stages. "Anger toward the therapist is expressed in poor attendance, emotional withdrawal, and self-destructive behavior" (p. 272). The author describes the primary transference that members enact with a female therapist. Members view the therapist maternally, and some see her as self-centered and neglectful, as a competitor for control of the group, or fear overwhelming her with their needs. "At some points, she is experienced as though she was the abuser" (p. 272). There is a real lack of trust for the group leader just as there is lack of trust in their mothers.

Ellenson (1989) addresses the incredible rage, anger, and hostility experienced by those who have been sexually abused. Rage engenders conflicts between the survivor's self-representation and ego ideal or superego. "Thus the

existence of rage and its attendant hostility is deeply repugnant to the survivor, painfully lowering self-esteem" (p. 593). This statement by the author is the only mention in the literature on sexual abuse that there may be a connection between hostility and low self-esteem.

Gans (1989) states that hostility is anger directed at another person and that it exists on a continuum from irritation to preoedipal rage. The author explains that hostility takes on special significance in group therapy where the members do not simply talk about their anger, they have angry relationships. He stresses the importance of the leader understanding the meanings and functions of hostility and the leader's willingness to serve as a lightning rod for it. The author stresses that along with all the negative aspects of hostility there are positive aspects of hostility that are often unappreciated and underestimated. "People who express hostility are not hopeless and have not given up. They are very much in the fray and their expressions of anger imply a future, maintain hope, and suggest that things can be different. By registering outrage at injustice, anger can initiate reform" (p. 505).

Hostility appears to be a common attribute in sexually abused adolescents, yet it may not be as negative an attribute as one might expect.

### Self-Injury

Favazza and Conterio (1988) define behavior that is self-injuring as cutting, self-abuse, self-mutilation, self-injury, para-suicide, and deliberate self-harm. "The most common self-injury behaviors include: cutting, burning, breaking bones, pinching the skin, ingesting, injecting and inserting foreign material, interfering with the healing process of wounds, punching, slapping, picking skin, and pulling hair" (Blume, 1990, p. 185). In the study conducted by Favazza and Conterio (1988), 49% of the self-injurers stated that they had been sexually abused and 45% stated that

they had been physically abused. Some experienced both kinds of abuse which explains the overlap. The researchers believe that self-injury may be a direct expression of self-blame. For example, one woman continually injured one of her hands and was finally able to share that she was attempting to destroy the hand that had been forced to touch a neighbor's penis. Some self-injurers inject urine or feces into their bodies as a demonstration of the desperate need to make sense of earlier experiences. Some self-injurers convert deeply rooted emotional pain to manageable physical pain. If a person lacks a capacity to express emotional pain in emotional terms, the person can express pain physically.

Blood-letting is a way that self-injurers strive for control. The predictability of being able to produce blood feels reassuring. The self-injurer's goal is to numb feelings. An intense emotional state precedes the self-injuring behavior. The injuring acts allow the person to escape from feelings that are too intense. The self-injurious behavior creates a state of numbness and the person feels in control once again. When referring to a client, Blume (1990) states that "cutting distracts her, relieves the tension and provides a kind of a hypnotic state or high" (p. 185). The self-injurer sees everything split into two parts which are either good or bad. This attitude affects everything he/she views in life. This all-or-nothing outlook is reflected in how a self-injurer might view a parent. If a self-injurer wants to view a parent as good, and bad feelings toward that parent emerge, the person would want to injure himself or herself. Self-injuring is an addictive behavior and is progressive. It results in highly manipulative behavior and many self-injurers get the attention that they cannot admit they need. Blume (1990) states the self-injurer's behavior must be stopped before the sexual abuse issues can be addressed in therapy.

Many times the self-injury behavior is rooted in guilt because the persons blame themselves for the incest. Therapy aimed at reducing the guilt is effective

although the therapeutic process may many times cause the survivor to have memories and flashbacks which will cause the self-injuring incidents to increase as the person tries to control the feelings. Many self-injurers are very angry people who do not know how to express their anger. "Their self-hate and hatred make their bodies the perfect object for the focus of their anger" (p. 188).

Shapiro (1987) believes that self-blame in survivors of sexual abuse is the psychic link to self-mutilating behaviors. The author states that "it is important to examine the dynamics related to the incest and bring to light the residue of self-blame within the victim" (p. 53). Therapeutic goals should therefore be designed to address these issues and resolve the self-blame in order for the victim to stop the destructive behaviors.

## CHAPTER IV

### TREATMENT

#### Problems in the Treatment of Adolescents

Everstine and Everstine (1989) clearly define the problems with the treatment of adolescents who have been sexually abused. "Adolescence is one of the most complex and turbulent stages of life. This difficult period can often try the patience of the wisest of adults to its limits. When a sexual trauma is introjected into this naturally problematic time, it can pose extremely complex questions for the therapist" (p. 66). The therapist must find ways to help the adolescent survivor resolve issues relating to his or her still-evolving sense of self as well as issues relating to his or her developing sexuality. The authors state that unresolved childhood trauma may cause an adolescent to experience a sudden behavioral change. A young person undergoes dramatic, cognitive growth. As a result, concepts that were once beyond a person's understanding suddenly come into focus. An adolescent of 14 may suddenly understand that what happened to him or her at six was sexual molestation and this in turn may create radical behavioral changes. Sexual trauma that was not revealed or resolved as a child can suddenly revive for the adolescent. "The overt symptoms often emerge quite rapidly, usually in conjunction with an adolescent awakening to the opposite sex, as well as to her own burgeoning sexual development" (p. 79).

Adolescent survivors of sexual abuse may resist therapy. Everstine and Everstine (1989) state that frequently an adolescent victim may refuse to admit that he or she needs help. In addition, an adolescent's self-destructive acting out or intense self-loathing may make it impossible for the adolescent to participate in a healthy,

constructive process such as psychotherapy. The guilt that the adolescent experiences may cause a resistance to treatment.

### The Treatment of Children

James (1989) believes that the most important consideration in the treatment of children who have been sexually abused is that healing is not likely to occur until the child has worked through the trauma. Repressing the experience leaves it available to surface and cause problems later. She refers to this as "returning to the pain" (p. 4). The author utilizes the Traumagenic States (Finklehor and Browne, 1986) for evaluating the impact of the trauma during assessment and for developing treatment plans. She compares the child's experiences and presenting problems against the characteristics of each of the traumagenic states. This allows the therapist to examine the specific dynamics of each child's situation and provide applicable treatment. The author believes that nondirective techniques are not effective in the treatment of these children. A straightforward approach using guided play, direct discussion, and an open, active approach is needed for the child. "Children cannot initiate discussion of matters that overwhelm them, or those they have hidden from themselves" (p. 11).

Walker and Bolkovatz (1988) describe play therapy in the treatment of children who have been sexually abused. The authors state that play therapy helps to facilitate the development of personal power which helps the child to move from victim to becoming a survivor. In addition, it helps the child to rebuild trust and personal efficacy which was lost through the abuse. "It teaches the child how to positively control his or her world again" (p. 268).



### Family Systems Approach to Treatment

Friedman (1988) describes a family systems approach to treatment. He describes the dysfunctional family unit as having confused roles, poorly defined intergenerational boundaries, and a problematic spousal relationship. Intervention goals therefore address the organizational and interactional aspects of the family system that both prompted and maintained the incest. There is still much controversy within the mental health field concerning the treatment approach used with incestuous families.

Giaretto (1980) has developed a treatment program which emphasizes initially providing individual treatment to the family members and then later proceeding to a more systems-based level of intervention. The family members attend individual therapy and group treatment based on their particular role within the family system. Marital and/or family treatment then occurs either following or simultaneously with their participation in their respective groups.

Treatment considerations within the family systems approach borrowed from Friedman (1988) include:

1. Resolution of the individual problem precipitants reflected in the perpetrator's belief system regarding intimacy, privacy, sexuality, self-esteem, independence, and children.
2. Resolution of the psychological trauma to the children created by the incestuous behavior.
3. Developing a more stable spousal relationship, which will be characterized by increased assertiveness, more clearly defined and realistic role expectations, resolution of conflicts associated with intimacy, developing more effective stability that will foster one another's independent functioning.
4. Attempt to assist the adults to become more adequate parents.
5. To facilitate the independent functioning of individual family members.

6. Assist the family in developing support systems in their external environment in order to help the family become less enmeshed.
7. The child victim of incest will need to learn to re-establish trust in both parents. (pp. 336-338)

### The Treatment of Offenders

Salter (1988) addresses the need for court mandated therapy for sex offenders. She states that rarely will a treatment center take a voluntary sex offender because few of them ever follow through with treatment. The author explains the high level of denial with sex offenders. The following summarizes some of the types of denial which must be dealt with in treatment:

1. Admission with justification.
2. Physical denial (Having an alibi).
3. Psychological denial (I'm not the type of person who would do this).
4. Minimizes the extent of the behavior.
5. Denial of seriousness of behavior and need for treatment.
6. Denial of responsibility of behavior. (Salter, 1988).

Treatment goals must address admitting that he committed the acts, describing the fantasy and planning involved, accepting responsibility, and accepting the seriousness of the behavior. Salter (1988) states that treatment for sex offenders usually involves family therapy, group therapy and behavioral techniques.

Family therapy addresses the nonsexual problems that the offender escapes from by sexually acting out. Group therapy addresses the cognitive distortions, destroys secrecy and breaks down the isolation characteristics of offenders. "Behavioral therapy decreases deviant arousal patterns and gives offenders tools for self-control" (p. 112). In addition, offenders need assertive skills training, social

skills training, and sex education training. Offenders should also have completed a course in relapse prevention which is beneficial for maintaining change in sex offenders.

Wolf, Conte, and Engel-Meinig (1988) describe the treatment for sex offenders at the Northwest Treatment Associates in Seattle, Washington. This facility has developed a treatment plan which is an alternate to incarceration. It is a multimodal approach to intervention. They begin with extensive evaluation to determine if the sex offender is safe enough to be treated in the community. Treatment planning involves control, treatment, and transition out of treatment. The offenders attend group, individual, and family therapy. Reentry is the final phase which includes a series of tasks which must be achieved before termination of treatment.

Perkins (1991) stresses the importance of determining the factors which led to the acquisition of sex offending and the factors which maintain the offending. The author describes treatment techniques with offenders who are institutionalized in England. Deviant interests are assessed by self-reports and then penile erection responses to this material are measured with a penile phethysmograph (PPG). This helps the offender to accept his sexual interest patterns and can also aid in monitoring treatment. Aversion therapy is another treatment technique where aversive stimuli such as electric shock or unpleasant smells is paired with responses to deviant imagery or thoughts. Covert sensitization is a technique where the offender images a scene that is relevant to his offending and then images an unpleasant consequence such as being arrested. The use of castration and anti-libidinal medication has also been used in the past in the treatment of sex offenders.

### The Incest Diversion Program

Another aspect of a family systems approach that has become a useful treatment alternative is The Incest Diversion Program (Kempe and Kempe, 1984). This program has now become a legal option for some offenders, particularly those who can benefit from a family systems approach.

The Incest Diversion Program was developed in order to:

1. Minimize the number of criminal filings on incestuous fathers.
2. Eliminate the need to have children testify about sexual assaults committed by their parents.
3. Alleviate, as much as possible, the trauma associated with the criminal justice system.
4. Allow immediate therapeutic intervention with family members to begin without being delayed by procedural obstacles.

The client must agree to :

1. Make payment for any expenses incurred in the therapy.
2. Make a commitment to attend therapy sessions prescribed.
3. Make a good effort to change.

This program offers the nonviolent, first time offender an opportunity to be diverted from the judicial process if the person is willing to undergo treatment and to follow through in the programs set up by professional counselors. If admitted, the person must commit to treatment which will probably last for two years. Criminal charges will be filed if the person does not complete the program. It seems that the knowledge of this program helps to overcome the reluctance to report incestuous activity and treatment helps to build a healthy family unit.

### Specialized Treatment Programs for Survivors

Salter (1988) reports that the increasingly widespread acknowledgment of the extensive problem of sexual abuse and acceptance of the fact that traditional forms of

therapy (verbal therapy) are not effective with those who have been sexually abused has led to specialized treatment programs which address the problems of sexual abuse with victims and offenders.

Therapeutic techniques and strategies which have proved effective with survivors of sexual abuse include Gestalt experiences, psychodrama techniques, humanistic psychology techniques, hypnosis, guided imagery, and the use of metaphor. Courtois and Sprei (1988) have also identified expressive therapies as being effective with this population. "Expressive therapies such as art, movement, music, and journal therapy provide a non-verbal, symbolic mode of communication. Expressive therapies surface unconscious material and can also circumvent inhibitions arising from defense mechanisms and injunctions to secrecy" (p. 299). Art therapy with sexually abused adolescents has been used often (Buck, 1981; Carozza and Heirsteiner, 1982; Naitove, 1985; Sidun and Rosenthal, 1987; Yates and Beulter, 1985). Art therapists have a valuable asset in being able to use their medium to assess sexual abuse even before it has been revealed by the persons themselves. This is achieved by determining specific incest markers that are common in sexually abused persons' artwork (Cohen and Phelps, 1985). Bergart (1986) describes the arts as providing many helpful tools for use in group therapy with incest survivors. "When group members have difficulty in describing their feelings, they are often able to draw pictures that vividly communicate their emotions" (p. 274). She describes role-play as an effective technique as a way to rehearse new behaviors such as assertiveness, setting limits, and working through family conflicts. Poetry and letter writing can be used to stimulate feelings and initiate minimally threatening discussion. The author also described "guided fantasy" as a technique to unblock disclosure and to free associate to a dream that a group member may have brought up (p. 274). Powell and Faherty (1990) describe a 20 session treatment plan which utilizes group process and

creative arts therapy with latency age sexually abused girls. The authors state that verbal communication can be difficult for sexually abused children who are often depressed, angry, stressed, or excited. "Communication through the creative arts therapies is now seen by many in the mental health field as the most appropriate and least stressful ways to assess and treat the sexually abused child" (p. 36).

Through these specialized treatment centers, the current need for research may begin to be addressed. Most published studies involving sexual abuse are quasi-experimental in nature, since it is rare to find an incest study that utilizes a control group (de Young, 1982). Most studies are case histories and are clearly subjective in nature. "Small sample sizes and unsystematic evaluations based on clinical impressions have been the norm in research in this field" (Tabor, 1984, DA852857). Fromuth (1986) reports a lack of empirical evidence regarding the consequences of the abuse and this is particularly evident in the knowledge of the long-term impact of the sexual abuse.

#### Music Therapy as a Therapeutic Treatment Modality

From a review of recent writings, music appears to be effective for therapeutic interactions with adolescents. "Music is viewed positively by teenagers since it is an important focus of the adolescent sub-culture. The nature of music as therapy is therefore non-threatening as compared to other forms of treatment" (Kivland, 1986, p. 9). Kivland sees the need for further exploration of music therapy to increase self-esteem in various adolescent populations. In her study, music therapy was an effective tool for increasing self-esteem in adolescents diagnosed as conduct-disordered. Michel and Farrell (1973) investigated whether or not the learning of simple musical performance skills would affect self-esteem in fourteen elementary school-aged black students who were identified as having poor self-esteem. They

determined that skill development in music may be important in increasing self-esteem for the disadvantaged student who has problems. Music therapy was determined to be effective in increasing the self-esteem of juvenile delinquents, while reducing rebellion and distrustful characteristics (Johnson, 1981). Henderson (1983) conducted a study which measured awareness of mood in music, group cohesion, and self-esteem among hospitalized adolescent patients. He used an experimental and control group. The Coopersmith Self-Esteem Inventory was the instrument used to measure self-esteem. Significance was not achieved for scores on self-esteem and group cohesion, but significance was achieved on exact choices of adjectives used to describe recorded compositions, and on the number of pronouns used to express group feeling (p. 20).

Research performed by Cassity (1976) revealed significant gains in peer acceptance as a result of participation in a valued group music activity (guitar lessons) in a hospital setting. He observed that "subjects receiving the highest status also possessed the greatest musical skill" (p. 73). This implies that the degree of socialization achieved within the hospital is an important factor for the success of clients in the therapeutic community. Therefore, acquisition of musical skill can contribute to the success of clients in therapy. His research suggests that activities enhancing interpersonal relationships should be fostered and that music therapy has a significant influence on group cohesiveness. Naitove (1985) wrote a special project article on a national symposium on child molestation which was sponsored by the U.S. Department of Justice in Washington, D.C. in October of 1984. "Music was mentioned mostly as a facilitator of movement activities and group cohesiveness" (p. 116).

Sears (1968) emphasized the adaptability of music at many different levels to become uniquely versatile for structuring situations which can lead to feelings of

pride. Feelings of pride imply a positive self-concept. Michel and Martin (1970) conclude from their study that "the development of musical skill may be an aid in increasing the self-esteem of disadvantaged problem students, and consequently may generalize to increased self-confidence in other tasks" (p. 127). Ficken (1976) identifies the music therapist's problem of not being able to find suitable song material for sessions. He describes using the tool of song writing within these sessions in order to focus group members on individual therapeutic goals and to facilitate group process and unification (cohesiveness). Mark (1986) worked with adolescents on the issues of drug abuse with the premise that drugs and rock lyrics were closely interrelated with their own behavior. Discussing lyrics and issues encourages adolescents to consider alternative ways of coping with daily pressures, rather than resorting to the behaviors of withdrawal or aggression as is often seen in society today. Song lyrics were used in Mark's (1986) study to explore issues within songs and their relationship to her clients' lives, and also as a vehicle to encourage communication within the group. Ragland and Apprey (1974) used interpretation and discussion of lyrics as a specific goal while working with a 22 member adolescent group.

Clendenon-Wallen (1991) discovered an increase in self reported indicators of self-confidence for sexually abused adolescents following music therapy intervention. Two music therapy activities were used for each of the twelve weekly sessions. These activities included song writing, "rap" writing, song discussion, and musical improvisation. In addition, art, movement and relaxation were used with background music. The music therapy activities gave the clients opportunities to express themselves non-verbally and the activities were less confrontive than traditional group therapy techniques. The clients' self-confidence increased as they were given opportunities to try new experiences in a supportive environment. The music therapy



activities were especially effective for keeping the group members interested in coming to group and as a result there was very little absenteeism.

Although the research literature is sparse, there is enough evidence of music's ability to increase self-confidence and self-esteem to warrant further research. The behavior of self-confidence is a direct result of a person's self-concept and self-esteem. Considering evidence of the positive benefits of music on the self-concepts and self-esteem of adolescents, music's function to enhance group cohesiveness, and the importance of music to the adolescent peer culture, it appears that music therapy can be an important therapeutic element in group therapy with sexually abused adolescents.

### Research Hypotheses

Hypothesis 1: There will be no difference in post-test scores between the two groups on the Buss-Durkee Hostility Inventory.

Hypothesis 2: There will be no difference in post-test scores between the two groups on the Self-Confidence Core.

Hypothesis 3: There will be no difference in pre- to post-test gain scores on the Buss-Durkee Hostility Inventory or the Self-Confidence Core between the two groups.

Hypothesis 4: There will be no difference in the pre- to post-test subscale scores on the Buss-Durkee Hostility Inventory between the two groups.

Hypothesis 5: There will be no correlation between hostility and self-confidence scores for all subjects.

## CHAPTER V

### METHODOLOGY

#### Subjects

This study is concerned with intrafamilial incest wherein the sexual abuse involves family members since all the survivors in the study were sexually abused by family members.

The subjects in this study were two groups of randomly selected sexually abused adolescent girls ranging in age from 14-17. The subjects had all been molested over a period of time either by a father, step-father, and in one case a step-grandparent. The subjects had all been diagnosed with Post-Traumatic Stress Disorder.

The No-Music Therapy Group had two members who were white and one member who was bi-racial. The four members of the Music Therapy group were black. There did not appear to be any differences among the subjects which could be attributed to race.

There were four members in the experimental group (music therapy group) and three members in the contact control group (the no music therapy group). There were originally 7 members in the experimental group and 6 members in the control group. The subjects had to attend 9 of the 12 sessions in order to be included in the study. Several group members dropped out and the remainder of the subjects attended sporadically and could not be included in the study.

Music Therapy Group

KL: This subject was a 17 year old black female. She had been sexually abused by her natural father since the age of 11. The sexual abuse progressed from back rubs to body massage and over the years involved masturbation and oral sex. The subject and father both denied that intercourse had taken place. The father was in treatment at the sexual abuse center. He lived away from the home and the subject stayed off and on in the home with the mother and two brothers. The subject had a poor relationship with the mother and did not communicate with her in any way. The subject had a severe case of anorexia and extremely poor self-esteem as evidenced by complete lack of assertiveness of any type, flat affect, no eye contact, and poor posture. She appeared very child-like and much younger than her actual age.

DB: This client was a black, 15 year old female. The subject reported being molested (touched in her private areas) at the age of 11 by a step-grandfather when visiting her grandmother one summer. She also stated that she had been sexually abused by her cousins and that no one knew about this. She was not ready to share the details. The subject had no problems asking others in the group questions, but she had a great deal of difficulty sharing anything personal about herself. The subject was obese, very outgoing and talkative. She appeared more mature and more like a 17 year old than a 15 year old. The subject reported that she could not get along with her mother, and at the time of the group she was living in foster care.

MN: This client was a black 14 year old female. She was sexually abused by her natural father, who was in the Air Force. Apparently, the subject had lived with her father from ages 1-8, then lived with her grandmother for two years and then returned to live with father at age 11. The sexual abuse involved oral copulation

which she stated was "done to me only", vaginal and/or anal intercourse several times daily, often in the van in the driveway or in the subject's bedroom at night. The subject stated that the sexual abuse began when she was 14 and when her stepmother became pregnant. The stepmother took a vacation to visit some relatives and the sexual abuse began then. The sexual abuse continued for several months until the subject became pregnant. The subject, being just a child herself did not know she was pregnant. Finally, it was discovered when she was 4 months pregnant and an abortion was performed. The sexual abuse history is more in depth with this subject because she had to give a deposition to the prosecuting attorney and much preparation in individual sessions had to be made in order to prepare her to disclose the details. There was little time for the details of her sexual abuse to come out in a natural and timely disclosure. Unfortunately, many individual sessions were spent literally trying to pull the information from this client who was mostly non-verbal and quite closed off and shut down. The subject was completely withdrawn, almost catatonic-like when she began the group. She had extremely poor self-confidence and lack of self-esteem as evidenced by poor posture, poor hygiene, no eye contact and no ability to express herself in any way. This subject was truly one of the most severely damaged survivors ever witnessed by this experimenter. She was extremely thin and possibly had an eating disorder, although this had not been diagnosed. The subject appeared to be very depressed and did not seem to have the energy to lift one foot in front of the other. She was listless, never smiling, and had completely flat affect. During the course of the group it was revealed in individual therapy that this subject was being molested by one of her brother's friends who stayed overnight on occasions. She had no boundaries or assertive skills to stop him. She said that she would lay there and let him do whatever he wanted to her body and would just keep hoping it would be over with soon. Needless to say, the

next critical individual sessions dealt with assertive skills and boundary work. The stepmother was instructed to not allow the friend of the brother to come into the home again.

LJ: This subject was a 17 year old black female. She was sexually abused by her step-father. The sexual abuse was extensive, involving intercourse, and had continued for several years. The subject was living in a foster home. She appeared very hostile. This subject was the typical text book survivor of sexual abuse. She had a very dysfunctional mother who the subject reported would sit at the TV and play Atari games for the entire day. The subject performed all the duties that the mother should have been doing. She was the total caretaker for two younger half-brothers. She did all the cooking and cleaning and bathing of the children. In addition, she filled in for the mother as a sexual partner for the step-father. The subject had a history of extreme physical and emotional abuse at the hands of the mother when she was a small child. She had refused to prosecute the step-father and he was still living in the home with his wife and two sons. The subject had anorexia, but had not been hospitalized for the disorder. The foster parents kept a close watch on her eating patterns.

#### No Music Therapy Group

AC: This subject was a 14 year old white female. She had been sexually abused by her natural father for many years. The sexual abuse consisted of holes in the bathroom door and walls so that he could view her and her sisters while bathing. The subject stated that he had fondled her breasts on several occasions but that he had not gone farther. It was the opinion of this researcher and other mental health workers at the agency that this client had experienced much more extensive sexual abuse than she would disclose. She may have blocked the memories from her

consciousness or she may have chosen not to disclose in order to keep from feeling the pain. The subject was sexually promiscuous. She was very distant from mother and refused to communicate with her in any way. The sexual abuse was disclosed by her younger sister who was only 8 years old. The father had raped the young child on the couch in the living room during Saturday morning cartoons while the grandmother was in the next room at the table reading the paper. The father was sent to prison shortly after the family began therapy at the agency.

HC: This subject was a 17 year old white female, sister to the above mentioned subject. She too was molested by the father, but again was reluctant to disclose details of her sexual abuse. This subject was sexually promiscuous but tended to have sex with a steady boyfriend. She could not be without a boyfriend and after breaking up with one would be going steady with another within a day or so. This subject was very quiet and reserved. In addition, she had flat affect and appeared emotionless and expressionless most of the time. Her entire identity appeared to be tied to her sexuality. She was not taking any kind of birth control until near the end of the group.

DS: This subject was a 17 year old, bi-racial female who was about 6 months pregnant when the group began. The mother had been quite dysfunctional, and she had two younger children aged 5 and 7 who had been sexually abused and were in treatment at the sexual abuse center. The mother also was a victim. The subject had been sexually abused by a step father and the abuse had included intercourse and had taken place between the ages of 11 and 14. She had been sexually active from the age of 14 and appeared much older than her age. She worked very hard at a job and was determined that her baby would have a better life than she had. She was always very clean and neatly dressed, and at times her appearance seemed to be obsessive (Every hair in place, perfect nails and etc.).

## Setting

The adolescent support groups were held at a sexual abuse center. The music therapy group met on Mondays from 5:00 to 6:30, and the no-music therapy group (contact control) met on Wednesdays from 5:00 to 6:30. The groups met in the music therapy room which was a large room equipped with tables, folding chairs, a blackboard and a large open area for movement and dancing. All of the subjects were also involved in individual therapy at the sexual abuse center. The philosophy of the sexual abuse center was humanistically oriented and upheld the belief that the entire family system must receive treatment in order for the survivor or the offender to recover. The center provided individual and group therapy for survivors, offenders and non-offending family members. Most of the offenders had been admitted into The Incest Diversion Program (Kempe and Kempe, 1984). The subjects in this study were randomly assigned to the experimental and control groups.

## Instruments

The 34-item core of descriptors pertaining to self-confidence was extracted from the 300-item Adjective Check List (Gough and Heilbruh 1983) (See Appendix A). This core of descriptors contains 20 indicative items and 14 contra-indicative items of self-confidence. The Adjective Checklist is set up with various cores which pertain to self-confidence. The self-confidence core was taken exactly as it appears in the test. The items were converted to a Likert Scale and randomly arranged.

The Buss-Durkee Hostility Inventory (Buss and Durkee, 1957), (See Appendix B) was used to measure pre- and post-test levels of hostility. This is a 66-item true/false questionnaire that includes seven subscales: negativism, resentment, indirect hostility, assault, suspicion, irritability, and verbal hostility.

A Music Survey (See Appendix E) was administered in order to gain information on the musical tastes and musical experiences of the subjects.

### Materials

Materials used in the experimental group were guitars, keyboards, an electronic drum machine, records and record player, art supplies, and percussion instruments. No music materials were used in the contact control group.

### Procedure

The music therapy group sessions consisted of check-in time, when subjects related how their week had gone. Emphasis was on sharing any crises which they may have had during the week. Two music therapy activities followed (See Appendix D). These activities included song or "rap" writing with rhythm playing, song discussion or improvisation, lyric analysis, movement to music, and art and music activities.

Other activities were used to foster non-threatening, non-sexual, and nurturing touch, providing an opportunity for the group members to expand their experience of touch beyond the sexual arena. Background music was used for these activities. Activities combining movement and music were used to assess and address issues related to body image. Relaxation and imagery were used with background music to explore issues of personal boundaries and resolution of anger. Sexual issues and promiscuity were addressed through song discussion and sex education literature.

Snacks were served during the group as a nurturing technique. A check-out period was included at the close of each session. The subjects had the opportunity to share how they felt about the group and the issues that were brought up in the session. They were asked to suggest topics for further group discussion.



The contact control group (No Music Therapy) was assigned the same issues as the experimental group (Music Therapy Group) for each weekly session, the difference being that the contact control group relied primarily on verbal and traditional therapeutic techniques, with the exception of a few art activities. No music of any type was used during these sessions.

There was a co-leader for the groups who was a trainee at the sexual abuse center. The co-leader mainly observed and because of her lack of experience chose to keep a peripheral position with not much input into the group. She did write the chart notes for the subjects.

The groups were closed and no new members were allowed to join until after the study was terminated.

#### Procedure for Informed Consent

The procedure for informed consent for the subjects was the same for the music therapy group and the contact control group. Each prospective group member was approached by her individual therapist during an individual session. The purpose of the group was explained and the random selection was explained to each prospective member. If the person agreed to participate in one of the groups, she was given an assent form to sign immediately and was given a consent form to take home to the parent or legal guardian to sign. She was asked to bring this signed form to the first meeting (See Appendix C).

#### Data Organization

By converting the Self-Confidence Core to a Likert Scale, a total score of self-confidence was obtained (See Appendix A). This alleviated the statistical problem of dealing with indicators of self-confidence which were expected to increase and contra-

indicators of self-confidence which were expected to decrease. In addition, the Likert Scale gave the subjects more options than the check list offered. Many of the subjects in the prior study (Clendenon-Wallen, 1991) appeared to have difficulty checking a category stating that the choices were either totally one way the other. Most of the subjects stated that they were somewhere in between and were reluctant to check a category. The conversion to a Likert Scale gave them more options and therefore should have assessed their self-confidence more accurately.

In order to investigate differences in scores between the pre- and post-tests and between groups for the Self-Confidence Core, a Repeated Measures Analysis of Variance was conducted. Self-confidence scores served as the dependent variable in the model with pre- or post-test being one factor and music therapy or traditional verbal therapy being the other. The analysis also considered the interaction between these two factors.

Similarly, differences between overall scores for pre- and post -tests and for groups on the Buss-Durkee Hostility Inventory were explored using a Repeated Measures Analysis of Variance (See Table 3, p.66). The only difference between this model and the previous model was the dependent variable which in this case was the overall Buss-Durkee score. A different approach was used to examine the Buss-Durkee Hostility Inventory subscores (See Appendix B). For this aspect of the analysis, the Wilcoxon Two-Sample Test was employed. A test for significant differences between groups for each subscale was calculated using the difference between pre- and post-test scores. Hence, seven tests were examined. The Pearson Correlation Coefficients test was used to determine if there was a relationship between low self-confidence and high hostility levels for the subjects in both groups.

Implementation of treatment (week by week session procedures of Music Therapy and No Music Therapy Groups) can be found in Appendix G.

## CHAPTER VI

### RESULTS

This study investigated the effects of music therapy when treating adolescent female survivors of sexual abuse. The data were collected from a small sample of seven individuals, four of whom received music therapy while the other three received traditional or no-music therapy. Two instruments were used to evaluate the effects of the two methods of treatment. The Buss-Durkee Hostility Inventory was one of the tools utilized (See Appendix B). This particular instrument contains the following seven subscales: Negativism (NE), Resentment (RE), Indirect Hostility (IN), Assault (AS), Suspicion (SU), Irritability (IR), and Verbal Hostility (VE). An overall score was calculated by summing the values from the subscales. Buss and Durkee have determined scores that are considered high for each of the subscales and the overall score. Scores that fall in the high range might indicate levels of hostile feelings that could cause problems. Also used was the Self-Confidence Core from the Adjective Checklist (See Appendix A), with a single score ranging from 34 to 170. Although there was no specific break-off point for determining a high score, higher scores implied higher levels of self-confidence. Regardless of the type of therapy received, each person was evaluated by both instruments before and after treatment. Groups were not matched and each subject was randomly selected for either the Music Therapy Group or the No Music Therapy Group.

## Summary of Hypotheses and Corresponding Results

### Hypothesis 1

There will be no difference in post-test scores between the two groups on the Buss-Durkee Hostility Inventory.

### Hypothesis 2

There will be no difference in post-test scores between the two groups on the Self-Confidence Core.

The first discussion concerns Hypotheses 1 and 2, above. One statistical model was used which addressed both hypotheses. This model (Repeated Measures Analysis of Variance) was chosen because the repeated measures made on each subject (each person took four tests) had to be taken into account.

A table of means (medians in parenthesis) for each treatment-test combination has been created (see Table 1, p. 64).

A formal assessment of the data was obtained by using a repeated measures ANOVA which accounted for four test scores per subject. The results of this can be found in Table 2, p. 65.

If there is any difference in mean test scores for the treatment-test combinations then the test of hypothesis for interaction (type\*test) and/or the test of hypothesis for type of therapy (type) should be significant. However, neither of these results are significant (For interaction,  $F = 0.21$   $p = 0.8899$ , with 3, 15 df; for type of therapy,  $F = 1.13$ ,  $p = 0.3365$ , with 1, 5 df).

A significant difference was found for the four test means ( $p = 0.0001$ ) but the difference lies between the Buss-Durkee scores and the Self-Confidence scores. Since the scales of the two tests differ so dramatically this result is of no practical use.

The ANOVA provides convincing evidence to accept Hypotheses 1 and 2.

Table 1

Means (Medians in Parenthesis) for Each Treatment Test Combination:  
BD - Buss-Durkee Hostility Inventory,  
SC - Self-Confidence Core

Type of Test	BD PRE	BD POST	BD DIFF
Music Therapy Group	27 (21)	24(23.5)	3 (1)
No Music Therapy Group	47.3 (48)	34 (35)	13.33 (6)

Type of Test	SC PRE	SC POST	SC DIFF
Music Therapy Group	114.25 (114)	121.25 (123)	-7 (-5.5)
No Music Therapy Group	124.33 (126)	128.67 (129)	-4 (-3)

### Hypothesis 3

There will be no difference in pre- to post-test gain scores on the Buss-Durkee Hostility Inventory or the Self-Confidence Core between the two groups.

Hypothesis 3 requires an explanation. In order to determine the outcome of this hypothesis, the difference between pre- and post-test scores for each subject and for each of the two tests (Buss-Durkee and Self-Confidence) must be determined. In addition, each subject falls into one of two treatment groups (Music Therapy and No Music Therapy). Therefore, two comparisons must be made: between the two treatment groups for Buss-Durkee and between the two treatment groups for Self-Confidence.

Table 2

## General Linear Models Procedure

Type = Type of therapy (Music Therapy or No Music Therapy)

Test = Means of 4 tests (pre-, post-test Self-Confidence Core, pre-, post-test Buss Durkee Hostility Inventory)

Type \* Test = Interaction of Buss Durkee Hostility and Self Confidence Core.

Tests of Hypotheses using the Type III MS for ID (Type) as an error term

Source	DF	Type III SS	Mean Square	F Value	P > F
<b>Type</b>	1	980.583333	980.583333	<b>1.13</b>	<b>* 0.3365</b>

\*  $p > .05$

Tests of Hypotheses using the Type III MS for ID (Test) as an error term

Source	DF	Type III SS	Mean Square	F Value	P > F
<b>TEST</b>	3	55275.89129	18425.29676	<b>68.04</b>	<b>* 0.0001</b>

\*  $p < .05$

Tests of Hypotheses using the Type III MS for ID (Type • Test ) as an error term

Source	DF	Type III SS	Mean Square	F Value	P > F
<b>TYPE•TEST</b>	3	168.20238	56.06746	<b>0.21</b>	<b>* 0.8899</b>

\*  $p > .05$

The following are the results of the two tests:

Comparisons of pre- to post -test gain scores from the ACL Self-Confidence Core and the Buss-Durkee Hostility Inventory are presented in four tables which identify the experimental (Music Therapy Group) and the contact control group (No Music Therapy Group), (See Tables 3-6, pp. 66-67).

This hypothesis was tested by using a Wilcoxon Rank Sum test for each of the tools; Buss-Durkee and Self-Confidence. This involved finding the pre- and post-test differences (By subtracting the pre - post), ranking the differences and

summing the ranks for one therapy type. This is the same test which is used later to determine significance in the Hostility Inventory subscales.

Table 3  
Self-Confidence Scores and Differences:  
Music Therapy Group (n=4)

Subject	Pre-Test	Post-Test	Differences
LJ	137	144	-7 (2.5)
MN	91	95	-4 (4)
KL	85	102	-17 (1)
DB	144	144	0 (7)
			Total: 14.5

Table 4  
Self-Confidence Scores and Differences:  
No Music Therapy Group (n=3)

Subject	Pre-Test	Post-Test	Differences
DS	146	153	-7 (2.5)
HC	126	129	-3 (5)
AC	101	104	-3 (6)
			Total: 13.5

If each test of hypothesis is done at a level of significance of 0.05 the sum of ranks must be more than 17 or less than 7 to conclude that a difference exists. The sum of ranks for the two tests did not fall in the rejection region and therefore it is concluded that there was no difference in pre- to post-test gain scores on the Buss-

Durkee Hostility Inventory or the Self-Confidence Core between groups. Therefore, Hypothesis 3 must be accepted.

Table 5

Buss-Durkee Scores and Differences:  
Music Therapy Group (n=4)

Subject	Pre-Test	Post-Test	Differences
LJ	47	33	14 (6)
MN	21	16	5 (4)
KL	19	23	-4 (1)
DB	21	24	-3 (2)
			Total: 13

Table 6

Buss-Durkee Scores and Differences:  
No Music Therapy Group (n=3)

Subject	Pre-Test	Post-Test	Differences
DS	39	35	4 (3)
HC	55	49	6 (5)
AC	48	18	30 (7)
			Total: 15

#### Hypothesis 4

There will be no difference in the pre- to post-test subscale scores on the Buss-Durkee Hostility Inventory between the two groups.



A different method of analysis was necessary to examine the Buss-Durkee Hostility Inventory subscores. For this part of the investigation, the difference between each individual's pre-therapy score and post-therapy score on each subscale was computed and is in Appendix F, Chart 1. These values were used in the Wilcoxon Two-Sample Test to determine if there exists a significant difference between the means of the differences between pre- and post-test scores for the two treatment groups. This nonparametric test requires ranking the differences from smallest to largest with ties given the mean of the ranks that would usually be assigned if the values for the observations were unique. The results of the ranking procedure are also found in Appendix F, Chart 1.

According to data collected by Buss and Durkee (1957), most people score below 38 in terms of total hostility on the Buss-Durkee Hostility Inventory (1957), with women scoring slightly lower than men. More important than an overall score of less than 38 are the seven categories and what constitutes a high score for each of them.

The following is a list and explanation of the seven categories of hostility which are examined in the inventory:

#### NE NEGATIVISM

High Score: 4 and above

Negativism usually is oppositional behavior against authority. It involves refusing to cooperate and can be seen in behavior that can range from passive noncompliance to open rebellion against rules or conventions.

#### RE RESENTMENT

High Score: 4 and above

Resentment involves being jealous of others, often to a level of hatred. It is often a feeling of anger at the world over real or imagined mistreatment.

#### IN INDIRECT HOSTILITY

High Score: 6 and above

Indirect hostility involves behavior that directs hostility toward someone in a roundabout way. It can be devious in that, through malicious gossip or

practical jokes, the hated person receives the hostility but cannot do much about it. Other indirect behaviors, such as door slamming and temper tantrums, allow a person to discharge general feelings of hostility that may not be directed against anyone in particular.

#### AS ASSAULT

High Score: 6 and above

Assault involves actual physical violence and the willingness to use physical violence against others. It is usually seen in fights with other people rather than in the destruction of objects.

#### SU SUSPICION

High Score: 4 and above.

Suspicion involves the projection of hostility onto others. It can vary from being distrustful and wary of others to serious beliefs that other people are planning one harm.

#### IR IRRITABILITY

High Score: 8 and above

Irritability is a readiness to explode at the slightest provocation. It may be seen in behaviors such as quick-temper outbursts, grouchiness, and rudeness.

#### VE VERBAL HOSTILITY

High Score: 9 and above

Verbal hostility involves the expression of negative feelings verbally to others, both in what is said and in how it is said. It can be seen in the verbal styles of arguing, shouting, and screaming, and in the verbal content of threats, curses, and overcriticism.

Comparisons of pre- to post-test scores from the Hostility Inventory are presented in two tables which identify the experimental (Music Therapy Group) and control group (No Music Therapy Group). (See Tables 3 and 4, p. 66).

The procedure for each subscale test can be outlined in this manner:

$H_0 : u_1 = u_2$  the means of the differences for the treatment groups are equal

$H_1 : u_1 \neq u_2$  the means of the differences for the treatment groups are not equal

level of significance :  $\alpha = 0.10$

rejection region :  $u = 0$


$n_1 = 3$


$n_2 = 4$

Table 7

Hostility Inventory Scores Subcategories:  
Music Therapy Group (n=4)

CATEGORIES OF HOSTILITY														
SUBJECT	NE		RE		IN		AS		SU		IR		VE	
KL	1	1	4	3	2	4	1	0	7	6	2	7	2	2
MN	2	1	6	5	0	0	4	3	5	4	1	1	3	2
DB	1	0	4	3	2	1	5	4	5	5	1	4	3	7
LJ	5	5	5	1	5	8	8	4	5	1	9	8	10	6
	PRE TEST	POST TEST	PRE TEST	POST TEST	PRE TEST	POST TEST	PRE TEST	POST TEST	PRE TEST	POST TEST	PRE TEST	POST TEST	PRE TEST	POST TEST

 Indicates high score\* on pre-test

 Indicates high score\* on post-test

\* See description of categories (p. 70) for what determines a high score


Along with the frequency tables, the means and standard deviations for all of the above test results are listed in Appendix F, Chart 2.


Since none of the test statistics,  $u$ , are equal to the critical value of 0, there is not enough evidence to reject the null hypothesis for any of the seven tests. Therefore, one can not claim a significant difference in the means of the differences for the two treatment groups for any subscale. Hypothesis 4 must be accepted.

Table 8

Hostility Inventory Scores Subcategories:  
No Music Therapy Group (n=3)

CATEGORIES OF HOSTILITY														
SUBJECT	NE		RE		IN		AS		SU		IR		VE	
AC	5	3	7	8	7	8	10	7	9	6	6	8	11	9
HC	2	2	8	0	7	3	8	2	7	1	7	5	9	5
DS	2	2	4	3	3	3	8	8	9	8	7	6	6	5
	PRE TEST	POST TEST	PRE TEST	POST TEST	PRE TEST	POST TEST	PRE TEST	POST TEST	PRE TEST	POST TEST	PRE TEST	POST TEST	PRE TEST	POST TEST

 Indicates high score\* on pre-test

 Indicates high score\* on post-test

\* See description of categories (p. 70) for what determines a high score

### Hypothesis 5

There will be no correlation between hostility and self-confidence scores for all subjects.

Hostility and Self-Confidence scores for all subjects can be found in Tables 3-6 (pp. 66-67).

A Pearson Correlation Coefficients Analysis was conducted and no correlation was found for either the pre-test or post-test scores (Pre-Test:  $r = 0.27475$  and  $p = 0.5510$ ), (Post-Test:  $r = 0.12766$  and  $p = 0.7850$ ). Hypothesis 5 was accepted. The results of this analysis can be found in Appendix F, Chart 3.

In summary, none of the five hypotheses set forth in this study were rejected. However, the subject sample was extremely small and differences could have been apparent with a larger subject sample.

### Survey

The Music Survey was given to both groups on the initial session. The subjects responded to the Music Survey (Appendix E) by listing favorite songs such as; "A Piece of my Love", "Every Rose has a Thorn", "Straight Up", "The Way you Love Me", "I'll Be There For You", "Imagine", "Never Say Good-bye", "Congratulations", "Whip Appeal", "Fantasy", and "Let Go". Favorite Musical Groups included Bon Jovi, Ozzy Osborne, Led Zeppelin, Stevie Nicks, Def Leppard, Poison, Guns n' Roses, UB40, Vixen, Europe, Bardeaux, Vesta, and Baby Face. Favorite styles of music included rock, reggae, rap, and blues. All respondents except one stated that they liked to dance. All respondents stated that they liked to sing. When asked what they used music for, entertainment, fun, enjoyment and relaxation were the responses. Three of the seven subjects said that they had taken music lessons and two stated that they had performed in musical groups. Only one subject had a parent that played a musical instrument. The information from this questionnaire was helpful for planning the music therapy activities at least for preference of musical styles.

## CHAPTER VII

### DISCUSSION

Even though the results of this study were not significant, important changes occurred and notable observations were made. Since the treatment of sexual abuse is a new area of research, this information may benefit researchers and clinicians. In addition, this study contributes to the research literature in the field of music therapy.

#### Music Therapy Group

KL scored a very low 85 out of a possible 170 points on her pre-test for self-confidence (See Table 1). Her hostility inventory pre test showed a very high score in the suspicion category, and she also scored high in the resentment category (See Table 3). The subject had a severe case of anorexia and nearly died before this experimenter was able to get her hospitalized in a special hospital for eating disorders (When this crisis arose, the subject rejected her individual therapist and was only willing to talk to and cooperate with her group leader, which was this experimenter). She had tried to kill herself on several previous occasions by refusing to eat for days and almost dying. The subject stated to her individual therapist that she was too scared to kill herself any other way and that this path to suicide was her only option. Her participation in the first six weeks of group consisted of her slouching on the table and refusing to participate in any way. She refused eye contact with anyone, yet she was listening closely as one could see reactions in her facial expressions to things that were going on. Following the hospitalization, the subject began to open up and participate more in group. She was given much support by the group with phone

calls, drawings and cards sent to her. This seemed to bond her with the group and she was able to trust more when she returned. The excellent intensive therapy she received at the hospital was certainly beneficial.

DB scored 144 out of a possible 170 on the self-confidence questionnaire pre test (See Table 1), and she scored the same post-test. She did not appear to be very hostile as evidenced by her scoring high only on the suspicion category and resentment category of the hostility inventory (See Table 3). During the course of the group she came in one week with a lot of bruises on her face and arms. She reported that the caretaker had beat her up a few days previous. This experimenter was able to get children's services to remove her from that home and place her in a safe foster home. This subject liked music and became very involved in the music therapy activities.

MN only scored a 95 out of a possible 170 on the pre-test for self-confidence (See Table 1). She increased her self-confidence only a few more points post-test and therefore did not appear to make much progress in this area. The subject did not appear hostile and indeed only scored high in the suspicion and resentment categories on the hostility inventory (See Table 3). She continued to have these same hostile attributes post-test. She was very withdrawn in group and her only participation, although minimal, was during music therapy activities (excluding dance and movement). Her depression appeared to lift as the group progressed, and she seemed to like coming to group, even smiling on occasion. Her appearance improved and she began coming to group clean and neatly dressed. The subject was able to minimally disclose details of her sexual abuse to the other group members and remained mostly non-verbal throughout the duration of the group. She was unable to do the album cover activity and appeared to be very limited in her ability to express herself either

verbally or non-verbally or through art. As the group progressed, the subject became more aware of the predicament she was in. Her father might go to prison or at the least get discharged from the service. The father was in treatment and the step-mother attended also. The subject lived with the step-mother, but the step-mother would not bond with the subject and resented her. The step-mother would come to her groups and individual sessions with herself and her baby dressed in new clothes and looking very neat and clean. She refused to buy the subject any clothes or to give the subject support in keeping her clothes and body clean. The step-mother became angry and oppositional during a meeting to discuss these issues. She would only state that she wanted her husband back and for the subject to go and live with someone else in the family. The step-mother had a newborn baby and was working a full time job to support herself, the baby, and her three step-children. She was exhausted and angry at her situation and had no empathy for the subject. The subject knew that eventually she would have to leave the home. Her natural mother was an alcoholic and she had not seen her since she was a small child, therefore there was no possibility of her going with her. She did express her fear in individual sessions that she would be separated from her two natural brothers whom she loved very much. In addition, she appeared quite attached to the new baby. The situation seemed hopeless for her and she sank into despair near the end of the group. Her affect became flat, and her personal hygiene became poor again. It should also be noted that the subject was observed to possibly be masturbating during the first two sessions of group as she sat with her jacket over her arms and lap and her hands were moving under the jacket in her crotch area.

LJ scored 137 on the pre-test for self-confidence (See Table 1), and did raise her score post-test although not significantly. She exhibited high levels of hostility as evidenced by her pre-test hostility scores (See Table 3), but did appear to reduce the



hostility in several categories post-test. The subject retained her high score in Irritability post-test and added the category of Indirect Hostility post-test. Indeed, near the end of the group the subject appeared ready to explode at the slightest provocation and did display behaviors of grouchiness and rudeness during group. She mothered the two small children in the foster home much like she had mothered her two half-brothers, and she was very bonded to the male head of household and very distant from the foster mother. The subject had no friends and would not become involved in any social activities. There was much concern from this experimenter that the subject could be setting up a reenactment of her original sexual abuse. This experimenter encouraged the foster parents to allow the subject to get a part time job at a fast food restaurant, become involved in activities at school to encourage social skills and peer relationships, and for the parents to hire a sitter for their children instead of having the subject constantly care for their children. When this was brought to the attention of the foster parents by this experimenter, the foster parents became defensive, oppositional and angry. Following this event, the client became very hostile, oppositional in group and tried to sabotage the progress of the group until the group was terminated. The subject was quite verbal in group but appeared to want to control the group and keep the group from achieving goals for the sessions.

### No Music Therapy Group

AC had very low self-confidence and scored a low of 101 on the pre-test for self-confidence (See Table 2) out of a possible score of 170. She scored 104 on the post-test and therefore did not significantly raise her self-confidence level during the course of the experiment. The subject had an extremely high level of hostility scoring high on 6 of the seven categories of hostility pre-test (See Table 4). She continued to

have a high level of hostility post-test as evidenced by still scoring high in 6 of the 7 categories. Negativism was dropped on the post-test but Verbal Hostility was added post-test. Dropping Negativism from her inventory post-test could be due to her developing less of a need to exhibit oppositional behavior towards authority. The subject had a grandmother living in the home whose authority she resented. Individual therapy work with the subject and her sister included the older sister stopping her bossing and mothering of the subject and allowing her to become more responsible for herself. She seemed to look up to and respect DS, an older group member and developed a good relationship with this experimenter. It seemed that she could begin to see other older females as people that she did not oppose, who accepted her and who were not in authority over her. Adding the verbal hostility category post-test could have been a result of the dyad sessions with the subject and her mother. Through the course of these sessions the subject was able to begin in a limited way to express feelings of anger towards her Mom for not protecting her when Dad would be physically abusive to her and for the sexual abused suffered by her and her sisters. The subject reported being suicidal at times and related that she talked frequently about suicide with her best friend who had also been sexually abused. Following the first month of participation in the group this subject became extremely depressed and reported in group that she was going to commit suicide. Following the group that evening this experimenter brought in the subject's mother and discussed the situation with her, called suicide crisis and made arrangements for an on call crisis counselor to come to the center, and then privately counseled the subject until the crisis worker arrived. Following several hours of evaluation by the crisis worker, the decision was made that the subject would go home with her family, the family members would work shifts and watch her throughout the night, and that an In Home Therapist would visit the home the next day for evaluation and planning.

The crisis worker said that the In Home Therapist would spend 8 hours each day in the home working with the subject and her family until the crisis was resolved. The In Home Therapist would make arrangements for the subject to meet daily at school with the school counselor and would plan the details for the safety of the subject until the crisis was resolved. This experimenter was shocked to find out the next week in group that the In Home Therapist had not shown up the next day and in fact had not contacted the family for three days following the incident. The non-assertive and dysfunctional aspects of the family this early in treatment was probably the reason that the family did not contact this experimenter and notify her of the problem. The subject reported that she connected well with the In Home Therapist and was working through the crisis. At this point the Sexual Abuse Center workers were grateful that the situation had worked out okay and a follow up was conducted with the Community Mental Health Center that was in charge of the In Home Therapist Program to ensure that this mistake would not take place again and possibly put another person's safety in jeopardy. In addition, a new rule was established at the sexual abuse center. The workers themselves would follow up on a suicide crisis in case the system failed again. This experimenter thought that the topics brought up in group during the first four sessions had caused the suicide crisis with this subject as the post-traumatic symptoms increased. During the course of the group some of the subjects began to disclose details of their sexual abuse. The subject did not disclose, but it was obvious from her physical withdrawal as evidenced by body language and sudden silence that she was experiencing distress by the disclosures. She appeared to have a strong denial system and seemed to have denied any thoughts or feelings concerning her sexual abuse. It is possible that this event triggered memories and feelings which were intrusive and depression and suicidal ideation resulted.

The subject reported being sexually active and stated that she did not use any birth control. Attempts were made by this researcher to encourage the subject and her mother to make an appointment at a family planning clinic. They postponed it time and again and finally near the end of group the mother and subject followed through. The subject came to group one evening with multi-colored prophylactics.

HC scored a 126 on her pre-test for self-confidence (See Table 2), and only increased her self-confidence post-test by 3 points. She scored high in all the hostility categories except one on her pre-test (See Table 4). Interestingly, her post-test scores reveal an incredible reduction in her hostility with no high scores in any of the Hostility Inventory categories. This phenomenon was discussed with the family therapist as this experimenter tried to find possible explanations. The family therapist nonchalantly remarked that it was not surprising to her considering the disclosure and work that this subject had made. It appears that in this case disclosure provided an excellent means for the release of anger and hostility. Her sister (AC) did not disclose, and hostility remained highly elevated on her post-test. The subject was very loyal to the group, attending regularly and appeared to be very interested in her therapeutic progress.

DS appeared to have some self-confidence as she rated herself 146 out of a possible 170 pre-test on the self-confidence questionnaire (See Table 2). She did manage to increase her self-confidence seven points post-test. Her hostility levels were elevated on 3 categories of the Hostility Inventory pre-test (See Table 4), and she reduced this by one post-test. She retained the categories of assault and suspicion post-test. The subject appeared to be tough and a street-wise type of person. She was serious about healing and invested a great deal in the group. The subject missed the last session of the group as she had gone into labor and had her baby. The group continued following the completion of the study, and four weeks following the birth

of the baby, the subject brought the baby to group. It appeared to be a joyous occasion for the group members as they took turns holding the baby. It should be noted that this subject completed her post-test four weeks following the end of the group, and this could have been a confounding variable in the results of the study.

### Comparison of Music Therapy and No Music Therapy Group

A description of the weekly sessions and procedures for the Music Therapy Group and the No Music Therapy Group can be found in Appendix H.

Week 1: The Music Therapy Group (MTG) had some difficulty with the trust activity, but the subjects appeared to be less reluctant than the No Music Therapy Group (NMTG) to do the trust activity. The MTG seemed to have developed more group cohesion and trust from the keyboard activity and song discussion.

Week 2: The MTG appeared to respond with much more content to the key question; Have you ever thought that you really identified with a person, story, or message in a song? If so which one, and why? The NMTG had a great deal of difficulty with their question; Have you ever thought that you really identified with a character, story, or message in a book or movie? If so which one, and why? Perhaps this was because adolescents are much more familiar with the music of their culture than the books and movies of their culture. The NMTG acted as if the group leader was asking the impossible and that it was an unreasonable request. After much prompting and examples, one of the group members said that she related to the example of Whoopi Goldberg's role in "The Color Purple". When asked why, she stated that she too had experienced the emotional as well as sexual abuse that the character had in the movie. The MTG came up with songs easier, but the content was shallow and they avoided choosing songs that referred to their sexual abuse in any way. When the song "What's the Matter Here?" was played, the group

processed the lyrics and some of the subjects agreed that they had been treated like the young boy in the song. The subjects were able to relate the "cuts and sores that don't heal with time or with age" to the emotional wounds that were a result of their sexual abuse.

Week 3: The MTG appeared to grasp what was requested of them much better than the NMTG did, and the MTG appeared to draw their self-portraits with more ease than the NMTG did. The discussion of the song lyrics previous to the drawing activity might have been beneficial for the subjects to be thinking about change. The background music during the drawing activity may have put the subjects more at ease for drawing. This experimenter was surprised at the difficulty that the subjects in both groups had with this activity. It may be very difficult for sexual abuse victims to draw a picture of themselves because of the distorted body image that so many of them have.

Week 4: The subjects in both groups were very reluctant to share any details of their sexual abuse. A few of the subjects in each group at least told who had sexually abused them and one stated how long the abuse had lasted. When comparing the sentence completion with the MTG and NMTG, the content of both appears to be very expressive. The MTG appears to disclose more feeling in the song as compared to the NMTG's poem. The MTG expresses guilt, love, and hope. The NMTG expresses strength yet despair, and really does not express feelings or emotions. Perhaps the musical background for the lyrics was instrumental in evoking more emotion in the song as compared to the poem. The subjects in both groups had a great deal of difficulty with the feeling activity. The subjects in the MTG were reluctant to experiment with the musical instruments. Finally, this experimenter announced that she was leaving the room and that the subjects needed to have their feelings worked out in ten minutes when she returned. The subjects

appeared less inhibited as they could be heard through the open door as they began to play the instruments and talk together. The NMTG had difficulty doing the feeling charade activity. They kept putting feelings back in the bowl and took up a great deal of time until they found a feeling that was less confrontational. Feelings such as afraid, lonely, and betrayed were placed back in the bowl. Feelings such as anger and sadness were done but with reluctance.

Week 5: There was less resistance in both groups to disclose details of their sexual abuse. Most group members were able to tell who had sexually abused them and for how long the abuse had continued. The MTG's "Rap", although not related to their sexual abuse is reflective of the anger and boundary problems of this population. The NMTG's artwork on the mural included a crying eye with a band aid "to cover the hurt", a ribbon that was tied up in knots (The subject said that it depicted her feeling happy and having a good time partying), and a picture of a face with a sign which read "Help" over it. One subject was only able to write "I'm not ready" on the mural. She said this referred to boys and sex when asked, but this experimenter thought it meant more than what she stated. The subject did not appear to be ready to address her sexual abuse.

Week 6: The "Rap" written by the MTG shows that the group had achieved a high level of group cohesion. The song mentioned expressing their feelings which was an important component to the therapy and showed that they were aware of this purpose. The song also showed how important they thought that talking about their sexual abuse was to their healing. I think that it is interesting that they bring up the "damaged goods" syndrome in a round-about way. Even though they were sexually abused they are still people with needs and wants. The emphasis is being active in their own healing in the last two lines. I believe that approaching the song writing slowly and not placing demands on the group too early was beneficial is allowing the

group to address their sexual abuse when they were ready. The song writing activity appeared to be a non-threatening way to express their feelings. The album cover activity appeared to be more difficult for the subjects. The albums revealed many of the problems faced by those who are sexually abused. Titles were "Confused", "Survivors", and "Peer Problems". Songs listed on the back include; "Pain Lasts Momentarily", "Afraid of Love", "Walkin' Out", "Alone", "Drugs and Drinking", "Relationship Problems", "Crime, Killing, Abortion", "Face the Fire", and "Stolen Moments". Even though the subjects were not asked to make the album covers relevant to their sexual abuse, these themes were dominant in the activity. The NMTG had no difficulty brainstorming problems until they were asked to brainstorm problems related to their sexual abuse. This proved to be very confrontational for the subjects and this experimenter had to offer many suggestions. Many of the suggestions were rejected by the subjects such as "Sexual problems", "Problems in school", "Problems expressing feelings", and etc. It appeared that they had a strong denial system concerning problems that may have been caused by their sexual abuse.

Week 7: The MTG appeared to become involved in the imagery more easily than the NMTG. In addition, the MTG appeared more relaxed during the imagery. The music seemed to facilitate the imagery more. The music which accompanied the boundary drawing activity appeared to be helpful. The NMTG took much longer to do the activity and appeared more oppositional than did the MTG. They asked more questions about what was required in the activity.

Week 8: The background music appeared to be helpful for the "Body Sculpting of Emotions" activity. The MTG seemed to be able to express emotions more easily than did the NMTG. Perhaps the music evoked emotions and therefore set the scene for the expression of emotions. Both groups had difficulty with the "Round Robin Back Rub" activity. One MTG member stated that it was "Gay" to



touch another woman. After nurturing touch was explained, the subject appeared to understand it better and was willing to participate. Subjects in both groups stated that it felt uncomfortable to touch or to be touched by another person when the touch is not sexual. Most subjects were able to say that they had not experienced nurturing touch in the past, and many said that they had not experienced nurturing touch from their mothers. The music appeared to make the activity less confrontational as the MTG had less problems than the NMTG did with this activity.

Week 9: The NMTG was very closed and only one group member was willing to voice her opinions. The others could not be engaged in discussion concerning their thoughts or feelings concerning sex. The songs appeared to facilitate the discussion of sex in the MTG. The subjects were able to talk about the ideas expressed through the songs and then added some of their own opinions. None of the group members were able to share whether they were sexually active in the music therapy group. One of the members of the NMTG did state that she was sexually active (She was pregnant and perhaps she thought everyone knew anyway). Most of the MTG members were able to talk about being pressured by males for sex.

Week 10: The NMTG had much more difficulty with the activities of "Confronting the Offender" than did the MTG. Discussion of the song may have given the subjects an idea of how one would go about writing a letter and made the activity less abstract and confronting. The background music may have been relaxing and evoked more emotional response for the MTG during the letter writing part. It is interesting to note that both groups had difficulty writing the letter in first person and tended to write more of a generic than a personal letter to their offender.

Week 11: The MTG appeared to respond to the music and imagery. They were receptive to using it when they were having flashbacks. The NMTG members were minimally involved in the imagery and did not appear to be concentrating. They

did not seem to be interested in using it in the future. The song "Child" appeared to facilitate the MTG to talk about their mothers and their reactions to their sexual abuse. The discussion with the NMTG was guarded and very little disclosure took place.

Week 12: The MTG was very interested in discussing the song "Code of Silence" after singing it as a blues tune. The words seemed to have more meaning to them as opposed to the NMTG who only read the poem. The NMTG was minimally involved in discussing the poem and much facilitating by this experimenter had to take place. The song appeared to give the words more meaning to the MTG. The MTG appeared to become more involved with the anger imagery than the NMTG did. There was more feedback from the MTG concerning the imagery and their reactions to it. Their comments showed that they were more interested and possibly it was more effective with the MTG than the NMTG.

### Conclusion

This study shows the importance of disclosure in the reduction of anger and hostility. The music therapy activities provided non-confrontational means for disclosure. Those in the group who were able to disclose and confront their sexual abuse issues appeared to reduce their hostility levels more than the others. Music evokes feeling and expression of feeling. Disclosure which includes self-expression of feelings may function to reduce anger and hostility. The statistical analysis did not support that the Music Therapy Group significantly decreased their overall hostility level more than the No Music Therapy Group, yet some of the subjects had a dramatic reduction in test scores on hostility. In addition, there was no significant change in self-confidence, although the Music Therapy Group did appear to gain more self-confidence throughout the course of the study than did the No Music Therapy Group.

The subject sample was very small and differences might have been apparent in a larger sample.

Many of the group members attended sporadically and many dropped out before the end of the group. The small sample size which resulted from these occurrences would make it impossible to attain any statistical significance in the study. It may be difficult to conduct research studies which utilize an experimental and control group with treatment groups for the sexually abused. First of all, treatment groups do not usually exceed 10-12 people because they may be ineffective beyond this number. If dropout and poor attendance are then taken into account, there might be too small of a sample to gain any statistical significance. Perhaps these factors have contributed to the paucity of research in this field especially concerning treatment groups. Blake-White and Kline (1985) found that 40% of group members dropped out of group anywhere between the first to the fifth of the incest survivor group sessions. The authors attributed this high dropout rate to the overwhelming anxiety and distressing symptoms which accompany the memories.

Many studies have attempted with limited success to measure self-concept with adolescents who have been sexually abused (Goldstein, 1988); (Tufts, 1984); (Orr and Downes, 1985); (Clendenon-Wallen, 1991). One explanation for this phenomenon (Tufts, 1984) is that individuals who have been sexually abused may have incentive for presenting themselves in a more favorable light. The authors state that it is easy to choose the more desirable response on self-concept measures, and children may be prone to "fake good" in order to not feel blamed for the sexual abuse or to try to appear less damaged in order to avoid disruption of their families (p. 184). Clendenon-Wallen (1991) reported that subjects appeared to check conflicting descriptors of themselves on the Adjective Checklist, Self-Confidence Core which was the instrument used in the study to measure self-confidence. This may be that

because of the confusion and distorted body image of sexually abused adolescents, they cannot accurately describe themselves. The author states that there is the possibility that persons who have been sexually abused relate to two separate images of themselves, the pre-abuse person and the post-abuse person. They may view themselves with a distorted self-perception - as they remembered themselves before their sexual abuse occurred (p. 79). Kinard (1980) measured self-concept with children who were physically abused. Although the subjects appeared to have very poor self-concepts as evidenced by sad, withdrawn and depressed affect, no significance was found that they did in fact have poor self-concepts. The author attributes this to the belief that children of abuse have no sense of identity and therefore are unable to evaluate themselves accurately on self-concept measures. Stovall and Craig (1990) conducted a study which measured the mental representation and self-concept of sexually abused, physically abused and non-abused but distressed latency-aged females. The instrument used to measure self-concept was the Piers-Harris Children's Self-Concept Scale. This instrument for measuring self-concept is unique in the fact that it is a measure to assess preconscious and conscious self-concept. In the study the physically and sexually abused children were more likely to have positive conscious images of self and others, whereas their unconscious perceptions revealed quite disturbed perceptions of self and others. "This suggests that abused children tend to split off more negative perceptions and these perceptions remain unconscious and thus not available for conscious thought" (p 241).

Following Week 5 of the groups, it was decided that instead of asking the group members to share events from the past week that they would only be allowed to share any crises which they may have experienced during the previous week. Too much time was being taken up in group for seemingly meaningless and trivial sharing. Many of the more verbal group members seemed to try to use this time to

delay the group activities and to dominate and control the group. There are several possible explanations for this behavior. The subjects may have been using this manipulation of delaying the work that needed to be done on their sexual abuse issues as an avoidance coping mechanism; if they were successful in keeping discussion at a superficial level, then they would not have to remember or feel the pain associated with their sexual abuse. Frequently this behavior appeared to be passive-aggressive attempts to sabotage the group by keeping it off task.

It was assumed that singing activities in the Music Therapy Group would be advantageous since all respondents stated that they liked to sing on the music survey, but this proved to be a false assumption. Most of the subjects in the Music Therapy Group were reluctant to sing in group, and when asked why would state that they sang only when alone or that they were too shy to sing in front of others. In addition, group members were reluctant to dance in the Music Therapy Group even though they stated that they liked to dance. The same reasons were given for not participating in this activity. It is important to note that two of the four group members in the Music Therapy Group had been diagnosed as anorexic and another member was possibly anorexic although not diagnosed as of the time of the group. The remaining group member was obese. Extremely poor body image that is related to eating disorders could have been a factor in their refusal to dance in group. Certainly, this population has the need for ways to develop better body image and self-image. It appears that movement and music activities for adolescent victims with eating disorders may create a great deal of resistance.

Friedrich (1990) strongly believes in the "importance of helping the child to discuss, as much as possible the various instances of sexual victimization that resulted in the treatment" (p. 119). He states that he is more directive than other therapists when it comes to this issue. He says that when they are resistant verbally, then the

use of non verbal means such as drawings or role play may be helpful. "This can foster the relationship to the point where resistance can be overcome" (p. 119). The author says that "nondirective therapists believe that the work should focus only on what the child presents within the therapy session", and that these therapists believe that this approach is more respectful and natural to the child (p. 120). The author points out that children struggle to derive meaning from their experiences and they look to adults for direction. They may feel confused if the purpose of therapy is not made clear. The author also states that "Accessing the sexual abuse begins the process of integrating these elements into the child's life in a new and positive way, rather than allowing them to remain unchanged and to emerge at different critical transition points as the individual grows older" (p. 122).

In this experimenter's opinion, nondirective therapy has not been an option. The clients seen at the sexual abuse center were generally divided into two groups. Those with insurance were often given a limit as to how many sessions that the insurance company would pay for. Most could not afford to continue therapy once the reimbursement stopped. Therefore, the therapy had to be highly goal oriented and structured in order to address issues of importance. The indigent clients who could not afford to pay were often at risk of leaving therapy at any given time and therapy was often sporadic. Transportation from Children's Services or the foster homes was usually unreliable. The clients that were from very dysfunctional homes received little motivation and support from family members to attend and were at the risk of being withdrawn from therapy at any time. This experimenter agrees with the author that the therapist must seek disclosure as quickly as possible and that therapy must be goal oriented. Music therapy is an ideal vehicle for achieving these goals.

The clients are given opportunities to disclose in safe and non-confrontational ways through song writing and song discussion, and goals can be addressed in this

manner also. Clendenon-Wallen (1991) states, "The songs that were used had a storytelling format which was one step removed from the adolescent's own experiences" (p. 79). The adolescents were able to empathize with the principal character's experience or feelings and in so doing projected their own personal feelings and experiences into the discussion. Song disclosure facilitated self-disclosure by creating a non-threatening environment for verbal interaction. The author's description of how music therapy functions therapeutically was observed in this study also. The subject MN in this study who was mostly nonverbal and non-expressive was able to express herself through the music therapy activities. Although her participation was minimal, it might have been less in a traditional therapy group. She was able to disclose during one group with a great deal of support from the group members and this experimenter that her father had sexually abused her and that she had an abortion. The subject AC retained her high levels of hostility and her low self-confidence throughout the course of the group. This could be attributed to the fact that she would not or could not disclose any details of her sexual abuse and consistently avoided the subject. This subject might have shown more progress if she had been in the Music Therapy Group. The non-confronting aspect of Music Therapy could have provided her with a means for self-expression which may have helped to facilitate disclosure and therefore therapeutic progress.

The therapist must be willing to bring up confrontive issues while working with adolescents who have been sexually abused. Many therapists who are working in this field are also survivors of sexual abuse. From the experience of this experimenter, many people go into this type of work to try to heal themselves. Many have done therapeutic work on their own issues, but one must be aware of the fact that the road to healing for those that have been sexually abused is a long and difficult process because of the complexity of issues. Many therapists get hooked on issues

brought up in group or they will avoid issues which they have not personally addressed or resolved. This impedes the progress of the clients and can in many ways be damaging. For instance, a therapist may not have resolved the anger which he/she may have towards the offender. If the client is bonded with the offender and estranged from the mother when entering therapy, the client may not feel anger towards the offender. The therapist may transfer her own anger to the offender and encourage the client to be angry towards the offender. These problems of countertransference can cause the client to be confused and withdraw from the therapist which impedes therapeutic growth. The therapist may avoid addressing important issues because of lack of expertise regarding the treatment of sexual abuse. Indeed, this was the case with this adolescent support group. The adolescent Music Therapy Support Group had grown to 14 when this experimenter resigned the sexual abuse center where this experiment took place. The Music Therapy and No Music Therapy Groups were combined and new members were added. The therapist who was hired to work with the adolescents had no experience with sexual abuse and announced during the first group that the group would be "fun" and that the group would be working on self-esteem. She assured the group members that they would not have to discuss their sexual abuse if they did not want to. This information was relayed to this experimenter by a group member and a staff member. The opinion of this experimenter is that ethically the issues must be presented to the clients even though they are uncomfortable. Many adolescent group members may drop out as was the case in this experiment. The clients must be given the opportunity to grow and heal, and therapists must not be concerned about high attendance or large numbers. Even though many of the group members attended sporadically and many dropped out, they must have at least gained something which may be useful in the future. The content of the sessions, although very confrontive and undoubtedly



threatening to many, was designed to address the problems and issues. Authors Everstine and Everstine (1989) state that adolescents may be resistant to therapy, and they may refuse to admit that they need help. The authors believe that the adolescent's self-destructive acting out behavior may make it impossible for the adolescent to participate in a healthy, constructive process such as psychotherapy. The authors attribute this to the guilt that the adolescent experiences. In the opinion of this experimenter, the hostility experienced by this population may be an even more contributing factor in their resistance to therapy. Considering the fact that the Music Therapy Group appeared to decrease their hostility more than the No Music Therapy Group, music therapy may provide a much needed therapeutic medium for adolescents who have been sexually abused. Powell and Faherty (1990) state that a positive therapy experience during the latency years (pre-adolescence) will facilitate an open response to adolescent or adult groups later on. The authors report anger in their clients but they do not emphasize its' existence or refer to hostility in the clients. Perhaps early detection and therapy during the latency years may prevent the hostility and anger which is seen so frequently in adolescents who have been sexually abused.

Adolescents are a difficult population to work with. At the sexual abuse center where this experiment took place the least favorite population to work with were the adolescents. Sexual abuse work is extremely difficult work in itself. In order for therapists to keep from "burning out" it is important that the therapist receive some kind of positive feedback that tells them that the work they do is beneficial. Children, latency age and adult survivors respond to treatment and appear to make progress. Adolescents on the other hand are often hostile, silent, and unable to face the issues of their sexual abuse. Without the positive feedback of treatment progress, work with adolescents becomes the most difficult work to do.

The subjects in both the music therapy and no music therapy groups exhibited anger and hostility in varying degrees throughout the course of the experiment. One subject came to group one evening with the words "Fuck" and "Shit" written on her hand and drew a picture of a tornado on a lyric sheet during the group. Friedrich (1991) states that "Affect is frequently activated at those times when abuse is discussed. This includes anxiety, depression, and anger" (p. 121). The author points out the positive aspects by saying that "a previously overinhibited child now has the opportunity for the display of affect that is neither punished nor creates too much internal anxiety, the opportunity for growth has been enhanced" (p. 121). Perhaps the anger that sexually abused females have may be a result of the societal taboo which does not accept the expression of anger or aggression by women (Courtois and Sprei, 1988). "As a consequence, females frequently feel that they have no right to anger, which becomes repressed and expressed in disguised forms such as passive-aggressive behavior, depression, manipulateness, anxiety, and somatic complaints" (p. 293). The authors state that the victimized female may further express anger through self-blame, self-contempt, and self-defeating and self-abusive behaviors. This unexpressed anger can become rage of a frightening intensity. The authors stress the need to introduce anger-management techniques and activities where the person can learn to express anger in ways that are modulated and not self-destructive (p. 293). The unexpressed anger appears to create an underlying hostility in adolescent females as witnessed by this experimenter. In retrospection, more music therapy activities designed to address the issue of anger and hostility would have been advantageous.

Adams-Tucker (1984) states that the teenage victim can be verbally adept and capable of communicating quite well, but often in reality this is not the case. "Teenage girl victims will be mute, preferring not to talk or to answer only 'yes' or

'no' or 'yeah' or 'I don't know'" (p. 512). The author offers several possibilities for this response in adolescent victims. This response may be because the person is frightened or ashamed, she may have been threatened by the father if she tells, or she may be reluctant to talk about the incest still another time to yet another adult who might not take her seriously. The hesitancy may be attributed to the fact that the adolescent has regressed and is now functioning at the level of a much younger person. Several of the subjects in this study did in fact appear to be regressed to a much younger age (KL and MN). Many of the adolescents in this study were non verbal and reluctant to talk, disclose or express themselves. It is this experimenter's opinion that the music therapy activities were beneficial in providing non-verbal means of communicating feelings and ideas for the subjects in the Music Therapy Group. It appears that being able to express feelings non-verbally may pave the way for developing the ability to express feelings and thoughts verbally. Clendenon-Wallen (1991) states that "music provides a 'magical bridge' which permits the mind and body which is barren, expressionless, and uncommunicative to begin to identify and express through communication the feelings and thoughts which have been shut down" (p. 79). The author describes those who are sexually abused as existing in a numb and un-feeling limbo as they have had to suppress their feelings and emotions while the sexual abuse was taking place. This functions as a coping mechanism and most individuals stay shut down until adulthood when the sexual abuse surfaces often in the form of PTSD. The author states that if these individuals can un- numb and begin to identify and express the feelings related to their sexual abuse, then they may avoid the occurrence of PTSD.

Horowitz's (1976) treatment plan based on the symptoms of denial and intrusion state that catharsis should be encouraged through encouraging emotional relationships when a client experiences numbness as a symptom of denial. If a client

experienced intrusive symptoms such as rage or fear, the treatment would include support and suppression or desensitization. Horowitz states that both intrusion and denial help the person to resolve the trauma. Therapists must use caution while conducting groups because individual members may be in different phases of denial or intrusion. For example, a music therapy activity which was designed to address feelings of anger or rage could be detrimental to a person who was in the intrusive phase yet be very beneficial to one who was in the denial phase. There is a delicate balance which must be obtained, and the therapist must be perceptive of reactions of the individual group members. A co-leader should always be present that is capable of taking a person from the group in order to process with the client and skillfully move the client back into the denial side. Caution should also be exercised when conducting imagery with groups. Imagery appears to be an effective technique to move a client into the under-controlled intrusive phase when the person is in the over-controlled denial phase, but it would be detrimental to the client who was already in the intrusive phase.

It is interesting to note that all subjects in both groups scored high in the Resentment and the Suspicion categories on the Hostility Inventory pre-test. All but two of the seven subjects in the study retained the high score of Suspicion post-test. Only two subjects out of the seven retained a high score on the Resentment category post-test (See Tables 3 and 4). Resentment as outlined by Buss and Durkee (See Appendix B) involves being jealous of others, often to a level of hatred. It is often a feeling of anger at the world over real or imagined mistreatment. It is possible that being in a support group and hearing that others have gone through similar experiences as your own may reduce that level of hatred towards others as the group member develops empathy towards the other group members. Powell and Faherty (1990) state that placing sexually abused pre-adolescent children in a group lessens

their feelings of isolation and increases their feelings of self-worth and connectedness. Sexually abused children often feel that they are the only ones in the world to have had this experience. Cohen (1991) emphasizes the importance of group therapy for children who have been sexually abused. She says that participating with abused peers helps to decrease their feelings of isolation and being different. These factors may also be responsible for the loss of resentment. It is doubtful that suspicion would be significantly reduced after a three month group, and it could possibly take years of therapy and healing for the survivor of sexual abuse not to be suspicious to a large degree. A certain amount of suspicion can be a positive attribute for the survivor. It functions as a protection at times and may keep the person from getting re-victimized. The conclusion we may draw from this is that group therapy may be very successful in reducing resentment but may not be effective in reducing suspicion in those who have been sexually abused.

The random selection of subjects for the two groups created problems. AC and HC (sisters) happened to be placed in the same group. Ideally siblings should not be placed in the same group. Powell and Faherty (1990) recommend that siblings not be placed in the same group as established family patterns can interfere with group process. In the opinion of this experimenter these two subjects may have progressed further in treatment had they been placed in separate groups. They may have been less inhibited and felt freer in disclosing or sharing with the other group members. An attempt to conduct this study at another facility prior to this demonstrates these problems. The adolescents were at a job training facility where they lived in dormitories. They were extremely guarded and disclosure was almost non-existent. It finally became apparent that the reason was that they all lived together, there was constant gossip, and the girls feared that the males in the facility would find out that they had been sexually abused or even worse get access to the details of their sexual

abuse. The sisters in the study had many boundary and privacy problems in their everyday life. It is easy to see that they would not compound these problems by disclosing or sharing something that might get used against them later on or told to a sister's friend or boyfriend.

This study suggests the importance of developing and/or improving the relationship of the survivor with the mother or a mother figure such as a female foster parent. The progress made by the subjects in this group appeared to depend somewhat on which of the subjects were able to bond and resolve anger issues with their mothers, step-mothers, or foster mothers. The subjects AC, KL, LJ, MN, and DB did not make much progress with bonding or learning to communicate with their mothers or mother figures. The subjects HC and DS did make some progress in this area and as a result appeared to lower their hostility levels more than the other group members. Their self-confidence scores did not show a noticeable increase. Walker and Greene (1986) state that the relationship with one's parents and peer relationships are particularly important to self-esteem. Since survivors of sexual abuse have poor parental relationships as well as peer relationships, it would follow that they would have problems with self-esteem (self-confidence). Boatman and Borkan (1981) describe the rage that the survivor feels towards her mother because of her lack of protection. The authors state that anger towards the mother was difficult for the girls to accept. These observations indicate that recognition, acceptance, and expression of the anger felt towards the mother would be an excellent therapeutic goal for the survivor. The non-confrontational aspects of music therapy may be an excellent means for survivors of sexual abuse to relate feelings to the mother and likewise for the mother to express herself to the daughter.

### Suggestions for Further Research

The high drop-out rate in sexual abuse groups may explain the paucity of research studies with treatment groups for the sexually abused. When forming sexual abuse groups, perhaps attention should be given to having an extra large group to begin with such as 18-20 group members. The core group which is left after the drop-outs occur may be enough to provide data for statistical significance.

Stovall and Craig (19990) used the Piers Harris Self-Concept Scale for measuring self-concept in those who have been sexually abused. Their results imply that an instrument for measuring self-concept in those who are sexually abused cannot rely on self-reports and should be able to measure unconscious perceptions about self as well as conscious perceptions in order to obtain an accurate measure of self-concept. Therefore, further studies should consider using the Piers-Harris Self-Concept Scale in order to obtain a more accurate measure of a subject's self-concept.

The progress made by the subjects in this group appeared to depend somewhat on which of the subjects were able to bond and resolve anger issues with their mothers, step-mothers, or foster mothers. Music therapy dyads with the survivor and the mother or female caretaker could prove to be very beneficial in the treatment of sexual abuse. An excellent study would be to measure hostility with the survivors in one group participating in music therapy dyads with their mothers or mother figures while the subjects in the control group did not.

In the opinion of this experimenter, research studies with adolescent survivor populations should include activities which address the issues of anger and hostility. Perhaps if the adolescents are given tools to use for coping with anger and hostility in the initial stages of the group then they may be less likely to drop out of the group.

### Summary

Clearly, there are important conclusions which can be drawn from this study. Music therapy may provide the missing link to the problems of treatment with sexually abused adolescents. Perhaps adolescents can have more success in treatment since music therapy appears to be successful in reducing their hostility. Music therapy facilitates disclosure which in turn may reduce hostility. This therapeutic medium may provide the opportunity for sexually abused adolescents to participate constructively in treatment. Treatment and growth as an adolescent may be instrumental in avoiding PTSD as an adult.



**PLEASE NOTE**

Copyrighted materials in this document have not been filmed at the request of the author. They are available for consultation, however, in the author's university library.

**Appendix A**  
**Adjective Check List**  
**Appendix B**  
**Buss-Durkee Hostility Inventory**

**University Microfilms International**

**Appendix A**  
**Adjective Check List Self Confidence Core**

**Appendix B**  
**Buss-Durkee Hostility Inventory**

**Appendix C**  
**Consent Form and Assent Form**

## CONSENT FORM

For Parent or Legal Guardian

I understand that my child or ward is being asked to participate in a study. This project will contribute information for a graduate study conducted by Joy Clendenon-Wallen, RMT-BC (Music therapist). Data will be gathered and the results may be published. I understand that all information collected about my child or ward will be kept confidential. I understand that I am free to withdraw my consent at any time. The purpose of the research is to determine music therapy's effectiveness in increasing the self-confidence of individual group members. I understand that my ward or child will be selected to participate in one of two groups. In one group, music therapy activities will be used to foster self-expression and increased self-confidence in conjunction with traditional group therapy. In the other group, no music therapy activities will be used and therapy will consist entirely of traditional group therapy.

I understand that by signing this form, I agree to allow my child or ward to do the following: (1) answer a short questionnaire before the study begins; (2) complete a checklist at the initiation and termination of therapy; and (3) attend 12 weekly sessions.

If I have any further questions concerning my child or ward's rights as a participant in this study, I may contact Joy Clendenon-Wallen.

I have read the above information, and have had an opportunity to have my questions answered, and I voluntarily agree to allow my child or ward to participate in this project.

SIGNATURE\_\_\_\_\_

(Parent or legal guardian)

DATE\_\_\_\_\_

## ASSENT FORM

For Client

I understand that I am being asked to participate in a study. This project will contribute information for a graduate research study conducted by Joy Clendenon-Wallen, RMT-BC (Music therapist). Data will be gathered and the results may be published. I understand that all information collected about me will be kept confidential. I understand that I am free to withdraw my assent at any time. The purpose of the research is to determine music therapy's effectiveness in increasing the self-confidence of individual group members. I understand that I will be selected to participate in one of two groups. In one group, music therapy activities will be used to foster self-expression and increased self-confidence in conjunction with traditional therapy. In the other group, no music therapy activities will be used and therapy will consist entirely of traditional group therapy.

I understand that by signing this form, I agree to do the following: (1) answer a short questionnaire before the study begins; (2) complete a checklist at the initiation and termination of therapy; and (3) attend 12 weekly sessions.

If I have any further questions concerning my rights as a participant in this study, I may contact Joy Clendenon-Wallen.

I have read the above information, and have had an opportunity to have my questions answered, and I voluntarily agree to participate in this project.

SIGNATURE\_\_\_\_\_

NAME PRINTED\_\_\_\_\_

DATE\_\_\_\_\_

## Appendix D

### Activities

**Music Therapy Group**  
**Week 2**

Name:

1. Fight For Your Rights
2. He Doesn't Even Know That I'm Alive
3. Livin' on a Prayer
4. Runnin' on Empty
5. Floating Free as a Bird
6. That's Just the Way it is
7. I Get by with a Little Help from my Friends
8. Born in the USA
9. Lost in a Dream
10. Perfection
11. Sometimes I Feel Like a Man in the Wilderness

How do you feel that the song you chose best expresses yourself or your feelings?



Music Therapy Group

Week 2

NAME OF PERSON YOU ARE INTERVIEWING.

THEIR FAVORITE SONG.

NAME OF THEIR FAVORITE GROUP OR PERFORMER. (LIST AS MANY AS YOU LIKE)

HAVE YOU EVER HAD THE DESIRE TO LEARN A MUSICAL INSTRUMENT?

IF SO, WHICH ONE?

HAVE YOU EVER THOUGHT THAT YOU REALLY IDENTIFIED WITH A PERSON, THE MESSAGE, OR A STORY IN A SONG?

IF SO, WHICH ONE AND WHY?

DO YOU HAVE A SPECIFIC USE FOR MUSIC?

IF SO, WHAT IS IT?

No Music Therapy Group

Week 2

NAME OF PERSON YOU ARE INTERVIEWING.

THEIR FAVORITE ACTIVITY.

WHAT IS IT ABOUT THIS ACTIVITY THAT YOU LIKE THE MOST?

HAVE YOU EVER BEEN IN LEARNING SOMETHING NEW?

IF SO, WHAT IS IT?

HAVE YOU EVER THOUGHT THAT YOU IDENTIFIED WITH A  
CHARACTER, STORY, OR MESSAGE IN A BOOK OR MOVIE?

IF SO, WHICH ONE AND WHY?

## No Music Therapy Group

## Week 4

Before I came here, I Didn't think about my past that much

I used to believe That the world was fair

Then I felt Like someone broke my looking glass

I didn't Think that I could put it back together again

I won't hang on to The broken dreams of the past

Because if I do My plans for the future will be lost

I'll Brave the world head on

And others will Remember me when I'm gone

## Music Therapy Group

## Week 4

Fill in the lines to make a complete sentence.

C	G	AM	G	DM	AM	AM	G
Before I came here, I			<u>Felt so guilty just being alive</u>				

C	G	AM	G	DM	AM
I used to believe			<u>All I had to do was give</u>		

G	AM
Then I felt	<u>Worse</u>

G	AM	AM	G
I didn't	<u>Look for miracles</u>		

C	G	AM	G	DM	AM	AM	G
I won't hang on to			<u>Abusive people in my life</u>				

C	G	AM	G	DM	AM
Because if I do			<u>The road could become narrow again</u>		

G	AM
I'll	<u>Love myself</u>

G	AM
And others will	<u>See that I am free</u>

Music Therapy Group

Week 5

“RAP”

I was shopping at the mall  
Snakin' my way through the hall  
My feet were screaming, my back was tired  
I got some coffee so I could feel wired

Kept my balance on a little kid's head  
He looked up and said drop dead  
Then I saw red, and red said  
You should have gone to McDonalds instead

We were buying stuff for us  
Muzzles for friends and we got on the bus  
Our friends liked muzzles, thanked us profusely  
They got close to us and nuzzled us loosely

## Music Therapy Group

## Week 6

GRACE HOUSE RAP

Well this is grace house  
And were in a little group  
And we all also have  
Different attitudes  
But we all been abused  
So when we come here  
We let our feelings appear  
Then all our problems  
Seem a little more clear  
We all have a purpose in this world  
We have to talk about  
What's happened to us girls  
It may have happened more than once  
But we're still people with needs and wants  
We have formed an organization  
For people like us  
So we don't sit around and just make a fuss

Music Therapy Group

Week 7

IF HE TRIES

If he tries  
Just pull away

If he asks why  
Say no way

If that don't work  
Ask him why

Why  
Why  
Why  
Why

Why me

Music Therapy Group  
No Music Therapy Group

Week 9

ARE YOU READY FOR SEX?

You are not ready:

1. If you have any guilt feelings about your present level of involvement.
2. If you are afraid that you will be humiliated you will lose your reputation.
3. If one person is pressuring the other for sex
4. If you are trying to prove something:
  - a. Trying to prove your love for the other person.
  - b. Trying to prove your self-worth.
  - c. Trying to prove that you are mature.
  - d. Trying to prove that you can attract male/female.
  - e. Trying to get attention, affection of love.
  - f. Trying to rebel against parents, society, etc.
5. If you are hoping to improve a poor relationship or improve one that is "growing cold".
6. If you cannot discuss the potential of spreading sexual transmitted diseases without embarrassment.
7. If you can't discuss and agree on an effective method of birth control.  
(Remember the details, responsibilities and cost of birth control should be shared)
8. if you haven't discussed and agreed on what both of you will do if pregnancy occurs. (Remember, sooner or later, all methods of birth control will fail)



Music Therapy Group  
No Music Therapy Group

Week 12

CODE OF SILENCE

Everybody's got a million questions  
Everybody wants to know the score  
What you went through  
Its something you  
Should be over now

Everybody wants to hear the secrets  
That you never told a soul before  
And its not that strange  
Because it wouldn't change  
What happened anyhow

But you swore to yourself a long time ago  
There were some things that people never needed to know  
This is one that you keep  
That you bury so deep  
No one can tear it out

And you can't talk about it  
Because you're following a code of silence  
You're never gonna lose the anger  
You just deal with it a different way

And you can't talk about it  
And isn't it a kind of madness  
To be living by a code of silence  
When you've really got alot to say

You don't want to lose a friendship  
There's nothing that you have to hide  
And a little dirt  
Couldn't hurt no one anyway

And you still have a rage inside you  
That you carry with a certain pride  
In the only part of a broken heart  
That you could ever save

But you've been through it once  
 You know how it ends  
 You don't see the point  
 Of going through it again  
 And this ain't the place  
 And this ain't the time  
 And neithers any other day

So you can't talk about it  
 Because you're following a code of silence  
 You're never gonna lose the anger  
 You just deal with it a different way

So you can't talk about it  
 And isn't it a kind of madness  
 To be living by a code of silence  
 When you've really got alot to say

I know you well enough to tell you've got your reasons  
 That's not the kind of code you're inclined to break  
 Some things unknown are best left alone forever  
 And if a vow is what it takes  
 Haven't you paid for your mistakes

After the moment passes  
 And the impulse disappears  
 You can still hold back  
 Because you don't crack very easily

It's a time honored resolution  
 Because the danger is always near  
 It's with you now  
 But that ain't how it was supposed to be

And it's hard to believe after all these years  
 That it still gives you pain and it still brings tears  
 And you feel like a fool  
 Because in spite of your rules  
 You've got a memory

But you can't talk about it  
 Because you're following a code of silence  
 You're never gonna lose the anger  
 You just deal with it a different way

But you can't talk about it  
And isn't it a kind of madness  
To be living by a code of silence  
When you've really got alot to say

**Appendix E**  
**Music Survey**

### Music Survey

Name:

Favorite Song:

Favorite Musical Group:

Favorite Style of Music:

Do you like to dance?

Do you like to sing?

What do you use music for?

Have you ever taken music lessons?

Have you ever participated in any musical groups?

Do either of your parents play a musical instrument?

## Appendix F

### Charts

### CHART 1

**Difference between each individual's pre-therapy score and post-therapy score on each subscale of the Buss-Durkee Hostility Inventory**

ID	TYPE	NE_DIFF	RE_DIFF	IN_DIFF	AS_DIFF	SU_DIFF	IR_DIFF	VE_DIFF
1	MUSIC	1	1	1	1	0	-3	-4
2	MUSIC	0	1	-2	1	1	-5	0
3	MUSIC	1	1	0	1	1	0	1
4	MUSIC	0	4	-3	4	4	1	4
5	TRADITIONAL	0	1	0	0	1	1	1
6	TRADITIONAL	2	-1	-1	3	3	-2	2
7	TRADITIONAL	0	8	4	6	6	2	4

ID	TYPE	NE_RANK	RE_RANK	IN_RANK	AS_RANK	SU_RANK	IR_RANK	VE_RANK
1	MUSIC	5.5	3.5	6.0	3	1	2.0	1.0
2	MUSIC	2.5	3.5	2.0	3	3	1.0	2.0
3	MUSIC	5.5	3.5	4.5	3	3	4.0	3.5
4	MUSIC	2.5	6.0	1.0	6	6	5.5	6.5
5	TRADITIONAL	2.5	3.5	4.5	1	3	5.5	3.5
6	TRADITIONAL	7.0	1.0	3.0	5	5	3.0	5.0
7	TRADITIONAL	2.5	7.0	7.0	7	7	7.0	6.5

## CHART 2

**The frequency tables, means and standard deviations for all of the subscales of the Buss-Durkee Hostility Inventory**

TYPE OF THERAPY = MUSIC			
VARIABLE	LABEL	MEAN	STANDARD DEVIATION
PRENE	PRE-THERAPY-NEGATIVISM	2.25000000	1.89296945
PRERE	PRE-THERAPY-RESENTMENT	4.75000000	0.95742711
PREIN	PRE-THERAPY-INDIRECT HOSTILITY	2.25000000	2.06155281
PREAS	PRE-THERAPY-ASSAULT	4.50000000	2.88675135
PRESU	PRE-THERAPY-SUSPICION	5.50000000	1.00000000
PREIR	PRE-THERAPY-IRRITABILITY	3.25000000	3.86221008
PREVE	PRE-THERAPY-VERBAL HOSTILITY	4.50000000	3.69684550
POSNE	POST-THERAPY-NEGATIVISM	1.75000000	2.21735578
POSRE	POST-THERAPY-RESENTMENT	3.00000000	1.63299316
POSIN	POST-THERAPY-INDIRECT HOSTILITY	3.25000000	3.59397644
POSAS	POST-THERAPY-ASSAULT	2.75000000	1.89296945
POSSU	POST-THERAPY-SUSPICION	4.00000000	2.16024690
POSIR	POST-THERAPY-IRRITABILITY	5.00000000	3.16227766
POSVE	POST-THERAPY-VERBAL HOSTILITY	4.25000000	2.62995564
PRESC	SELF-CONFIDENCE CORE PRE-THERAPY	114.250000	30.54368456
POSSC	SELF-CONFIDENCE CORE POST-THERAPY	121.250000	26.42442052
PREBD	BUSS-DURKEE INVENTORY PRE-THERAPY	27.0000000	13.36662510
POSBD	BUSS-DURKEE INVENTORY POST-THERAPY	24.0000000	6.97614985

TYPE OF THERAPY = TRADITIONAL			
VARIABLE	LABEL	MEAN	STANDARD DEVIATION
PRENE	PRE-THERAPY-NEGATIVISM	3.00000000	1.73205081
PRERE	PRE-THERAPY-RESENTMENT	6.33333333	2.08166600
PREIN	PRE-THERAPY-INDIRECT HOSTILITY	5.66666667	2.30940108
PREAS	PRE-THERAPY-ASSAULT	8.66666667	1.15470054
PRESU	PRE-THERAPY-SUSPICION	8.33333333	1.15470054
PREIR	PRE-THERAPY-IRRITABILITY	6.66666667	0.57735027
PREVE	PRE-THERAPY-VERBAL HOSTILITY	8.66666667	2.51661148
POSNE	POST-THERAPY-NEGATIVISM	2.33333333	0.57735027
POSRE	POST-THERAPY-RESENTMENT	3.66666667	4.04145188
POSIN	POST-THERAPY-INDIRECT HOSTILITY	4.66666667	2.88675135
POSAS	POST-THERAPY-ASSAULT	5.66666667	3.21455025
POSSU	POST-THERAPY-SUSPICION	5.00000000	3.60555128
POSIR	POST-THERAPY-IRRITABILITY	6.33333333	1.52752523
POSVE	POST-THERAPY-VERBAL HOSTILITY	6.33333333	2.30940108
PRESC	SELF-CONFIDENCE CORE PRE-THERAPY	124.333333	22.54624876
POSSC	SELF-CONFIDENCE CORE POST-THERAPY	128.666667	24.50170062
PREBD	BUSS-DURKEE INVENTORY PRE-THERAPY	47.3333333	8.02080628
POSBD	BUSS-DURKEE INVENTORY POST-THERAPY	34.0000000	15.52417470



**CHART 3**

**Pearson Correlation Coefficients Analysis**  
**Buss-Durkee (BD) and Self-confidence Scores (SC) for all Subjects.**

**PRE-TEST**

Pearson Correlation Coefficients / Prob . | R| under Ho :  $\rho=0$  / N = 7

	SC SCORE	BD SCORE
SC SCORE	1.00000	0.27475
SELF-CONFIDENCE CORE SCORE	0.0	0.5510
BD SCORE	0.27475	1.00000
BUSS-DURKEE HOSTILITY INVENTORY SCORE	0.5510	0.0

**POST-TEST**

	SC SCORE	BD SCORE
SC SCORE	1.00000	0.12766
	0.0	0.7850
BD SCORE	0.12766	1.00000
	0.7850	0.0

**Appendix G**  
**Description of Session Procedures**

## WEEK BY WEEK SESSION PROCEDURES MUSIC THERAPY AND NO MUSIC THERAPY GROUPS

### Description of Activities

#### Music Therapy Group

Week 1: The subjects were asked to give their names and tell something about themselves to the group. Goals for the group were set forth by the subjects: 1. Learn to have fun. 2. Be able to talk with mother. 3. Stop being depressed. 4. Feel more secure. 5. Build up self-confidence. 6. Confront offender. Ground rules for the group were established as follows: 1. Don't interrupt when others are talking. 2. Attend regularly. 3. Confidentiality. 4. No put-downs. 5. Listen. 6. Be honest. 7. You can pass if you do not want to share. The meaning of a support group was discussed. The electronic keyboard was introduced and the chords to the song "Lean on me" (Withers,1972), were taught to the group. The subjects took turns on the keyboard as they learned the chords. The song "Lean on me" (Club Nouveau,1987) was played and discussion of lyrics followed with an emphasis on trust. A trust activity followed which involved playing the song "Lean on Me" once again. The subjects were paired off and were asked to turn their backs to each other and to push against one another as they slowly sat down on the floor from a standing position. Next, the subjects took turns blindfolding each other and leading the blindfolded one around the room. Following these activities the subjects processed how much trust it required and how they would need a lot of trust to share and support each other in the group. The final part of group consisted of the subjects going through song books of popular songs and being allowed to photocopy a song to take home and for possible use in future groups. Subjects were asked to share

how they felt about the first group and were asked to come the next week with ideas for songs to learn.

### No Music Therapy Group

Week 1: The subjects were asked to give their names and tell something about themselves to the other group members. Goals for the group were set forth by the subjects: 1. Learn to deal with anger effectively. 2. Find ways to deal with problems. 3. Learn to express yourself and your feelings. 4. Learn not to blame yourself. 5. Have more self-confidence. 6. Become more grown-up. 7. Learn to trust again. Ground rules were established as follows: 1. One person talks at a time. 2. You can pass if you do not want to share. 3. Confidentiality. 4. No put-downs. 5. Attend regularly. 6. Be honest. The meaning of a support group was discussed. The subjects were asked to name persons in their lives who had been supportive and how they were supportive. The subjects responded to the question of how they could be supportive to each other as the group proceeded. The group was then asked to participate in a trust activity. They were paired off and instructed to turn their backs to each other and to push against one another as they slowly sat down on the floor from a standing position. Next, the subjects took turns blindfolding each other and leading the blindfolded one around the room. Following these activities the subjects processed how much trust it required and how they would need a lot of trust to share and support each other in the group. There was still some time left for the group, and the subjects were asked to write down on a piece of paper how they felt that their sexual abuse had affected their ability to trust others. They were instructed to fold the paper up, and then the papers were put in a bowl and mixed up. They took turns reading the papers and were given the opportunity to give feedback to what had been

written. The subjects were asked how they felt about the first group, and they were asked to come the next week with topic ideas for future groups.

### Music Therapy Group

Week 2: Each subject shared how their week went, and they were given the opportunity to share songs that they liked for possible use in future groups. The group was paired off and the group members were asked to conduct an interview with their partner (See Appendix D). It was thought that this would be less confrontive for the subjects and would be more effective for the group members to get to know each other better since they had all been very reluctant to share much about themselves in the previous session. They shared what they had learned about their partner with the other group members. The next activity consisted of a tape being played which contained excerpts from eleven different songs (See Appendix D). The subjects were asked to choose one song that they identified with and to share with the group why they identified with that particular song. This activity was non-confrontational and allowed the subjects to choose from a wide variety of songs which could facilitate disclosure such as "Sometimes I Feel Like a Man in the Wilderness" or probably would not facilitate disclosure such as "Born in the USA". The final activity was playing the song "What's the Matter Here?" by 10,000 Maniacs (1987). Discussion of the lyrics followed. Closure was brought to the group by the subjects being asked how they felt about the group and what had taken place.

### No Music Therapy Group

Week 2: Each subject shared how their week went, and they were given the opportunity to offer suggestions of topics for future groups. The group was paired off and the subjects were asked to conduct an interview with their partner (See Appendix D). It was thought that this would be less confrontive for the subjects and

would be more effective for the group members to get to know each other better since they had all been very reluctant to share much about themselves in the previous session. They shared what they had learned about their partner with the other group members. The subjects were then asked to brainstorm feelings and list them on the bulletin board. They were then asked to choose a feeling and to share with the group why they identified with that particular feeling. This activity was non-confrontational as the subjects could choose happy , sad, angry, hurt, disappointed, silly, and etc. The subjects were then asked to take paper and magic markers and to represent one feeling through art. Volunteers shared their artwork with the group and named the feeling that they were portraying. There was not much processing of this activity as it was too early in the group formation and trust had not been developed yet. Processing could have been too confrontive at this point. The subjects were given an opportunity to express their feelings about the activities of the session. Closure was brought to the group by the subjects being asked how they felt about the group and what had taken place.

### Music Therapy Group

Week 3: The session opened with the subjects relating how their week had gone. The first activity concerned change. The song "Man in the Mirror" by Michael Jackson (1987) was played. Discussion of the song lyrics followed. The song was played again and the group members were asked to draw a picture of themselves in a photocopy of a mirror while the song was playing. When the song was finished, they were asked to list attributes of themselves on the front of the picture and to list on the back of the picture the things that they wanted to change about themselves. They were asked to each in turn share their self-portrait and the items they had listed on front and back. Group members were encouraged to lend support and ideas for ways

to change to the subject who was sharing. At the end of group the song "Changing Every Day" by Culture Club (1983) was played and the subjects discussed the lyrics. Closure was brought to the group by group members being asked how they felt about the group and what had taken place.

#### No Music Therapy Group

Week 3: The session opened with the subjects sharing how their week had gone. The first activity concerned change. The subjects were asked to share significant changes which had taken place in their lives. They were asked to draw a picture of themselves in a photocopy of a mirror. They were also asked to list attributes of themselves on the front of the picture and to list on the back of the picture the things that they wanted to change about themselves. The subjects shared their self-portrait and the items they had listed on front and back with the group. Group members were encouraged to lend support and ideas for ways to change to the subject who was sharing. The subjects role played themselves as being changed as they interacted with a partner. They were given suggestions for scenarios to role play their "changed self". This activity was processed and the subjects were given the opportunity to say how they felt while they were acting out their changed self. The final part of group involved the subjects sharing what things they would like to change about their lives. Support and ideas for these changes was given by the group members. Closure was brought to the group by the subjects being asked how they felt about the group and what had taken place.

#### Music Therapy Group

Week 4: Check in time with the subjects sharing how their week had gone. The subjects were offered the opportunity to volunteer to tell the other group members who had sexually abused them and to share details of their sexual abuse. Next, this

experimenter played the guitar and sang the lyrics to the song "Dust in the Wind" by Kerry Livgren (Most known for the rendition by the group "Kansas"), (1977, 1978). Lyric sheets were passed out and the subjects were asked to join in and sing along. After they were confident that they knew the melody, they were handed out a form with lines to the song for them to complete. The beginning of the lines had been changed in order to make the song more applicable to the subjects and their situation. The subjects were then asked to share their song lyrics with the other group members. Then a group activity followed where they were asked to do the activity as a group and write the lyrics on the blackboard. The song that they wrote as a group can be found in Appendix D. The group sang the song together with guitar accompaniment. The subjects discussed their thoughts and feelings concerning the lyrics they had written as a group. Following this activity, the subjects were asked to use musical instruments to express at least two feelings related to their sexual abuse. They had access to various instruments such as an electric bass, a drum, a tambourine, the electronic keyboard and various small percussion instruments. They were given some time to experiment with the instruments and then were asked to play their "feelings" for the other group members. The other group members would try to guess which feeling they had portrayed. Closure to the activity involved asking the subjects if the musical improvisation helped them to get more in touch with certain feelings and if so which ones. They were asked how it felt for them to express these feelings through music. Copies of the original song written in the group were made for the group members to take home with them. Closure was brought to the group by the subjects being asked how they felt about the group and what had taken place.



### No Music Therapy Group

Week 4: The group began with check in time and the subjects shared events from the previous week. Following this, the subjects were offered the opportunity to volunteer to tell the other group members who had sexually abused them and to share details of their sexual abuse. The subjects were handed out a sentence completion sheet and were asked to fill in the words to complete the sentence. It was suggested that they could make it read like a poem if they so wished. Volunteers shared their poems and were given feedback from the group. The subjects were asked to do the same sentence completion but this time as a group (See Appendix D). They completed the sentences on the blackboard. They read it together as a group and then discussed their thoughts and feelings concerning the poem. The next activity was a feeling charade game. The subjects were asked to write down on three separate slips of paper three feelings which they had that were connected to their sexual abuse. These were folded and placed in a bowl and mixed up. The subjects took turns drawing a feeling from the bowl and acting out the feeling until someone guessed it. They were given the option to pass the feeling to another or to put it back in the bowl and draw another if they did not want to do that particular feeling. Discussion followed this activity with emphasis on processing how they felt about acting out these feelings and why they were reluctant to do certain feelings. Copies were made of the poem for the group members to take home. Closure was brought to the group by the subjects being asked how they felt about the group and what had taken place.

### Music Therapy Group

Week 5: The group began with check in time and the subjects shared events from their lives during the past week. The subjects were again offered the opportunity to share details of their sexual abuse with the other group members. The

subjects were introduced to the electronic drum machine and were allowed to experiment with creating tracks with various beat patterns. The subjects were asked to work together to create a beat pattern that would sound appropriate for a "Rap" song. They experimented until they were satisfied with a particular rap beat. The subjects had gained some skill at song writing the previous week in a non-confrontational way, and it was decided that they were now ready to write a song on their own. They were asked to brainstorm lyrics for a "Rap" song and these ideas were put on the blackboard. The subjects were given freedom to choose their topic for the song. They eventually came to a consensus on the lyrics. They played the "Rap" beat on the electronic drum machine and did the "Rap" lyrics "Shopping at the Mall" (See Appendix D) to the beat. They were asked how it felt to express their ideas and feelings through song writing. The subjects were asked what feelings they associated with their sexual abuse. They listed anger, aloneness, fearfulness, and shame. These feelings were processed with the emphasis on reducing or getting rid of these feelings. Lyric sheets were passed out for the song "Best of Times" by Peter Cetera (1988). Discussion of lyrics followed listening of the song. The group members stated during closure that they wanted a copy of the "Rap", and they were promised that the lyrics would be typed up and passed out at the next session.

#### No Music Therapy Group

Week 5: The group began with check in time and the subjects shared events from their lives during the past week. They were again offered the opportunity to share details of their sexual abuse with the other group members. The subjects were asked to participate in an art activity. They were given a large mural size piece of paper and provided with magic markers. They were asked to jointly create a mural to put up in the room. They were asked to draw something which they thought

represented some aspect of their sexual abuse. Next they were asked to brainstorm feelings which they might have had regarding their sexual abuse. They listed depressed, sadness, frustration, confusion, anger, rage, fear, and shame. These feelings were processed with the emphasis on reducing or getting rid of these feelings. The group members shared ideas for solutions. Closure was brought to the group by the subjects being asked how they felt about the group and what had taken place.

### Music Therapy Group

Week 6: "Rap" lyrics were passed out. The subjects were asked to share any crises which they may have had during the previous week. The subjects were given the opportunity to disclose any details of their sexual abuse. Following this, they were told that they would not be asked specifically to share details of their sexual abuse at the beginning of group again, but they were encouraged to do so at any time during the remainder of the groups. They were asked to write another "Rap" song. The topic for the "Rap" which they wrote in this group had to in some way deal with their sexual abuse. The result of that "Rap" was entitled "The Grace House Rap" (See Appendix D). The subjects performed the "Rap" several times along with the electronic drum machine and with rhythm instruments. Next, the subjects participated in an album cover activity where they were given a piece of white cardboard the exact size of an album cover and magic markers. They were asked to title the album cover what they would name themselves or their experiences. They were asked to list songs on the back which were songs that they had made up themselves and that had to do with their feelings or experiences. They listened to the instrumental music of Andreas Vollenweider while completing their albums. The music was from the album "Caverna Magica" (1983 CBS Inc.). The subjects shared their art work with the

group and read the songs they had written on the back. They were encouraged to give each other feedback on their artwork and songs. The subjects were asked to look deeper into the meaning of their artwork and songs to see if there were hidden messages about themselves. Closure was brought to the group by the subjects being asked how they felt about the group and what had taken place.

#### No Music Therapy Group

Week 6: Group members were asked to share any crises which they may have had during the previous week. The subjects were given the opportunity to disclose any details of their sexual abuse. Following this, they were told that they would not be asked specifically to share details of their sexual abuse at the beginning of group again, but they were encouraged to do so at any time during the remainder of the groups. Since the group had listed one of their goals as "Find ways to deal with your problems" it was decided that this would be the theme of this group. A problem solving activity was used. The subjects were asked to think of a problem which they had. They chose "Boredom" for the first problem. The subjects brainstormed solutions to the problem. Then they were each asked to think of three problems which they had and to write them down on paper. They were asked to write down possible solutions to the problems which they listed. The group reformed and the subjects were asked to share with the other group members their problems and solutions. The subjects were encouraged to give each other feedback about other possible solutions or ways that they had learned to deal with that problem in a different way. Next the subjects were asked to brainstorm problems related to their sexual abuse. They were asked to think of possible solutions for these problems also. Closure was brought to the group by the subjects being asked how they felt about the group and what had taken place.

### Music Therapy Group

Week 7: The subjects were asked to share any crises that they may have had during the previous week. This session was centered around personal boundaries. The instrumental music of Andreas Vollenweider, "Down to the Moon" (1986, Sinus Studio) was used to facilitate imagery. A short section of relaxation preceded the imagery. The subjects were asked to picture themselves some place outdoors, and they were asked to imagine a person coming towards them. They were to have an interaction of some type with this person. Then the person would walk away and the subjects would return to reality in the therapy room. This activity was processed as the subjects discussed their experiences through imagery and were able to see boundary problems that they had individually. The subjects were then asked to draw themselves and then to draw a boundary around themselves as they imagined theirs would look like. Instrumental music from "The Rick Wakeman New Age Collection, The Family Album" (1987, President Records Ltd) was played during this activity. This activity was processed as the subjects shared their drawings and gained insight into the problems with their boundaries. The subjects were asked to write a "Rap" about their boundaries. They came up with the Rap they titled "If He Trys" (See Appendix D). They performed the "Rap" along with a beat pattern from the electronic drum machine. Closure was brought to the group by the subjects being asked how they felt about the group and what had taken place.

### No Music Therapy Group

Week 7: The subjects were asked to share any crises that they may have had during the previous week. This session was centered around personal boundaries. The first activity involved relaxation and imagery. The subjects were asked to picture themselves some place outdoors, and they were asked to imagine a person coming

towards them. They were to have an interaction of some type with this person. Then the person would walk away and the subjects would return to reality in the therapy room. This activity was processed as the subjects discussed their experiences through imagery and were able to see boundary problems that they had individually. The subjects were then asked to draw themselves and then to draw a boundary around themselves as they imagined theirs would look like. This activity was processed as group members shared their drawings and gained insight into the problems with their boundaries. The final activity involved role playing interactions with others where they practiced assertive boundaries and ways to protect their boundaries. Closure was brought to the group by the subjects being asked how they felt about the group and what had taken place.

#### Music Therapy Group

Week 8: The subjects were asked to share any crises that they may have had during the week. The topic for this session was "Touch". The first activity was "Body Sculpting of Emotions". Background instrumental music from "The Tomita Planets", 1976, RCA Records, was used which is actually a synthesized version of Gustav Holst's "The Planets". Subjects were instructed to pay attention to their own feelings and their partner's feelings while they were portraying various emotions. They were told that if they felt uncomfortable being touched as their partner moved their body around to portray an emotion, they could choose to ask the person to not touch them but to instruct them verbally how to move their body. They were also told that this would be an excellent opportunity for them to practice assertiveness and being sensitive to others. Next, the song "Looking Up" by Donna Summer (1980) was played and group members did round-robin back rubs. Discussion followed about their experiences with this activity as it related to their personal boundaries and

the need for them to develop ways to touch which are nurturing and not sexual. The subjects discussed the lyrics of the song "Looking up". They were told that they could bring a tape to the next session to play near the end of the session. Closure was brought to the group by the subjects being asked how they felt about the group and what had taken place.

#### No Music Therapy Group

Week 8: Group members were asked to share any crises that they may have had during the week. The topic for this session was "Touch". The first activity was "Body Sculpting of Emotions". Subjects were instructed to pay attention to their own feelings and their partner's feelings while they were portraying various emotions. They were told that if they felt uncomfortable being touched as their partner moved their body around to portray an emotion, they could choose to ask the person to not touch them but to instruct them verbally how to move their body. They were also told that this would be an excellent opportunity for them to practice assertiveness and being sensitive to others. Next, the group members did round-robin back rubs. Discussion followed about their experiences with this activity as it related to their personal boundaries and the need for them to develop ways to touch which are nurturing and not sexual. The subjects were asked to list on the blackboard instances of nurturing touch and instances of non-nurturing touch. They were encouraged to think of ways to get nurturing touch and ways to keep from getting non-nurturing touch. Closure was brought to the group by the subjects being asked how they felt about the group and what had taken place.

### Music Therapy Group

Week 9: The subjects were asked to share any crises that they may have had during the previous week. Two songs were played; "Let's Wait Awhile" by Janet Jackson (1986), and "I Want your Sex" by George Michael (1987). Discussion followed concerning the two contrasting portrayals of sex. The "I Want your Sex" song's idea involves the man pressuring the woman to have sex, and the "Let's Wait Awhile" song's idea is to think out and not make hasty decisions when considering sexual interaction. The "Are You Ready for Sex" (See Appendix D) handout was passed out next, and group members took turns reading aloud. Discussion of this handout followed. The next part of the group was spent talking about birth control. The subjects were given information about Planned Parenthood and encouraged to visit the organization if they were sexually active. The subjects spent the remainder of the session role playing scenarios of encounters with the opposite sex building on what they had learned and experienced from sessions 7 and 8. They practiced their assertive skills involving touch and practiced asserting their boundaries. At first this experimenter invented scenarios and then the group members took over and thought up their own. The group concluded with the group members playing their tapes. Several of the group members danced while the others sat back and watched. This activity proved to be an excellent tension reliever for those who chose to participate as the session was quite tense considering the topic. Closure was brought to the group by group members being asked how they felt about the group and what had taken place.

### No Music Therapy Group

Week 9: Group members were asked to share any crises that they may have had during the previous week. The "Are You Ready for Sex" (See Appendix D)



handout was passed out next, and group members took turns reading aloud. Discussion of this handout followed. The next part of the group was spent talking about birth control. The subjects were given information about Planned Parenthood and encouraged to visit the organization if they were sexually active. The subjects were then asked to respond to direct questions which were written on the blackboard.

1. How has the sexual abuse changed your feelings about sex? 2. How do you make choices about sexual feelings? 3. What would you need from a relationship to feel okay about being sexually involved? The subjects spent the remainder of the session role playing scenarios of encounters with the opposite sex, building on what they had learned and experienced from sessions 7 and 8. They practiced their assertive skills involving touch and practiced asserting their boundaries. At first this experimenter invented scenarios and then the group members took over and thought up their own. Closure to the group involved the subjects being asked to try out their new skills they learned in group during the week.

#### Music Therapy Group

Week 10: The subjects were asked to share any crises that they may have had during the previous week. The topic of this session was "Confronting the Offender". Tracy Chapman's song "For you" (1988) was played and discussion of lyrics followed. The subjects were asked if the lyrics of this song could be coming from a person who had been sexually abused and who was writing to her offender. Discussion followed. The subjects were then asked to write a letter to their offender. Background instrumental music from Ray Lynch's "Deep Breakfast" tape (1984, Ray Lynch Productions) was used. The subjects were then asked to volunteer to share their letters with the others. Focus was on the courage it took to do this and what their feelings were about accomplishing this. The emphasis was on empowerment

and how confronting the offender either in person or on paper can often empower the person who has been sexually abused. There was discussion of how their power had been taken away when they were molested, and discussion of other ways to empower themselves besides writing the letter. The song "Love Will Find a Way" by Lionel Richie was played and the lyrics were discussed. The focus of the discussion was on the pain that the subjects had experienced from their sexual abuse, but also on hope and encouragement, and the fact that love in their hearts will help them find a way through rough times. Closure was brought to the group by the subjects being asked how they felt about the group and what had taken place.

#### No Music Therapy Group

Week 10: The subjects were asked to share any crises that they may have had during the previous week. The topic of this session was "Confronting the Offender". The subjects were asked if they had ever thought about what they would say to their offender if they had the opportunity to do that. The subjects were then asked to write a letter to their offender. Group members were asked to volunteer to share their letters with the others. Focus was on the courage it took to do this and what their feelings were about accomplishing this. The emphasis was on empowerment and how confronting the offender either in person or on paper can often empower the person who has been sexually abused. There was discussion of how their power had been taken away when they were molested, and discussion of other ways to empower themselves besides writing the letter. They were asked to brainstorm ideas of ways to empower themselves and these were written on the blackboard. Next, the subjects enjoyed drawing themselves on the blackboard as super heroes. Closure was brought to the group by the subjects being asked how they felt about the group and what had taken place.

### Music Therapy Group

Week 11: The subjects were asked to share any crises they may have had during the previous week. This group consisted of the subjects discussing what types of coping mechanisms that they use when they are having flashbacks or memories of their sexual abuse. Suggestions were offered by the group members to each other and this experimenter offered suggestions also. The group participated in relaxation and imagery to the instrumental music of "Chariots of Fire" (1981, Polydor LTD). The subjects were taught how to do their own relaxation and imagery as a technique to relieve anxiety and as a medium for replacement of flashbacks. They were taught techniques for "grounding" themselves when these intrusive feelings and thoughts are intense. These techniques of grounding were to talk to themselves and reassure themselves that they were here in the present, to focus on their surroundings which are in the present and not the past, and to immediately become involved in an activity which required them to think about the activity rather than the intrusive thoughts or feelings. Lyric sheets were passed out and the song "Child" by Holly Near (1983) was played. Group discussion followed with emphasis on the second verse. Subjects were asked how their mother reacted to their sexual abuse. They were encouraged to talk about their feelings towards their mothers and to offer suggestions for ways to improve their relationship with their mothers. Closure was brought to the group by the subjects being asked how they felt about the group and what had taken place.

### No Music Therapy Group

Week 11: The subjects were asked to share any crises they may have had during the previous week. This group consisted of the subjects discussing what types of coping mechanisms that they use when they are having flashbacks or

memories of their sexual abuse. Suggestions were offered by the group members to each other and this experimenter offered suggestions also. The group participated in relaxation and imagery. They were taught how to do their own relaxation and imagery as a technique to relieve anxiety and as a medium for replacement of flashbacks. They were taught techniques for "grounding" themselves when these intrusive feelings and thoughts are intense. These techniques of grounding were to talk to themselves and reassure themselves that they were here in the present, to focus on their surroundings which are in the present and not the past, and to immediately become involved in an activity which required them to think about the activity rather than the intrusive thoughts or feelings. Following this activity the subjects were asked how their mother reacted to their sexual abuse. They were encouraged to talk about their feelings towards their mothers and to offer suggestions for ways to improve their relationship with their mothers. Closure was brought to the group by the subjects being asked how they felt about the group and what had taken place.

### Music Therapy Group

Week 12: The subjects shared any crises which they may have had the previous week. Copies of the poem entitled "Code of Silence" were passed out (See Appendix D). The subjects took turns reading the lines. This experimenter played a twelve bar blues riff on the guitar and showed the subjects how to fit the words to the handout into the song. The group sang the verses through several times, each time getting more of a feel for the rhythm. Discussion of the lyrics followed. Emphasis was on the importance of disclosure and talking about their sexual abuse in order to "Lose the anger" as the poem states. The subjects thought of ways to reduce and get rid of their anger. Guided imagery followed to the instrumental music of "Kitaro", (1988, Amuse America Inc.). The imagery involved picturing their anger as a colored

liquid inside a form of their own body. They were asked to imagine the colored liquid draining out of their body slowly and being replaced by a different colored liquid and a different feeling. Following the imagery, the subjects shared their imagery with the other group members. They were encouraged to try imagery on their own when they were experiencing overwhelming feelings. The subjects individually shared their thoughts and feelings about the group. They did not need to terminate with each other as they were all to continue with the group after the termination of the experiment. They were then given the post-test for Self-confidence and the Hostility Inventory. The song "Lean on Me" by Club Nouveau (1987, 1986) was played while the subjects ate snacks. Group concluded with this experimenter playing the guitar while the subjects sang "That's What Friends are For" by Bacharach and Sayer (1982).

#### No Music Therapy Group

Week 12: The subjects shared any crises which they may have had the previous week. Copies of the poem entitled "Code of Silence" were passed out (See Appendix D). The subjects took turns reading the lines. Discussion of the poem followed. Emphasis was on the importance of disclosure and talking about their sexual abuse in order to "Lose the anger" as the poem states. The subjects thought of ways to reduce and get rid of their anger. Guided imagery was used which involved picturing their anger as a colored liquid inside a form of their own body. They were asked to imagine the colored liquid draining out of their body slowly and being replaced by a different colored liquid and a different feeling. Following the imagery, the subjects shared their imagery with the other group members. They were encouraged to try imagery on their own when they were experiencing overwhelming feelings. The subjects individually shared their thoughts and feelings about the

group. They did not need to terminate with each other as they were all to continue with the group after the termination of the experiment. They were then given the post-test for Self-confidence and the Hostility Inventory. Afterwards they ate snacks and socialized the last ten minutes of group.

Appendix H  
HSIRB Acceptance Form



*Human Subjects  
Institutional Review Board*

TO: Joy Clendenon-Wallen  
FROM: Ellen Page-Robin, Chair *EP-R*  
RE: Research Protocol  
DATE: September 1, 1988

This letter will serve as confirmation that your research protocol, "The Effect of Music Therapy on the Self-Confidence of Sexually Abused Adolescents" is now complete and has been signed off by the HSIRB.

If you have any further questions, please contact me at 387-2647.



**Human Subjects Institutional Review Board  
Human Subjects Approval Form**

Received: \_\_\_\_\_

**DIRECTIONS:** Please type or print each response - except signatures. Ref. to the Western Michigan University Policy for the Protection of Human Subjects to determine the appropriate level of review.

**PRINCIPAL INVESTIGATOR** Joy Clendenon-Wallen, RMT-8C **DEPARTMENT** Music Therapy

**Home Phone** (513) 298-8934 **Office Phone** (513) 461-5143

**Home Address** 2965 Berkley Ave. **Office Address** 945 Brown St.

Kettering, OH 45409 Dayton, OH 45409

**PROJECT TITLE:** The Effect of Music Therapy on the Self-Confidence of Sexually Abused Adolescents

**SUBMISSION DATE:** 7-8-88 **PROPOSED PROJECT DATES** Sep. 88 **TO** Nov. 88

**Note:** The principal investigator should not initiate the research project until the protocol has been reviewed and approved by the Human Subjects Institutional Review Board.

**APPLICATION IS:** ☒ New ☐ Renewal ☐ Continuation ☐ Supplement

**SOURCE OF FUNDING:** \_\_\_\_\_  
(if applicable)

Joy Clendenon-Wallen, RMT-8C  
Signature of Investigator

**STUDENT RESEARCH (Fill out if applicable.)**

**Name of Student** Same **Phone** \_\_\_\_\_ **Address** \_\_\_\_\_

**The research is:** ☐ Undergraduate Level ☒ Graduate Level

**Faculty Advisor** Brian Wilson, RMT-8C **Department** Music Therapy

**Signature of Faculty Advisor** Brian F. Wilson **Phone** 7-4724

**VULNERABLE SUBJECT INVOLVEMENT (Fill out if applicable.)**

**Research involves subjects who are:** (check as many as apply)

- |   |   |
|---|---|
| 1. <input checked="" type="checkbox"/> <u>children</u><br><u>approximate age 15-18</u>                    | 6. <input type="checkbox"/> <u>Other subjects whose life circumstances may interfere with their ability to make free choices in consenting to take part in research</u> |
| 2. <input type="checkbox"/> <u>mentally retarded persons</u><br><u>check if institutionalized</u>         | _____   |
| 3. <input checked="" type="checkbox"/> <u>mental health patients</u><br><u>check if institutionalized</u> | _____   |
| 4. <input type="checkbox"/> <u>prisoners</u>  | _____   |
| 5. <input type="checkbox"/> <u>pregnant women</u>   | (Describe Please)   |

HSIRB

Received: \_\_\_\_\_

LEVEL OF REVIEW: Please indicate here if you think that the research project is exempt from review, subject to expedited review, or subject to full review.

\_\_\_\_ Exempt (Forward 1 application to IRB Chair)

Which category of exemption applies? # \_\_\_\_\_

\_\_\_\_ Expedited (Forward 2 applications to IRB Chair)

X Subject to full IRB review (Forward 3 applications to IRB Chair)

Comments: Grace House, the sexual abuse center that has expressed interest in this research project, wants to sponsor an adolescent support group beginning in September, 1988. This group would provide an ideal opportunity for me to begin the research.

Your application was reviewed and the Human Subject Institutional Review Board (HSIRB) has determined that:

- \_\_\_\_ 1. The proposed activities, subject to any conditions and/or restrictions indicated in Remarks below, have (a) provided adequate safeguards to protect the rights and welfare of human subjects involved, (b) established appropriate procedures and/or documents to obtain informed consent, and (c) demonstrated that the potential benefits of the research substantially out-weigh the risks.
- \_\_\_\_ 2. The proposed activities, for reasons indicated in Remarks below do not provide adequate protection for the rights and welfare of the human subjects.

At its meeting on \_\_\_\_\_, the HSIRB (approved) (provisionally approved... see remarks) this application with regard to the treatment of human subjects. The HSIRB categorized this application as:

- \_\_\_\_ 1. Involving subjects at no more than minimal risk.
- \_\_\_\_ 2. Involving subjects at more than minimal risk.

REMARKS:

\_\_\_\_\_  
Signature HSIRB Chair

\_\_\_\_\_  
Date

Protocol #:

**DIRECTIONS:** Please type or print the requested information - except signatures. You may attach additional sheets as necessary and reference the appropriate page.

**PRINCIPAL INVESTIGATOR:** Jov Clendenon-Wallen, RMT-8C **Date** 6-22-88

**TITLE OF PROJECT:** The Effect of Music Therapy on the Self-Confidence of Sexually  
.. Abused Adolescents.

**ABSTRACT:** Briefly describe the purpose, research design, and site of the proposed research activity.

The purpose of this study is to determine if the use of music therapy activities in an adolescent support group will increase significantly the self-confidence of group members, as compared to a no-music-therapy adolescent support group, or control group. Both of these support groups will consist of sexually abused adolescents. Music therapy activities will be provided during 12 weekly sessions to the experimental group.

The 34-item core of descriptors pertaining to self-confidence was extracted from the 300-item Adjective Check List (Gough, Heibron, 1983 ed.). This core of descriptors contains 20 indicative items and 14 contraindicative items of self-confidence. The items were randomly arranged on the checklist. A pre- and post-test will be administered to the control group and the experimental group. The hypothesis is that the group receiving music therapy will report more indicative items and fewer contraindicative items relating to self confidence on the post-test, compared to the no-music-therapy control group.

In addition to the Adjective Check List instrument, the Music Therapy Attitudinal Observation Inventory will be used to gather data on individual subjects for each session. The level of participation of individual group members and their attitudes toward the music therapy activities will be recorded. The categories of participation include high participation, low participation, and undecided level of participation (varied participation response). The categories of attitude include wholehearted attitude, reluctant attitude, and undecided (varied attitude response).

The data gathered from this instrument should support the data obtained from the Adjective Check List. The hypothesis is that the higher the participation and the more wholehearted

(continued--see attached page)

**CHARACTERISTICS OF SUBJECTS:** Briefly describe the subject population (e.g., age, sex, prisoners, people in mental institutions, etc.). Also indicate the source of subjects.

The subjects will be 12 male or female victims of sexual abuse, age 15-18. The subjects will be randomly selected from a list of those interested in participating in an adolescent support group. Fliers will be sent out to community mental health centers, social service agencies, and counseling centers in order to announce the formation of the group. Selected group members will be those adolescents who are in therapy but currently functioning within the community. They may be living at home or in foster care.

**SUBJECT SELECTION:** How will the subjects be selected? Approximately how many subjects will be involved in the research?

The group will be limited to 12 members and the subjects will be randomly selected from a list of possible subjects who have identified themselves as being interested in participating in such a group.

Protocol #:

**CONFIDENTIALITY OF DATA:** Briefly describe the precautions that will be taken to ensure the privacy of subjects and confidentiality of information. Be explicit if data is sensitive.

A numerical coding system will be used to identify each subject. Both the coding system and the subject's file will be kept in a locked desk drawer of the investigator's desk which is accessible only to the investigator. All names will be removed upon receipt of post-test data.

**BENEFITS OF RESEARCH:** Briefly describe the expected benefits of the research. Typically, victims of sexual abuse have poor body images, lack self-confidence and self-esteem. The research project will benefit group members by providing opportunities to increase their self-confidence, self-expression, and improve their body images. This will be accomplished through song writing, dance and movement to music, musical improvisation, and music skills. In addition, this research project seeks (continued--see attached):

**NO SUBJECTS:** Briefly describe the nature and likelihood of possible risks (e.g., physical, psychological, social) as a result of participation in the research.

The risk should be no greater than any expected risk of the no-music-therapy control group, although no risk appears likely to occur.

**PROTECTION FOR SUBJECTS:** Briefly describe measures taken to protect subjects from possible risks, if any.

Shirley Shroer, L.I.S.W., the clinical director of the sexual abuse resource center, will lead the group. As an experienced professional therapist, she will aid in processing sensitive issues or information that may arise during the course of the group.

As standard procedure, ground rules for the group will be established. These rules will state that any information revealed during group meetings will never be repeated to anyone outside the group. In addition, no subject will be forced to share information unwillingly. All subjects must treat other group members with respect.

**INFORMED CONSENT:** Please attach a copy of the informed consent form. If oral consent will be obtained, describe procedures for obtaining and documenting such consent. (Subject should be given a copy of the consent form).

Two forms attached.

**QUESTIONNAIRES OR INTERVIEW SCHEDULES:** If questionnaires, interview schedules or data collection instruments are used, please identify them and attach a copy of what will be used in the project.

Questionnaire attached. Two data collection instruments attached.

Continuation of Abstract:

the attitude, the greater the self-report of items indicative of self-confidence.  
A simple questionnaire will be administered to the experimental group at the initiation of therapy in order to gain useful information for the music therapist.

Continuation of Benefits of Research

to provide evidence of the benefits of music to this population in order to promote the field of music therapy in newly evolving areas of the discipline.

## BIBLIOGRAPHY

- Adams-Tucker, C. (1984). Early treatment of child incest victims. American Journal of Psychotherapy, 38(4), 505-514.
- American Psychiatric Association. (1987). Diagnostic and statistical manual of mental disorders. (3rd ed. revised). Washington, DC: Author.
- Bagley, C. & Ramsey, R. (1985). Disrupted childhood and vulnerability to sexual assault: Long-term sequels with implications for counseling. Paper presented at the Conference on Counseling the Sexual Survivor, Winnipeg, Canada.
- Bayer, C. & Bacharach, B. (1982). That's What Friends Are For. Burbank, CA: Warner Brothers Music Corp.
- Bergart, A.M. (1986). Isolation to intimacy: Incest survivors in group therapy. Social Casework: The Journal of Contemporary Social Work, 67(5), 266-275.
- Blake-White, J. & Kline, C. (1985). Treating the dissociative process in adult victims of childhood incest. Social Casework, 66, 394-402.
- Blitstein, S. & Michel, J. (1979). Use of videotape feedback with severely disturbed adolescents. Child Welfare, 58(4), 245-52.
- Blume, E.S. (1990). Secret survivors: Uncovering incest and its aftereffects in women. New York: John Wiley and Sons.
- Boatman, B. & Borkan, E. (1981). Treatment of child victims of incest. The American Journal of Family Therapy, 9(4), 43-50.
- Bradshaw, J. (1988). Healing the shame that binds you. Deerfield Beach, FL: Health Communications, Inc.
- Branden, N. (1969). The psychology of self-esteem. New York: Bantam Books.
- Brooks, B. & Dalby, R. (1990). The self-esteem repair & maintenance manual. Long Beach, CA: Kincaid House.
- Brown, S. (1979). Clinical illustrations of the sexual misuse of girls. Child Welfare, 58(7), 435-442.
- Buck, J. (1981). House, tree, person techniques. (rev. ed). Los Angeles: Western Psychological Services.
- Buck, R. & Mershan, N. (1987). What's The Matter Here? In 10,000 Maniacs [singing group], In My Tribe. Burbank, CA: Elektra/Asylum Records.

- Buss, A.H. & Durkee, A. (1957). Buss-Durkee Hostility Inventory. In A Salter, Treating child sex offenders and victims (pp. 287-290). Newbury Park, CA: Sage Publications.
- Carozza, P. & Heirsteiner, C. (1982). Young female incest victims in treatment: Stages of growth seen with a group art therapy model. Journal of Clinical Social Work, 10(3), 165-175.
- Cassity, N. (1976). The influence of a music therapy activity upon peer acceptance, group cohesiveness, and interpersonal relationships of adult psychiatric patients, Journal of Music Therapy, 13(2), 66-76.
- Cavaiola, A. & Schiff, M. (1989). Self-esteem in abused chemically dependent adolescents. Child Abuse and Neglect, 13, 327-334.
- Cetera, P. & Leonard, P. (1988) Best of Times. One More Story. Burbank, CA: Warner Brothers Records, Inc.
- Chapman, T. (1988). For You. Burbank, CA: Elektra/Asylum Records.
- Clark, M. & Delson, N. (1981). Group therapy with sexually molested children. Child Welfare, 60(3), 175-182.
- Clendenon-Wallen, J. (1991). The use of music therapy to influence the self-confidence and self-esteem of adolescents who are sexually abused. Music Therapy Perspectives, 9, 73-81.
- Club Nouveau. (1987). Lean on Me. Burbank, CA: Warner Brothers Records, Inc.
- Cohen, F.W. & Phelps, R.E. (1985). Incest markers in children's artwork. Arts in Psychotherapy, 12(4), 265-283.
- Cohen, J. (1991). Psychotherapy meets fundamentalism in the treatment of an adolescent. In W. Friedrich (Ed.), Casebook of sexual abuse treatment (pp. 196-213). New York: Norton.
- Cohen, T. (1983). The incestuous family revisited. Social Casework: The Journal of Contemporary Social Work, 28(2), 154-161.
- Cole, C. & Barney, E. (1987). Safeguards and the therapeutic window: A group treatment strategy for adult incest survivors. American Journal of Orthopsychiatry, 57(4), 601-609.
- Courtois, C. (1979). The incest experience and its aftermath. Victimology: An International Journal, 4, 337-347.
- Courtois, C. & Sprei, J. (1988). Retrospective incest therapy for women. In L. Walker (Ed.), Handbook on sexual abuse of children (pp. 270-308). New York: Springer.

- Cratty, B. J. & Martin, M.M. (1969). Perceptual motor efficiency in children. Philadelphia: Lea & Febiger.
- Culture Club. (1983). Changing Every Day. Colour by Numbers. New York: Virgin Records, Ltd.
- De Francis, V. (1969). Protecting the child victim of sex crimes committed by adults. Denver, CO: American Humane Association.
- de Young, M. (1982). The sexual victimization of children. Jefferson, NC: McFarland.
- Downer, A. (1984, 1985). Prevention of child sexual abuse: A trainer's manual. Seattle, WA: Seattle Institute for Child Advocacy Committee for Children.
- Downer, A. (1984). The development and testing of an evaluation instrument for assessing the effectiveness of a child sexual abuse curriculum: Talking about touching. Seattle, WA: Committee for Children.
- Ellenson, G. (1989). Horror, rage, and defenses in the symptoms of female sexual abuse survivors. Social Casework: The Journal of Contemporary Social Work, 70(10), 589-596.
- Everstine, D.S. & Everstine, L. (1989). Sexual trauma in children and adolescents: Dynamics and treatment. New York: Brunner/Mazel.
- Favazza, A. & Conterio, K. (1988). The plight of chronic self-mutilators. Community Mental Health Journal, 24(1), 22-30.
- Ficken, T. (1976). The use of songwriting in a psychiatric setting. Journal of Music Therapy, 12(4), 163-172.
- Finkelhor, D. (1979). Sexually victimized children. New York: Free Press.
- Finkelhor, D. (1980). Risk factors in the sexual victimization of children. Child Abuse and Neglect, 4, 265-273.
- Finkelhor, D. (1986). A sourcebook on child sexual abuse. Newbury Park, CA: Sage Publications.
- Finkelhor, D. & Browne, A. (1988). Assessing the long-term impact of child sexual abuse: A review and conceptualization. In L. Walker (Ed.), Handbook on sexual abuse of children (pp. 55-71). New York: Springer.
- Friedman, S. (1988). A family systems approach to treatment. In L. Walker (Ed.), Handbook on sexual abuse of children (pp. 326-349). New York: Springer.
- Friedrich, W. (1990). Psychotherapy of sexually abused children and their families. New York: W. W. Norton.



- Fromuth, M. (1986). The relationship of childhood sexual abuse with later psychological and sexual adjustment in a sample of college women. Child Abuse and Neglect, 6, 95-102.
- Gallagher, M.M., & Slater, B.R. (1982). The Theme Creation Test for Youths. Experimental Edition. Baltimore, MD: Authors.
- Gans, J. (1989). Hostility in group therapy. International Journal of Group Psychotherapy, 39(4), 499-516.
- Garret, S., & Ballard, G. (1987). Man in the Mirror. In Michael Jackson [performer] "Bad". New York: MJJ Productions Inc., Epic, Sony Music Distributors.
- Giarretto, H. (1980). Humanistic treatment of father-daughter incest. In L. G. Schultz (Ed.), The sexual victimology of youth (pp. 140-162). Springfield, IL: Charles Thomas.
- Goldstein, E. (1988). Self-image characteristics of adolescent female incest victims. Dissertation Abstracts International, 47(1-B), 374. (University Microfilms No. DA 8603089)
- Gordon, L. (1955). Incest as revenge against the preoedipal mother. Psychoanalytic Review, 42, 284-292.
- Gough, H.G., & Heilbruh, A.B. (1983). The Adjective Check List. Palo Alto, CA: Consulting Psychologists Press.
- Groth, N. (1982). The incest offender. In S. Sgroi (Ed.), Handbook of clinical intervention in child sexual abuse (pp. 215-239). Lexington, MA: Lexington Books.
- Haugaard, J.J. & Reppucci, N.D. (1989). The sexual abuse of children. San Francisco, CA and London: Jossey-Bass.
- Henderson, S. (1983). Effects of a music therapy program upon the awareness of mood in music, group cohesion, and self-esteem among hospitalized adolescent patients. Journal of Music Therapy, 20(1), 14-20.
- Herman, J. (1981). Father-daughter incest. Cambridge, MA: Harvard University Press.
- Horowitz, M.J. (1976). Stress-response syndromes. New York: Jason Aronson.
- Jackson, J. (1986). Let's Wait Awhile. Control. Hollywood, CA: A&M Records, Inc.
- James, B. (1989). Treating traumatized children: New insights and creative interventions. Toronto, Canada: Lexington Books.

- Johnson, E.R. (1981). The role of objective and concrete feedback in self-concept treatment of juvenile delinquents in music therapy. Journal of Music Therapy, 18(3), 137-147.
- Kempe, R. & Kempe, H. (1984). The common secret: Sexual abuse of children and adolescents. New York: W.H. Freeman .
- Kinard, E. M. (1980). Emotional development in physically abused children. American Journal of Orthopsychiatry, 50(4), 686-696.
- Kitaro. (1988). Dawn/Rising Sun. Ten Years. Los Angeles, CA: Amuse America, Inc., Geffen Records.
- Kivland, M. J. (1986). The use of music to increase self-esteem in a conduct disordered adolescent. Journal of Music Therapy, 23(1), 25-29.
- Kline, D. (1977). Child abuse and neglect: A primer for school personnel. Reston, VA: Council for Exceptional Children.
- Langmade, C. J. (1983). The impact of pre- and postpubertal onset of incest experience in adult women as measured by sex anxiety, sex guilt, sexual satisfaction and sexual behavior. Dissertation Abstracts International, 44, 917B. (University Microfilms No. DA 8316517)
- Lew, M. (1988). Victims no longer. New York: Nevraumont.
- Livgren, K. (1977, 1978). Dust in the Wind. New York: Don Kirshner Music, Sony Music Entertainment.
- Lynch, R. (1984). Deep Breakfast. Stanford, CA: Ray Lynch Productions, Windham Hill Records.
- Maltz, W., & Holman, B. (1987). Incest and sexuality. New York: Lexington Books, Health & Co.
- Mannarino, A. & Cohen, J. (1986). A clinical-demographic study of sexually abused children. Child Abuse and Neglect, 10, 17-23.
- Mark, A. (1986). Adolescents discuss themselves and drugs through music. Journal Of Substance Abuse Treatment, 5, 247-249.
- McIntyre, M. C., & Livingston, R.N. (1984). Women, sex and alcoholism. Alcoholism, (1), 44-45.
- McKay, M. & Fanning, P. Self-esteem. Oakland, CA: New Harbinger.
- Meiselman, K. (1978). Incest: A psychological study of causes and effects with treatment recommendations. San Francisco: Jossey-Bass.
- Michael, G. (1987). I Want Your Sex. Monogamy Mix. New York: CBS Records.

- Michel, D. & Farrell, D. (1973). Music and self-esteem: Disadvantaged, problem in an all black elementary school. Journal of Research in Music Education, 21(1), 80-84.
- Michel, D. & Martin, D. (1970). Music and self-esteem research with disadvantaged, problem boys in an elementary school. Journal of Music Therapy, 7(4), 124-127.
- Mitchell, J. (1985). The Ninth Mental Measurement Yearbook, 1, 52-53. Lincoln, NE: University of Nebraska Press.
- Naitove, C.E. (1985). Protecting our children: The fight against molestation. A National Symposium, October 1-4, 1984-Washington, DC. The Arts in Psychotherapy, 12(2), 115-116.
- National Center on Child Abuse and Neglect. (1981). Study findings: National study of the incidence and severity of child abuse and neglect. DHHS Publication No. OHDS 81-30325 (pp. 4-5). Washington DC: U.S. Government Printing Office.
- Near, H. (1983). Child. Holly Near Watch Out!. Oakland, CA: Redwood Records.
- Neubauer, L. (1989). Self concept and patterns of substance abuse in female adolescents with a history of sexual abuse. Dissertations Abstracts International, 49, (11), 3271-A. (University Microfilms No. DA8902981)
- O'Brien, J. D. (1987). The effects of incest on female adolescent development. Journal of the American Academy of Psychoanalysis, 15(1), 83-92.
- O'Brien, S. (1986). Why they did it: Stories of eight convicted child molesters. Springfield, IL: Charles C. Thomas.
- Oppenheimer, R., Howells, K., Palmer, R.L., & Chaloner, D.A. (1985). Adverse sexual experiences in childhood and clinical eating disorders: A preliminary description. Journal of Psychiatric Research, 19(2-3), 357-61.
- Orr, D. & Downes, M. (1985). Self-concept of adolescent sexual abuse victims. Journal of Youth and Adolescence, 14(5), 401-409.
- Patten, S.B., Gatz, Y.K., Jones, B., & Thomas, D.L. (1989). Post-traumatic Stress Disorder and the treatment of sexual abuse. National Association of Social Workers, Inc, 34(3), 197-203.
- Perkins, D. Clinical work with sex offenders in secure settings. In C. Hollin & K. Howells, (Eds.), Clinical approaches to sex offenders and their victims (pp. 151-177). New York: John Wiley & Sons Ltd.
- Peters, J. (1976). Children who are victims of sexual assault and the psychology of offenders. American Journal of Psychotherapy, 30, 398-421.

- Powell, L. & Faherty, S. L. (1990). Treating sexually abused latency age girls: A 20 session treatment plan utilizing group process and the creative arts therapies. The Arts in Psychotherapy, 17, 35-47.
- Ragland, Z. & Apprey, M. (1974). Community music therapy with adolescents. Journal of Music Therapy, 11, 147-155.
- Ralston, E. (1986). Myths and facts about sexual abuse. Protecting Children, 3(1), 12-13.
- Richie, L. & Phillinganes, G. (1983). Love Will Find a Way. Hollywood, CA: Motown.
- Rush, F. (1980). The best kept secret: Sexual abuse of children. New York: McGraw-Hill.
- Russell, D. (1983). The incidence and prevalence of intrafamilial and extrafamilial sexual abuse of female children. In L. Walker (Ed.), Handbook on sexual abuse of children (pp. 19-36). New York: Springer.
- Saltman, V., & Solomon, R.S. (1982). Incest and the multiple personality. Psychological Reports, 50(2), 1127-1141.
- Salter, A. (1988). Treating child sex offenders and victims. Beverly Hills, CA: Sage.
- Schlesinger, B. (1982). Sexual abuse of children: A resource guide and annotated bibliography. Toronto, Canada: University of Toronto Press.
- Sears, W. (1968). Processes in music therapy. In E.T. Gaston (Ed.), Music in therapy (pp. 30-44). New York: Macmillan.
- Shapiro, S. (1987). Self-mutilation and self-blame in incest victims. American Journal of Psychotherapy, 41(1), 46-54.
- Sidun, N. M. & Rosenthal, R. (1987). Graphic indicators of sexual abuse in Draw-a-Person tests of psychiatrically hospitalized adolescents. The Arts in Psychotherapy, 14(1), 25-33.
- Skorina, J. K., & Kovach, J.A. (1986). Treatment techniques for incest-related issues in alcoholic women. Alcoholism Treatment Quarterly, 3(1), 17-30.
- Slater, B. (1988). Assessment-intervention interface using the theme creation test for youths. In L. Walker (Ed.), Handbook on sexual abuse of children (pp. 198-215). New York: Springer.
- Sloan, G. & Leichner, P. (1986). Is there a relationship between sexual abuse or incest and eating disorders. Canadian Journal of Psychiatry, 31(7), 656-660.

- Stovall, G. & Craig, R. (1990). Mental representations of physically and sexually abused latency-aged females. Child Abuse and Neglect, 14, 233-242.
- Summer, D. & Bellotte, P. (1980). Looking Up. Universal City, CA: GMPC/Sweet Summer Night Music, Geffen Music Productions.
- Tabor, G. L. (1984). Incest: Effects of specific trauma variables on the self-concepts and locus of control views of adolescent female incest victims before and following six months of group treatment. Dissertation Abstracts International, 46(10-B), 3609-3610. (University Microfilms No. DA 8528957)
- Tomita, I. (1976). The Tomita Planets. New York: RCA Records.
- Tufts' New England Medical Center, Division of Child Psychiatry. (1984). Sexually exploited children: Service and research project. (Final Report for the Office of Juvenile Justice and Delinquent Prevention). Washington, DC: U.S. Department of Justice.
- Vangelis. (1981). Chariots of Fire. New York: Polydor Records.
- Verleur, D., Hughes, R.E., Dobkin de Rios, M. (1986). Enhancement of self-esteem among female adolescent incest victims: A controlled comparison. Adolescence, 21(84), 843-854.
- Vollenweider, A. (1983). Caverna Magica. New York: CBS Inc.
- Vollenweider, A. (1986). Down to the Moon. Bern, Switzerland: Sinus Studio.
- Wakeman, R. (1987). The Family Album. The Rick Wakeman New Age Collection. London: President Records Ltd.
- Walker, L. & Bolkovatz, M. (1988). Play therapy with children who have experienced sexual assault. In L. Walker, (Ed.), Handbook on sexual abuse of children (pp. 249-269). New York: Springer.
- Walker, L. & Greene, J. (1986). The social context of adolescent self-esteem. Journal of Youth and Adolescence, 15(4), 315-322.
- Walsh, C. (1986). The self-concept and sex-role orientation of adult incest victims in therapy. Dissertation Abstracts International, 47 (5), 1611-A. (University Microfilms No. DA8618698)
- Waterman, J. & MacFarlane, K. (1986). Sexual abuse of young children. New York: The Guilford Press.
- Withers, B. (1972). Lean On Me. In Club Nouveau [singing group], Lean On Me Remix, (1987, 1986). Burbank, CA: Interior Music (BMI), Warner Bros. Records, Inc.

- Wolf, S., Conte, J. & Engel-Meinig, M. (1988). Assessment and treatment of sex offenders in a community setting. In L. Walker (Ed.), Handbook on sexual abuse of children (pp. 365-383). New York: Springer.
- Yates, A. and Beutler, L.E. (1985). Drawings by child victims of incest. Journal of Child Abuse and Neglect, 9, 183-189.