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The Effects of Music Therapy on the Self-Esteem and Locus of Control of Children Survivors of Domestic Violence

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THE EFFECTS OF MUSIC THERAPY ON THE SELF-ESTEEM AND LOCUS OF CONTROL OF CHILDREN SURVIVORS OF DOMESTIC VIOLENCE

by

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The purpose of this study was to measure the effects of a volunteer music therapy program on the self-esteem and locus of control of children survivors of domestic violence residing in a shelter for domestic violence. An experimental group which received music therapy and a no-contact control group were used in this study. The Coopersmith Self-Esteem Inventory Scale was used to measure the subjects' self-esteem while the Nowicki-Strickland Locus of Control scale was used to measure the subjects' locus of control in both groups. These tests were administered before and after treatment for the experimental group. The control group was pre-tested during their first week in the shelter, and post-tested during their last week.

No significant difference between groups was found for the subjects' self-esteem while significant differences were found between groups for the subjects' locus of control. It appeared that some individual subjects in the experimental group benefited from their involvement in the music therapy sessions.

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CHAPTER I

The Effects of Music Therapy on the Self-Esteem and Locus of Control ofChildren Survivors of Domestic Violence

Domestic violence is a widespread problem affecting families and couples of all races, religions, ethnic, socioeconomic, and sexual orientation statuses. It is estimated that every 18 seconds in America an incident of domestic violence occurs with approximately 95% of these incidents committed by men (Afolagan, 1993; Fortune, 1995). The number of battered women range between 1 to 6 million a year, approximately 3 million children witness spouse abuse (Straus, Gelles, & Steinmetz, 1980) with the number of children who are abused ranging from 1 1/2 to 2 million a year (Germain, 1984; Pynoos & Nader, 1990; Tomkins, Mohamed, Steinman, Macolini, Kenning, & Afrank, 1994). Studies by the American Humane Association indicate the one in six child abuse cases also involve abuse of the mother (Germain, 1984). A national survey investigating married couples estimated that 1.6 million wives in the United States are beaten or severely assaulted each year (Straus et al. 1980). Domestic abuse has been described as occurring in up to 16% of all marriages every year in 50%-60% of all marriages over their course (McKay, 1994). It has been suggested that newer marriages are more prone to violence, with a typical pattern of two to three serious attacks per year (Germain, 1984). Many researchers believe that most beatings are not reported whether they occur in marriages and other relationships.

Within the past two decades, an increased range of services have been established for those involved in domestic violence. The first shelter for battered women was established in Chiswick, England by Erin Pizzey in 1971 (Kuhl, 1984). Since then many communities have developed programs which offer assistance to

battered women. These programs include shelter, short and long-term counseling for the victims, batterers and children, advocacy, and support groups (Kuhl, 1982).

A variety of counseling techniques have been used with survivors of domestic violence. In a study examining the responses of the professional community to battered women, it was found that 77% of counselors talked with the women, 25% listened, 15% offered information, and 4% intervened. It has been suggested that abused women may be "incapable of seeking solutions to their abuse", thus a more direct approach may be more effective than a passive approach for these women (Kuhl, 1982, p.56).

The many elements of violence and abuse may include verbal, physical, sexual, and emotional aspects. Those who are affected include the intended victims, such as the mothers, and the unintended victims, such as the children. This paper will address the various types of violence as well as the various participants in the abuse, mainly focusing on the children.

The effects of domestic violence on children are many and include physical and psychological effects. Common problems include low self-esteem, deficits in social skills, conduct problems, low cognitive abilities, school problems, physical damage, and symptomatic reactions. These children may also develop helplessness and assume little responsibility in their lives. This will be referred to as "locus of control" in this paper. The effects of domestic violence on children will be discussed in more detail later as well.

It has been suggested that violence is a learned behavior (Straus et. al. , 1980). Early intervention may prevent children of domestic violence from becoming violent in their adult relationships. Therapeutic interventions need to take into account the trauma of living in a violent household, the family's postviolent adaptation, and the child's developmental status. Psychodynamic approaches, behavior modification, group

counseling, and preventive programs have been identified as treatment techniques to use with children of domestic violence (Moore, Galcius, & Pettican, 1981).

Music therapy is a versatile type of treatment which may employ these identified techniques. Music therapy can provide a non-threatening, enjoyable, creative outlet of communication by using music and music interventions to help these children express their feelings and emotions (Moore-McElroy, 1991). This can also help other identified problems of children of domestic violence as well.

The Purpose of the Research

The purpose of this study was to examine the effects of music therapy on the self-esteem and the locus of control of children survivors of domestic violence. Levels of self-esteem and locus of control were chosen to be investigated in this study as these were identified as areas which are at risk in children survivors of domestic violence. These areas were investigated by using a music therapy experimental group, and a no-contact control group.

CHAPTER II

REVIEW OF LITERATURE AND RATIONALE FOR RESEARCH

The Legal System

The legal system may help stop the cycle of violence and help victims regain some power. Victims who witness their spouses being arrested may learn that they have some control. This may help them to take a stronger stand to prevent future violence (Mederer & Gelles, 1989). In addition, the arrests of the abusers as well as required appearances in court demonstrates that domestic violence is considered a serious crime (Goolkasian, 1986).

Unfortunately, the legal system has a history of responding inappropriately to domestic violence cases. The failure of police to enforce arrest can reduce the victim's sense of empowerment and safety (Simon, 1995, p. 71):

> Lenient treatment by the prosecutor communicates to the offender and the victim that the violent behavior is considered trivial. This is likely to feed into the offenders' perceptions that they have done nothing wrong and encourages them to continue to blame the victim.

The manner in which those involved in the legal system interact with a battered woman may affect her psyche. Symptoms of posttraumatic stress disorder may be triggered by authoritative questioning. When male authority figures use raised voices, intimidation, aggressive gestures, they may trigger feelings or memories associated with the violence the victim had experienced. She may then respond to these people in the same manner which she responded to her batterer. She may even be intimidated to the point of agreeing with suggestions of engaging in behaviors which she did not, may

become angry and risk arrest, and she may withdraw and speak very little about the violence (Dutton & Goodman, 1994). This may then continue into the court system in that the victim may become reluctant to cooperate with the prosecution due to the confusion, lack of support, and lack of understanding about the process of the prosecution she may experience (Goolkasian, 1986).

Parameters of Abuse

"Violence is defined as an act carried out with the intention, or perceived intention, of causing physical pain or injury to another person" (Straus & Gelles, 1986. p. 467). Kuhl defined abuse in domestic violence situations as: "the use of psychological or physical force on, or to coerce one unwilling spouse without regard for that person's rights" including "verbal abuse, pushing and/or shoving, slapping, kicking and/or punching, throwing objects, choking, sexual assault, physical imprisonment, and using or threatening to use a weapon" (Kuhl, 1983, p. 49). Along with physical and verbal abuse, victims in these situations also suffer from emotional, sexual, and financial abuse (Mathias, Mertine, & Murray, 1995).

Spouse Abuse

The violence typically associated with spouse abuse frequently escalates in frequency and intensity over time, which can eventually lead to murder. According to statistics from the Center for Disease Control, male battering is the single most common cause of physical injury in adult women (Jacobson, 1993). According to the 1982 FBI Uniform Crime Reports, 30% of U.S. female homicide victims are killed by their husbands or boyfriends (Crites & Coker, 1988). Family violence has been viewed as a learned behavior involving intensely ingrained family dynamics which are taught from one generation to the next (Weidman, 1986).

Batterers will often deny or minimize their violent behavior as well as the seriousness of their behavior (Goolkasian, 1986; Simon, 1995). Many men who batter women have learned from their fathers to use violence as a means of control. When these men are emotionally dependent on their wives and fear losing them, they will behave violently if their female partners show signs of independence and separateness (Crites & Coker, 1988).

Most often the violence in these domestic situations is directed toward the woman, whether she is a wife, mother, girlfriend, lover, or significant other. These women were often raised in homes where they were physically and sexually abused by their parents (Davis & Carlson, 1987; Jacobson, 1993; Kuhl, 1984; Rachor, 1995). The psychological consequences of this past abuse include passivity, lack of assertiveness, low self-esteem, lack of body awareness, deficit coping skills and communication skills, inappropriate expression of feelings, stress, posttraumatic stress disorder, social and emotional isolation, learned helplessness, learned victim behavior, irrational negative self-talk, and mistrust (Cassity & Theobold, 1990; Kuhl, 1984). The identities of these women are based on pleasing others, being responsible for others, and being nurturant to others. These women are cautious, timid, subdued, and less expressive. They also tend to repress their anger, become emotionally reserved, minimize or deny the abuse, avoid confrontations, have difficulty coping with stress and trauma, retreat into fantasy, and are mistrustful of others intentions (Bookles-Pratz & Mertin, 1990; Cassity & Theobold, 1990; Kuhl, 1984, Star, 1978). In contrast, Jacobson's (1993) findings indicate these women may not be timid, but hold back their feelings to create a peaceful environment.

In contradiction to societal myths and stereotypes, battered women do not "cause" the abuse by engaging in highly masculine behaviors (Dutton & Goodman, 1994; Kuhl, 1984). Women who are abused are rarely highly masculine, aggressive,

or efficient. According to Jacobson (1993) researchers have found "no evidence" of women doing anything to provoke the violence since violence by the men had apparently little to do with the actions, reactions or behaviors of the women (p.4).

This violent behavior creates a cycle of violence within the family. There is a great need to break this cycle and hopefully stop the pattern of violence from being passed on to future generations. To achieve this, therapeutic interventions need to be developed to help those involved in the violence to identify and express their feelings constructively in open, safe environments. Jacobson (1993) believes that by being able to express themselves, those involved in domestic violence situations will begin to validate their often suppressed thoughts and feelings, and thus will begin the process of healing.

Those closest to the abused women are more likely to be involved and affected by the abuse. The children of women who are abused are often involved in the abuse in some form. Sixty-three percent of the 420 women in Kuhl's (1983) study said their children knew of the violence with 30% witnessing the violence and 31% witnessing and seeing the results. Twenty-four percent had witnessed the violence, saw the results, and talked with the mother. Nine percent helped their mothers by listening, 2% offered information, 3% intervened in the violence, and 17% were unable to help.

In another study (Hilton, 1992), 90% of children of the 420 battered women were reported as indirect victims of the violence. This included witnessing the violence, witnessing the physical and/or emotional effects after the violence, fathers threatening their children or using them to insult their mothers, and the women being beaten while pregnant or holding their children. It can be argued that this witnessing is a form of emotional violence. Although the children often realize that they are not in control when they witness this violence, they frequently intervene due to the feeling of protection that they have for their mothers (Afolagan, 1993). Acting upon the need to

intervene and not being capable of effective intervention may deepen their feelings of having little sense of personal control, guilt, and vulnerability (Elbow, 1982; Kuhl, 1982).

Child Abuse

Spousal abuse may be directly linked to child abuse. Children are at a higher risk of being battered when their mothers are also being battered. These children also suffer from emotional abuse from being exposed to this type of environment. According to McKay (1994), child abuse is 15 times more likely to occur in families where domestic violence is present (McKay, 1994). In these violent homes, children are physically abused 33% to 50% of the time (Pynoos & Nader, 1990). Almost two-thirds of abused children are parented by battered women, while 40% of children who are abused are exposed to some type of spousal abuse (McKay, 1994). These findings suggest that children are often exposed to various types of family violence (Sternberg, et al., 1993). Even those children who are not physically abused are highly vulnerable to neglect and emotional abuse (Davis & Carlson, 1987).

It has been found that 80% of men who batter women also batter their children (Tomkins et al., 1994), and children in violent homes are three times more likely to be physically abused by their fathers than by their mothers (McKay, 1994). Stark and Flitcraft (1988) found that approximately 50% of abused children are abused by a male batterer, 35% are abused by their battered mothers, and the remaining 15% are abused by both parents. Although the fathers' violence against their children occurs when violence is directed to the women, children in close physical proximity are often accidentally struck. As the mother tries to protect her child, the chance of abuse by the father to the child increases. This can also occur when children try to intervene and protect their mothers. They may also become direct targets of their fathers' anger and

frustration, and may be used to create indirect threats of violence against their mothers (Grusznski, Brink, & Edleson, 1988). In addition, the severity of the abuse to the wife is predictive of the severity of the child abuse. The manner in which the child is abused strongly resembles the maltreatment of the mothers (McKay, 1994).

Abuse towards the children from the mother may develop indirectly. A punitive style of discipline may result when the mother is trying to protect her child from the assailant (Garbarino, 1993). Since battered women often give their abusers their full attention to control the level of violence, or may withdraw from the family to protect themselves, children may also be neglected by their mothers. Other abusive behaviors directed towards the children by these mothers are likely to emerge from this stress (McKay, 1994). Often the mothers cannot retaliate against their assailants and externalize the blame unto their children (Afolagan, 1993). Since abusive mothers may also lack a basic understanding of child growth and development, they may have unreasonable expectations of child behavior at various stages (Germain, 1984). The mothers may also be psychologically unavailable to their children due to their need to focus on their own survival (Tomkins et al., 1994).

Perceptions of Parents by the Children

Many children in abusive situations have difficulty understanding and demonstrating congruent emotions towards their parents. They may even be punished when they attempt to express their feelings towards their parents. The ability to differentiate and integrate emotional concepts may be a slowed process when children have experienced traumatic relationships with their parents. Defensiveness and idealization may alter the children's perceptions of their abusive parents. Children who are abused and witness abuse have more negative perceptions of abusive than non-abusive parents, and also have negative perceptions of their abused mothers. They are

able to express their varying feelings of abusive and non-abusive parents, and are able to discriminate between positive and negative aspects of their relationships with their perpetrators. However, they do not appear to transfer or generalize their feelings about their abusive parents to nonviolent parents (Sternberg, Lamb, Greenbaum, Dawud, Cortes, & Lorey, 1994).

Often children in these situations feel responsible for the violence in their homes and for their mothers leaving. They may internalize the idea of creating the violent behavior of others, and possibly feel inadequate for not preventing the violence between their parents. As a reaction to these feelings of inadequacy, they may then attempt to calm their fathers and protect their mothers. These children may also try to not upset their mothers because they are aware of the stress which their mothers are experiencing. Thus, a great deal of energy can be put into trying to make their mothers' lives easier (Alessi & Hearn, 1984; Bookles-Pratz & Mertin, 1990, Elbow, 1982; Grusznski, Brink, & Edleson, 1988). Since the parents in these situations are often unable to act as caregivers, the children may in turn act out the roles of parents. This new responsibility gives the children power in an otherwise chaotic lifestyle (Afolayan, 1993; Bookles-Pratz & Mertin, 1990; Grusznski et al., 1988; Pynoos & Nader, 1990). Those who experience a great sense of responsibility for their parents' behavior tend to be older, are exposed to more extreme violence in their homes, and have experienced more negative life events (Jaffe, Wilson, & Wolfe, 1988).

Causes of Abuse

There are multiple stressors in families where there is a prevalence of domestic violence. These may include poverty, social isolation, unemployment, drug and alcohol problems, and health related issues (Gardiner, 1992). In part, these stressors and problems with communication may cause the family to become a network of

violent, interacting individuals. In these situations family members often begin to distrust one other and isolate from each other. The children of these families may be favored by one parent and thus, as a reaction, be physically and/or emotionally rejected by the other. These children may also be used by one of their parents against the other as a means of punishment. The children may then internalize the violence and may become abusive to themselves as well as towards one another as a reaction to the violence they see and feel around them (Denzin, 1984; Moore et al, 1981).

Psychodynamic Theory

From a psychodynamic view, children of domestic violence have deeply ambivalent emotions in attachments with their mothers. Isolation forces these children to develop ambivalence and withdrawal which can lead to a need to provoke others in order to relieve the burden of accumulated tension (Galdston, 1986). These children may experience helplessness in response to feelings of rage. This inhibits their development of their ego strengths and self-esteem which, in turn, leads to an increase in outbursts of anger and other means of acting out (Waldo, 1987).

Behaviors such as these are modeled from the parents who often love and hate simultaneously and are unable to sort out, recognize, and accept responsibility for their emotions. In reaction to these poor coping skills, these parents behave in angry, belligerent, and contemptuous manners. The men in these relationships tend to be more domineering and defensive, while the women may be more tense, fearful, and sad (Jacobson, 1993). For the parents, this often develops into a crisis instead of an angry outburst. The parents themselves are intimidated and may defend themselves by withdrawing beyond a range of involvement for fear of getting hurt (Galdston, 1986; Moore et al, 1981).

The aforementioned behaviors and fears of the parents provide the children with a view of the world as being threatening. The children may begin to believe that safety is only found at home with their mothers. The children's identities can become embedded in developing aggression into violence or withdrawal, with little room for learning the uses of aggression for growth, play, work, or education. There is an inability of both the parents and the children to use aggression in positive manners (Galdston, 1986).

Along with the violent uses of aggression, there is a threat of abandonment and/or retaliation which may dominate the mother-child relationship. Because the child may act out when s/he feels aggression, the child is then identified as one to be feared. The mother then fears this action, confirming the child's fear of aggression in the self and others. This in turn becomes a relationship of aggression versus regression. From this there is a stoppage of the ego development which inhibits the ability for these children to develop and use their aggression positively (Galdston, 1986).

Living in these highly stressful environments can lead to long-term mental health concerns (Garbarino, 1993). Children may choose submissive or aggressive strategies to resolve interpersonal conflicts, instead of using more constructive means to resolve conflicts.

Effects of Domestic Violence on Children

Due to the many stressors which children of domestic violence experience, they may be unable to concentrate in school, have low school performances, and frequently have low attendance rates. They can become anxious when they are away from the abused parents to the point of becoming physically ill from worry or may create a false illness to stay home to protect their abused parents. These children may also have

fewer interests and fewer social activities (Afolagan, 1993; Wolfe, Zak, & Wilson, 1986).

Children in domestic violence situations may develop many psychological problems due to their exposure and involvement in domestic violence. Children who are physically abused exhibit problems which relate to their affective and socio-emotional development. These children are at greater risk to develop problems in the expression and regulation of emotional reactions (Wolfe & Jaffe, 1991). Children who witness spousal abuse are at a similar risk to children who have been abused (Gardiner, 1992; Tomkins et al, 1994). Children who witness violence, but are not physically abused themselves, have psychosocial deficits which are less extensive and severe than those who are abused, yet are still greater than their typical peers (Hughes, Parkinson, & Vargo, 1989; Tomkins et al., 1994).

By both witnessing violence and being victimized are related to the extent of behavior problems which these children may exhibit. A combination of witnessing and being abused has more serious consequences for the child (Davis & Carlson, 1987). Children who witness abuse, are physically abused, or are both witnesses and victims are at a greater risk of developing a range of problems. These typically include: anxiety, depression, distress, aggression, lack of assertiveness, difficulty with anger management, conduct problems, a low range of social competence, social isolation, deficits in empathy abilities, shyness, low self-esteem, suicide attempts, feelings of shame, guilt and confusion, posttraumatic stress disorder, stress symptoms, symptomatic reactions, low cognitive, verbal, and motor abilities, developmental impairment, physical damage, emotional trauma, violence towards self and others, poor school performances, other related school problems, and attention deficit disorder (Bookles-Pratz & Mertin, 1990; Cassity & Theobold, 1990; Garbarino, 1993; Hershorn & Rosenbaum, 1985; Hinchey & Gavelek, 1982; Hughes, 1988; Jaffe,

Wilson, & Wolfe, 1986, Jaffe et al., 1986b; Mathias et al., 1995; Pynoos & Nader, 1990; Rogers, 1995; Slotoroff, 1994; Sternberg, Lamb, Greenbaum, Cicchetti, et al., 1993; Tomkins et. al, 1994; Westra & Martin, 1981; Wolfe & Jaffe, 1991; Wolfe et al., 1985; Wolfe, Zak, Wilson, & Jaffe, 1986). As a result they may withdraw and/or become physically and verbally abusive. Their affect may be flat or inappropriate. They may have an inability to express their feelings, use aggression to solve problems, have impaired peer relations, behave in immature and/or regressive manners, and have poor problem-solving and organizational skills (Alessi & Hearn, 1984; Cassity & Theobold, 1990; Moore, Galcius, & Pettican, 1981). Children in domestic violence situations are often socialized into a model of fear, violence, and hatred.

Not only does the type of involvement in witnessing parental violence have various effects on children, but the type of violence which their parents display also has various effects. Witnessing interparental physical and verbal violence has different effects on the behavior problems of the children. In a study by Fantuzzo, Depaolo, Lambert, Martino, Anderson, and Sutton (1991), interparental verbal conflict only resulted in a moderate level of conduct problems, whereas verbal plus physical conflict revealed clinical levels of conduct problems and moderate levels of emotional problems.

A combination of these types of interparental conflicts while living in a shelter evidenced significantly higher levels of externalizing and internalizing behaviors, social competency, and maternal acceptance. Also, the aggression which parents direct towards their children have a stronger impact on the behavior problems of the children (Jouriles, Barling, & O'Leary, 1987).

Along with the different effects which the types of violence have on the behaviors of these children, the frequency and intensity of the violence have also been observed as having different effects. Children who showed clinical-range problems in

Wolfe et al.'s study (1985) had been exposed to a higher frequency of violence and had experienced more negative life events.

Gender Differences

It has been suggested that marital turmoil has a greater effect on boys than girls. Boys may have more problems with externalized, internalized and undercontrolled behaviors (i. e. aggressiveness, verbal abuse, noncompliance) whereas girls have difficulties with internalized and overcontrolled behaviors (i. e. anxiousness, withdrawal, good behavior) (Emery, 1982; Emery & O'Leary, 1982; Hershorn & Rosenbaum, 1985; Jaffe, et al, 1986b). The level of exposure to interparental violence of boys correlates with more adjustment difficulties and higher at risk scores for males than females (Jaffe et al., 1986a & b; Stagg, Wills, & Howell, 1989). Boys also showed lower levels of social competence, social achievements, and peer relationships (Jaffe et al., 1986b).

In looking at empathetic skills, girls may have more difficulty than boys in identifying the emotional states of others (Hinchey & Gavelek, 1982). In addition to being at risk with impaired empathy skills, girls may also develop a lack of trust. Adolescent girls may develop extreme distrust in others, which may generalize to all men (Carlson, 1984).

Age Differences

Age differences may influence how children react to parental violence. Infants tend to be irritable, have difficulty sleeping, suffer from diarrhea, and are frequently ill. Children of preschool age also tend to be irritable, are reluctant to leave their mothers, are fearful of being alone, and tend to regress to earlier developmental stages. These children at this stage are open about the violence that is occurring in their families.

Both preschool age and school age children may feel responsible for the violence in their families. Elementary age children are eager to please their parents and make new friends, yet they can also be hostile and aggressive. They may also be sensitive, withdrawn, passive, may cling to other people, and may become anxious. Children who are 11 years and older may be very protective of their mothers. They may also be very guarded and secretive about their family situations, often denying that the violence ever occurred. Adolescents may develop intense feelings of ambivalence towards both parents. Children from the ages of 2 to 17 initially solve problems by hitting, using abusive language, attributing their own faults and mistakes to other people and inanimate objects, feeling responsible for their parents fighting, and may be confused about their feelings for their fathers (Alessi & Hearn, 1984; Carlson, 1984).

Violence as a Learned Behavior

Each generation of violent families learn to be violent by being a member of a violent family (Straus et al., 1980). It has been suggested that when they become adults, individuals raised in violent homes may react to situations in which they feel they are not in control with violent behavior, or may be more accepting of violence directed towards them. This in turn can have a negative impact on their personality structures (Kuhl, 1982; Tomkins et al., 1994; Waldo, 1987).

Some children who witness domestic violence learn to model their parents' behaviors by becoming aggressive. They learn that violence is a means of resolving conflicts, may lack the basic skills to react in emergency situations, and may experience anxiety about self-control issues (Elbow, 1982; Jaffe, Wilson, & Wolfe, 1988; Straus et al., 1980). They may also learn that those who love each other hurt each other, and that it is acceptable to hurt loved ones (Carlson, 1984; Crites & Coker, 1988; Straus et al., 1980). In addition they learn that if violence is reported to others there are few

consequences. They may believe that sexism is to be encouraged, violence is an appropriate means of stress management, and victims of violence are to tolerate the violence they experience (Jaffe, Wilson, & Wolfe, 1986a).

These children may also develop distorted beliefs regarding men, women, and family (Ragg, 1991). They begin to associate violence against women as maleness and being victimized by men as femaleness. They learn that love is possession, authority and discipline is the right to control by force, needs and wants are unwarranted demands, and that expressions of feelings show weakness, loss of control, and will be responded to with violence (Elbow, 1982). Expressing anger is especially difficult for these children. Since they know that anger may result in violence, they have not witnessed positive ways in which to express their anger. This inability to express anger in a positive manner reflects a lack of control (Grusznski et al., 1988; Slotoroff, 1994).

Abusive children learn that violent behavior is approved by adults who are important in their lives (Crites & Coker, 1988; Straus, et al., 1980). By only observing the short term reinforcements they do not understand the long term consequences. Thus they learn the use of coercive power and violence as a way to influence loved ones without being exposed to constructive uses of aggression (Crites & Coker, 1988; Tomkins et al., 1994).

Identifying With Aggressors

Children of domestic violence often identify with the aggressors, and may model their behavior from those that cause the danger (Garbarino, 1993). These children are challenged by their lack of impulse control which has long term negative effects on regulating their aggressive behavior and victimization (Pynoos & Nader, 1990). Boys who witness their fathers beating their mothers are three times more likely

to becoming batterers, and may have more difficulty in the destruction of property and cruelty to family and peers (Davis & Carlson, 1987; Davies, 1991; Tomkins et al., 1994). Boys who are raised in the most violent households have a rate of wife-beating 1,000% greater than boys living in non-violent homes (Straus et al., 1980). The majority of abusive men have witnessed or experienced abuse as children (Hinchey & Gavelek, 1982; Rachor, 1995; Star, 1978; Tomkins et al., 1994; Waldo, 1987). Shepard found that of 100 men who battered women, 31% reported they had witnessed wife abuse in their families, and 24% reported being abused as children. Shepard concluded that these men may find it more difficult to adopt new behaviors which they were never exposed to as children. Similarly, Rachor (1995) found that batterers frequently admitted to knowing of no other behaviors to have their needs met.

Although a history of abuse is more common in violent families, not all abusers were raised in violent families. There are also parents who were raised in violent homes who are able to discontinue the cycle of violence in their families. These parents experienced more social supports and were open about their abuse and the feelings associated with it. They were also more likely to have been abused by only one parent while maintaining a supportive relationship with the other parent (Kaufman & Zigler, 1987).

Locus of Control

Children of domestic violence may have difficulties understanding their sense of responsibility, or their locus of control. Some studies have investigated the locus of control of abused children (Barahal, Waterman, & Martin, 1981; Simmons & Weinman, 1991; Slade, Stewart, Morrison, & Abramowitz, 1984). Children living in a violent, unstable environment are believed to develop helplessness and/or assume little responsibility for their behaviors. These children may cope with the anxiety of

these stressful situations by projecting blame for their faults and behavioral problems onto the environment (Slade et al., 1984). By comparing abused children to non-abused children, it was found that abused children had a more external locus of control than their typical peers. These results suggest that abused children perceive success as contingent on their actions, yet perceive failure as noncontingent on their behaviors (Slade, Morrison, & Abramowitz, 1984).

Similar results were found in another study by Barahal, Waterman, and Martin (1981). Using an experimental group of abused children and a control group of nonabused children, the authors found that abused children were more likely to feel that outcomes are determined by external factors than their non-abused peers. These children were also less likely to assume personal responsibility for negative behaviors and experiences.

In examining characteristics of children in an emergency shelter, a significant correlation between poor self-esteem and external locus of control was found ($r = -.5286$; $p = .001$), (Simmons & Weinman, 1991). Subjects consisted of 117 girls and 46 boys who were admitted to an emergency shelter for abuse and/or severe family disturbance. The subjects were evaluated using the Coopersmith Self-Esteem Inventories and the Nowicki-Strickland Locus of Control. The mean scores for the Coopersmith Self-Esteem Inventories were 50.52, and the average score for the Nowicki-Strickland locus of control were 19.82. The correlation between low self-esteem and external locus of control indicates that early intervention may be necessary to prevent serious mental health problems for children who are raised in violent households.

Early intervention may prevent children of domestic violence from becoming violent in their adult relationships. There is a need to develop therapeutic approaches to child witnesses of violence that take into account the traumatic nature of the experience, the family's postviolent adaptation, and the child's developmental status. Emphasis on dealing with anger and expressing feelings, alternatives to violence, safety issues, role expectations, and self-responsibility can be beneficial. This can begin with very young children who can work through specific traumatic events using play and words (Davies, 1991; Elbow, 1982; Jaffe, Wilson, & Wolfe, 1986; Jaffe et al., 1988; Ragg, 1991). There is also the potential of mother-toddler therapy for interrupting the defenses and family dynamics that promote this learned behavior of violence. A positive relationship between the mother and the toddler may predict the child's continuing ability to use the mother's help in regulating affect and behavior during times of frustration or stress (Davies, 1991).

With older children either a psychodynamic approach, behavior modification, or task-centered work can be employed (Moore et al., 1981) In addition, an emphasis on adaptive thinking processes, emotional expression, beliefs regarding violence, responsibility and family interactions, and interpersonal problem-solving can be taught (Ragg, 1991). Learning about perspective-taking, modeling, and reinforcement and behavior rehearsal could also be beneficial (Jaffe et al., 1986).

In a group counseling program, Jaffe et al (1988) found that abused children who participated enjoyed the therapy group, improved their safety skill strategies, and reported a more positive perception of their mothers and fathers. Likewise, in a preventive program developed by Hughes (1982), children in a shelter for battered women were able to benefit from a positive one-to-one relationship with staff members

and appeared to be adjusting positively and showed strength and an increase in coping skills.

It has been suggested that domestic violence service providers need to help abused women recognize how their children might be affected by the violence in the home. To reach this goal, battered women will need to understand the link between family violence and spouse abuse. Service providers can also help the women place responsibility for the violence with the abusers or accept the necessity of altering their own parenting if they were abusive with the children. These service providers can also help to empower abused mothers to seek new ways to protect themselves and their children, and to find the nature of their relationships with violent partners (McKay, 1994). It has also been suggested to discuss with the children the violence which is occurring in their families, the separation which they are experiencing, the lack of the children's responsibility for the violence, and reassure the children that they are not alone in these situations (Gardiner, 1992).

Music Therapy for Domestic Violence Survivors

Music therapy may be a beneficial medium for survivors. In a 1990 study by Cassity & Theobold researching the assessments and treatments employed by music therapists for survivors of domestic violence, eighty of the 2,564 active registered and certified music therapists surveyed reported working with clients involved in domestic violence. Of that group forty-four percent worked with battered women and 42% worked with the children of battered women. Sixty-five percent reported working from two to more than 10 years with survivors of domestic violence (Cassity & Theobold, 1990).

Abused children are often unable to develop stable capacities for the moderation of feelings and trust. It may be difficult to explain the traumatic experiences that they

witnessed and/or experienced. Music therapy may offer a voice or expressive medium for these memories which are difficult to express verbally (Rogers, 1995). The non-verbal aspect of music is helpful for facilitating self-expression through an expressive, symbolic mode of communication. Those who avoid expressing feelings and discussing issues can use music as a means for self expression.

Music therapy can provide a creative outlet of communication by using music and music interventions to help clients express their feelings and emotions. This form of treatment may elicit unconscious material, and may break down defenses and withdrawal (Clendenon-Wallen, 1991). Music therapy may also provide an understanding of the inner psyche and physical experiences which clients can work through with the music therapist (Rogers, 1995).

Music therapy has been shown to also increase the self-esteem of adolescents who have been sexually abused (Clendenon-Wallen, 1991). In her study, Clendenon-Wallen used music therapy interventions with four randomly selected adolescent girls between the ages of 14 and 17 who had been sexually abused. The subjects participated in at least 9 of 12 music therapy sessions facilitated by the author once a week. After using music therapy interventions such as song writing, song discussion, improvisation, lyric analysis, creative movement, relaxation, imagery, and drawing, Clendenon-Wallen found positive changes in self-confidence and self-esteem of her sexually abused clients. It was believed that the music therapy interventions "were empowering for the clients as evidenced by the learning of new skills..."(Clendenon-Wallen, 1991, p.78).

Music therapy has also helped abusive parents become more nurturing to their children. In a study by Moore-McElroy (1991), five families who were referred to the Kalamazoo Child Guidance Clinic participated in the Parent-Child Nurturing Program as part of each family's court-ordered treatment. Six parents participated along with

eleven children for fifteen weeks. The parents reported that they enjoyed music therapy activities, such as listening and discussion, song-writing, and relaxation, and found them to be of therapeutic benefit. In addition, the music therapy program helped to facilitate nuturance between abusive parents and their children (Moore-McElroy, 1991).

A variety of music interventions can be employed in the treatment of clients of domestic violence. Instrumental performance has been used with song/lyric composition and discussion used with adolescents. To express affect, music listening/discussion and instrumental performance techniques have been employed. Imagery has been utilized to improve self-concept by using listening, instrumental performance, composition, and guided imagery. Instrumental and age-appropriate musical games have been used to improve the cognitive skills of the children. To improve interpersonal functioning among children, music interventions which require cooperation among peers have been incorporated. With adolescents, instrumental performance, music listening, discussion, and singing have been used to improve parent and peer relations. In assessing the physical well-being of children (i.e. physical coordination, crossing the midline, balancing, and bilateral independent task performance), dance, body action songs, movement, and playing instruments have been employed (Cassity & Theobold, 1990).

A drumming technique designed by Slotoroff (1994) for assertiveness and anger management targets behavioral problems by helping clients increase awareness of their feelings, emotions, thoughts and coping skills. The combination of the physical expression and sound of the drumming can be helpful in eliciting and expressing anger. This technique could be useful to survivors of domestic violence as difficulty expressing anger has been identified for this clientele (Grusznski et al., 1988; Slotoroff, 1994). The author found that all patients who used this technique were able to discuss their self-awareness and reflect on themselves and their behaviors.

Statement of Need

The purpose of this study is to examine the effects of music therapy on the self-esteem and the locus of control of children survivors of domestic violence. The self-esteem and locus of control were chosen to be investigated in this study as these were identified in the literature review as areas which are at risk in children survivors of domestic violence. In addition, a correlation was found between poor self-esteem and external locus of control for children residing in an emergency shelter (Simmons & Weinman, 1991). This study was designed to investigate this type of correlation as well.

Research Hypotheses

Hypothesis 1: There will be no difference at baseline between groups on the Coopersmith Self-Esteem Inventories or the Nowicki-Strickland Locus of Control Scale.

Hypothesis 2: There will be no differences in matched post-test scores between the two groups on the Coopersmith Self-Esteem Inventories.

Hypothesis 3: There will be no differences in post-test scores between the two groups on the Nowicki-Strickland Locus of Control Scale.

Hypothesis 4: There will be no difference in pre- to post-test gain scores on the Coopersmith Self-Esteem Inventories.

Hypothesis 5: There will be no correlation between self-esteem and an internal locus of control for all subjects in the two groups.

Hypothesis 6: There will be no differences between the self-esteem and locus of control between boys and girls in either group.

CHAPTER III

METHODOLOGY

Subjects

Participants included children survivors of domestic violence who resided at SAFE House in Ann Arbor during the time of treatment. Twenty participants were involved in this study including 9 males and 11 females, ranging from the ages of 7 to 16. SAFE House is a state-funded domestic violence shelter which includes services such as counseling and advocacy for both the abused women and their children. The children could also participate in a ten week support group, Kids Club, which is a program conducted by the University of Michigan Psychology Department. This group allowed the children to identify their feelings, any guilt they may have felt, their fears, gender roles, family relationships, and aided in conflict resolution. These children could also receive individual therapy, tutoring, and were invited to participate in various activities offered by the volunteers. SAFE House supports the children with their school transitions by providing such services as transferring records, arranging transportation to and from school, and setting up advocacy through teachers and counselors. SAFE House also provides its own children's support group which addresses issues such as safety and domestic violence. The backgrounds of these participants vary in terms of social status, education, economic status, culture, race, and religion. The shelter is for temporary residence with a maximum stay of 30 days per family. The average stay for a family is approximately two to four weeks.

Informed Consent

This experimenter met with Western Michigan University's Human Subjects Institutional Review Board Committee to obtain consent to work with the children of SAFE House. After a review of the purpose and design of the research, this study was approved by the committee. Research commenced when this approval was obtained.

Before obtaining consent from the children's mother, the therapist explained to each mother the purpose of this study. A script was read to the mothers explaining the music therapy sessions, the purpose of the sessions, the testing, and the fact that participation was voluntary (see Appendix A).

Before obtaining assent from the children, the therapist read a script describing the sessions, confidentiality of the tests, and that participation was voluntary (see Appendix A).

Materials

Materials that were used included recorded music (see Appendix B), accompanying instruments (i. e. guitar, keyboard), recorders, percussion instruments, movement materials (i. e. parachute, scarves, streamers), graphic art materials (i. e. markers, crayons, construction paper) and writing materials.

Instruments

The Coopersmith Self-Esteem Inventories (Coopersmith, 1981) were administered to the participants before and after treatment. This test is composed of 58 items which yield six scores: general self, short-form, school-academic, home-parents, total self, and the lie scale. Only the general self scores were examined in this study. The test is written for children ages 8 to 15, and takes approximately 10 to 15 minutes

to administer. It is a pencil and paper test, with statements written as generally favorable or unfavorable aspects about the self which the clients indicate as "like me" or "unlike me". The scores may range from 0 to 100 with lower scores indicating a low self-esteem, and higher scores indicating high self-esteem.

The Nowicki-Strickland Locus of Control Scale was administered to the participants before and after treatment as well. This test consists of 40 questions that are answered by marking either the "yes" or "no" space next to the question. This is also a paper and pencil measurement in which two official shortened versions were used including 19 questions for children in grades 1 to 6, and an additional 4 more questions for children in grades 7 to 12. In the versions used for the younger children, scores of 8 to 19 indicate an external locus of control score, scores of 7 to 4 indicate an intermediate locus of control, and scores of 3 to 0 indicate an internal locus of control. The scores for the older children's version range from 9 to 22 as external locus of control, 8-4 indicating an intermediate locus of control, and 3 to 0 as an internal locus of control (Robinson & Shaver, 1973).

Design and Procedure

This study included two groups of children survivors of domestic violence: an experimental group which received music therapy and a no-contact control group. The researcher facilitated the music therapy groups. The ages in the groups ranged from 6 to 14, with the clients being placed by appropriate age ranges. Self-esteem and locus of control were tested using the Coopersmith Self-Esteem Inventories, and the Nowicki-Strickland Locus of Control Scale. These were administered before the children attended music therapy sessions, and again at the end of treatment which usually occurred during their last week in the shelter. Interventions used during music therapy sessions included singing, listening with discussion, instrumental improvisation, song-

writing, movement, creative writing, drawing to music, and relaxation. The minimum duration of participation which data was used consisted of four sessions with a maximum of ten to twelve sessions. Sessions were usually held two times a week for the children and lasted from 30 to 60 minutes depending on the needs and availability of the children. The reason for this time line is that most residents stay at SAFE House for one month, although some families may stay for shorter or longer periods. The desired number of participants in the music therapy group was 10 to 15. These groups were conducted between November, 1996 and July, 1997.

The Experimental Group

Experimental subjects were divided into two groups based on appropriate age ranges: One group was for 6 to 8 year olds, and another was for 9 to 14 year olds. Before each of the music therapy sessions began, rules regarding behaviors were established. These rules included no physical or verbal abuse, such as no hitting, kicking, swearing, name calling, or telling other participants to "shut up". If these rules were violated the children were given three warnings. If the inappropriate behaviors did not stop after the third warning, the participants were asked to leave the sessions for a five minute time out. After the time out, the participants were invited back to the sessions if they felt they could participate appropriately. If they felt they could not, they were asked to not rejoin the group but were invited to attend future sessions.

A typical session for the 6 to 8 year old subjects began with a hello song. The clients were encouraged to sing along but were not required to do so. The purpose was to focus the children on the session that was starting, and to learn names of the subjects. Other singing interventions followed including songs about feelings, self-esteem, and individual qualities. The goal of these songs were to help the children

express their feelings and views of themselves. Instrumental improvisation techniques were used to help the participants express themselves in non-verbal ways. As the participants played on drums and other percussion instruments, they were allowed to express however they felt at the current time through the instruments. Improvisations were both structured and unstructured, depending on the needs and boundaries of the participants. This type of intervention was used most frequently as improvisations resulted in expression of feelings. Song-writing was also used during these sessions to help participants identify their feelings. A closed technique was used in which they were encouraged to write their own words in pre-existing songs (refer to Appendix B). Several participants improvised with a blues technique in which they would improvise lyrics over a standard blues chord progression. Movement interventions were used such as expressive movement to recorded music and were designed for individual movement, small groups moving together, or for the entire group. These movement techniques included creative movements with scarves or streamers, and using a parachute. The goals of these interventions included developing group cohesiveness, developing trust among the subjects, and creative self-expression. To assist in relaxation exercises, participants were encouraged to use imagery of relaxing places, people, or objects while listening to recorded music (refer to Appendix B). The purpose of this was to help participants learn relaxation techniques to help them cope with any stresses they were experiencing. Drawing was also used in the sessions to help them express their views of themselves, their families, friends, and the situations they were experiencing. The sessions ended with a closing song such as "This Little Light of Mine". The closing song served as closure to the group. After all interventions, the therapist attempted to discuss and process the interventions with the children, however, most children were not open to this.

A typical session for children ages 9-14 included many of the aforementioned interventions at an age-appropriate level. Participants were encouraged to bring songs that they liked to listen to and/or perform. The purpose of this was to identify what the songs meant to the participants and how they felt when they listened and/or performed these songs. Using song-writing techniques, these subjects also improvised with a blues technique. Instrumental improvisation was used to help elicit feelings and develop cooperation in terms of listening to other group members play their improvisations. Creative movement was also used with these participants to help facilitate self-expression and self-esteem. Drawing exercises, such as drawing album covers, were used to help participants express their feelings about their family, friends, and themselves. Relaxation interventions were used to help the subjects develop techniques to cope with stress.

The Control Group

After ten subjects completed the research requirements for the experimental group, the therapist assessed the self-esteem and locus of control of a no-contact control group consisting of 10 children who resided in SAFE House. Each subject was administered the Coopersmith Self-Esteem Inventories and the Nowicki-Strickland Locus of Control Scale within the first week of the subjects' residency in the shelter, and again during their last week in the shelter. Other than music therapy, these children were offered the same services within the shelter as the children who participated in the music therapy group. The purpose of the control group was to determine if there were any differences in self-esteem and the locus of control between the music therapy experimental group and the control group. Testing was conducted between July 1997, and October, 1997.

CHAPTER IV

RESULTS

The Coopersmith Self-Esteem Inventories Scale (CSEI) was used to assess the self-esteem of the subjects, while the Nowicki-Strickland Locus of Control Scale (NSLC) was used to assess internal locus of control vs. external locus of control of the subjects in this study.

Hypothesis 1: There will be no difference at baseline between groups on the Coopersmith Self-Esteem Inventories or the Nowicki-Strickland Locus of Control Scale.

Result: This hypothesis was accepted. There were no significant differences between groups on these measures at baseline. The experimental group had average baseline scores 78.8 (SD = 15.47), while the control group had average scores 77.4 (SD = 13.60) for the CSEI. At baseline for the NSLC, the experimental group scored an average 9.4 (SD = 4.06), while the control group had average scores 9.4 (SD = 3.41). There were no significant differences between groups on this measure at baseline, ($t = 0, p = 1$).

Hypothesis 2: There will be no differences in matched post-test scores between the two groups on the Coopersmith Self-Esteem Inventories.

Result: This hypothesis was accepted. There were no significant interaction effects between groups in matched post-test scores on the Coopersmith Self-Esteem Inventories. Average scores on the CSEI for the experimental group were as follows: (1) pre-test, 78.8 (SD = 15.47), (2) post-test, 76.8 (SD = 12.26). Average scores on the CSEI for the control group were as follows: (1) Pre-test, 77.4 (SD = 13.60), (2) Post-test 71.4 (SD = 14.52) (See Table 1).

Table 1

Mean Scores on the Coopersmith Self-Esteem Inventory (CSEI)

Group	Pretest	Posttest
Experimental	78.8 (SD = 15.47)	76.8 (SD = 12.26)
Control	77.4 (SD = 13.60)	71.4 (SD = 14.52)

Note. n = 10 in each group.

There were no significant interaction effects between groups on this measure ($F < 1$), nor was there a main effect of Group ($F < 1$) on pre-testing and post-testing ($F = 3.17, p < 0.09$). Subjects in the experimental group received an average of 6.6 (SD = 3.03) music therapy sessions between completion of the CSEI at baseline and post-intervention. There was an average of 3.3 weeks (SD = 1.51) between Completion of the CSEI pre- and post-intervention for the experimental group, and an average of 2.4 weeks (SD = 0.70) between pre-test and post-test completion of the CSEI for the control group (See Table 2).

A Mixed-Analysis of Variance was used to investigate the effect of music therapy interventions on locus of control as assessed by the NSLC questionnaire.

Hypothesis 3: There will be no differences in post-test scores between the two groups on the Nowicki-Strickland Locus of Control Scale.

Result: This hypothesis was rejected. The experimental group had significantly lower locus of control scores compared to the control group, t= ($p < 0.05$). There was an average percent change of x = - 4.21% (SD = 14.21) and x = 10.33% (SD = 13.09) in the NSLC score in the experimental and control groups, respectively.

Table 2

Raw Scores on the Coopersmith Self-Esteem Inventory (CSEI) and Pre- and Post-Test

Group	Age	Gender	Scores at Pre-Test	Scores at Post-Test	# Weeks Pre-Post Test	# Sessions Pre-Post Test
Exp.						
1	7	F	72	68	5	10
2	9	F	50	58	3	6
3	9	F	70	72	4.5	9
4	7	M	92	90	5	10
5	9	F	94	98	5.5	11
6	8	F	78	80	2	4
7	7	M	60	72	2	4
8	11	M	94	66	2	4
9	8	F	90	76	2	4
10	6	F	88	88	2	4
Control						
1	14	M	94	92	2	N/A
2	16	M	88	72	3	N/A
3	6	M	78	78	2	N/A
4	8	F	82	86	2	N/A
5	10	M	76	68	2	N/A
6	7	M	68	52	2	N/A
7	8	F	80	72	2	N/A
8	7	F	52	44	2	N/A
9	11	M	94	80	4	N/A
10	12	F	62	70	3	N/A

Average scores for the experimental group were: (1) pre-intervention, x = 9.4 (SD = 4.06), (2) post-intervention, 8.6 (SD = 3.50). Average scores for the control group were: (1) pre-test, 9.4 (SD = 3.41), (2) post-test, 11.5 (SD = 2.76). There was a

significant interaction effect between NSLC scores and Group, F (1,18) = 5.8 (p < .03) (See Table 3, Figure 1).

Table 3

Mean Scores on the Nowicki-Strickland Locus of Control Scale

Group	Pre-test	Post-test
Experimental	9.4 (SD = 4.06)	8.6[a] (SD = 3.50)
Control	9.4 (SD = 3.41)	11.5 (SD = 2.76)

Note. n = 10 in each group.

[a]Significant difference between mean Experimental and Control group scores at Post-test, $p < 0.03$.

Specifically, the experimental group had significantly lower NSLC scores post-intervention compared with the control group, t = -2.06 (p < 0.05).

There was an average percent change of - 4.21% (SD = 14.21) and 10.33% (SD = 13.09) in NSLC scores in the experimental group and control group, respectively (See Table 6).

Hypothesis 4: There will be no difference in pre- to post-test gain scores on the Coopersmith Self-Esteem Inventories.

Result: This hypothesis was accepted. There were no significant differences in pre- to post-test gain score on the Coopersmith Self-Esteem Inventories.

A Mixed Analysis of Variance was used to investigate self-esteem as measured by the CSEI as a function of a Music Therapy interventions.

There were no significant interaction effects between groups on this measure ($F < 1$), nor was there a main effect of Group ($F < 1$) or pre-testing and post-testing ($F = 3.17$, $p < 0.09$).

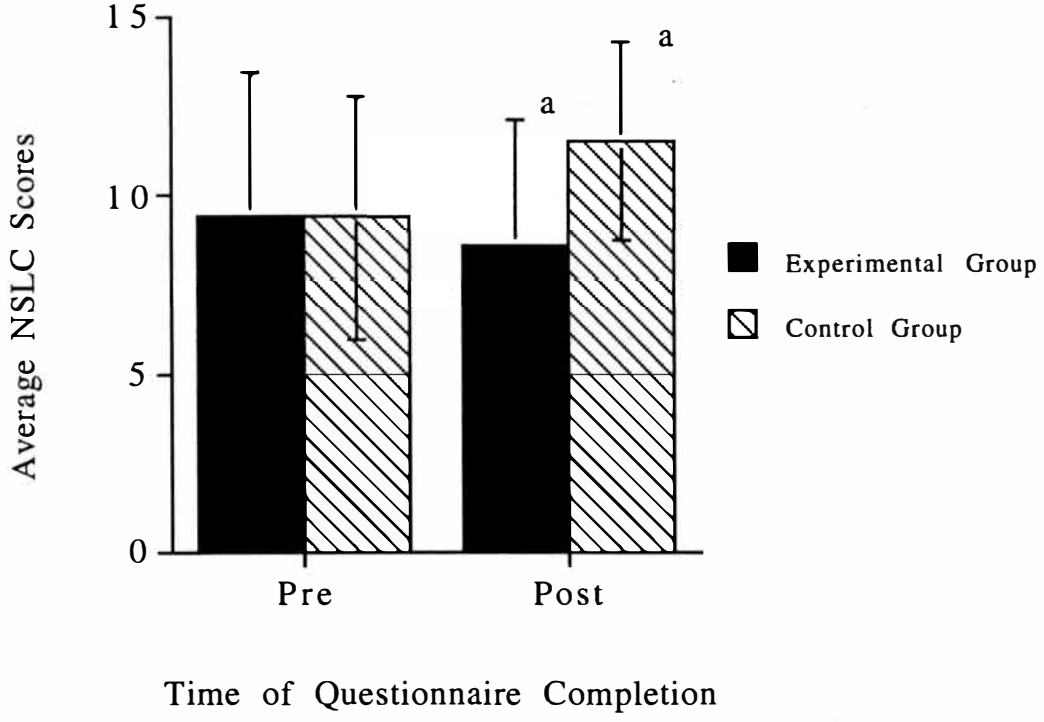

Figure 1. Average Total Scale Scores on the Nowicki-Strickland Locus of Control Scale for the Experimental Group (n = 10) and the Control Group (n = 10). Values that share the same lowercase letter indicate a significant difference between groups ($p < 0.03$). Vertical lines show standard deviation.

The average number of sessions and weeks between pre- and post-intervention completion of NSLC for the experimental and control groups, respectively, was the same as that for the CSEI (See Table 6).

Hypothesis 5: There will be no correlation between self-esteem and an internal locus of control for all subjects in the two groups.

Result: This hypothesis was rejected. There was a correlation of r = -0.53 on SEI and NSLC scores at pre-test and a correlation of r = -0.59 between scores on these

Table 4

Percent Change in NSLC Scores

Subject	Experimental Group	Control Group
1	-21.05	0.00
2	-5.26	31.82
3	-10.53	26.32
4	-15.79	5.26
5	-21.05	5.26
6	0.00	-10.53
7	0.00	10.53
8	26.32	21.05
9	0.00	0.00
10	5.26	13.64
Ave. Percent Change[a]	-4.21 (14.21)	10.33 (13.09)

[a]SD in parentheses.

scales at post-test, both of which may be considered moderate correlations (See Table 7).

Hypothesis 6: There will be no differences between the self-esteem and locus of control between boys and girls in either group.

Result: This hypothesis was accepted. There were no statistically significant differences between the self-esteem and locus of control between boys and girls in either group. Neither the number of weeks between pre-test and post-test questionnaire completions ($F < 1$) nor gender ($F < 1$) appeared to be a mediating factor in either test.

Leven's Test for homogeneity of variance indicated that this assumption of univariate analysis was not violated with regard to any of the above analyses.

Table 5

Percent Change in CSEI Scores

Subject	Experimental Group	Control Group
1	-4	-2
2	8	-16
3	2	0
4	-2	4
5	4	-8
6	2	-16
7	12	-8
8	-28	-8
9	-14	-14
10	0	8
Ave. Percent Change[a]	-2 (11.51)	-6 (8.33)

[a]SD in parentheses.

Table 6

Raw Scores on the Nowicki-Strickland Locus of Control Scale and Pre-Test and Post-Test

Subject	Age	Gender	Scores at Pre-test	Scores at Post-test	# Weeks Pre-Post Test	# Sessions Pre-Post Test
Exp.						
1	7	F	11	7	5	10
2	9	F	16	15	3	6
3	9	F	10	8	4.5	9
4	7	M	10	7	5	10
5	9	F	9	5	5.5	11
6	8	F	6	6	2	4
7	7	M	13	13	2	4
8	11	M	3	8	2	4
9	8	F	12	12	2	4
10	6	F	4	5	2	4
Control						
1	14	M	10	10	2	N/A
2	16	M	7	14	3	N/A
3	6	M	6	11	2	N/A
4	8	F	9	10	2	N/A
5	10	M	13	14	2	N/A
6	7	M	16	14	2	N/A
7	8	F	5	7	2	N/A
8	7	F	8	12	2	N/A
9	11	M	8	8	4	N/A
10	12	F	12	15	3	N/A

Table 7

Comparison of NSLC and CSEI Scores at Pre- and Post-Test

Group	NSLC Pre-Test	CSEI Pre-Test	NSLC Post-Test	CSEI Post-Test
Exp.				
1	3	94	5	98
2	4	88	5	88
3	6	78	6	80
4	9	94	7	68
5	10	70	7	90
6	10	92	8	72
7	11	72	8	66
8	12	90	12	76
9	13	60	13	72
10	16	50	15	58
Control				
1	5	80	7	72
2	6	78	8	80
3	7	88	10	92
4	8	52	10	86
5	8	94	11	78
6	9	82	12	44
7	10	94	14	72
8	12	62	14	68
9	13	76	14	52
10	16	68	15	70

CHAPTER V

DISCUSSION AND RECOMMENDATIONS

In summary, it appeared that subjects who participated in the music therapy sessions had more individual gains in self-esteem and locus of control than did those in the control group.

Although the overall analysis between groups in matched post-test scores on the Coopersmith Self-Esteem Inventories was nonsignificant, the experimental group had more individual subjects with higher post-test scores in self-esteem than did the control group. Specifically, the percent change of 7 subjects in the control group went in a negative direction, whereas four subjects in the experimental group also had negative gains with one subject showing a -28. This drastic individual reduction in score affected the average percent change in the experimental group.

It is noteworthy that while the overall analysis was nonsignificant, there was an average change of -2% (SD = +/- 11.51) between pre-test and post-test for the experimental group, while there was an average change of -6% (SD = +/- 8.33) in CSEI scores between pre-test and post-test for the control group (See Table 3). Thus, self-esteem scores did drop for both groups, however there was a larger decrease in scores for the control group indicating less self-esteem for these subjects compared to the experimental group. It could be suggested that coming to terms with difficult issues of abuse could have had negative effects in perceived self-esteem for subjects in both groups. By residing in a shelter for domestic violence, these subjects were faced with issues of abuse and how to resolve them. Perhaps the music therapy afforded the experimental group some degree of protection against a further decrease in perceived self-esteem.

Most children in both groups pretested fairly high on the self esteem inventories (mean score of 78.8) compared to Simmons and Weinman's study (1991) of children in emergency shelters (mean score of 50.52). By testing high, these subjects had little room to improve during the posttesting. Perhaps an instrument investigating other areas of need should be used when working with this clientele. In researching appropriate instruments for this clientele, this researcher found limited resources. A measurement of views, attitudes, or behaviors regarding interpersonal interactions was desired, but an appropriate instrument could not be found at the time of research. A violence measurement would be appropriate as this experimenter observed violence as a means of interacting with others and demonstrating emotions with these clients.

It is interesting to note the direction of change in scores for the Nowicki-Strickland Locus of Control Scale in the experimental group vs. the control group. The experimental group scores decreased indicating more internal locus of control while the control group scores increased indicating a more external locus of control. Perhaps volunteering to go to music therapy increased the internal locus of control for the experimental group. By coming to sessions, these subjects added more responsibility to the tasks for which they were already responsible in their lives.

Although not significant, a consistent correlation was found between the Coopersmith Self-Esteem Inventories and the Nowicki-Strickland Locus of Control Scale during pretesting and posttesting. This suggests a correlation between low self-esteem and an external locus of control, as well as high self-esteem and an internal locus of control, supporting Simmons and Weinman's (1991) findings.

Within the experimental group, three subjects had an increase in their self-esteem and internal locus of control after treatment. Two showed an increase in self-esteem while their locus of control remained the same after treatment based on the instruments used in this study. One subject's self-esteem and locus of control remained

the same. Another subject's self-esteem dropped while his locus of control became more external after treatment. In contrast, only one subject in the control group showed this type of relation (lower self-esteem and the locus of control becoming more external) after posttesting. In both the experimental and control groups, 7 subjects in each group pre-tested with external scores. Two subjects in the experimental group pre-tested with intermediate scores while three subjects in the control group pre-tested with intermediate scores. Only one subject in the experimental group pre-tested with an internal locus of control. These scores support the findings of Slade, Morrison, & Abramowitz, (1994,) which suggested that children from violent backgrounds have a more external locus of control than their typical peers.

Although there were no statistically significant differences between the self-esteem and locus of control between boys and girls in either group, this experimenter noted that out of nine males in both groups, only one in the experimental group showed an increase in his self-esteem. Of the three boys in the experimental group, one showed an increase of 12 points, one showed a decrease of 2 points, and the third showed a decrease of 18 points. Only one boy in the experimental group and one out of six in the control group showed internal gains in their locus of control. Four out of seven girls in the experimental group showed gains in their self-esteem, while only one out of four in the control group showed in increase. Similarly, four girls in the experimental group showed gains in their internal locus of control while all four girls in the control group showed no internal gains. In summary, both genders showed more gains in the experimental group than in the control group.

It is noteworthy to look at the individual scores of the pre-testing and post-testing. Five of the subjects in the experimental group (four girls and one boy) showed an increase in self-esteem while five (a different combination of four girls and one boy) also showed an internal gain in their locus of control. In contrast, only one girl in the

control group showed an increase in self-esteem, while another boy showed an internal gain of his locus of control. The children who attended the most music therapy sessions (6 to 11 sessions) showed a more internal gain of their locus of control. This could be attributed to having more contact with music therapy and/or residing in the shelter for a longer period of time, which may have helped them to develop a higher sense of responsibility. It can also be suggested that these children learned to accept more responsibility as the therapist had them lead and organize activities during the music therapy sessions. In these instances, participants led interventions such as instrumental improvisations by stating how structured these improvisations would be, and by cueing other group members in and out of the improvisations. These participants would also lead their own interventions such as "Musical Simon Says". Perhaps this type of leadership could have effected their locus of control by giving them more responsibility during the music therapy sessions. The effects of this type of leadership should be investigated in further research.

One boy in the experimental group showed a significant reduction in his self-esteem scores dropping from a 94 to 66 when posttested two weeks later. This was a surprising finding as this participant verbalized his enjoyment and enthusiasm of the music therapy sessions and had participated in both groups and individual sessions. Participation in music therapy sessions may have elicited uncomfortable issues and/or feelings. Perhaps the reduction in perceived self-esteem occurred because of this, as difficult issues are not easy to address and may have made this participant feel badly about himself. Another possible explanation for the drop may have been because he was disappointed that his treatment was coming to an end. He did verbalize to the therapist that he wanted to continue with the music therapy sessions, but his family was leaving the shelter.

Results of this study should be interpreted with caution, particularly since the number of subjects was relatively small. Several conditions impacted the low number of subjects who participated in the music therapy sessions. Although this experimenter pretested 29 subjects who met the criteria for being in the experimental group, only 10 participated in the treatment condition.

The experimenter met with most of the mothers who had children in the appropriate age ranges. Some of the mothers were not available when this therapist was at the shelter due to working at night or other obligations. All of the mothers with whom the experimenter spoke to gave their permission for their children to participate in this study. Both the mothers and the children were assured that they could choose to not participate at any time and that there would be no negative consequences on their stay at the shelter. Many of the children utilized this privilege. It is assumed that once they knew of their right to say "no" to an adult, they exercised this right with the music therapist. Six subjects who met the criteria for the experimental group discontinued their treatment by exercising this right.

Another factor which impacted this study was the fact that some families would leave without the experimenter being informed. Eight subjects who met the criteria for the experimental group and three subjects in the control group left before the experimenter was notified. In addition, some families were exited from the shelter due to breaking rules or other violations. Two subjects who met the criteria for the experimental group were affected by this.

Fewer subjects in the control group discontinued their participation in the study than did those in the experimental group. Of the 14 pretested, two left the shelter without the experimenter being informed, one was exited due to a violation, one began to stay with other relatives, and one mother stated that she did not want her son to "talk to anyone anymore".

A requirement to posttest subjects in the experimental group was for the clients to attend the music therapy sessions consistently. As attending music therapy sessions was voluntary, three subjects in the experimental group did not attend the music therapy sessions consistently and therefore were discontinued from treatment.

The experimental research for this study was interrupted for one month. Although the experimenter received permission from the director of SAFE House before any interactions with the children occurred, the director was unclear as to what was occurring during the music therapy sessions, and did not permit the research to continue until she had met with this experimenter. The research was able to resume after this experimenter explained her training, credentials, and the types of interventions which were being used during the music therapy sessions.

More clear and consistent communication could have omitted this confusion. Perhaps conducting an inservice for the staff at SAFE House would have eliminated the confusion and concerns about the music therapy session. This experimenter had conducted an inservice a year prior to this research when volunteering for another music therapy program at this shelter. This inservice explained the purpose of using music therapy in the shelter and interventions were also demonstrated. It appeared that this inservice was helpful as there was good support for the music therapy sessions after this. It may have been helpful to conduct another inservice as there were new staff and volunteers at the time of this study.

The census of the shelter dropped in the spring and summer. Weeks would pass without any children in the shelter who were age-appropriate for the study. During this time the experimenter would call the shelter to find out if any children of appropriate age had come into the shelter. The therapist would then come to the shelter at the subjects' convenience.

Most of the children in the experimental group were in the 6 to 9 year old range. This experimenter did meet with teenagers and encouraged them to participate. The clients were assured that the sessions would be facilitated according to their needs and interests, and that they would not be in groups with the younger children. It was difficult to get adolescents, especially adolescent girls into the music therapy sessions. This experimenter explained to the adolescents that the music therapy sessions would be designed to fit their specific needs, yet it was still difficult to engage them. This may explain why there were no adolescents in the experimental group. Four adolescents did agree to the pretesting, and one 14 year old girl came to three music therapy sessions. She did not attend consistently though, because she exercised her right to say no. This client expressed to this experimenter that she appreciated being able to refuse treatment when she did not want to attend music therapy sessions.

The low number of adolescents in the experimental group may be attributed to their right to say "no" to the experimenter. By given this choice, these adolescents may have felt empowered by saying "no" and making choices for their treatment at SAFE House. In contrast, 4 subjects in the control group were in the 10 to 16 year old range. Perhaps this higher number is reflected because these clients did not have to participate in music therapy sessions.

Perhaps explaining to the reluctant adolescents that they would not be exposed during or after the music therapy sessions would have increased participation. By directly asking the adolescents what their fears and/or concerns of attending music therapy sessions were, these issues could have been addressed by the experimenter. It may have also been helpful to assure the adolescents that if difficult issues were to arise, they would be treated in a therapeutic manner.

Violence used as a means of resolving conflicts was observed in some of the earlier music therapy sessions as was a lack of impulse control. Some of the children

had difficulty coping with differences with other clients and would use violence as a means to be heard. It appeared that these children did not feel that there were any consequences to their violent behaviors. This supports the findings of several authors (Elbow, 1982; Jaffe, Wilson & Wolfe, 1986; and Straus et al .,1980). These children also had difficulty expressing their anger constructively which resulted in a lack of control. This supports the findings of Grusznski et al (1988), and Slotoroff (1994).

Most of the children in the music therapy groups used hitting and abusive language to solve their problems, which supports Alessi and Hearn (1984) and Carlson's (1984) findings. These inappropriate behaviors decreased during the number of music therapy sessions in which they participated. These participants began to use the music therapy interventions (i.e. improvisations, movement) to express their anger and frustration. By developing leadership roles which were described earlier, these participants became less aggressive and more responsible during the groups. It is also suggested that as the individual members of the groups began to work with one another, the violent episodes decreased.

Some gender differences were also observed during the music therapy sessions. In support of the findings by Emery, 1982; Emery and O'Leary, 1982; Hershorn and Roshenbaum, 1985; and Jaffe et al., 1986; boys were observed to be more aggressive, were more verbally abusive, and at times were noncompliant. Girls were less aggressive than the boys and were more likely to comply with the sessions or simply withdraw. These may be behaviors that were learned by living with abusive fathers and submissive mothers, or the children may have been acting out what they believed to be appropriate gender roles.

Different behaviors were also observed in different age groups in the music therapy sessions. Elementary age children were generally eager to please the therapist and make new friends, yet they were also observed to be aggressive and hostile. Most

children were unwilling to talk about their family situations. These children tended to be guarded and secretive about their family situations.

Suggestions for Further Research

It is recommended that a different instrument be used to evaluate children survivors of domestic violence regarding their attitudes, views, and/or use of violence. The children in this study tended to use violence as means to get attention, or to stop the behaviors of other children. It would be helpful to have a clear idea as to how these subjects view and/or use violence in their lives. Interventions could then be facilitated to help these children realize the effects of violence on themselves and others. Interventions could also be used to help them identify and practice more constructive ways of expressing their feelings which make them act out violently.

It appears that as socialization skills increased, violent and aggressive behaviors decreased for some participants during the music therapy sessions. This could suggest that positive socialization techniques may decrease these inappropriate behaviors. By using interventions such as improvisation and movement, group cohesion may develop. Perhaps more emphasis on this socialization component could be used in future designs.

Investigating how children who are abused, children who witness abuse, and children who are both witnesses and abused react to music therapy interventions is also suggested. The literature review suggests that these different types of abuse may lead to different types of problems. By knowing what types of abuse the subjects are exposed to, interventions may be facilitated to suit their needs more appropriately. This investigator was not allowed access to this information of the subjects used in this study. Clear and consistent communication with staff should be developed to build trust with one another to help understand the clients and their needs.

The realities of conducting music therapy in domestic violence shelters impacted the results of this study. Short-stays of clients influence consistency in sessions as did the willingness of clients to participate. Finding ways of encouraging more support for music therapy sessions is also suggested. It was difficult to know which subjects would be in specific sessions as music therapy was not required and the children were not required to attend every session which occurred during their residence at the shelter. Because of this, many subjects did not qualify for the entire study as they did not continue to come to music therapy sessions, or did not come consistently.

Perhaps identifying a specific time for music therapy when no other activities were occurring would have helped the participation in this study. During most of the music therapy sessions, especially when the shelter census was high, the children could also spend their time in the playroom. Without these types of distractions, perhaps more clients would have attended more music therapy sessions. Again, good communication with staff could help to design programs based on clients' needs. Programs could be designed to encourage more participation in music therapy sessions by not having other distractions, such as open playroom time, compete with sessions.

It is suggested that more music therapy research be conducted in domestic violence. This author found little previous research in music therapy and domestic violence. This is an area which is in need of positive therapeutic interventions, especially early interventions for the children. With early intervention, it may be possible to help these children avoid or work through the range of problems to which they may be susceptible. From the results of this study, it is suggested that music therapy may be beneficial for children survivors of domestic violence. This experimenter received positive feedback from the clients and staff at SAFE House regarding the music therapy sessions.

Appendix A

Scripts

SCRIPTS

When obtaining consent from the mothers, the therapist read: "I would like your child to participate in music therapy sessions. These sessions will include singing, listening to music, playing instruments, movement, relaxation, and drawing. The purpose of these sessions is to allow your child to express him/herself verbally and non-verbally. Two tests will be administered before your child comes to the first session, and again before you leave the shelter. Your child is not required to participate, and there will be no negative effects on you or your child if you do not want him/her to participate or if s/he chooses not to participate."

When obtaining assent from the children, the therapist read: "You are invited to participate in music therapy sessions. These sessions will include singing, listening to music, playing instruments, movement, relaxation, and drawing. I will also be asking you some questions before you attend the sessions and again during your last week here at the shelter. These questions will not be graded or shown to your family. You may participate in any of these interventions and may choose not to participate in any of these as well. Even though your mother has agreed to let you participate in these sessions, you do not have to participate if you don't want. You are not required to attend and will not receive any negative consequences if you do not participate."

Appendix B

Songs and Recordings Used

HELLO SONG

Hello (Name)

Hello (Name)

Hello (Name)

It's good to see you today.

CAN YOU FEEL THE LOVE TONIGHT

There's a calm surrender to the rush of day
When the heat of the rolling world can be turned away.
An enchanted moment and it sees me through.
It's enough for this restless warrior just to be with you.

And can you feel the love tonight? It is where we are.
It's enough for this wide-eyed wanderer that we got this far.
An can you feel the love tonight, how it's laid to rest?
It's enough to make kings and vagabonds believe the very best.

There's a time for everyone, if they only learn
That the twisting kaleidoscope moves us all in turn.
There's a rhyme and reason to the wild outdoors
When the heart of this star crossed voyager
Beats in time with yours.

And can you feel the love tonight? It is where we are.
It's enough for this wide-eyed wanderer that we got this far.
And can you feel the love tonight, how it's laid to rest?
It's enough to make kings and vagabonds believe the very best.
It's enough to make kings and vagabonds believe the very best.

FEELINGS

Sometimes I'm feelin' happy and I'm wearin' a smile;
let me show you how I look when I'm feelin' happy.
Sometimes I'm feelin' sad and I'm wearin' a frown;
let me show you how I look when I'm feelin' sad.

Oh feelings don't always stay the same, they can change.
Sometimes I'm happy, sometimes I'm sad. It's o.k.
It's not bad

Sometimes I'm feelin' mad and I stamp my feet;
let me show you how I look when I'm feelin' mad.
Sometimes I'm feelin' tired and I have to yawn;
let me show you how I look when I'm feelin' tired.

Oh feelings don't always stay the same, they can change.
Sometimes I'm happy sometimes I'm sad. It's o.k.
It's not bad

I LIKE ME

I like me, I like me, because I _____

I like me, I like me, because I _____

I like myself, because I _____

I like myself, because I _____

LEAN ON ME

Sometimes in our lives,
We all have pain. We all have sorrow
But if we are wise, we know that there's
Always tomorrow

Lean on me when you're not strong.
And I'll be your friend, I'll help you carry on.
For it won't be long, 'til I'm gonna need
Somebody to lean on.

Please swallow your pride.
If I have things you need to borrow
For no-one can fill those of your needs
That you won't let show

You just call on me brother when you need a hand
We all need somebody to lean on.
I just might have a problem that you'll understand
We all need somebody to lean on.

Lean on me when you're not strong.
And I'll be your friend, I'll help you carry on.
For it won't be long, 'til I'm gonna need
Somebody to lean on.

LEAN ON ME

(Close form)

Somtimes in our lives _____

We all _____

But if we are _____we know that there's _____

CHORUS:

Lean on me when _____

And I'll _____

I'll help you _____

For it won't be long _____

Please _____

If I have _____

For no one _____

You just _____ when _____

We all _____

I just might _____

We all _____

LOVE HOUSE

How do you build a love house? How do you make it strong?
How do you build a love house? So it will last you long?
You cannot build a love house with wood and brick and glass.
It takes talking and working and playing and praying
To make a love house last.

Talking, in the good times and the bad times
It takes a lot of time to talk things through.
Working to build foundations for tomorrow
Binds us all together when there's healthy work to do.
Playing in the winter time and summer time
We're children and we need some time to play.
Praying through lovely days and lonely night
In the living and the dying we will pray.

How do you build a love house? How do you make it strong?
How do you build a love house? So it will last you long?
You cannot build a love house with wood and brick and glass.
It takes talking and working and playing and praying
To make a love house last.

PUFF THE MAGIC DRAGON

Puff the magic dragon lived by the sea
And frolicked in the autumn mist in a land called Honah Lee.
Little Jackie Paper loved that rascal Puff
And brought him strings and sealing wax and other fancy stuff, oh,

CHORUS

Puff the magic dragon lived by the sea
And frolicked in the autumn mist in a land called Honah Lee.
Puff the magic dragon lived by the sea
And frolicked in the autumn mist in a land called Honah Lee.

Together they would travel on a boat with billowed sail.
Jackie kept a lookout perched on Puff's gigantic tail.
Noble kings and princes would bow when-e'er they came;
Pirate ships would lower their flags when Puff roared out his name, oh,
(CHORUS)

A dragon lives forever but not so little boys
Painted wings and giant rings make way for other toys.
One gray night it happened Jackie Paper came no more
And Puff that mighty dragon he ceased his fearless roar, oh,
(CHORUS)

His head was bent in sorrow, green scales fell like rain.

Puff no longer went to play along the cherry lane.

Without his life-long friend, Puff could not be brave

So Puff that mighty dragon sadly slipped into his cave, oh,

(CHORUS)

STAND BY ME

When the night has come

And the land is dark

An the moon is the only light we see

No I won't be afraid

No I won't be afraid

Just as long as you stand by me

If the skies that we look upon

Should crumble and fall

And all the mountains should crumble to the sea

I won't cry, no I won't cry

No I won't shed a tear

Just as long as you stand by me

So darlin', darlin', stand by me

Oh, stand by me

Long as you, only you, stand by me

TURN, TURN, TURN

CHORUS

To everything (turn, turn, turn)

There is a season (turn, turn, turn,)

And a time for every purpose under heaven.

A time to be born, a time to die;

A time to plant, a time to reap;

A time to kill, a time to heal;

A time to laugh, a time to weep.

(CHORUS)

A time to build up, a time to break down;

A time to dance, a time to mourn;

A time to cast away stones;

A time to gather stones together.

(CHORUS)

A time of love, a time of hate;

A time of war, a time of peace;

A time you may embrace;

A time to refrain from embracing.

(CHORUS)

A time to gain, a time to lose;

A time to rend, a time to sow;

A time to love, a time to hate;

A time of peace, I swear it's not too late.

YOU'VE GOT A FRIEND

When you're down and troubled, and you need some love and care,

And nothin', nothin' is goin' right,

Close you eyes and think of me and soon I will be there,

To brighten up even your darkest night.

CHORUS

You just call out my name, and you know wherever I am,

I'll come runnin' to see you again.

Winter, spring summer or fall, all you have to do is call,

And I'll be there, you've got a friend.

If the sky above you grows dark and full of clouds,

And that ol' north wind begins to blow,

Keep your head together, and call my name out loud,

Soon you'll hear me knockin' at you door

(CHORUS)

Now ain't it good to know that you've got a friend,

When people can be so cold? They'll hurt you, yes and desert you.

And take you soul if you let them, oh, but don't you let them.

(CHORUS)

RECORDINGS

Ciani, S. , (1988). In Neverland. RCA Records, 2036-4-P

Hoffman, J. , (1985). Children's Relaxation Tape. Rhythmic Medicine, Shawny Mission, Kansas

Enya, (1991). Shepard Moons. Reprise Records, 9 26775-4

Appendix C

Consent for Research Participation

Western Michigan University
Department of Music Therapy
Principal Investigator: Brian Wilson
Research Associate: Amy Bogetto

I understand that my child has been invited to participate in a research project entitled "The Effects of Music Therapy on the Self-Esteem and Locus of Control of Children Survivors of Domestic Violence". The purpose of this study is to examine the effects which music therapy has on the self-esteem and the locus of control of children survivors of domestic violence. I further understand that the purpose of this project is to fulfill Amy Bogetto's thesis requirement.

My consent for my child to participate in this project means that my child will be administered the Coopersmith Self-Esteem Inventories as well as the Nowicki-Strickland Locus of Control Scale. If my child participates in is study, these two tests will be administered during the first week of our residency in the shelter and again during the last week. The music therapy sessions will include interventions such as singing, listening, discussion, instrumental improvisation, movement, drawing, creative writing, and relaxation. Each session will occur twice a week for approximately 50 minutes. Children are invited to attend for the duration of their residency in the shelter. The children may refuse to participate at any time, including the time which they are in the sessions. If my child refuses or quits, there will be no negative effect on his/her stay at the shelter. If the music therapy sessions are found to be positively effective, this information will be given to other music therapists to further help other children in these situations.

I understand that my child's participation in this study will be confidential. This means that my child's name will not be included in any documentation or description of the study. No names will be used if the results are published or reported at a professional meeting.

I understand that the only risks anticipated are the disclosure of painful emotions and the possible ramifications of another child's coping strategies of these emotions (e.g. yelling, throwing objects, hitting, kicking). I understand that the therapist will intervene according to SAFE House's interventions should another child become aggressive towards my child. If a situation arises in which the therapist feels she cannot be effective, the children's coordinator will be notified and my child will be given appropriate interventions. As in all research, there may be unforeseen risks to my child. If an accidental injury occurs, appropriate emergency measures will be taken; however, no compensation or treatment will be made available to me except as otherwise specified in this consent form.

I understand that I may also withdraw my child from this study at any time without any negative effect on services to me or my child. If I have any questions of concerns about this study, I may contact Amy Bogetto at 930-9689 and/or Brian Wilson at 616-387-4724. I may also contact the Chair of Human Subjects Institutional Review Board at 616-387-8293 or the Vice President for Research at 616-387-9298 with any concerns that I have.

My signature below indicates that I give my permission for _____ to attend music therapy sessions, and to be given the Coopersmith Self-Esteem Inventories along with the Nowicki-Strickland Locus of Control Scale. Any effects found may be reported to other music therapists to help other children in these situations. In additon, the results and data will be retained for three years.

_____ _____

Signature Date

Western Michigan University
Department of Music Therapy

Principal Investigator: Brian Wilson

Research Associate: Amy Bogetto

I understand that I have been asked to participate in a research project entitled "The Effects of Music Therapy on the Self-Esteem and Locus of Control of Children Survivors of Domestic Violence". The purpose of this study is to examine the effects which music therapy has on the self-esteem and locus of control of children survivors of domestic violence.

I understand that if I agree, I will be given the Coopersmith Self-Esteem Inventories and the Nowicki-Strickland Locus of Control Scale during my first week in the shelter as well as my last week in the shelter. I understand that if I participate in the music therapy sessions, I will be involved in interventions such as singing, listening, discussion, instrumental improvisation, movement, drawing, creative writing, and relaxation. I understand that if I do not wish to participate, there will be no negative effects on services to me. Even if I agree today to participate by signing this form, I can change my mind when we begin answering the questions on the inventories and scale, the sessions, or at any time during the inventories and scale and/or the sessions.

If I choose to answer the inventories and the scale, and if these answers prove to be helpful, these results may be shared with other music therapists and the staff at SAFE House. If they are not helpful, they will not be shared with other professionals.

I understand that you would like to compare the answers of the inventories and scale of those who participate in the music therapy sessions to those who do not. By signing below, I am also agreeing to let you make these comparisons with my answers.

I understand that my name will not be on any of the forms and that you will use a code number instead. You will keep a list of names and code numbers that will be destroyed once you have shared any important information with other therapists or staff at SAFE House.

If I have any questions or concerns about this study, I may contact Amy Bogetto at 930-9689.

My signature below indicates that I agree
1) to be tested with the Coopersmith Self-Esteem Inventories and the Nowicki-Strickland Locus of Control Scale;
2) to participate in music therapy sessions;
3) for my scores to be compared with other test scores of participants in this study; and
4)for the scores of the tests, if found to show differences between groups, to be reported to other music therapists and the staff at SAFE House.

Print name here_____

_____ _____

Sign name here Today's Date

Appendix D

Human Subjects Institutional Review Board Confirmation

Human Subjects Institutional Review Board

Kalamazoo, Michigan 49008-3899

WESTERN MICHIGAN UNIVERSITY

Date: 12 November 1996

To: Brian Wilson

From: Richard Wright, Chair

Re: HSIRB Project Number 96-08-25

This letter will serve as confirmation that your research project entitled "The Effects of Music Therapy on the Self-Esteem and Locus of Control of Children Survivors of Domestic Violence" has been **approved** under the **full** category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you must seek specific approval for any changes in this design. You must also seek reapproval if the project extends beyond the termination date. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: 9 November 1997

xc: Amy Bogetto

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