

Pedagogical Implications for Teaching Students with a History of Sexual Trauma: An Essay regarding the Q&A Session following the Presentation

Grace Johnson

Independent Scholar, California, USA

The five minute Q & A session that followed my presentation at the 2013 *Phenomenon of Singing* Symposium served as a wake-up call for me. The comments changed my mind about how I plan to proceed with my research. In fact, they convinced me that I must continue. In this essay, I will address those comments as well as additional ones from subsequent conversations, emails, phone calls, etc. in the days that followed the meeting.

In the past decade, the years following the completion of my dissertation *The Effects of Childhood Sexual Abuse on the Adult Singing Voice* (Johnson 2004), I have presented and written about various aspects of the research on numerous occasions. Nonetheless, several times I have been turned down as a speaker because my topic was considered depressing. Indeed, some found the subject matter off-putting, as well they should, as it covers atrocities—egregious breaches of social covenant. As Herman (1992) attests, “certain violations of the social compact are too terrible to utter aloud: this is the meaning of the word *unspeakable*” (p.1).

More common, though, has been the response that I received at the *Phenomenon of Singing* 2013 Symposium. The single word that the first audience member uttered is a word that has been said to me for the past decade at conferences, in emails, in notes, and in furtive whispered comments—“finally.” Finally, someone is addressing this; finally, this is in the open; finally, I am heard; finally, we can do something about this; finally, there will be help. Formally, I heard the word as validation for the need for my research. In St. John’s, for the first time, I heard the word as a chilling indication that there has been little progress toward solutions. The expression “finally” suggests a transition, a new direction. That this word continues to be the response attests that the subject continues to be silenced—silenced perhaps by fear; or worse, by indifference and ignorance. Unfortunately, with silence and secrecy, “the story of the traumatic event surfaces not as a verbal narrative but as a symptom” (Herman, 1992, p. 1). Many of these symptoms (often referred to as sequelae to sexual abuse) can directly compromise the singing voice (Johnson, 2004; 2009).

Following a brief overview of the effects of post-trauma on the singing voice and the implications for teachers, the focus of this essay will be on answers, recommendations, and unanswered questions that surfaced at the 2013 Symposium and in subsequent discussions. A more in-depth summary of the research can be found in the NATS article (Johnson, 2009) or the dissertation (Johnson, 2004).

Overview of the Research

Methodology

The qualitative, holistic, post-factum, phenomenological reflection study explored the relationship between the adult singing voice and Childhood Sexual Abuse (CSA) through (1) a multi-discipline literature review and (2) case studies. Inferences drawn from the literature review regarding CSA and singing were compared to essential themes derived from the case studies. Disciplines included in the literature review were Vocal Pedagogy, Psychology, Speech-language Pathology, and Music Therapy. Although no one discipline addressed a relationship between singing and CSA history directly, each provided information relevant to singing and/or

CSA from which a connection could be inferred. For the case studies, a convenience sampling was narrowed from a pool of participants to four female voice teachers who self-identified as having a history of CSA. From transcripts of the narratives, readers independently derived common themes.

Findings

The themes yielded from the narratives were supported in the multi-discipline literature. Findings indicated that singers with a history of CSA could present symptoms associated with post-trauma that were directly counterproductive to singing. In addition, symptoms of both post-trauma and therapeutic treatments for post-trauma could be impacted by the act of singing. (See Appendices A and B for further explanation of the relationship between components of singing and psychological-physiological response to post-trauma.)

Implications for Voice Teachers

Given the high prevalence of sexual assault, childhood sexual abuse, and subsequent post-trauma effects (Herman, 1992; Briere & Scott, 2006), the likelihood exists that a voice teacher will encounter a student with this history. It is not necessary for a teacher to know this history, but teachers with an awareness of post-trauma symptoms will be less likely to be caught off guard (Johnson 2009). As an example, in the picture below, I am simulating a singer being asked to sing an arpeggiated [a] vowel while watching my tongue in a mirror. This exercise incorporates two actions that were mentioned by the case study participants as causing a significant degree of distress: Singing an [a] vowel and looking in a mirror. The addition of touch could further compound the distress.



My first awareness that sexual abuse could influence singing occurred nearly two decades ago when one of my students confided that her psychiatrist advised her to stop singing because breath management for singing caused her to retrieve memories of incest faster than she could process them (Johnson 2004). If I had known then what I know now, I would have handled the situation differently.

Answers, Solutions, and Recommendations

Presently, regarding sexual abuse post-trauma effects on singing, there are profound questions and concerns to address; however, the nature of the topic often causes reluctance for public questions and discussion. First, I will give you the answers that I have. They are gleaned from research, conversation with mental health care professionals, colleagues, and most important from numerous CSA survivors who have generously shared their stories and insight with me. Following the completion of my dissertation and the publication of a NATS *Journal of Singing* article, I have heard from survivors in North America and Europe. I rarely receive responses to my replies. Secrecy and confidentiality continue to cloak this topic with needed protection but smothering silence. I advise the following.

Know Pertinent Laws and Regulations

Currently, singers with voices impacted by sexual trauma and the teachers who teach them are left somewhat to fend for themselves—without standard guidelines. Teachers of singing seem to fall between the cracks with regulations. In a manual touting “what every helping professional needs to know” about ethical conduct, voice teachers are not in the list of “helping professionals” (Merrill Education, 2009, cover). Is the impact and influence of voice teachers under-rated sufficiently to deem them harmless? Unlike other professionals who help singers (e.g. psychologists, ENTs, speech-language pathologist, etc.), teachers of singing have no licensure or mandatory regulation beyond those of every citizen in their country/state/province and those of their institution, if they are so affiliated. These laws vary. For example, in the United States, each state determines laws pertaining to mandatory reporting (Matthews & Kenny, 2008). (In many cases, voice teachers are mandated reporters by law without being aware of it.) Teachers without institutional or organizational affiliation are especially vulnerable to transgression since they must rely solely on personal ethics for behavior regulation. In addition, they are more likely to teach minors. Although professional organizations offer codes of ethics, they lack power (beyond exclusion) to enforce them.

Do No (More) Harm

The command for healthcare providers to “do no harm” can certainly be worthy advice for voice teachers. It becomes paramount when applied to treatment for CSA survivors (Lindy & Wilson, 2004). CSA survivors are vulnerable to additional harm; they are at risk for re-victimization (Herman 1992). The advice in this case must be “do no more harm.” The following six instructions are taken, in part, from advice given to psychotherapists who treat adults who were sexually abused as children (Briere, 1997). (1) Recognize the difference between a voice lesson and psychotherapy (Rosen & Sataloff, 1997); (2) honor confidentiality; (3) respect boundary issues; (4) stay self-aware; (5) be highly cautious with touch; and (6) bear witness. (See Appendix C for a reprint of the expanded form from the 2009 *Journal of Singing* article.)

Collaboration

My advice to singers with voices compromised by post-trauma symptoms and to their teachers is to establish a healing team. Precedent for collaboration of the Arts and Counseling (Gladding, 1998) can serve as an initial step. Few voice teachers have extensive training in psychology/counseling and few counselors have training in Vocal Pedagogy. The ideal

collaboration would be one in which the lines of communication are open among all parties—patient/student, health care providers, and teachers/coaches.

The success of the collaboration will depend upon a realistic awareness of the challenges involved. For example, issues of confidentiality and communication would need to be spelled out explicitly. Here, again, regulations will vary from stringent (health care professionals) to non-existent (voice teachers/coaches). Additional obstacles might include fee variance, insurance regulations, consultation scheduling, and treatment scheduling. The problems are daunting, but the possibilities are limitless—the benefits for the client outweigh the inconvenience to the providers.

Trust

Lack of trust for authority figures was one of the themes mentioned by the case study participants. How does one who has suffered profound betrayal regain the ability to trust? How can a student learn from a teacher s/he is unable to trust? The teacher's job is to be trustworthy. What greater gift could there be than to enable a student to regain the ability to trust? As with most of singing—lessons learned are not limited to singing.

Questions and Discussion

1. Regarding the student whose psychiatrist advised her to stop singing—how would you handle it now?

Receiving that question was a poignant moment. I remember that I looked away from her eyes, froze, signed the drop slip, and watched her flee my office. Now...I would offer her a chair; I would listen; I would wait for solutions to make their way into our conversation. (I would love to know how the psychiatrist found the connection between singing and repressed memory retrieval.) I wish I could relive it and do it better.

2. How does one weigh confidentiality with safety?

A teacher brought into confidence by the student can be placed in a confounding situation—complicated by personal beliefs, moral concerns, and legal ramifications. When does secrecy hinder freedom; when does revelation violate freedom? Let the teacher be forewarned that to breach confidentiality—to break the trust of a vulnerable CSA survivor is akin to joining the ranks of the survivor's abuser.

3. If I observe obvious signs of post-trauma effects, should I share my conclusions with the student?

No. Voice teachers are neither qualified nor legally sanctioned to make health diagnoses. I would advise consulting the guidance of a psychologist or psychiatrist.

4. If a parent lets me know that the teenaged student was sexually abused, but the student does not mention it, what should I do?

5. Private studio teachers are more likely to have students who are not adults. How does that affect decisions regarding suspicion of/or confiding of abuse?

6. What if the student refuses to seek additional help?

7. Pertaining to touch and boundaries: it is advised that voice teachers (especially male voice teachers working with female voice students) consider additional cultural implications regarding the teacher-student relationship. Do the benefits of touch in teaching voice outweigh the risks?

8. Will response (CSA sequelae/singing) be different for a teenager than for an adult?

9. Private studio teachers do not have the advantage of support systems within the infrastructure that, say, a college teacher has. How can they build support systems that are feasible, confidential, and affordable?

10. If singing is exacerbating flashbacks, should singing continue?

The questions raised are not only troubling, heartbreaking, and inconvenient, they are also complicated by legal, ethical, and moral constraints. The first three questions and my response were discussed at the Symposium. The remaining questions and comments are from conversation that ensued in the days that followed my presentation and from conversations at other venues—primarily workshops and single emails. For me, there are more questions than answers and much needed conversation.

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Appendix A

The effects of CSA sequelae on selected components of Singing

The psychology literature describes psycho-physiological response to post-trauma that can be inferred to have significant impact on singing technique (Briere, 2006; Herman, 1992; Rothchild, 2002; Van der Kolk, McFarlane & Weisaeth, 1996). These include altered emotionality (inappropriate emotion for the situation); asthma; avoidance (behaviors and addictions such as smoking); body armoring (extreme muscle tension); neurological change; dissociation (a disconnect of body and mind that can block physical sensation); GERD; pseudoepilepsy (Bremner, 2002); and Paradoxical Vocal Cord Disorder (PVCD)—adduction on inhalation (Treole, 1960; Freedman, M; Rosenberg, S; Schmaling, K., 1991).

“Body Armoring” is a phrase coined by psychiatrist Wilhelm Reich (1949) that indicated muscle spasm anywhere on the body. When there is no biological reason, it is determined to be psychogenic. When the abdomen is involved, breathing and vibrato are compromised. When the larynx is involved, the term psychogenic dysphonia describes the condition (Butcher, Elias, & Raven, 1993). More currently, this is referred to as Psychogenic Muscle Tension Dysphonia (PMTD) (Johnson, Gonzales, Chang, Manes, Manville, & Ames, 2010). (See the picture below.)



Psychogenic Muscle Tension Dysphonia
Image from www.VoiceInfo.org with permission

Tables 1 and 2 present and organize the information from two perspectives. Table 1 lists the psychological/physiological symptoms first and then presents components of singing that could be impacted by those symptoms. Table 2 lists the primary areas of singing and then explains how they might be affected by symptoms of post-trauma.

CSA Sequelae	Component Of Singing
altered emotionality	performance demands
asthma	breathing
avoidance	phonation
body armoring	breathing; phonation, laryngeal stability
change to hippocampus	memory; performance demands
dissociation	proprioception; breathing; laryngeal stability
GERD	phonation
pseudoepilepsy	performance demands (?); memory (?)
PVCD	breathing; performance demands

Table 1. Effects of CSA sequelae on components of singing

Area of Singing	Effects of CSA Sequelae
posture	lessened awareness; muscle tension, problem with mirrors
breathing	tight abdomen; asthma/PVCD
phonation	laryngeal tension
resonance	proprioception; numbing/lack of secondary vibrations
classification	possible strong emotional reaction
student/teacher	difficulty with trust
performance demands	inappropriate anxiety level; epilepsy; memory

Table 2. Areas of singing and possible effects of CSA sequelae

Appendix B

Possible effects of singing practice/technique on CSA sequelae

Singing can be compromised by post-trauma but it can also be an instrument of healing. Nonetheless, there is a price to pay for the healing—the loss of psychological-physiological defenses. The body awareness necessary for singing (proprioception) interferes with dissociation, but as the singer heals, s/he also loses the psychological protection of dissociation. So, too, does managed breathing present a dichotomous situation. Breathing for singing required abdominal tone—the abdominal muscles must be able to relax as well as contract. The release of abdominal tension negates (protective) body armoring. Along this line, breathing exercises used for relaxation/performance anxiety relief can actually increase anxiety in singers with a trauma history (Wolf, 1989).

Singing Technique	Effect on CSA sequelae
body awareness	interferes with dissociation
abdominal/thoracic breathing	interferes with body armoring; facilitates remembering
practice/performance	Improves mood; facilitates connection to self/others

Table 3. Possible effects of singing practice/technique on CSA sequelae

Appendix C

Do no more harm (Johnson, 2004)

Recognize the difference between a voice lesson vs. psychotherapy: The dynamics of both a voice lesson and a psychotherapy session are similar—the teacher and student meet one-on-one weekly for several years; an atmosphere of trust is established; and the focus on the student is intense. The similarity can draw either the teacher or student into a pseudo-psychotherapeutic relationship. The teacher is not trained as a therapist and must avoid acting as one. However, this does not preclude acting in a supportive manner. Voice teachers have extensive experience with helping students find ways to alleviate anxiety. Certainly, teachers are advised to offer words of encouragement and comfort. Furthermore, voice teachers are often in an ideal position to recommend professional counseling to the student. (Teachers are advised to have contact information readily available.)

Honor confidentiality

If students disclose a history of CSA, teachers should assure them of confidentiality. (One participant described her teacher's breach of confidentiality as an additional trauma abuse.) Keep in mind that confidentiality vs. secrecy can be confusing for CSA survivors. Teachers must be very clear that confidentiality has limits, especially regarding situations deemed dangerous.

Respect boundaries

The teacher must establish clear boundaries for the teacher-student relationship by spelling out expectations for practice and lesson behavior. Furthermore, the teacher must respect the student's personal boundaries, which may be different from the norm and may or may not be articulated. (Three of the four participants remembered feeling confused, uncomfortable, and even numb by touch from a voice teacher even though they had given their permission.) Finally, if a student's personal boundaries are inappropriate, the teacher must address that with tact and kindness

Stay self-awareness

Psychotherapists are advised to stay self-aware when treating adults who were sexually abused as children. This advice applies equally to voice teachers. Specifically, teachers must stay psychologically healthy and self-controlled so that they do not impose their own needs onto a student. These would include inappropriate anger, sexual behavior, or psychological intrusion. (One participant described a voice teacher who violated psychological boundaries in the guise of helping as "just another abuser.") Teachers who have their own history of CSA, especially if they possess the double-edged gift of empathy, will have to be especially diligent in recognizing countertransference.

Be highly cautious touch

Rather than being abandoned as a voice-teaching tool, touch should be understood as powerful, with potential for both healing and harming. Traditionally, touch has been inherent to teaching voice, and arguments in its defense are compelling. Through touch, the teacher can discern and correct misalignment and harmful tension quickly, gently, and efficiently. However, for a student with abuse issues, touch can be threatening and counterproductive. Furthermore, teachers are vulnerable to sexual harassment suits if the student misunderstands the intent. Teachers are

advised to use extreme caution when touching a voice student. Be attentive to the student's body language and ask permission. Several teachers have shared with me ideas for "safe" touching—especially abdominal. One is to have the student touch his/her own body and then place the teacher's hand over the student's hand. This is beneficially in two ways: first, the student has complete control of the situation; and second, the student will have tactile feedback. Another idea is to have soft inanimate objects such as a stuffed animal or bouncy ball to place against the body. This is not only safe, but also comforting.

Bear witness

The atmosphere of trust in a private lesson may lead the student to confide details of a history of abuse. In listening, the teacher bears witness and allows the unspeakable to be heard. This is a gift. Respond as appropriate to disclosure of any grief. Consulting a counselor (after the student has left) for advice about proceeding is recommended. This would not be a violation of confidentiality; the student's name need not be mentioned.