Music therapy within an integrated project for families exposed to domestic violence: A qualitative study of professionals' perspectives

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Abstract

This paper focuses on a collaborative project that took place from 2012-2015 between an NHS Music Therapy Service for children and young people, a Child and Adolescent Mental Health Service and the charity Housing for Women. Music therapy interventions for children and young people took place alongside therapeutic family interventions. The families involved had all experienced exposure to domestic abuse. A qualitative study of professionals' perceptions of the project took place after the project had ended, using a methodology of Interpretative Phenomenological Analysis. Interviews with non-music therapy professionals were transcribed and analysed, providing data about perceived benefits for children and families, the evolving perspectives of the professionals involved, and the degree to which processes in music therapy were communicated and understood.

Keywords: music therapy, children and young people, families, integrated care, domestic violence, interpretative phenomenological analysis.

Introduction

During the periods 2009-2011 and 2012-2015 staff in an NHS Music Therapy Service engaged in two separate collaborative projects with the charity Housing for Women (HfW), in which children who had been affected by domestic violence were referred to music therapy. The first project involved two music therapists and two HfW support workers. In the second project the Child and Adolescent Mental Health Services Early Intervention Team (CAMHS EIT) from the same Trust was involved, with two CAMHS EIT therapists working with support workers from the charity and parents, alongside the children's music therapy sessions. Individual music therapy sessions were delivered in a women's refuge, or in an NHS health centre, while group sessions took place in a children's centre. The approach to music therapy was improvisational, psychodynamically informed, and child-led. Following the end of the 2012-2015 project, I felt some uncertainty about whether music therapy had been effectively integrated with the other interventions. This provided the motivation to devise a retrospective study to explore the perceptions of other professionals, to ascertain areas of difference or convergence, or any unexpected outcomes from the work.

Music therapy with children exposed to domestic violence

While studies exist exploring the impact of music therapy on women exposed to domestic violence (Curtis 2016, de Juan 2016, Hernández-Ruiz 2005) there is relatively little in the music therapy literature exploring music therapy with children exposed to domestic violence. Children exposed to domestic violence can face a complex range of challenges. These can include difficulties with affect regulation, problems with peer relationships, somatic responses, learning disabilities and low self-esteem (Hester et al 2007). It is important to emphasise that there is no predictable pattern of responses/symptoms for children in this situation.

Perhaps surprisingly, the idea that children can suffer post-traumatic symptoms comparable to those experienced by adults is relatively recent, but has gained wider acceptance (Hester et al 2007). Emotional trauma need not involve direct violence towards the individual, but can be the result of exposure to violence towards others (for example the child's mother). Whether or not there is direct physical abuse towards the child, the effects of witnessing violence can be devastating for psychological, emotional and physical well-being and development (Shipway 2004).

Since there is no single diagnosis for children exposed to trauma, medical treatments often tend to focus on specific identified behaviours, rather than on underlying issues (Cook et al 2017). By contrast, music therapists can take an holistic approach which may take into account any diagnoses, but will begin with the child as they present in the therapy session in the here-and-now. Robarts (2014) describes integrative processes in music therapy with children who have experienced complex trauma, where music therapy can help with both regulatory processes as well as rebuilding the child's sense-of-self through creativity. Fairchild et al (2016) demonstrated the benefits of a supported performance, as part of a music therapy programme, in fostering positive relationships within families exposed to domestic violence, while Pasiali (2013) observed positive changes in parent-child interactions in music therapy for families with a similar history.

Non-verbal aspects of trauma

Often, traumatic experiences cannot be accessed verbally, thus the process of integration into normal experience cannot take place. Wesley (2003 p. 119) makes the point that 'trauma experienced by children particularly prior to language comprehension remains sensory, symbolic, and primitive', and describes her music therapy work with a 10 year old boy with a history of physical, emotional and sexual abuse. Carey (2006 pp.215-216) states that the goal of creative therapies 'is to access hidden, sensation-type memories that are stored in the right brain and eventually to connect these images to the left brain, thus making the memories available for verbal recall'. Swallow (2002) has demonstrated the capacity of music to facilitate connections between the left and right hemispheres of the brain. In other words, as early trauma may not be possible to verbalise, music may be a useful tool for expressing painful emotions and memories (Sutton 2002), which may in turn help with affect regulation and with facilitating verbalisation.

Attachment theory/play

Attachment theory is central to Bannister's 'regenerative model' of therapy (Bannister 2003). She sees creative therapies as providing an opportunity to rebuild the traumatised child's sense of identity and self-worth.[1] Secure attachment is a key element in building

[1] While Bowlby, who originally developed the theory, is not specific about the effects on children of indirect exposure to violence, he identifies the danger of cycles of violence within families and sees family violence as a distortion of adaptive care giving behaviour (Bowlby 1988).

resilience, which is in turn crucial in enabling children to recover from traumatic experiences (Hester et al 2007). Camilleri, a music therapist who has worked with at-risk inner city children in the USA, describes how the traumatised child 'will need help redefining her understanding of a dangerous world and her reactions to it, through the strengthening of primary relationships which can counteract feelings of insecurity, distrust, and low self-worth' (2007 p.59). One of the purposes of music therapy is to facilitate the child's ability to form healthy attachments. While it is important to emphasise that children exposed to domestic violence may often have a loving, close relationship to their mother, exposure to violence may threaten this attachment for various reasons, which in turn can have a negative impact on peer relationships.

Winnicott's emphasis on the importance of play in the child's emotional development is linked to attachment (1979), in particular the importance of early relationships in the child's development of a sense of self. Stewart and Stewart (2002) describe their work with a child who, initially unable to play due to early trauma, was helped into a more playful space through music therapy. Likewise Frank-Schwebel suggests that music can be used as a 'transitional space' in which 'the patient recreates a relationship from a developmental point of the beginning of separation' (2002 p. 204). She describes the re-enactment of early relationships through sound. In these regressive experiences 'lies hope for a new relational experience' (ibid).

Music therapy and integrated care:

Integrated care has become a major priority in health and social care (Field 2011). The government document 'Integrated Care and Support: Our Shared Commitment' (National Collaboration for Integrated Care and Support 2013) talks about the danger of care being 'fragmented, delayed or duplicated' (p. 6) where there is insufficient collaboration between professionals. Within the music therapy service we often work with children and young people where some of the difficulties we encounter reside within the family rather than the child alone. In these instances, integration with other services becomes crucial to the work. When we work with children and young people who receive input from other services, it is important to consider how we fit into the overall picture. It is also helpful to understand how we are perceived by other professionals.

In this project there were five key professionals: two children's support workers from HfW, two CAMHS EIT therapists with specialism in family interventions (one Art Therapist and one systemic family therapist) and one Music Therapist. As the Music Therapist, my role was to conduct individual work with each referred child and to run a music therapy group for other children.

Children, young people and parent victims of domestic abuse were referred by HfW support workers in consultation with the project team. Some families lived in the refuge while some were involved with HfW outreach services. Each child received ten individual music therapy

sessions while each parent had three consultation sessions with one CAMHS therapist and one HfW support worker: one before, one during, and one after the child's block of music therapy. I was present in the first and third of these consultations. The CAMHS therapists also had a consultation role in relation to the HfW Support workers in line with established models (Southall 2005). There was scope for extending beyond this model into further blocks of music therapy and into core service where needed.

NICE Guidelines on working with domestic violence (National Institute for Health and Care Excellence 2014) support various aspects of this work. There is clear emphasis on the 'wide range of ill-effects that exposure to domestic violence and abuse can have on children and young people' (4.9) and on 'the importance of working concurrently with both the non-abusive parent or carer and child' (4.10).

Aims of the study

The study aims to explore the following questions:

- How was music therapy perceived by the other professionals on the project?
- What were the benefits and disadvantages of the project as a whole for children and families?
- How did professionals perceive their individual roles in the context of the team?

Methods

This is an exploratory qualitative study following a procedure of semi-structured interviews, followed by transcription and analysis using procedures of interpretative phenomenological analysis (IPA). IPA provides a model for research where description of individual experience is the raw material from which data is extracted and analysed (Smith et al 2009).

Four professionals (two support workers from HfW and two CAMHS EIT therapists) were interviewed. Support workers are referred to as S1 and S2 and CAMHS therapists as T1 and T2. I contacted potential participants and together we arranged the date and venue for their interview. The interviews lasted about an hour each and were conducted by an independent co-researcher with experience in interview-based qualitative research. The rationale for engaging an external interviewer was that interviewees might have been likely to respond more freely to questions about the project (for example, if they had anything negative to say about the music therapy input) if they were speaking to someone perceived as impartial.

The interviews followed a semi-structured design, allowing space for the interviewees to elaborate beyond their immediate answers to these questions, and were designed in consultation with the interviewer. We used the same set of questions for both the support workers and the CAMHS therapists. S2 was unique in having also taken part in the project

which took place 2009-2011, and she referred to this during her interview. The interview questions focused on three main areas:

- The individual's involvement with the project, how they fitted in and what they saw as their role
- Discussion of an individual case, with a focus on the role of music therapy
- General thoughts about the benefits or disadvantages of the project as a whole

Transcription and analysis

All of the interviews (with all children, young people and parents' names having been replaced with pseudonyms) were transcribed by approved NHS members of staff, adhering to the Trust's policy on information governance. IPA methods were applied to the transcripts. IPA focuses on three key areas: phenomenology, hermeneutics and idiography (Smith et al 2009). In short, the focus is on lived experience, interpretation and on the particular as opposed to the general. 'For IPA, analysis always involves interpretation' (ibid. p. 35), which means that the researcher is dynamically interacting with the data all of the way through the process. This process, in practical terms, followed these stages:

- Listening to the interviews
- Reading through the transcripts several times
- Making notes on the transcripts
- Identifying emergent themes
- Identifying superordinate themes
- Close analysis of key segments of text
- Identifying over-arching categories

I took notes on my personal responses to the data throughout and identified my own preconceptions as they became apparent, as part of a reflexive process referred to in IPA as 'bracketing' (ibid.).

Findings

10-12 superordinate themes were identified within each interview and these were then grouped into 4 over-arching categories:

1. Professional roles and relationships
2. The project in a wider context
3. Therapy and the child
4. Working with families

I will examine these categories and, in the subsequent discussion, relate my findings to the study's questions.

1 – Professional roles and relationships

This category brings together discussions about how each person was identified by themselves and others in the context of the project as a whole, and throws light on how they worked together as a team. The support workers had key roles as co-ordinators of the project, but were also the people whose professional identities were most obviously affected by their experiences. S1 commented: '*It made me realise what I didn't know, so I thought I better go off and get some training because I realised what…we are dealing with'.* T1 referred to S1's developing role in response to taking part in meetings with parents, which led to her undertaking further study.

This was supported by S2, who also emphasised her personal development. There was also acknowledgement of their position as the link between the families and therapeutic services. T1 identified the support workers' role in meetings with parents, where they would: *'…help us help them [the parent] in the room mostly because of the relationship they already had with them*.'

Both T1 and T2 talked about gaps in their understanding of music therapy. For T2 this concerned the difference in approach to missed sessions. (In this project I had made a decision that sessions would be made up when missed, by either client or therapist, and this was not something she had anticipated. It created some logistical problems with co-ordinating the work and she identified this as a difference in 'model'). T1 had a practical focus in this respect, simply referring to the need to co-ordinate the timing of sessions, whereas T2 emphasised a difference in the theoretical model being applied, stating that she had expected '*…a sort of more psychodynamic model which would then would contain the 10 [sessions]…and would interpret the missing spaces.'*

T1 referred to vagueness about the music therapy evidence base in the initial discussions with parents and T2 said that her explanation of music therapy to parents would focus on therapeutic work in general, rather than music therapy in particular. Neither placed an emphasis on music therapy as a specific intervention, rather examined the value of individual therapeutic work per se. I will examine some of the implications of this in the discussion section later in this paper.

All four professionals talked not only about sharing information, but also about shared perspectives and understanding, involving all of the professionals, including the music therapist. There was a strong focus on thinking about the integrated work as a dynamic, evolving process, where maintaining a responsive, flexible attitude is central to this shared approach. S1 showed how this shared approach was transferred to the children, who were implicitly aware that the professionals would be talking to each other. She referred to the journey to the session when the interactions between children and support workers would reveal useful things about them:

'…because they knew we were taking them to Luke it sort of was part of the same trust I think, it wasn't sort of separate, it wasn't like having a one-to-one separately but they kind

of knew, they knew that we would tell Luke anything significant as well, so it was all part of handing over'.

This implies that the children perceived a connection between support workers and the music therapist, and were possibly able to make use of this. Another aspect of professional role was in the delineation of tasks between CAMHS and music therapy. Both CAMHS therapists talked about the importance of supporting the music therapist by taking responsibility for the family work, allowing the individual work with the child to take place unimpeded. T2 talked about this in terms of 'protecting' the music therapy space while T1 acknowledged that this was a new way of working for the music therapist.

Above all there was a strong sense conveyed of the need to balance various needs, those of the family, the child, and the interface between both of these and the outside world, so that working 'in parallel' and identifying shared aims were crucial to the project.

2 – The project in a wider context

There was some discussion about the project in the context of other services in the borough as well as the medium to long term impacts of the project on children and families. While all four professionals expressed positive views on the project as a whole, there was also discussion about its limitations. T1 identified some of the difficulties with keeping families engaged, and emphasised the need for a pragmatic approach: *'…you know sometimes you can only go that much and some change is enough'*

This idea was also explored by S1:

'Interviewer: and so how do you think that project helped the families that were referred to it?

S1 'I am just trying to think of all the children we saw, because the more that we have touched on, the more complex families, they don't give you instant feedback, and 10 weeks is not very long really. I think the consultations with mums always felt like something had been achieved … on the whole you would always feel like something had been clarified or shifted or kind of understood…'

This is a very tentative response and seems to suggest that the slight shifts in perspective that took place through the consultations were significant for parents, but that there were limitations in the impact of other aspects of the project. S1 considered the context in terms of how services sit next to other services within the borough:

'I don't think children's workers would make things worse but I do think they need to know that they're part of a wider children's services within the borough with mental health and schools and all the rest of it…'

This suggests a role for this project in increasing the awareness of wider context for the support workers, that without this they might make less of an impact. S2 talked about the importance of the professional meetings in helping them to consider the ongoing work with families, and to provide context for future referrals:

'…it was our chance as professionals to have the space to talk about anything that we are not sure about or we want support with or we need to discuss about those families. It was our opportunity to do that, and also we used to use that opportunity to just talk about any families we were gonna refer once those sessions were done, so we could start already brainstorming and working and seeing how it fit, it fits in.'

Within the larger context, music therapy was seen as important by S2 in particular. She discussed the long-term impacts of individual music therapy with the child as she saw them:

'…there are families where I have seen the positive and you know being based locally you get to still see the children, so you can see that the impact that it's had, the therapy, because they're still flourishing, they're still developing and, you know, when you're based in a refuge, you're going into that school back and forth, because there's other children, so you're meeting teachers that knew that the child was having therapy, you know, once upon a time, has watched that child grow, so you see you're getting feedback from that as well, so you can see the impact that therapy has had, um, and also where you get children who later on, when they see you out and about, they mention, you remember when we used to go there and we use to do that and that's linked in with therapy as well, so of course you can see the positive and the fact that it's still ongoing for a lot of our children'.

This also clearly demonstrates that she is attaching importance to feedback from other professionals, such as teachers outside the project, locating the intervention within the developing contexts of the child's life.

3 – Therapy and the child

Discussion about therapeutic processes for the child links to the primary question about perceptions of music therapy in the context of the project. An idea that clearly emerges from the data is the importance of *relationship* for the child. This can be seen to take various forms, from discussion about attachment, to the importance of engagement in the therapeutic process, to the child's perception of the person of the therapist.

S1 placed the therapeutic relationship in the context of future relationships, indicating her understanding that the therapeutic relationship might have a lasting impact, while the importance of *engagement* as a therapeutic factor was discussed by T2 in relation to children in music therapy:

'because for me the benefit is out of - the child is engaging with it, yeah, it's not so much looking for…a particular outcome… I think it's about the child engaging in the process…'

T1 also talked about the importance of relationship for the child in therapy, seeing this in one case as impeding the child's ability to make use of music:

'I think there were times when he couldn't use the music because he was so preoccupied with the relationship because…his needs were much more around that, and therefore you know I think it was a struggle to use the music'.

T2, by contrast, explored the benefits of musical interaction in giving the child a feeling of validation, and the role of the therapist in receiving and processing what the child brings, musically:

'…having a space, an adult for themselves, an adult who didn't have their own agenda…was just so important, and having a medium which, if they struggled with words, they could use another way to, to try and make sense of something, and to communicate something by being out of sync, giving a sense of maybe something not fitting or making sense for them'.

Awareness of the impact of past experiences on the child's current functioning and needs was seen as important in informing therapy. S1 here identifies a link between past trauma and behaviour:

'I think the worst part of the DV [domestic violence] *was when he was quite young and sort of pre-cognitive and I think that…was having an impact on his general behaviour'.*

This might lead to thoughts about the child's perception of the therapist. Qualities of approachability are identified, described here by S2 in the context of therapist expertise in understanding the child's specific needs:

'the therapists had already factored in the nature of our clients, so they knew that there's certain things that they have to do make sure that the child is relaxed, the child is feeling comfortable. There's no sort of pressure, because that's what the child's always been used to: pressure'.

S2 is here contrasting the child's experiences within the project with their life experiences prior to this. There is an implication that the therapist takes the child's accustomed way of being into account and behaves in a way that removes this sense of 'pressure' for the child. The phrase 'certain things they have to do' underlines her perception of this expertise, conveying a specificity in the music therapist's approach, perhaps key behaviours or ways of relating that enable the child to develop trust, despite their difficulties in this area.

4 – Working with families

This category brings the focus onto the parent and other family members, and how interviewees described their experiences of guiding parents through the process of both their own interventions and their understanding of the individual music therapy work with their children. Both CAMHS therapists identified a tendency for families to begin from a

starting point of a lack of understanding of music therapy, or indeed of any sort of therapeutic intervention. T2 made the following assertion:

'I think with most of the parents actually when you start at the beginning, I don't think they have a clue what any therapy work is going to be like'.

Both identified that they might work with the parent on understanding the value of therapeutic work with their child. In relation to the family work, S1 also described the families' initial position as being unused to reflection about their own patterns of relating and behaviour:

'for some families it was the first time they have been asked to reflect on how they parent, and why, and where it comes from … often it was their first brush with any sort of reflection'.

Thus, the general position of families at the start of the process was seen to be one of unknowing, stemming from a lack of experience of either therapeutic intervention or personal reflection. S1 identified a danger that parents might not gain an understanding of their child's therapeutic process if they are kept separate from it:

'I think the danger of taking the child to another venue, doing something nice with them and bringing them back again is that the mums never really get to understand what's happened or why or what their role in that is'.

T1 discussed the process of encouraging the parent to think about the impact of traumatic experiences on the child's development:

'…it very much was clear to us that mum needed some help to think about…the effect of domestic violence on children's development and how some of those behaviours are very typical of children growing up in these sort of families and how the brain gets affected and so, more kind of psycho-education type of work'.

This places the therapist in an expert's position in relation to the parent, enhancing their knowledge through educational methods. T2 also described collaborative approaches where the aim is to raise awareness of the challenges the child faces through shared thinking with the parent.

T2 framed the work with the parent within the concept of *containment*, identifying a process whereby parental anxiety was contained within the work done by the CAMHS therapist, allowing the individual work with the child to take place unimpeded. She also emphasised the importance of including work with the family in any future model, expressing the view that therapeutically informed family work is a crucial precursor to any individual work with the child. Furthermore, T1 identified a related phenomenon, that parents might be better able to access help for themselves knowing that their child is being supported:

'For lots of parents the idea that their child is getting something enables them to be able to access what they need, whereas if you sometimes say to the parents, I think we need to do some work with you they feel like 'oh you know it's not about me it's about my child'.

Indeed this tendency to locate 'difficulty' in the child prior to family work links a statement of T2: '*when you have…individual work without this sort of setting up work at the beginning, the individual work with the child could be seen as evidence that everything is in the child, and I feel that's not helpful'.*

Thus, music therapy was seen by the CAMHS therapists as working within the framework provided by a family-based approach. Where difficulties are located not only in the child, but in the family as a whole, music therapy with the child was seen to need the additional support of family interventions in order to have any positive impact.

Discussion

This new way of working for me meant that I had less direct contact with parents than I was accustomed to, and a clearer focus on the work with the child. I had positive expectations about this model. However it also required some adjustment. Although the lack of one-to-one contact with parents allowed me to focus more on the child, it also left me feeling detached from the work in some respects. This experience of detachment provided me with part of the motive for this study, because my curiosity about the whole process remained undiminished after the project had ended.

The process of IPA involves frequent reflection throughout the process of data analysis, during which the researcher's preconceptions can come to light (Smith et al 2009). Throughout the data analysis I kept a diary to facilitate this process. Some important preconceptions came to light.

Firstly, the relevance of psychodynamic concepts to this work, in particular containment (Bion 1984), became apparent in particular when analysing T2's interview. I share many of T2's theoretical stances, so when she talked about containment in the therapeutic process with families, this resonated with me. Acknowledging this became important during the analysis, and I was aware of the temptation to refer to T2's statements as definitive. However, it was also clear that her comments about containment were relevant to the discussion.

Secondly, I assumed that other professionals would have perceptions of music therapy processes. I had expected them to say more about what happens in music therapy and why it might have been helpful, or not. All of the professionals cited benefits of music therapy for the children, although the specific value of *music* therapy as opposed to therapy using some other medium was not generally emphasised, except in T2's statement about the value of non-verbal interaction in therapy (see above: 'Therapy and the child'). The overall emphasis was on the value of the child's *relationship* with the therapist, irrespective of the medium

through which this relationship developed. T1 perceived the child's relationship with the therapist as, in one case, impeding their capacity to make use of music in sessions. While this may be a valid observation, it also carries an implication that music-making might be seen by a music therapist as a higher priority than therapeutic relationship, whereas my own formulation would be to regard the two as intrinsically linked. This suggests that such a formulation may not have been communicated clearly in our shared discussions about the work. T2 emphasised the value of 'engagement' of the child with therapy, which frames the therapeutic relationship in a broader context, and this was echoed in statements of the other professionals, all of whom affirmed this using different terminology.

While all the professionals spoke about the difficulties encountered when explaining music therapy to parents, there was an understanding that most parents eventually recognised the value of therapeutic intervention for their children. The CAMHS therapists both stated clearly that music therapy would not have been beneficial without this intervention with the family. This idea was also borne out by the way in which the support workers talked about the value of the family work. S2's experiences of the earlier project, which did not involve CAMHS therapists, provided a different slant with a stronger emphasis on the potential value of music therapy both as an agent of change for the child and as a source of support for the parent. A picture emerged from all four interviews of parents needing support and containment in order to be able to make use of therapeutic services for both themselves and their children. There was, it should be noted, some lack of clarity about the degree to which music therapy as an intervention was explained to families.

A key side effect of the project was the impact of the experience on the HfW support workers. Both spoke about the project as a learning process which fundamentally changed their perspectives on how to work with children and families exposed to domestic violence. Thus, the third research question can be broadly addressed by stating that, while the CAMHS therapists perceived their roles to be providing advice, support and a space for reflection to the rest of the team, the support workers experienced their roles as mutable. They shifted over the course of the project from a reactive to a responsive position, deepening their capacity for empathy and understanding towards the families through their participation in various aspects of the work.

Conclusions and recommendations for further research

The project was seen by all four professionals as having benefits for both parents and children. This included both the music therapy input and the CAMHS EIT support. The lack of discussion about processes specific to music therapy might indicate that more detailed communication about these to other professionals would be helpful in future projects of this type. This could include a discussion about the approach to missed sessions which both CAMHS therapists highlighted as a logistical challenge.

T1's separation of the client's use of music from the client's relationship with the therapist would seem to indicate that formulations of *musical relationship*, in particular how these can interface with some of the psychodynamic and systemic concepts with which CAMHS professionals are very familiar, were not communicated sufficiently in this instance. A related idea that might be explored is whether the sharing of audio or video excerpts from music therapy with other professionals would be beneficial when working with this client group.

S2's comments about long term impacts and the value of feedback from other people in the child's life, such as teachers, might indicate a need for longitudinal studies to explore the impact of music therapy for children and young people over a time scale beyond the end of interventions.

Interviews with parents would be a desirable addition to the data given time and resources. It would also be helpful to explore children's perceptions of the interventions and incorporate these into future research designs. Positive perceptions of this project also indicate a need for intervention studies to evaluate the impact of music therapy within a context of integrated work with children exposed to domestic violence.

Limitations of the study

As this is a qualitative study with a very small sample, no general conclusions about music therapy in the context of integrated work can be drawn from these findings. Despite efforts to reduce bias by engaging an independent interviewer, participants were aware that interviews would be analysed by the PI, a colleague with whom they had worked on the project, leading to some likely response bias. As the study was conducted retrospectively, after a period of approximately six months following the conclusion of the project, there may have been some difficulty with recall during the interviews.

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References

Bannister, A. (2003), *Creative Therapies with Traumatized Children*. London: Jessica Kingsley

Bion, W. R. (1984). Learning from experience (1962). *London: Karnac*.

Bowlby, J., (1988). *A secure base*. Routledge.

Camilleri, V. (2007) *Healing the Inner City Child: Creative Arts Therapies with At-risk Youth*. London: Jessica Kingsley

Carey, L. (2006) *Expressive and Creative Arts Methods for Trauma Survivors*. London: Jessica Kingsley

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., DeRosa, R., Hubbard, R., Kagan, R., Liautaud, J. and Mallah, K., (2017). Complex trauma in children and adolescents. *Psychiatric annals*, *35*(5), pp.390-398.

Curtis, S.L., (2016). 'Music Therapy for Women Who Have Experienced Domestic Violence'. In *The Oxford Handbook of Music Therapy ed J. Edwards.* Oxford: Oxford University Press.

de Juan, T.F., (2016). Music therapy for women survivors of intimate partner violence: An intercultural experience from a feminist perspective. *The Arts in Psychotherapy*, *48*, pp.19-27.

Fairchild, R., Thompson, G. and McFerran, K.S., (2016). Exploring the meaning of a performance in music therapy for children and their families experiencing homelessness and family violence. *Music Therapy Perspectives*, *35*(1), pp.36-49.

Field, S. (2011). *NHS Future Forum: Summary report on proposed changes to the NHS*. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127540.pdf (Accessed on 13/01/17)

Frank-Schwebel, A. (2002) 'Developmental Trauma and its Relation to Sound and Music', in Sutton, J. 2002 *Music, Music Therapy and Trauma*. London: Jessica Kingsley

Hernández-Ruiz, E. (2005). Effect of music therapy on the anxiety levels and sleep patterns of abused women in shelters. *Journal of Music therapy*, *42*(2), pp.140-158.

Hester, M., (2007). *Making an impact: Children and domestic violence: A reader*. London: Jessica Kingsley Publishers.

National Collaboration for Integrated Care and Support, (2013) *Integrated care and support: our shared commitment.*

Pasiali, V., (2013). A clinical case study of family-based music therapy. *Journal of Creativity in Mental Health*, *8*(3), pp.249-264.

Robarts, J.Z., (2014). Music Therapy and Children with Developmental Trauma Disorder. *Creative Arts and Play Therapy for Attachment Problems*, pp.67-83.

Shipway, L., (2004). *Domestic violence: A handbook for health professionals*. Psychology Press.

Smith, J. Flowers, P. and Larkin, M. (2009) *interpretative Phenomenological Analysis.* London: Sage

Southall, A. ed., 2005. *Consultation in child and adolescent mental health services*. Radcliffe Publishing.

Stewart, R.W. and Stewart, D., (2002). » See me, Hear me, Play with me: Working with the Trauma of Early Abandonment and Deprivation in Psychodynamic Music Therapy.«. *Sutton, Julie P.(Hg.). Music, Music Therapy and Trauma. International Perspectives. S*, pp.133-152.

Sutton, J.P., (2002). *Music, music therapy and trauma: International perspectives*. Jessica Kingsley Publishers.

Swallow (2002) 'The Brain – Its Music and its Emotion: The Neurology of Trauma' in Sutton 2002 *Music, Music Therapy and Trauma*. London: Jessica Kingsley

Wesley, S.B., (2003). The Voice from the Cocoon: Song and Imagery in Treating Trauma in Children. *Psychodynamic Music Therapy: Case Studies*, pp.105-122.

Winnicott, D. W., (1979) *Playing and Reality.* London: Penguin