Parents' perspectives on their child's music therapy: A qualitative study

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Abstract

This qualitative study explored parents' perspectives on their child receiving individual music therapy in a community setting in an NHS service in London, UK. Parents of children aged 6-11 receiving or recently discharged from music therapy took part. Data were collected through semi-structured interviews which were digitally recorded, transcribed and analyzed following procedures of inductive thematic analysis. Music therapy was generally perceived to provide a nurturing environment for children, and communication with music therapists was mostly experienced as helpful, but with some perceived challenges. Parents perceived positive outcomes of music therapy, including children becoming calmer and engaging more with musical activities at home. Understanding of music therapy was perceived as an evolving process for parents. Some parents described a need for more information prior to music therapy. The findings of this study broadly support the model in the service of working with children aged 6-11 without parents generally present during sessions. However, there were indications that, for some families, a more flexible approach might be beneficial for the child. Participants' commentaries on perceived outcomes for children indicate potential for intervention studies investigating the impact of music therapy, while broader perceptions of the value of music therapy indicate a need for studies exploring reasons for effectiveness.

Keywords: music therapy, children, parents, semi-structured interviews, thematic analysis

Introduction

Music therapy with children is a psychological, neurological and physiological intervention which often focuses on the emotional well-being of the child, addressing difficulties with, for example, social communication, self-esteem and attachment (Aigen, 2014; Bunt & Stige, 2014; Darnley-Smith & Patey, 2003). The importance of parents' roles in music therapy with children has been explored in texts on practice, theory and in case studies (Edwards, 2011; Fearn & O'Connor, 2003; Jacobsen & Thompson, 2016; Oldfield, 2011). Qualitative studies have explored parents' perspectives on their child's music therapy, identifying positive perceptions of outcomes, beneficial experiences for both children and family members, as well as some barriers to engagement (Allgood, 2005; Flower, 2014; Procter, 2005; Schwartzberg & Silverman, 2017; Thompson & McFerran, 2015). While music therapy eludes one simple definition (Bruscia, 2014), a common approach in the UK, sometimes referred to as "improvisational music therapy" (Bruscia, 1988; Wigram, 2004), is for the therapist to use music with a client in non-directive interaction. Influential schools of music therapy in the UK pioneered by Alvin (1975) and Nordoff and Robbins (2007) could be described in this way.

The role of parents in the music therapy literature

In the music therapy literature on working with children, two distinct approaches towards parents are described. In the first of these, the therapist works with the child alone in the sessions. The parent and therapist may exchange information about what is happening in the child's life, and how therapy is developing, reflecting on links between the two. This model is described in much of the case study literature (Brown, 2013; Darnley-Smith & Patey, 2003; Levinge, 2015; Nordoff & Robbins, 2007; Primadei, 2014). Music therapy case studies in pediatric work often consist of detailed descriptions of sessions, with occasional references to the parallel process of liaising and negotiating with the people around the child: parents, teachers and other health professionals (Diamond, 2012).

A scoping search of qualitative research into parents' perspectives on their child's music therapy was conducted prior to this study. In the only identified qualitative study on parents' perceptions of this model, Procter (2005) described how sessions were framed as a confidential space, so that events in sessions are not disclosed to the parent. This aligns music therapy with a

psychotherapeutic approach, treating the child as an autonomous individual with their own right to privacy, independent of the parent (Blake, 2011; Klein, 1997). Procter reported that parents, while appreciative of the rationale for this stance, were less inclined to see the benefit in the case of their own children (2005).

The second approach focuses on music therapy with parent and child together. In this model, the parent is in the music therapy session with the child, whether this is an individual session or a group (Fearn & O'Connor, 2003; Horvat & O'Neill, 2008; Jacobsen & Thompson, 2016; Nicholson, Berthelsen, Abad, Williams, & Bradley, 2008; Oldfield, 2011). The literature on this approach has more to say about parents. Qualitative research into parents' perspectives on children's music therapy is focused almost exclusively on parent-inclusive clinical work. Participants report perceived positive outcomes for the child and enhanced parental understanding of the child's needs, as well as feelings of closeness arising from shared enjoyment of music (Allgood, 2005; Oldfield, 2003; Schwartzberg & Silverman, 2017; Thompson, 2017; Thompson & McFerran, 2015).

Parents' engagement with the music therapy service

This study focused on a National Health Service (NHS) music therapy service in London, UK, in a community health setting. This is a service for children and young people aged 0-19, covering a wide range of reasons for referral. Within this service, the model of work with children aged six and over is aligned with that described in another study by Procter (2005) in that parents of children over five years old are typically not in the therapy room during their children's sessions. Parents take part in an initial consultation before their child begins therapy, after which regular meetings with the allocated therapist form an important part of the child's care.

Music therapy is often an unfamiliar intervention for families referred to the service. Parents' initial expectations of music therapy may include some misconceptions. The approach of music therapists in the service can broadly be described as "improvisational music therapy", with the proviso that each therapist has developed their individual approach to the work. Clinicians in the music therapy team try to communicate clearly and concisely about the aims and purpose of the work, both before sessions begin, during the process, and at discharge. The focus is on the needs of the child. Since the service works with children who have various reasons for referral, ages and family backgrounds (see table 1),

it may be difficult to predict how much information parents need. The current study focused on parents of children in the age range of 6-11 years-old. Parents normally bring children to sessions and have regular review meetings with the treating therapist. Parents are crucial to the work with the child for various reasons, for example:

- Facilitating their child's participation by encouraging them to attend and bringing them to sessions.
- Providing the team and treating therapist with important information about the child, both initially, and as therapy progresses.
- Responding to information and advice from the therapist about changes observed in the child, so that their child receives optimum benefit from music therapy.

Parents' involvement with the therapeutic intervention work may be key to effectiveness, but there may be gaps in knowledge and/or communication, as well as feelings of disempowerment, due to the parents typically not being present in the sessions (Procter, 2005).

Study Rationale

Several studies have identified the need for further research into parents' perceptions and experiences of their child's music therapy (Schwartzberg & Silverman, 2017; Thompson, 2017; Thompson & McFerran, 2015). Research into parents' perspectives on music therapy where they are not present in their child's sessions is scarce. In the only identified study, by Procter (2005), parents identified the importance of the relationship with their child's music therapist, while also describing feelings of disempowerment associated with this way of working. There has been no detailed exploration of parental experiences in the identified music therapy service, where therapists typically work in this way with children aged 6 and over. Thus, the study seeks to gather data which will inform practice at the local level, while also contributing to the wider qualitative evidence base.

Aims of the study

The research question, "What are parents' perspectives on their child's music therapy in an NHS community setting?" formed the basis of the study. Linked to this are three subsidiary questions:

- What perceived changes took place for the child and parent during music therapy?

- What challenges did parents experience in relation to their child's music therapy?
- How did parents experience communication processes with their child's therapist?

In keeping with a qualitative methodology and an inductive approach, the research questions maintained an open stance (Agee, 2009). Since the research was taking place within an NHS setting, the priorities of the NHS, which include "Empowering Patients", were central to the rationale for this research (NHS England, 2014, pp. 12–13).

Methods

Setting

The setting was a community health center in London, where children and young people aged 0-19 years receive music therapy from a locally commissioned NHS service. At the time of the study, referrals to the service were made by professionals in health, education and social care. Referral reasons included developmental, emotional/behavioral, social communication and psychological concerns (see Table 1). Once a referral was accepted, following an initial meeting with the parent and clinical coordinator for the music therapy team, a child or young person received three assessment sessions. The treating therapist then had a meeting with the parent to decide on a care plan. If a decision was made to continue with music therapy, a block of six sessions followed before another review meeting and a decision on whether to continue or to discharge from the service. Thus, the minimum number of sessions required for a full block of therapy was nine, after which some children might be discharged from treatment. Typically, children and young people received between nine and fifteen sessions in total, although in some cases sessions extended beyond this number.

Table 1: Music therapy service referral criteria

The Music Therapy Service accepts referrals for children and young people (up to the age of 19 years) who have a moderate to

severe profile of emotional and psycho-social needs. These may include:

- **Emotional difficulties**
- **Psychological difficulties**
- **Social/behavioural difficulties**
- **Communication difficulties**
- **Relationship difficulties**

<u>Examples of appropriate referrals to the service include:</u>

- **Children and young people who present with moderate to severe emotional, social and/or behavioural difficulties associated with a specific learning difficulty, syndrome or disorder including:**
  - **Autistic Spectrum Disorder including Aspergers Syndrome**
  - **Attention Deficit Hyperactivity Disorder**
  - **Pervasive Developmental Disorders**

- **Communication Difficulties**
- **Children and young people who present with moderate to severe emotional, social and/or behavioural difficulties associated with a physical disorder.**
- **Children and young people who present with moderate to severe emotional, social and/or behavioural difficulties perhaps as a result of:**
- **Trauma (e.g. accidents, assaults, bullying etc)**
- **Bereavement**
- **Difficulties in forming significant relationships (eg with parents/siblings/peers), separation/attachment issues.**

- **Anxiety and depression**
- **Life transitions (e.g. in care, divorce related, school transfer)**
- **Abuse (emotional, sexual, physical, neglect)**

Children and young people who present with suicidal or self harming ideas or have attempted to intentionally self harm will be eligible to access the Music Therapy service in conjunction with CAMHS.

Sampling and recruitment

A strategy of convenience sampling was followed within set inclusion criteria. Convenience sampling can be defined as "a sample selected because it is *accessible* to the researcher" (Braun and Clarke 2013, p. 84). Recruitment was guided by the following inclusion criteria: children of participants were receiving individual music therapy or had been recently discharged from the service. Parents of children who had received fewer than nine sessions of music therapy were excluded so that all children would have completed at least one full block of sessions. Parents and carers were recruited as participants from the current and recent caseload of the music therapy service. An earliest discharge date of January 10, 2017 was set to exclude participants for whom the treatment might be too long ago for adequate recall. The sample size aimed for was 10-15, to be large enough to capture a range of perspectives, but manageable for transcription and analysis within the time frame of the project (Braun & Clarke, 2013).

The study excluded parents of children under 5, because music therapy with this group typically has a family-centered emphasis, including more group work, with parents often taking part in music therapy sessions. The study also excluded parents of children aged 12 and over, for whom parental involvement often diminishes as the young person becomes more independent. For the 6-11 age group, there was scope for exploring parents' experiences of being involved with, but separate from, the clinical work. Potential participants were identified through a search of current caseload on an electronic database, and a list of recently discharged service users was supplied by the Trust's health informatics team. In January 2018, 37 children were identified from the current caseload and 59 from recent discharges. Of these, 40 children met the inclusion criteria.

Since the researcher was a member of the music therapy team, parents of children that the researcher was working with in a clinical context were excluded, since this would have been likely to influence their responses more significantly than other participants. Parents of children treated by any other therapists on the team were eligible for inclusion, provided all other inclusion criteria were met.

Letters about the study were sent to parents/carers from the manager of the music therapy service, along with a participant information sheet and consent form. The letter invited potential participants to contact the researcher via email, telephone or letter if they were interested in taking part. Participants opting in were given a minimum of 24 hours in which to withdraw from the study before their interview, as well as a one-month period following the interview in which their data could be withdrawn. They were reassured that a decision either way would not affect the quality of care for their child. Participants were asked to sign duplicate consent forms, including one participant copy and one to be retained by the researcher. They were given the opportunity to ask questions about the consent form and information sheet in advance of the interview.

Data Collection

Semi-structured interviews were conducted by the first author and ranged from 42 to 73 minutes in length. The researcher used a set of questions based on the following topic guide to structure the interviews:

- *Child's reasons for referral to music therapy*

- *Parents' understanding and expectations of music therapy prior to the child's referral.*
- *Perceptions of change during the period in which music therapy took place.*
- *Any changes in parenting strategies, use of music at home, understanding of specific issues relating to the child's reasons for referral which resulted from participation in music therapy.*
- *Understanding of music therapy at present time: how would the participant describe music therapy to someone who had no knowledge of it?*
- *Quality of communication about music therapy by professionals (both referrer and members of the music therapy team) prior to music therapy sessions beginning.*
- *Level of parental involvement in the therapy process, including perspectives on being in the room, or outside the room, during the child's sessions.*
- *Relationship with the child's treating music therapist, including regularity and quality of communication, trust, empathy and respect.*

Interviews took place at the health center where music therapy is delivered. Interviews were digitally recorded and transcribed verbatim and in full by the researcher. Transcriptions followed notation recommendations outlined by Braun and Clarke (2013). Since the research question was exploratory, a semi-structured interview format was an appropriate mode for gathering in-depth data (DiCicco-Bloom & Crabtree, 2006). Interview questions provided a framework for discussion, while the interview format allowed space for participants to explore issues not anticipated by the researcher, maximizing the possibility of producing unexpected findings (Magnusson & Marecek, 2015; Miller & Glassner, 1997). It must also be acknowledged that the devising of the topic guide was informed by the first author's position as a clinician on the music therapy team. In considering this aspect of method in relation to the qualitative evaluation agenda "EPICURE" (Stige et al., 2009), a tension can be acknowledged between the inductive approach and the reality that "existing disciplinary knowledge will inform problem formulation, processing, and interpretation" (p. 1511). While priority was given to the participants' voice, with space allowed for free discussion, the first author's agenda

was informed by previous clinical experience and perceptions of clinical priorities informed by theoretical background, including understanding of the music therapy literature.

Data Analysis

Data were analysed according to procedures of inductive thematic analysis (Braun & Clarke, 2006). Following transcription, interviews were listened to again in full and reread several times to increase familiarity with the data. Transcripts were imported into NVivo 11 to facilitate coding. This began with initial line-by-line coding of all the interview transcripts. Codes were then compared and merged where appropriate, to produce a list of codes across the full dataset. A hierarchy of themes and codes was created through an iterative process of devising themes, grouping codes into themes, referring back to the raw data and working towards a final structure. Extensive analytic memoing has been identified as essential to devising codes and themes (Saldaña, 2013), and this was employed throughout the analysis, and referred to frequently during writing-up.

Braun and Clarke specify the need to identify an epistemological stance when conducting thematic analysis, since the method is not attached to one epistemology (2006, 2013). Since this study is exploring experiences and involves interpretation on the part of the clinician researcher, the data is analysed within a constructivist paradigm, in which findings are "created" through the interaction between the investigator and participant (Guba & Lincoln, 1994, p. 111).

Reflexivity

The identity of the researcher as a clinician has been identified as a potential advantage in interview research, particularly regarding ease of recruitment and developing rapport (Hiller & Vears, 2016), but it was also important to consider the need to bracket preconceptions in order to remain open to new ideas presented by the participants. This careful balance between researcher and participant perspectives is usefully articulated by Finlay (2013) as the need for the researcher to remain "open and fully attentive" (p. 125) throughout the process and to "hold a tension between their past and present experience" (p. 124), so that preconceptions can be acknowledged and managed.

The clinician-researcher role can also be considered in relation to the EPICURE acronym for evaluating qualitative research (Stige et al 2009). In this instance "the nature and impact of the engagement" (p. 1509) of the researcher in clinical models of practice, including investment in a way

of working that has been developed over a long period of time, needs to be considered. As a practitioner, the first author brought preconceptions about the nature of the work, including reference to theoretical models derived from training, supervision and clinical discussions with colleagues. This includes a preconception that the models of music therapy practiced within the NHS service are clinically valid.

Throughout the process of submitting the ethics proposal, recruiting and interviewing participants, and transcribing and analyzing data, the first author kept a reflective diary. It was important to identify preconceptions as they emerged, particularly during the process of coding and constructing themes from the data (Underwood, Satterthwait, & Bartlett, 2010). Certain codes and themes were inevitably influenced by the researcher's theoretical stance as a music therapy clinician, for example, a code referring to *separation anxiety* is referencing attachment theory (Bowlby, 1978). Perhaps most importantly, the model of working without parents present in the room was a preoccupation of the first author, who experienced a tension between a perceived status quo in the service in question, and a need for flexibility in his own practice. This will be explored further in the discussion section.

Ethics

Ethical approval for the study was obtained from **the School of Health Sciences Research Ethics Committee at City, University of London**. The Research and Knowledge Manager in the NHS Trust classified the project as a "service evaluation", approving the study within the Trust. Ethical considerations for participants included the importance of confidentiality and information governance. Participants were informed that every effort would be made to anonymize their individual contributions when presenting the data. Written consent was obtained from participants.

It is important to consider the benefits for the participants when recruiting for interviews, and ensuring that these outweigh any risks (Emanuel, Wendler, & Grady, 2000; Kristensen & Ravn, 2015; Opsal et al., 2016). While qualitative interviews might be perceived as relatively low-risk for participants, there are nevertheless some issues around discussion of emotionally challenging topics, including awareness of the power imbalance between interviewer and interviewee (Brinkmann & Kvale, 2015; Kavanaugh & Ayres, 1998). The researcher was mindful of the need to consider possible

participant responses when discussing emotionally challenging topics, and how to respond supportively and sensitively.

Results

Participation

Disadvantages of opt-in recruitment in health research have been explored by Hewison and Haines (2006). In this instance, after 2-3 weeks, no potential participants had responded to the invitation letter. Follow-up telephone calls were made to potential participants by the researcher (as agreed by the university ethics committee) to ensure that the letter had been received, and to remind them about the study. Telephone calls prompted several positive responses to the invitation. Throughout the process of recruitment and data collection, the researcher made further attempts to contact all 40 potential participants. Some proved uncontactable. Three declined to take part in the study when contacted by phone. Following the scheduling of times for interviews, eight interviewees did not attend and four rescheduled, of which two attended on the second occasion, and two did not attend.

While inclusion criteria specified "parents and/or carers", in the event, all participants opting into the study were parents (nine mothers and one father). Participants' children had been receiving music therapy from a range of therapists on the team. Once 10 interviews had been recorded, the minimum number specified in the protocol, the researcher did not make further attempts to contact participants but remained open to conducting further interviews with anyone responding to the recruitment letter until a specified cut-off date of April 30, 2018. There were no further responses during this time (or after).

Findings from the interviews

Participants described a wide range of perspectives on their child's music therapy. While some parents were almost wholly positive in their reflections on music therapy, others were more ambivalent, and some reported negative experiences. An important focus of the questions was on parents' feelings about not being in the room during their child's sessions. Four out of the ten participants had spent some time in the therapy room with their child, usually at the beginning of the

work, as part of helping their child to feel settled. The remainder did not spend any time in the therapy room. This issue will be explored further in both the following analysis and in the discussion section.

Five themes were defined through the procedures of thematic analysis. Most of these themes provide an overview of aspects of parents' perceptions, while the final theme explores experiences from a chronological perspective. These were: *Parents had substantial concerns about their child's well-being, Parents sometimes felt disengaged from music therapy, Parents perceived music therapy as a nurturing environment for the child, Parents perceived positive outcomes from music therapy for their child, Parents perceived understanding music therapy as an evolving process.*

These themes will now be defined, described and elucidated, supported by illustrative quotations from the interview transcripts. Participants' names are replaced by P1-P10, to preserve anonymity. See Table 2 for a full list of themes and codes.

[Insert Table 2 Here]

Parents had substantial concerns about their child's well-being. This theme explores parents' perspectives on their child's specific needs, including the background to their music therapy referral. Parents spoke in detail about the challenges their children were facing. This included, for example, difficulties with social relationships with peers, difficulties with relationships within the family, feelings of isolation and difficulties controlling anger.

> [My child] wouldn't speak to us and he would just sob and then silent… it was not normal, it was very scary and [child] talked about not wanting to be here and life be better without [child]. (P5)

This theme also touches on the referral process, and the way the parent felt the child was perceived by their teachers at school and their peers, which often contributed to parents' sense of the child's isolation.

> Well [my child] was very disruptive. Even the rare occasion [child] was at school [child] was disruptive, if [child] didn't wanna do something [child would] swear at the teacher, run out of the class and go missing within the school grounds. They caught [child] one day trying to climb over the fence. (P3)

Referrals were frequently associated with challenging behavior at school, and this was sometimes linked to family violence or other past psychological trauma. Parents described their child's need for their support, both at home and in relation to music therapy.

> It's finding the tools to help [child] cope with that um and that's something [child is] gonna have to work at and I'm trying to explain to [child] that it's- it's not just sit in a room and [child's] therapist is gonna sort it, it- [child is] really got to be involved with it, so I wouldn't-, I'm not gonna force [child] if [child is] really upset going but I'm gonna try and help [child] to still see it through. (P4)

Parents sometimes felt disengaged from music therapy. This theme explores areas of challenge for parents during the child's therapy. Some parents described moments where they lost trust in the process. This sometimes included a loss of trust in the therapist themselves, or on other occasions a feeling that their child was disengaging or failing to engage. The loss of trust in the therapist, in one instance, included grouping them together with other health professionals, towards whom the parent had developed a skeptical attitude. The following describes the parent's perceptions of discussions with the therapist:

> It sounded the same as what I'd heard from everyone else, psychologists, psychiatrists, etcetera etcetera. It was wishy-washy, you know. There was no substance to it. (P3)

Similarly, one parent described a sense that the therapist had not listened to them enough about how to work effectively with their child, expressing their (the parent's) wish for their expertise on their child to be acknowledged.

> [Child is] my child. I know what my child needs. I know that is why we are here. We've taken time out of school to come here. (P7)

Sometimes the model of being outside the room during the child's session was felt to be a challenge. One parent felt that their child would have benefitted from music therapy more if they had been allowed to come into the room with the child.

> [My child] would have felt more comfortable… [they] would've engaged with [therapist] better I think. I think the fact [child] was in there on [their] own made [them] feel quite uncomfortable. (P10)

Linked to this, another parent described the following, with regard to confidentiality of the child's sessions:

> I felt that that bit of you know, 'we have to keep that interaction confidential' was perhaps taken a bit too far. (P9)

This indicates a feeling of disconnection from the child's therapy, in a way that was perceived as unhelpful by the parent.

Parents perceived music therapy as a nurturing environment for the child. Parents recognized certain features of music therapy which they perceived to be beneficial. Sometimes this was about the therapist actively supporting the child in their engagement. But they also identified beneficial aspects of the sessions being child-led. This was partly about given the child a space to be expressive, which was felt to be non-judgmental and safe.

> Music therapy doesn't necessarily tell you what to do. It's very much about you draw upon what the child is feeling and then find different ways of helping them. (P9)

It was in the opportunity for freedom of expression that parents talked most about the use of music. It was also about the sessions being for the child specifically, rather than for the child and parent. Despite some parents' initial misgivings about not being in the sessions with their child, they commonly expressed the view that the child got more out of the sessions working alone with the therapist than they would have done with the parents in the room.

> I understand it's really important that we're not in the session with [child] because it's not about us like I said. It isn't about how we perceive it, it's how [child] perceives it, and how [they] can get as much out of it as possible, so, if we was in the room, I think [they] would clam up a little bit more, because [child] hasn't got that attention. [Child's] mind then isn't just on the music and [therapist]. (P7)

Conversely, some parents noticed some benefits to their presence in the room. They appreciated the therapist's flexibility around this boundary.

> I know they did say the procedure that the parents not go in but for the first session we went in and we went in because [child] was the priority, so we did not say 'Oh this is how the system is, that we have to stick by it, even though it's not working for the child.' (P6)

Music was perceived as a motivating force for the child's engagement. Parents commented on their child's willingness to come to sessions. The child's relationship with the therapist was also perceived as important, particularly the process of developing trust over time.

Parents perceived positive outcomes from music therapy for their child. Parents described positive outcomes for their child resulting from music therapy. These included, most commonly, the observation that their child was calmer or more relaxed following music therapy. For some parents this was most obvious on the day of the session, and sometimes including the following day. Others described a more generalized feeling of calm. P2, for example, referred to "[child's] mood after music therapy or how, how relaxed [child] was at home". They also talked about their child's improved communication skills in several modalities, including verbal communication and a generally more outgoing approach to social relationships. Sometimes this included an increased capacity to reflect on and talk about emotions.

> [My child] has opened up to other people actually thinking about it, my family, [child is] more open to them than [they were] before. (P4)

Relationships were perceived to have improved in certain respects for some children. Parents also talked about their child's increased confidence, sometimes manifested in the expression of positive emotions. Another important development was increased use of music outside sessions. This included parents feeling more confident about using music, or about encouraging their child to use music. Sometimes this was for pure enjoyment, while on other occasions it was used to contain emotions.

> The only thing that as I say that I've tried with the keyboard, that [child] doesn't smash [their] room up now, [they will] sit and play music. (P1)
>
> What [child] does at home now, [child] … goes to the computer, [they go] to YouTube. [Child] looks for where they're playing music. [Child] now goes to get my

> cutleries and be beating the drum to rhyme with whatever music is going. Before [they] didn't do that. (P8)

Another parent speculated about whether they could play an active role in encouraging their child in this way, demonstrating an increased awareness of this possibility.

> It could be that [therapist will] just play a tune or a piano, or something like that, and, and that might um, you know, result in [child] making a song about [their] feelings, er, and what that does for me is it gives me an idea of perhaps, maybe I could do something similar at home? (P9)

There seemed to be no clear link between those parents who spent some time in the room during sessions and their perception of their child's improved capacity to use music outside the sessions, as this perceived change was reported by most participants.

Some parents had overall positive feelings about music therapy, feeling that it had benefitted their child, but without being able to be specific about which positive changes they could attribute to music therapy.

> It's like, how much of it was just the assistance that music therapy gave? I would give it a high rating. I don't know what specific things, but, I would give, there's a lot, I mean, this imaginary world and like, working with others and think-, you know, yeah, something in there was music therapy. (P5)

Parents' understanding of music therapy was an evolving process. This theme explores parents' reflections on their own understanding of their child's therapy; including how this developed over time. Communication with the music therapist was perceived to be important and parents reported having meetings with therapists at various points during the child's therapy, sometimes face-to-face, sometimes over the phone. Some parents described initial difficulties understanding the purpose of music therapy. This was sometimes linked to preconceptions picked up prior to referral. Several parents talked about their skepticism about music therapy, stating that they didn't expect it to do any good.

> At first I thought, I'm gonna bring [child] to three sessions never bring [them] back cos in my head, how's music therapy gonna help [them]? I'd been told, but [child]'s

> behavior. I honestly didn't believe that it was gonna calm [them] or [child] was even gonna care about it. (P1)

Some parents described their need for more information, particularly early in the process, with communication from the therapist described as sporadic, or they felt that more information at the beginning would have been helpful, to manage their own expectations.

> What is happening, what exactly, you know, just give me some indication of what actually happens, you know, what do you, is it driven by the children? Is it driven by the teacher [therapist]? Is it free- you know, is it just improvising? Is it just kind of just be free and do what you want? Is it spontaneous? Is there a structure? I had no idea. (P9)

Participants described the therapist being supportive and positive about their child's progress or reported receiving guidance from the therapist. This was sometimes about parenting strategies or ways of thinking about their child. Parents also received guidance about letting the child come into the therapy room on their own. This was perceived either as supportive or, by some parents, as authoritative.

> Interviewer: Was that something you talked about with the therapist, about whether you would be in the room or not?
>
> P6: [Therapist] said we are not allowed, parents are not allowed in the room.

Parents brought certain expectations to therapy which were challenged by their experiences, or through communication with the therapist. Some initial misunderstandings of music therapy were addressed, helping the parent to come to a clearer conception of music therapy. P8 talked about a preconception that music therapy would focus on their child learning how to play instruments. They reported that it was through conversations with the therapist that they came to understand music therapy more clearly.

> It helps to give [child] confidence of how to deal with people and how to help [child]…to monitor [child's] moods. (That's) my own understanding of music therapy. It has nothing to do with the child learning how to beat drums, the child learning how to play the piano. No. Music therapy's entirely different. (P8)

Discussion

This study has the potential to influence practice within the music therapy service through improving our understanding of therapist-parent relationships, and of children receiving music therapy. Parents are assumed to be the foremost experts on their children, providing interview data about their perceptions of their child's therapy, enabling the first author to identify perceived positive outcomes, gaps in communication, and avenues for further research. While Flower's (2014) study explored parent and therapist experiences of music therapy in dyadic work with a parent and child in an NHS setting, to our knowledge this is the first study of parent's perceptions of children's individual music therapy within an NHS service.

Perceived Positive Outcomes for Children

Interviews with parents revealed perceived positive outcomes of music therapy for their children. Parents described children being calmer after sessions, becoming more communicative, enhancing their ability to use music outside sessions, and developing strategies for emotional regulation. Relationships with the child's therapist were often characterized as communicative and trusting, and parents recognized these to be important therapeutic factors for the child and as contributing to their own engagement with music therapy as parents. Some of these results align with findings of other recent qualitative studies. Schwartzberg and Silverman found that parents recognized improvements in their children's "attention span, turn taking, impulse control, self-regulation, and communication skills" (2017, p. 105).

Challenges for parents

Music was perceived as helpful for self-expression, but parents were often unclear on how it was used. There were occasional references to expressing anger or enjoying playing the drum, but the use of music during sessions was discussed little. Although some parents described positive changes in their child, it was not always possible to be confident about attributing these changes specifically to music therapy because of the many other factors influencing their children's lives. Some of the challenges expressed by parents echo Procter's findings (2005) about feelings of disempowerment through being excluded from sessions. Whilst the initial skepticism reported by several parents over whether music therapy would "work" was in many cases dispelled by their subsequent positive

experiences, some parents described specific negative experiences and perceptions. These included the breakdown of the parent's trust of the treating therapist, feeling patronized by the therapist, or, in the case of P3, that they had never expected music therapy to "work", and that their prediction was proved accurate.

The need for more information, particularly early in the process, was frequently expressed. This would function both to manage expectations and to enable and perhaps encourage parents to use music with their children at home. One parent felt strongly that her presence in the room would have helped the child to engage. Parents who were present in the room for some of the sessions identified that experience helped them to support their child, gain trust in the therapist and understand more about music therapy. The identifying of misleading preconceptions about music therapy supports this idea, suggesting a need in some instances to give parents a clearer idea of "what music therapy is all about" (P8). How and when this is done remains open to discussion, as the educational needs of service users and families of service users are varied and complex. Syx (2008) explored how theories of adult learning can be applied and adapted in healthcare in order to best facilitate understanding of service users' needs, including awareness of the personal experiences of each person. Procter described how parents might "benefit from an awareness of the benefits for their child as well as information about what is happening" (2005 p. 53), as a way of seeking to alleviate potential feelings of disempowerment.

Working without the parent in the session

Despite the misgivings of some participants, this study seemed to suggest that there wss some validity to the choice of practice model within the service, where parents were typically not present in their child's music therapy sessions. There were clear statements from parents about the advantages of sessions being child-led, giving children space for freedom of expression. The practice of working individually with a child, without the parent in the room, also has strong precedents in the literature. Darnley-Smith and Patey, in their introductory text on music therapy, include a chapter entitled "Music therapy with Children", in which all the example case studies describe this type of work (2003). Nordoff and Robbins, in *Creative Music Therapy*, describe a therapeutic process which involves the development of "a meaningful form of coactive musicing" between the child and

therapist(s) (2007, p. 273). Music therapists often characterize the *therapeutic relationship*, that is, the relationship between the therapist and the child, as being central to the work (Brown, 2013; Darnley-Smith & Patey, 2003; Levinge, 2015). In certain contexts, work with parents present is also impractical, particularly where music therapists are based in schools (Annesley, 2014; Diamond, 2012).

This approach has been critiqued by Ansdell, who coined the term "consensus model", referring to work with both children and adults (2002, 2014). The term was used by Ansdell as a heuristic, in order to challenge a perceived status quo in UK music therapy. He described an emphasis in music therapy practice of the "primacy of the therapeutic dyad" (from which, in work with children, the exclusion of the parent might reasonably be inferred), along with the setting for the therapy room being "private and behind closed doors" (2014, p. 35). The historical links between psychoanalytic theory and music therapy practice have been well documented (Odell-Miller, 2018; Priestley, 1994). In Ansdell's consensus model (2002, 2014) we can perhaps identify links to Klein (1997), Bowlby (1978) and other theorists in a broad psychoanalytic tradition. It may be useful to quote Klein by way of illustration.

> I consider any far-reaching theoretical explanations to the parents before the beginning of an analysis as not only unnecessary but out of place… In every case I refuse absolutely to report any details of the analysis to them. The child who gives me its confidence has no less claim to my discretion than the adult (1997, p. 117).

Here the parent is clearly being kept at arm's length from the primary therapeutic relationship, between the analyst and the child.

Music therapists describing other models, where parents are present in the room either as observers or active participants, often present this as an innovation (Edwards, 2011; Jacobsen & Thompson, 2016; Oldfield, 2011). This is exemplified by Oldfield, who opens the book, *Music Therapy with Children and Their Families* with the statement: "It took me 17 years to realise that it would be beneficial to include parents in individual music therapy sessions with their children" (2008, p. 19). While it should be acknowledged that these alternative approaches were developed as a response to the needs of particular populations (for example, work with younger children or family-

focused work), the fact that bringing parents into the therapy room has been perceived as being outside the norm supports Ansdell's (2002, 2014) characterization of a status quo.

Procter (2005) found that parents not present in their child's sessions reported feelings of disempowerment, finding that parents generally did not see the applicability of confidentiality for their own child, despite acknowledging its more general benefits. The current study showed participants expressing some support for the child having their own space, separate from the parent. Several participants were very clear that their presence in the room would have inhibited their child's capacity for freedom of expression. This corroborates Procter's (2005) findings from consultation with music therapy experts, amongst whom there was "a perception that older children can benefit from space to 'grow' without a parent present" (2005, p. 53). Ansdell, despite his questioning of the "primacy of the therapeutic dyad" (2014, p. 35), acknowledged its applicability in some contexts (2002, 2014). Despite critiques of the consensus model, and the emergence of other models of practice which are sensitive to the needs of different populations, the findings of this study indicate that there remains a place for music therapy which retains a focus on the therapist-child dyad in the context of work with children aged 6-11 in this particular NHS service.

Limitations

Referring again to the EPICURE evaluation agenda (Stige et al 2009), while there was an intent on the part of the first author to "empower participants" (p. 1510) by seeking their perspectives, the reality that "health care systems usually bestow professionals and researchers with considerable authority and power" (p. 1510) is likely to have had some influence on participants' responses. Furthermore, despite the maintaining of confidentiality, interviews can nevertheless be experienced by participants as lacking sufficient anonymity to enable them to express opinions freely (O'Leary, 2010).

The sampling strategy and recruitment process were likely to have favored parents who were either very enthusiastic about music therapy (or possibly those who have strongly negative perceptions), may have been more inclined to participate, thus producing a prevalence of either positive (or strongly negative) views about the intervention. Furthermore, the group of participants would necessarily have consisted of parents who had the strength and capacity to participate in an

interview, with the possibility that parents under stress or with little time to spare in busy lives would have been unlikely to volunteer for the project. The authors also note that, while the study was open to parents and carers, all of the participants were parents. Thus, the views of carers who were not the biological or adoptive parents of children receiving music therapy were not expressed in this study.

Recommendations

Research into children's perspectives on their experiences in music therapy would complement the current study, as would focus group research within this team which explores music therapists' perspectives. Both alternative perspectives points of view triangulate well with those of parents. Parents' perspectives could be explored more widely through a questionnaire study, incorporating both qualitative and quantitative elements. Parents' views on gaps in knowledge indicate a need for research on communication processes around clinical work in music therapy.

Participants' commentaries on perceived outcomes for children indicated potential for intervention studies investigating the impact of music therapy. For example, the common perception amongst participants that children are calmed by music therapy suggests that intervention studies exploring impact on anxiety may be of value. Encouraging findings in some quantitative studies would also support this approach. Nicholson et al. (2008) found improvements in social communication and use of play in the home following a group intervention with parents and children. Gold et al. (2007) found positive outcomes in music therapy with older children when the emphasis was specifically on music-based techniques.

There is also potential for studies exploring mechanisms in music therapy (i.e. 'how does it work?'), for example through microanalysis of audio/video data. Studies comparing the benefits of music therapy including parents in the room with music therapy which emphasizes the therapist/child dyad would also be welcomed, in order to identify when one approach might be favored over the other.

Conclusion

Key findings of this study are that music therapy was perceived by parents to provide a nurturing environment for children in which there is potential for positive change. While barriers existed to communication between therapists and parents, and there may have been occasional

misunderstandings, relationships between parents and therapists were perceived by participants to be mostly helpful and positive. In future, some parents may benefit from more information being provided at the beginning of music therapy, both to manage their expectations regarding the impact of the work, and to establish clearer parameters for communication with the treating therapist.

The findings of this study broadly support the model in the service of working with children aged 6-11 without parents present during sessions. However, there were indications that, for some families, a more flexible approach might be beneficial for the child. It may be helpful for some children for their parents to be included for some or all of the time. This may help with the child's engagement, as well as helping parents to formulate strategies for using music at home.

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