Experiences of Trust in Music Therapy: Perspectives of Child Survivors of Domestic Violence

Ashley Doron, MT-BC
Pronouns: She/her

Advisor: Susan Hadley, Ph.D., MT-BC

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Experiences of Trust in Music Therapy: Perspectives of Child Survivors of Domestic Violence

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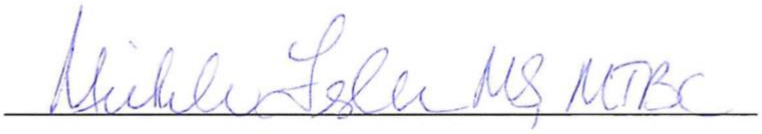
Susan Hadley, Ph.D., MT-BC, Thesis/Project Advisor

Nicole Hahna, Ph.D., MT-BC, Reader



Michele Fesler, MS, MT-BC, Reader

Abstract

This qualitative thematic analysis explored children's varying degrees of trust during music therapy after having witnessed domestic violence. As rates of domestic violence increase across the United States, children's sense of trust is affected and there is a need for further music therapy research from the perspectives of these children. In this study, semi-structured interviews were conducted with four child survivors of domestic violence after receiving four months of music therapy to explore how they understand and experience trust, as well as how trusting relationships are established and maintained with a therapist. Additional questions considered personal qualities that lead to trust or distrust, aspects of music therapy experiences that lead to additional trust in the therapist at different times, how experiences of trust change over time, what contributes to this change, and how the sociocultural locations of the therapist and child influence trust. The findings demonstrated that trust is a complex process that evolves over time and depends on certain qualities in a therapist, familiarity, and various aspects of music therapy. Three main themes with 13 sub-themes were found: qualities for trust and distrust (qualities that increase trust, qualities that decrease trust), process of developing trust and overall evolution (initial distrust/trust, insecurities and fears from participants' past, familiarity leads to trust, connection to family/friends, feelings and experiences with trust, builds over time), and qualities of music therapy experiences (autonomy and choice, familiarity and predictability, types of instruments, types of experiences, music contains a wide range of expression). Findings provide recommendations for how practicing music therapists can create a trusting therapeutic relationship with child, adolescent, and adult survivors of domestic violence.

Keywords: children, domestic violence/intimate partner violence, trust, relationship

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Introduction

Motivation for the Research

I began working with child survivors of domestic violence, also known as intimate partner violence, in May of 2018 after completing an internship, graduating from my undergraduate music therapy program, and receiving my music therapy board certification. I did not expect my first job out of college to be with a population that has experienced trauma. However, I knew that I wanted to work with children and was excited for the challenge. I have been at this job for five years and have truly enjoyed my time working with the families who attend this program. I have learned so much from interacting with them and the ways in which their past experiences influence many aspects of their lives daily.

According to Huecker et al. (2022), domestic violence is quite common, affecting approximately 10 million people every year. About 45 million children are exposed to domestic violence during their childhood (Huecker et al., 2022). The National Coalition Against Domestic Violence (2020) defines domestic violence as "the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior as part of a systematic pattern of power and control perpetrated by one intimate partner against another" (para. 1). It is about coercive control over someone else. Intimate partner violence, more specifically, includes physical, emotional, verbal, sexual, and financial abuse, as well as other forms of psychological abuse, including threats and stalking (Huecker et al., 2022). Although domestic violence has become more acceptable to talk about, there are many cases that go unnoticed.

When I first began working at this agency, I realized the lack of literature that exists on music therapy with survivors of domestic violence, and most of the research I found was focused on adult survivors. I knew then that I had an obligation as a music therapist and future researcher

to investigate various topics from the perspectives of child survivors of domestic violence. It is necessary to emphasize children's voices, as any feedback or knowledge gained from them could be insightful and invaluable to other therapists working with children in general, as well as those working specifically with survivors of domestic violence.

Witnessing domestic violence affects children physically, emotionally, behaviorally, cognitively, and socially. Lloyd (2018) stated that children may become withdrawn and anxious, exhibit regressive behavior, and may demonstrate separation anxiety from the non-offending parent. They may have low self-esteem, be insecure, and feel guilty and depressed. These children may exhibit sleep disturbances, difficulties with concentration and attention, and deficits with their overall cognitive skills. They may display aggressive behavior, anger, and hyperactivity, and may be more hypervigilant and hyperaroused, among other consequences (Lloyd, 2018). Additionally, Groves (1999) stated that "children who witness traumatic events, such as incidents of domestic violence, may feel helpless and see the world as unpredictable, hostile, and threatening" (p. 123). In a study conducted by Swanston et al. (2014), child participants reported diminished trust and confidence in adults' abilities to provide support and protection for them. Participants also explained feeling "let down and betrayed by adults" (p. 190) while witnessing domestic violence and after leaving the abusive environment and, therefore, became more reliant on themselves (Swanston et al., 2014).

Domestic violence is not just one isolated incident, it's a cycle that occurs repeatedly throughout a relationship. These children have experienced or are experiencing abuse between their parents or towards themselves on a consistent basis, and therefore, their understanding and experience of trust is jeopardized. They may have difficulty trusting others, including therapists, due to the traumatic experiences they have previously endured. Children need to feel safe and

comfortable around their parents to develop strong attachments and healthy, trusting relationships with their parents and other individuals. In the context of domestic violence, children are fearful of their offending parent and often do not get the security and safety they need from the non-offending parent as they, themselves, are typically unable to self-regulate around their abusive partner.

While working with child survivors of domestic violence, I became curious about the therapeutic relationship and how they experience trust with me as their therapist, especially given their trauma backgrounds. I noticed that some clients seemed to develop trust rather quickly, whereas others appeared to take a significant amount of time to even begin to do so.

In my experiences growing up, music has always been something I found comfort in. As a child, I used music as a way to escape reality. If I was struggling with strains in my relationships with friends or family, I would write songs to express my thoughts and feelings. I would sing, dance, and listen to songs that both validated my experience and increased positive feelings. I also took piano lessons, which was yet another creative outlet through which I could express what I could not communicate through words. I participated in choirs and musicals during grade school. While I was in college and studying music therapy, I was a part of choirs as well as an acapella group for three years. Music has been a form of healing, a comfort, a safe haven, a support, a creative process, and now, my career. I have found solace in engaging with music and feel at peace, whether I'm listening to a favorite song, playing an instrument and singing, or making music with others.

As I continue to work with child survivors of domestic violence in this current setting, it has become clear to me that for many of the children, our therapy sessions are incredibly special. This is likely due to many factors, one of which is that they are free to express their thoughts and

feelings through music however they choose during their hour. Similar to how music was a resource for me in my childhood, music also gives meaning to these children's experiences as well. During our sessions, the children have opportunities to be in control and choose the instruments they play, the experiences incorporated, songs to listen to and/or sing, etc. They share their stories and daily challenges through the music they create, and contrary to popular belief, they do not have to verbalize their trauma narratives for therapy to be successful.

Given that music had such wonderful effects on my life, I wondered how various aspects of music and music therapy could help to increase trust for those who are in a constant state of hyperarousal due to the abuse they witnessed. I became curious about how these children define and experience trust with a therapist during music therapy. A lot of research that has been conducted so far, both within and outside the music therapy field, states that trust is important and necessary within a therapeutic relationship (Bensimon, 2020; Campbell & Simmonds, 2011; Cohen et al., 2012; Cossar et al., 2016; Graham & Johnson, 2021; Lai et al., 2020; Moore & McAuthor, 2017; Valenti et al., 2020). Some research even describes qualities that therapists should possess with clients to increase that trust (Augsberger & Swenson, 2015; Campbell & Simmonds, 2011; Cossar et al., 2016; Edwards & Karnilowicz, 2013; Graham & Johnson, 2021; Mainey et al., 2009; Pinkney, 2013; Sapiro, 2020; Valenti et al., 2020). However, I became interested in what "trust" means to a child, and what experiences and factors lead a child to have trust with a therapist. I think that if we take the time to really get to know our clients in the beginning of therapy, ask questions, actively listen to their responses, and observe them, maybe we can learn more about what trust means and looks like in their world. Perhaps we can truly create a safer environment for them that increases their trust, and adapt the way we use and/or create music to meet their needs moment to moment.

For context, I am a white, cis, heterosexual, lower middle-class, neurotypical, non-disabled, educated, female. My intersecting identities, while affording me with a lot of privilege in society, influence the ways in which clients interact with and perceive me as well as the ways in which I interact with and perceive them. In some cases, this may enhance trust, while in others it may inhibit it.

Literature Review

Research Problem

Rates of domestic violence continue to increase in families across the United States. Specifically between 2015 and 2018, the percentage of victims of domestic violence increased from 0.18% to 0.23% (Morgan & Oudekerk, 2019), and as this continues, children's ability to develop and maintain trust with others decreases. They grow up learning that their home environment – the one place they are supposed to feel at peace and regulated – is unpredictable and unsafe. This may lead children to become more reserved and untrusting of others, including therapists. We, as music therapists, need to be aware of how trauma affects children's ability to feel safe and trust others. According to Campbell and Simmonds (2011), it can be difficult to foster trust with children in therapy for many reasons, including that they rarely refer themselves to treatment since a parent/caregiver usually does that for them, they can be hesitant to engage in the therapy process, they do not recognize that what they are going through is an issue, and they quickly agree with adults on their overall therapy goals. Therefore, we must be sensitive to children's needs and triggers that can change rapidly at any moment. It is important for us to understand how children, especially ones who have experienced domestic violence, may experience feelings of trust during their music therapy sessions and what qualities of the therapist, music, and/or aspects of the overall session may contribute to those feelings. With this

knowledge, therapeutic relationships can be strengthened, and children may feel safer and more confident to fully engage in the experiences and actively explore their thoughts and feelings.

Music Therapy with Survivors of Domestic Violence

Some literature exists regarding how participation in music and music therapy benefits survivors, both adults and children, of domestic violence and intimate partner violence. Several broad categories have been drawn from existing literature. Multiple articles emphasize that music provides a sense of safety and can assist in creating a supportive environment for this population in which all emotions can be expressed (Fairchild & McFerran, 2019; Hernandez-Ruiz, 2005, 2020; Purdon & Ostertag, 1999; Teague et al., 2006). With survivors of trauma, there is a possibility of revictimizing our clients who are already vulnerable. Several authors discussed the importance of using feminist practices with survivors (Purdon, 2006; York & Curtis, 2015) and York (2006) wrote about her work in a participatory action research project called, “Finding Voice”. Through this project, a group of women creatively shared their stories of experiencing domestic violence through poems, original songs, and dance, and later shared their work through a performance. Transitioning from a “therapy group” to a “performance group” was quite empowering for these survivors who had little control over their choices in previous relationships (York, 2006; York & Curtis, 2015). Purdon (2006) emphasized the importance of recognizing our own bias as therapists and our contributions, as well as those of the field of music therapy in general, in maintaining current harmful systems surrounding abuse and domestic violence. She also provided a set of markers to guide one’s practice, such as:

- Work in a way that is truly helpful to [survivors]. This means taking the time to hear the whole story of the abuse and gaining a thorough understanding of their situation, history, and context of the abuse.

- Engage in teamwork with the victim in an egalitarian fashion: listen to the [survivor], ask about [their] wishes and fears, and respond to diverse and complex needs.
- Provide information about services, the therapy process, next steps, and options.
- Demonstrate an attitude of respect, understanding, patience, support, and empowerment. (p. 209)

Fernández de Juan (2016) found in her study that sharing songs helped Mexican and Cuban adult females feel more comfortable and "safe enough to express and try to resolve the anxiety-producing issues through music" (p. 24). This research also supports the idea of acknowledging and centralizing the client's cultural background throughout the entire therapy process.

In several articles, the authors discussed the ways in which music therapy provides opportunities for adult survivors to process trauma and heal through creative self-expression. Some examples focused on the use of music and imagery and the use of mandalas (Hearns, 2010); songwriting to explore past and current experiences and to have control over one's own songs (Day & Bruderer, 2011; Day et al., 2009; Teague et al., 2006); lyric analysis and singing (Teague et al., 2006); as well as improvisation and playing instruments (Fernández de Juan, 2016; Teague et al., 2006). Ventre (1994) implemented Guided Imagery and Music (GIM) with a client, which helped her heal wounds of abuse and replace them with love, acceptance, and trust in herself. This client also maintained healthier relationships with others as well, which were built on trust and honesty. Several researchers worked with families, including Colegrove et al. (2018), who found that participation in music therapy helped parent survivors of domestic violence be less reactive and more responsive with their adolescent child, which led to improved relationships with less conflict and more trust. Similarly, Pasiali (2013) conducted a family case study with a mother and her two children who experienced domestic violence. This study

demonstrated how domestic violence causes mistrust and tension in the parent-child relationship. However, by actively engaging in music therapy for eight weeks, they began to create positive interactions and experience more pleasure and connection in their relationship.

Children's and adolescents' experiences were privileged and acknowledged in a handful of studies. Kim (2015) researched the effects of music therapy, specifically implementing children's musical preferences, and their responsiveness using pre and posttest scores from trauma assessments. During the early and mid-stages of therapy, these children had some difficulty making choices as they often asked the therapist to choose for them, they refused to sing with the therapist, and they appeared to have a difficult time improvising without clear structure or direction. Kim suggested that over time, clients may feel more comfortable engaging in these tasks and musically interacting with the therapist. Fairchild et al. (2016) interviewed children to share their perspectives regarding the meaningfulness of their participation in a group performance at the conclusion of a music therapy program. They reported an increase in feelings of empowerment and ownership. Kang (2017) found that children's self-expression increased by combining music and imagery and sand play during individual therapy sessions. In another study by Fairchild and McFerran (2019), children between the ages of 8 and 14 participated in a collaborative group songwriting experience to define how they use music as a resource in their lives as they cope with homelessness and violence in their families. The authors explain that "children were provided with a safe and inclusive space to express their views" (p. 105), but they do not go into detail about how this was accomplished. This experience demonstrated that music could provide an escape and sense of safety from challenges. Children described listening to music when they are sad to help them feel happy, and to validate their experiences in cases when they could relate to the lyrics (Fairchild & McFerran, 2019). In a study conducted by Annesley

(2018), non-music therapy professionals reported the importance of the therapeutic relationship for child survivors of domestic violence during music therapy sessions, and that the engagement specifically is what appeared to be significant. It was reported that musical interaction supports and validates the child's feelings, as the therapist receives and processes what and how they are playing (Annesley, 2018).

Several authors highlighted the benefits of facilitating music therapy groups with children and adults who have experienced family violence. Kim (2017) found that implementing a community-based music therapy group for children in South Korea who experienced poverty, maltreatment, and abuse reduced children's depression, anxiety, and withdrawn symptoms compared to a standard care group. Music therapy groups also were found to increase connection and gave children opportunities to collaborate with others (Fairchild & McFerran, 2019; Fairchild et al., 2016), which are especially important if they have experienced domestic violence and have been isolated because of that. It has also been found that adult survivors of domestic violence who participated in music therapy groups experienced a decrease in depression and anxiety (Fernández de Juan, 2016; Hernandez-Ruiz, 2005; Teague et al., 2006). They reported an increase in self-esteem and feelings of empowerment (Fernández de Juan, 2016; Whipple & Lindsey, 1999), as well as an increase in their social interaction during group singing experiences and communication during songwriting experiences (Whipple & Lindsey, 1999).

Additionally, various authors mentioned structural aspects they implemented during sessions with clients who have experienced domestic violence, perhaps for the purposes of increasing safety and trust, but this was not explicitly stated in the research. These aspects included repeating familiar songs, such as the greeting and goodbye songs (Kim, 2015, 2017; Pasiali, 2013), giving choices of instruments, props, songs, and activities, although not an

overwhelming amount of choice depending on the client (Kim, 2015; Pasiali, 2013). Teague et al. (2006) provided calming instruments, such as a singing bowl, for clients to use, and implemented creative arts exercises like journaling and creating mandalas. Kim (2015) acknowledged the importance of music therapists providing clear structure and guidelines in their sessions, especially when working with children who have experienced domestic violence. Similarly, Annesley (2018) stated that professionals need to demonstrate awareness of how the trauma that children and families experience affects their current functioning and presentation. Annesley also mentioned that approachability is an essential quality therapists should embody when working with this population.

Sexual abuse is another component of domestic violence that often goes unreported by children in their childhood. However, there are several articles in the music therapy literature specifically focusing on survivors of sexual abuse. Several authors discussed their work with child survivors of sexual abuse through case studies and described how they implemented various improvisational techniques (Robarts, 2003, 2006; Strehlow, 2009; Thompson, 2007). Other authors wrote case studies focusing on adolescent survivors, in which songwriting, improvisation, and drawing were typically used as ways for clients to explore and process their trauma (Lindberg, 1995; Schulze, 2018). Amir (2004) wrote a case study on an adult who engaged in improvisational techniques in music therapy to explore and process sexual abuse from their childhood. Similarly, MacIntosh (2003) explored various music experiences implemented and their benefits during groups with women survivors of sexual abuse. These experiences included songwriting, improvisation, singing, and drumming.

Assessments and treatments for this population have also been mentioned briefly in the literature. Surveys were conducted for music therapists to gain a better understanding of what

assessments and treatments were already being implemented with survivors of domestic violence (Cassity & Theobold, 1990; Hahna & Borling, 2003). A music therapy assessment instrument has also been created and described for children who have experienced abuse (Jacobsen & Killén, 2015).

In the literature on music therapy with survivors of domestic violence, the authors have focused on how music therapy can support survivors of domestic violence, but they have not explicitly researched trust.

Trust in Music Therapy

Little research has been conducted specifically on music therapy and trust. Bensimon (2020) acknowledged that trust is a "relational need" of survivors of trauma. In his research, seven relational needs perceived by music therapists working with survivors of trauma were identified, which include the need to be recognized, the need to be accepted, emotional expression and validation, emotional responsiveness, as well as safety, trust, and the need for connection. Bensimon stated that "clients must feel safe to show vulnerability and fully express themselves without fear of losing the therapist's respect and caring" (p. 248). Lai et al. (2020) conducted a critical interpretive synthesis in the music therapy literature to understand how music therapists describe safety, what strategies and methods they use to create safety, and how the therapeutic relationship may increase feelings of safety. They found that feeling safe and having trust increases emotional expression (Lai et al., 2020).

Session structure and approaches implemented to increase trust were also discussed in the literature. Participants in Bensimon's (2020) study explained that having sessions on the same day and time every week increased predictability for clients. Lai et al. (2020) found that the structure of every session should be similar, concrete, and playful to increase trust, and at the

same time though, music therapists need to be flexible and adapt their experiences to how young children present during sessions. Offering choices as well as providing opportunities for collaboration, such as leading and co-leading, has been shown to help children/adolescents gain a sense of control over their environment (Lai et al., 2020).

Various music experiences implemented with survivors of trauma have been described. Bensimon (2020) found that using familiar songs, with repetitive lyrics and melody, as well as songs with a predictable structure that include a beginning, middle, and end, creates safety. Music therapist participants in his study stressed the importance of playing simple, fixed, and consistent rhythms that clients can expect. Along these lines, music therapist participants noted that they can control various music elements, like rhythm, volume, tempo, and timbre, to increase safety. Several specific music experiences were described by participants in Bensimon's study, including musical validation, which strengthens client's self-concept and connects them to the present moment; musical witnessing as a self-object, which is when client's music reflects inner representations of themself while also being an external auditory object with which clients create dialog; and attuned musical involvement with the therapist, which increases emotional presence. As a conclusion from his study, Bensimon (2020) cautioned therapists to be aware of musical sounds and instruments that could be triggering to clients and cause harmful sensations. Additionally, Lai et al. (2020) found that drumming and musical games increase relaxation and playfulness, which in turn leads to further trust within the therapeutic relationship. These two articles mentioned, while focused on trust in music therapy, have not specifically focused on trust in relationship to child survivors of domestic violence.

While trust is something therapists are all trained to build with clients, they are generally not taught the ways in which they may cause harm unintentionally. Murakami (2018) spoke

about the potential harm caused in music therapy practice on a podcast, and then later in 2021, wrote an article about conceptualizing potential sources of harm within music therapy. She normalized the experience of harm and explained that it is bound to happen during sessions. In her Music Therapy and Harm Model (MTHM), she stated that clients can be physically and/or psychologically harmed from the following potential sources which are always present and inextricably linked during sessions: the music presented, the music therapist, the music experience, the therapeutic relationship, client's own music associations, and/or ecological factors. Murakami encouraged self-awareness and deep introspection to recognize and accept that one has most likely caused and/or allowed harm to occur in a session. She highlighted ways of minimizing harm, which include "vigilant observation and verification of client responses in sessions, recognition of client distress, identification of the distress source within the MTHM, and responsive modification of MTHM components under the music therapist's control to minimize distress and process negative experiences" (Murakami, 2021, Clinical Implications section, para. 3). She strongly recommended professional supervision combined with discussions of harm for therapists. Murakami suggested that specific guidelines on how to decrease harm should be written into our professional documents. She stated that she did not find any explicit definition of harm on the American Music Therapy Association (AMTA) or the Certification Board for Music Therapists (CBMT) websites, and that much more research needs to be done on the topic of harm (Murakami, 2021). This topic is relevant to this discussion of trust because the amount of harm that is happening during sessions will affect how safe the client feels as well as the level of trust they may or may not develop with their therapist.

Children's Trust with Helping Professionals

There has been a lot of research conducted on trust within helping and professional relationships outside of the music therapy field. Multiple authors agree that trust is a key ingredient to a successful therapeutic relationship (Campbell & Simmonds, 2011; Cohen et al., 2012; Cossar et al., 2016; Graham & Johnson, 2021; Moore & McAuthor, 2017; Valenti et al., 2020) and that it is necessary for child survivors of domestic violence to feel safe (Edwards & Karnilowicz, 2013). Several researchers found that trust is established over time with children and youth (Callaghan et al., 2019; Graham & Johnson, 2021; Jobe & Gorin, 2013; Pinkney, 2013; Sapiro, 2020). Jobe and Gorin (2013) explained in their research that youth feel safe as they continue to work with the same professional over a long period of time. Participants expressed concerns that if they told someone they were being abused, they would not be believed and were worried about being placed in care of local authorities. They disclosed abuse more often when they felt confident in themselves, they felt it was safe to speak up about it, and they trusted the person with whom they shared that information (Jobe & Gorin, 2013). Cohen et al. (2012) noted that in the early phase of treatment, youth tended to test the therapist in various ways to see if they were trustworthy. It was found that some may wait till the very end of a session to mention self-harm or an aspect of their trauma to see if the therapist will care enough to extend them. Sapiro (2020) stated that "trust building is not a straightforward or linear process; rather, it is dynamic and nuanced" (p. 7), which is important for professionals to remember, especially when working with children.

Consistency in a therapy relationship helps to build and maintain trust. Trust cannot be built when youth are passed around from worker to worker, as they do not want to share the same story repeatedly to different people (Pinkney, 2013). Augsberger and Swenson (2015)

found that regular meetings with the same worker led to positive relationships. Similarly, youth participants in Jobe and Gorin's (2013) study emphasized that a long-term relationship with a professional with whom they feel safe and confident increases their openness to share information and possibly disclose abuse more so than they would without trust. Multiple authors also discussed important factors needed to develop trust, which included collaborating with children on treatment planning (Valenti et al., 2020), encouraging them to make decisions (Callaghan et al., 2019; Graham & Johnson, 2021; Pinkney, 2013; Sapiro, 2020), giving them a sense of control by providing choices and autonomy (Graham & Johnson, 2021; Sapiro, 2020), and respecting their agency (Sapiro, 2020). Cossar et al. (2016) noted that helpers should equalize children's power in the relationship to support them in leading their own treatment, but that it's important to not just invite them to do so merely to meet a requirement. They stated that as therapists, we need to effectively communicate with children in ways they understand, which will vary from one child to the next, and be cognizant of issues of power (Cossar et al., 2016). Several children have even vocalized reasons they should be listened to, which are because "we know what we want and how we feel," "what we say is important," and "we're our own people and should have some privacy and make our own decisions" (Pinkney, 2013, pp. 10–11). Graham and Johnson (2021) mentioned that youth should be allowed to explore and process their own trauma experiences when they are ready to do so. Cohen et al. (2012) explained that clients will likely wait to discuss aspects of their trauma narrative or even identify coping skills until trust and safety have been developed with the therapist.

Therapists' qualities and characteristics are equally important to consistency in developing trust with clients, which has been explored by various authors. In the literature, it has been found that trust is formed through a genuine, authentic, and non-judgmental acceptance

towards children. Additionally, a caring interest as well as a sense of being listened to and heard must be communicated to children in therapy (Augsberger & Swenson, 2015; Campbell & Simmonds, 2011; Cossar et al., 2016; Edwards & Karnilowicz, 2013; Graham & Johnson, 2021; Mainey et al., 2009; Sapiro, 2020; Valenti et al., 2020). Therapists can also promote a sense of safety by validating children's opinions and perspectives (Campbell & Simmonds, 2011; Pinkney, 2013; Valenti et al., 2020). This includes honoring their truth (Campbell & Simmonds, 2011), and developing meaningful connections (Graham & Johnson, 2021) and secure "attachment" (Valenti et al., 2020) with them. Helpers must recognize that being safe and feeling safe may be interrelated but can be two different experiences for clients (Moore & McAuthor, 2017).

Several authors found that having empathy and demonstrating respect with children are necessary qualities for therapists (Campbell & Simmonds; 2011; Edwards & Karnilowicz, 2013). Campbell and Simmonds (2011) learned that offering unconditional positive regard and focusing less on diagnostic labels are necessary characteristics as well. The therapist needs to be fully present with children, self-aware, process their own unresolved childhood issues, and remove themselves from the "parental figure" role (Campbell & Simmonds, 2011; Geller & Porges, 2014). Geller and Porges (2014) suggest that it is crucial for therapists working with clients who have trauma backgrounds to demonstrate warm and soft facial expressions, maintain open and accepting body posture, use warm vocal tones and intonation, and regulate their breathing patterns, which will further increase presence. The therapist's presence greatly impacts the client's sense of safety but the client's perception of the therapist's presence moment to moment is what matters even more. The client needs to feel this presence themselves (Geller & Porges, 2014).

In another study, Rotenberg et al. (2008) looked at trust between children and general doctors, and it was found that children are more likely to trust and follow medical routines instructed by their doctors if they perceive them to be honest, they maintain confidentiality of their personal information, and they are reliable in following through with what they say they will do. During an interview conducted by Cossar et al. (2016), one teenager argued that trust needs to be reciprocal and that children also need to be honest with their social worker because when a child lies about something it can make the process more difficult. Edwards and Karnilowicz (2013) also learned from the participants they interviewed in their study that children feel safe when therapists are patient and take an interest in them. These participants explained that therapists need to feel what the child has felt and acknowledge and understand what they have gone through to build a stronger relationship. These authors encouraged therapists to build a warm connection with children by balancing their emotional investment in a client's story and trauma background without becoming overly involved and attached (Edwards & Karnilowicz, 2013).

Three studies found that professionalism and past experiences in trauma work were necessary for developing trust with children (Graham & Johnson, 2021; Mainey et al., 2009; Valenti et al., 2020). Valenti et al. (2020) and Cohen et al. (2012) found that, for trust to develop, the therapist needs to set clear boundaries and expectations, and create structure for clients during sessions. Cohen et al. (2012) found that therapists need to display a predictable and consistent demeanor and relationship each week. During focus groups conducted by Moore and McAuthor (2017), children and adolescents explained that people of similar races, religions, and regions to them are more trustworthy. They mentioned that observations of other's behaviors indicate whether they can be trusted. On the flip side, during a study conducted by Graham and

Johnson (2021), teenagers briefly mentioned negative qualities in a therapist that do not build trust. This included inexperience or being unable to relate to clients, putting pressure on them to speak about past traumas, removing activities if they missed sessions, and stopping all care once treatment ends.

Researchers found that familiarity increases feelings of safety. In the study by Moore and McAuthor (2017), children explained that trusted adults include family members, people they know, those who are genuine towards them, and those who their family members also trust. Furthermore, they shared that they more easily trust helpers whom their parents trust. Callaghan et al. (2019) found that having trust with helpers leads to self-expression in a comfortable environment, where children can freely share stories that they likely would not have without that trust. It is a fundamental need for children who have had traumatized experiences to feel safe and meaningfully connected to others so they can overcome their challenges (Graham & Johnson, 2021). Along the lines of familiarity, past experiences with an adult also influence how children develop trust with them. For example, if a child is being bullied at school and tells the teacher but nothing changes for them and they do not receive support, it is unlikely that they will trust the teacher to help them in the future with other difficulties, such as domestic violence (Davies, 2019).

Various strategies and approaches that increase trust for children in therapeutic settings have also been researched. In Campbell and Simmonds' (2011) study, participants encouraged therapists to help children externalize thoughts and feelings into the environment, be playful and join their world by fostering imagination, and give them space to explore their identities without feeling a need to please the therapist. They found that the therapist's relationship with a child may be significantly influenced by their parent's fear or reluctance to engage with them, so it is

important to build a strong alliance with the parent (Campbell & Simmonds, 2011). Valenti et al. (2020) used a humanistic or person-centered and trauma-informed approach with children and found that by implementing an ecosystemic approach, helpers could "integrate all relevant facets of an individual's ecosystem into services, including personal issues, family problems, community life, environmental struggles, financial health, and more" through an "eco-map" (Valenti et al., 2020, p. 117). Callaghan et al. (2019) discovered that youth feel safer in a group format, and trust is more easily developed because of participants' shared trauma history. For these youth who have experienced domestic violence, group sessions helped to build connections, strengths, and increased resources across participants. They stated that, "creative techniques in the group enabled [youth] to safely explore their experiences of embodied emotion, enabling a space for them to express and begin to name difficult emotional experiences" (p. 532). In this study, humor was also used to increase trust (Callaghan et al., 2019). Campbell and Simmonds (2011) noted the importance of being creative with the therapy space. A therapist participant in this study explained that making the environment a special place for children ignited their curiosity, contained their anxiety, and was a "retreat" for them if and when they were not feeling safe (Campbell & Simmonds, 2011). Graham and Johnson (2021) provided examples of comfort and sensory factors to consider for children, such as temperature, lighting, sounds, decorations in the room, and having snacks and comforting objects readily available.

Some researchers explored aspects affecting trust and disclosure. Sapiro (2020) found that children sometimes were more hesitant to trust helpers because of the limitations around confidentiality. In a study by Davies (2019), the child participants reported that disclosing the abuse to a professional could put them in more danger with the identified abuser and would thus experience anxiety around what could happen to them if they reported the abuse. Youth stated

appreciation for times when information shared was kept private, especially since it takes a lot of courage for children to confide in a professional. Augsberger and Swenson (2015) found that there is more value in being transparent with youth and letting them know certain information needs to be shared with other professionals and/or parents before doing so. Pinkney (2013) explained another aspect affecting trust, which was that helpers are typically pressurized and short staffed with too large a caseload; there is only so much time they can spend with their clients to further their relationship. A youth who worked with multiple caseworkers during their time in foster care explained that developing trust and being vulnerable was difficult (Augsberger & Swenson, 2015). Cossar et al. (2016) found that children sometimes perceived workers as interrogating them through constant questioning, and even experienced their words being twisted around at times, which negatively impacted the helping relationship. Moore and McAuthor (2017) found that the media and what children had been taught influenced their ideas of safety, who is safe/unsafe, and who they can and cannot trust. However, Pinkney (2013) suggested that some children may need to decrease how often and the extent to which they discuss abuse they have experienced, as this could cause issues for them in school or with their peers. Pinkney also stated that workers may want to focus on helping the child be less trusting of adults or peers. By only focusing on the positive aspects of trust, Pinkney proposed that we may overlook times where easily trusting others and disclosure may have unintended consequences and outcomes for children.

As I have shown here, there has been quite a bit of research conducted on the topic of trust between helpers and children in general, but none of this has been done in the field of music therapy.

Trauma and Recovery

Beyond research specifically regarding trust between children and helping professionals, there has also been more of a focus on trauma and recovery in recent literature. Various psychiatrists and authors have encouraged therapists to integrate a trauma-informed lens with all clients and human beings, including child survivors of domestic violence. According to The National Child Trauma Stress Network (NCTSN), "trauma-informed care" is about being aware of and understanding how experiences of trauma affect every facet of an individual's life, as well as their vulnerabilities and points of triggers. This type of care is about collaborating with all parties involved with the child, integrating evidence-based research, increasing physical and psychological senses of safety, guiding the child and family in their recovery, and supporting them as they continue to heal (2016). Being trauma-informed invites a paradigm shift from asking "What's wrong with you?" to "What happened to you?" (Perry & Winfrey, 2021).

In his book, *The Body Keeps the Score,* Bessel Van Der Kolk (2014) identifies the primitive brain as the "smoke detector" (p. 60), which is activated once the body detects a threat. The "smoke detector sends a message from the hypothalamus to the brain stem, which triggers stress systems and causes a fight, flight, or freeze response. He explains that with traumatic experiences, individuals begin to misinterpret situations as being safe or unsafe, which later causes the rational brain to become impacted. Similarly, Perry and Szalavitz (2017) describe how malleable a young child's brain is, and that consistent stress and trauma in a child's environment can have detrimental effects on how the brain functions for the rest of one's lifespan. Understanding how children cope with their trauma in the moment is helpful to consider when determining therapy approaches to incorporate with them. Bessel Van Der Kolk (2104) explains integrating a bottom-up approach with child survivors of trauma to increase their mind-body

connection as well as their presence in the moment. Deep breathing practices, yoga, music, art, movement, etc. are often implemented (Van der Kolk, 2014).

Several authors (Perry & Szalavitz, 2017; Van der Kolk, 2014) highlight the importance of strong attachment, relationships, and connection with loving family and friends. Perry and Szalavitz (2017) demonstrate this with the following quote: "…healing and recovery are impossible - even with the best medications and therapy in the world - without lasting, caring connections to others" (p. 260). Herman (2023) emphasizes these concepts further by explaining that trauma is both a psychological and a social issue, that people cannot recover in isolation, and that justice is a necessary and important part of recovery. She encourages trauma-informed training for communities, such as law enforcement and court systems, to facilitate compassion for survivors who experienced various forms of violence. Herman (2023) explains that survivors want to feel understood and validated by not only the offender, but also by any bystanders, in order to heal.

The above research suggests that integrating trauma-informed therapy with children who have experienced domestic violence could lead to further trust and healing in the helping relationship.

Deficiencies in the Literature

While there has been research on music therapy with survivors of domestic violence and with children who have experienced domestic violence, as well as research on children's experience of trust in helping relationships, there are no studies that are specifically focused on what contributes to a child's sense of trust with their music therapist. Authors state the obvious fact that trust is needed in the therapeutic relationship even more so with child survivors of trauma. They tend to gloss over important characteristics therapists should embody and mention

that trust and rapport are developed over time. In the music therapy literature, it is unclear as to whether trust is influenced by various aspects of music and music experiences or if it is a combination of that with certain aspects of one's overall approach to therapy.

Minimal music therapy research focuses on trust in the therapeutic relationship. Only a few articles highlight therapist qualities, implemented experiences, and therapy approaches that increase trust (Bensimon, 2020; Lai et al., 2020). Hardly any authors focus on trust in the music therapy relationship with child survivors of domestic violence. There is also a lack of research from the child's perspective, as it tends to come from the helper's point of view (Campbell & Simmonds, 2011; Pinkney, 2013; Valenti et al., 2020) and/or adolescents and young adults' points of view more often (Augsberger & Swenson, 2015; Callaghan et al., 2019; Graham & Johnson, 2021; Jobe & Gorin, 2013; Sapiro, 2020). Furthermore, most of the music therapy studies are with adult survivor participants rather than with children (Day et al., 2009; Fernández de Juan, 2016; Hearns, 2010; Hernandez-Ruiz, 2005; Hernandez-Ruiz, 2020; MacIntosh, 2003; Teague et al., 2006; Ventre, 1994; Whipple & Lindsey, 1999; York, 2006; York & Curtis, 2015). This current research study will be significant for practicing music therapists who work with child, teen, and adult survivors of domestic violence as it addresses this deficiency in the existing literature.

Purpose Statement

The purpose of this study is to explore and understand children's varying degrees of trust during music therapy sessions after they have witnessed domestic violence to improve the quality of music therapy services. For this research, I am defining "trust" as an interpersonal experience of confidently believing that someone is safe, reliable, and honest. I will study how the child participants understand and experience trust during music therapy sessions, and how

trusting relationships are developed and maintained with a therapist through a long-term, six-month program. Additionally, I will explore the qualities that lead participants to trust or not trust someone, the aspects of music and experiences that help them to have trust with a music therapist, and how trust changes over time from their perspective. The main research questions in this study included: (1) How do children understand and experience trust? (2) How are trusting relationships with a therapist established and maintained? Additional sub-questions included: (1) What qualities in a person lead a child to trust or not trust them? (2) What aspects of music therapy experiences lead a child to have additional trust in the therapist at different times? (3) How does a child's experience of trust change over time in long-term music therapy? What contributes to this change? (4) How do the sociocultural locations of the therapist and child influence trust?

Method

Theoretical Framework

This study adopts a constructionist framework (Matney, 2019). The ontological foundation of this framework is that there are many realities and truths. The epistemological assumptions related to this framework are that "humans construct reality and truth as they interpret their experiences of and in the world; all knowledge is grounded in our unique experiences" (Wheeler & Bruscia, 2016, p. 2). Hiller (2016) explains that "from an interpretivist perspective, all knowledge is grounded in our particular experiences; it is subjective and bound to the natural contexts in which we enact our lives" (p. 101). It's "co-created or *intersubjective* – produced through the interactions of the researcher and study participants" (Hiller, 2016, p. 102). Researchers working within this framework glean understanding and create meaning from the data, which are also influenced by their own values and perceptions (Wheeler & Bruscia, 2016).

In this framework, the focus is on subjectivity of the natural human experience; the purpose is to understand the ways in which humans individually and collectively make meaning; data collection is exploratory; the researcher continuously practices reflexivity to be conscious of the ways in which their own values and beliefs may be influencing the process and to maintain integrity of the data; and interpretation of the data is constructed and context-bound (Wheeler, 2016).

Research Methodology

In this research I engaged in a qualitative thematic analysis, also known as a qualitative content analysis (Hoskyns, 2016), in which I interviewed children and analyzed emerging themes from their responses around trust. Qualitative thematic analysis is a methodology in which researchers are "particularly interested in questions of quality and the subtlety of expression that participants use in their communications" (Hoskyns, 2016, p. 563). Although another person's experience can never fully be understood, it is in the meaning of the stories they share and the way they are explained that the listener is able to develop an interpretation of what is being shared. There is much to learn about a child just by listening to and/or observing them in various contexts.

Qualitative thematic analysis can guide music therapists in exploring and gathering information about how children experience music therapists and music. I adopted this method to emphasize the lived experiences as told by child participants during individual, semi-structured interviews, and analyzed how their understanding and experiences of trust during music therapy sessions have been influenced by the social conditions in which they live as survivors of domestic violence. Multiple perspectives across participants were analyzed for similar themes.

As stated, my theoretical stance is constructionist (Matney, 2019, p. 16) with a feminist lens as I engage with the participants and listen to and interpret the stories they share.

Recruiting Procedures

Participants were recruited according to the following criteria: they are between the ages of 8 and 12, have witnessed domestic violence, are English-speaking, participate in music therapy at a PALS (Peace: A Learned Solution) program located within a counseling center from one county located on the East coast for at least four months prior to engaging in this study, and willingly assent to participation. Children participate in music therapy sessions for six months while in the PALS program. This research study was fully described to the child survivor and their non-offending parent. They were both assured that choosing not to participate is totally acceptable and that if they decided not to participate, it would not negatively affect the child's therapy. The child and the parent were encouraged to take time to read over the consent and assent forms provided, ask questions, and share any concerns they may have had. If parents agreed to have their child participate, the child was then invited to participate in the research. The child was reminded that participation in this research was not mandatory, and that if they decided to not participate, it would not negatively affect the remainder of their time in therapy. They were also assured that withdrawing from the research at any time was permissible. Children continued to be recruited from April 2022 to July 2022 until there was enough participants in the study.

Participants

A total of four children (n = 4) participated in this study. Participant's names and other demographic information that could identify them from the research were removed. Participants

were, instead, assigned a letter from the first four letters of the alphabet and general demographic information was coded (see Table 1).

Table 1

Participant Demographics

Participant	Gender	Age	Race/Ethnicity	Neurodiversity	Offending Parent
A	Female	8 years old	Indigenous/Latina	Neurotypical	Father
B	Male	8 years old	White/Latino	Neurotypical	Father
C	Female	10 years old	White	Neurodivergent	Father
D	Female	12 years old	White	Neurotypical	Father

Data Collection

Once a child agreed to participate, their non-offending parent signed a consent form (see Appendix A), and they signed an assent form (see Appendix B). Participants were told the kinds of questions they would be asked during the study. Interviews were scheduled with the participants across one or two of their individual, in-person, music therapy sessions. Participants began these sessions by choosing an instrument and creating music with me for several moments. They then engaged in the semi-structured interview, which lasted anywhere between 25 and 40 minutes, and responded to a set of pre-determined questions (see Appendix C) that were adapted given the age, developmental level, and experiences of the child. Opportunities were provided for participants to share narratives of their experiences and understanding of trust in general and during music therapy sessions. Short breaks of about five minutes were provided when necessary. These interviews were videotaped and saved on a password-protected laptop. They were later transcribed verbatim. I engaged in a process of reflexive journaling regarding the experience after each interview. Additionally, I met with my academic advisor several times

while collecting the data, prior to and between interviews, to process the experience of conducting interviews and practice reflexivity.

Ethical Considerations

This research protocol 2022-064-56-C was approved by the SRU IRB on April 4, 2022. There were several possible risks that participants might encounter, including coercion and emotional discomfort due to past experiences where their trust may have been violated. Participants were not deceived during this study and were made aware of the purpose and rationale throughout the process. To mitigate against the risk of coercion, the child participants and their parents were continuously reassured that participation in the research is completely voluntary and that declining to participate would not negatively affect their remaining time in music therapy in any way. If emotional discomfort was experienced by the child during the interview, this would have been processed in the moment with them and the child would have been referred to the supervising therapist on site to process these feelings afterwards. The child participants were assured that they could stop the discussion any time they wanted to. To mitigate against discomfort in discussing trust, only children with whom I had worked for at least four months prior to this study were eligible to participate.

Data Analysis

I reviewed each recorded interview video and transcribed the verbal material from each one verbatim. I reviewed the transcripts for accuracy, taking note of participants' body language and tone of voice. I read through participants' responses during the interviews and engaged in a process of in vivo coding for all transcripts, in which I coded some of their exact words or phrases. Additionally, salient words, ideas, and experiences that children shared relating to trust were selected and labeled with a code that seemed to describe the core of what they were saying

in a process of descriptive coding. I sometimes used their words directly and sometimes found another word to describe their response. Transcripts were uploaded into ATLAS.ti, a qualitative data analysis software program, to help organize codes. I continued going through the transcripts and revising and merging codes. I also grouped various codes together according to relevant themes across participants. I consulted with my academic advisor to consolidate codes and create overarching themes.

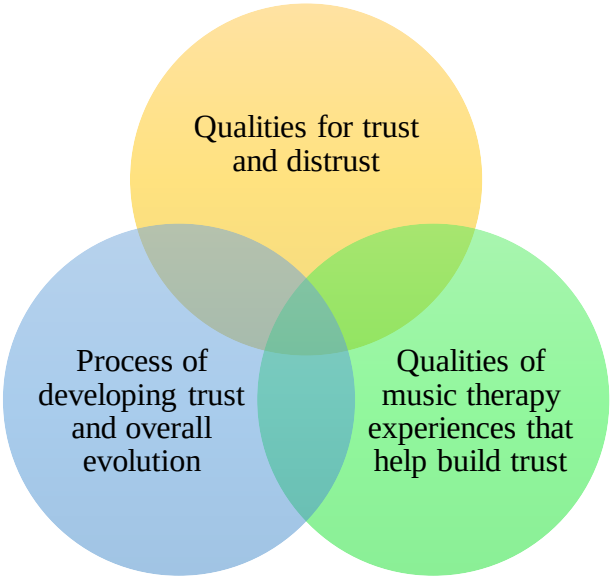
Findings

The purpose of this study was to explore and understand children's varying degrees of trust during music therapy sessions after they have witnessed domestic violence to improve the quality of music therapy services. Participants responded to various questions regarding their understanding and experience of trust during music therapy sessions, how they believe trusting relationships are developed and maintained with a therapist, the qualities that lead them to trust or not trust someone, the aspects of music and experiences that help them to develop trust with a therapist, and how trust changes and evolves over time.

Three main themes with 13 sub-themes were found during the data analysis. These themes were (1) qualities for trust and distrust, (2) process of developing trust and what that trust then leads to over time, and (3) qualities of music therapy experiences that help to build trust (see Figure 1). Each of these themes will be explored in detail in this section. Direct quotes of child participants will be included to present the findings more accurately and thoroughly. I will put the participant's assigned letter in parentheses immediately following the responses they shared.

Figure 1

Main Themes



Qualities for Trust and Distrust

Qualities that Increase Trust

Participants highlighted many qualities that could increase trust for them in their relationships with others, which included how they feel around the person, the appearance and gender of the person, positive traits in the person, and how the person is with others. Participants described trust in terms of the ability to be themselves and "speak freely" (D) around someone, feeling cared for, feeling "comforted" (D), and feeling seen. They focused on the ways that appearance plays a role in trust, stating that I "looked nice" (B). One child explained that she's more trusting "around women, girls…[because it is] easier to talk to them" (D), and that she trusts people who are honest and "open" with her and "not afraid to tell you things" (D). Participants trust people who are attentive and "listen" (D), are "kind" (C), "nice" (A, B, C), "outgoing" (D), "friendly and approachable" (D), who say "positive words about you" (A), who

"try to care about you" (A), and who "weren't mean" (A, B). In terms of qualities of the music therapist, participants stated that I provided support throughout therapy to "help answer questions" (D), maintained a beat for a participant to follow "instead of...trying to not be strong" (A), and gave "advice…and [gave] me better stuff to do" (A). The participants also paid attention to how a person is outside of the relationship with them, noting "how they treat other people" (D), as well as "how they are when you're not around them" (D) and whether they are consistent or predictable—always displaying the same personality.

Qualities that Decrease Trust

Additionally, participants described qualities that lead to distrust, which included negative actions of a person, how the person is with others, and degree of familiarity. Participants described distrust in terms of actions, such as whether a person "did something that was mean" (C), if they "lie" (B) and "constantly tell you lies" (D), if they "pretended to be nice" (C), if they "act annoyed around you" (D), and if they demonstrate any kind of "negative action towards you" (D). A participant further explained that she cannot trust people who "talk about other people to me…if they talk to me about other people then there's no problem if they talk about me to other people" (D). One participant explained that peer pressure also leads to distrust. Several participants described that they are untrusting of people who are unfamiliar to them and who they "didn't really know" (C). They stated, "Before I didn't really know you, so I was anxious." (D) and "If someone that was a stranger or something and they said that they knew my mom or dad, I wouldn't trust them…if I didn't know the person, or recognize them, or never seen them before then I wouldn't really trust them" (C).

Process of Developing Trust and Overall Evolution

Participants described a natural process of initially not trusting others, experiences that help to build trust over time, and what trust can then lead to once it's maintained. The following sub-themes will be described in this section: (1) initial distrust/trust, (2) insecurities and fears from participants' past, (3) familiarity leads to trust, (4) connection to family/friends, (5) feelings and experiences with trust, and (6) builds over time.

Initial Distrust/Trust

Although one participant stated that "trust comes easy" (D) for her, all participants described having initial distrust with someone new and unfamiliar. Several participants described being untrusting of "strangers" (B, C), as they were fearful of a possibility of harm and danger, and the unknown. At the beginning of music therapy sessions, participants explained that they felt "nervous" (C, D), "shy" (A), and "scared" (A, B) that I might harm them in some way, and "awkward" (D). One participant stated that she was "a little scared because I never been to PALS before then…I didn't really know what we would be doing…I didn't really know you that well then…I didn't know what was gonna happen." (C). Another participant stated, "at first, I wasn't so sure if I could tell my stuff" (A), and "when we were playing the hello song and I wouldn't know like what you were doing…I didn't know the beat or anything and then I was just like lost in the song" (A). They reported a lack of trust right from the start of therapy.

Insecurities and Fears from Participants' Past

Several participants described how negative past experiences influenced their ability to trust others. A participant explained that "I can't really trust my brother. Sometimes he says he will give me my toy back if I do something with him first…if I do that and after I'm done doing it and I ask for my stuffed animal back, he won't give me it back." (C). Another participant

stated that, in the past, a friend "tried to use me" (A). Participants expressed a fear of disappointing me, as evidenced by them saying "sorry" (B, D) throughout the interview. One participant may have feared my reaction when he said, "it's weird that you're hearing it for the first time" (B) regarding a recording of a meaningful song he was about to play. Participants described feelings of inadequacy when they said, "I'm not very good at [answering questions]." (D), "I have a hard time making decisions." (D), and "I'm trying to say the answers but it's super hard." (B). One participant explained that distrust breaks friendships by saying, "when I didn't trust someone, I didn't do what they told me to do…I felt good and bad" (A), and later added, "It felt a little bit bad too because I didn't actually trust them and then they didn't trust me" (A). Inner conflict was demonstrated through the following quotes: "Trust could be like people…do something for you and then you trust them but you're like, 'are you sure I should do it?' but you just trust them" (A) and "I also felt a little bit bad and mostly good though because I didn't do what's wrong" (A). This participant also conveyed feelings of isolation when she stated, "when I didn't trust anyone…it was bad to not get any advice from anyone" (A).

Familiarity Leads to Trust

One participant stated that "if you know someone very well…that knows you and that knows your mom" (C), they can be trusted. This participant explained that "my mom's friend that I knew…I actually trusted him to pick me up [from summer school]." (C), and that she would trust someone "if I've seen the person before" (C). Trust within the therapeutic relationship evolves and changes over time because "I know you better" (B, D), "I'm more comfortable…we know each other now" (D), "I already know what we're gonna do and you don't have to explain it" (A). After several months of therapy, participants expressed that they felt "so relaxed and I feel safe and I feel like I'm at home" (A), that they have "been here for a

while…it just kind of comes naturally – the trust" (D), and "you kind of get used to it and you like it even more, that you're used to going to it all the time" (C).

Connection to Family/Friends

Participants described how there is often initial distrust with someone new unless there is a family connection. One participant explained that "if [my aunt] told me that my mom texted them that they would maybe come get me [from school] if my mom couldn't make it. That's how I would know I could trust them." (C), and "if you know someone very well that's in your family" (C). Participants tend to believe those with whom they have close friendships as well, as one participant said, "trusting your best friend is like trying to be a good person" (A). A participant explained that she felt nervous in the beginning of music therapy because she was in a "separate room from mom" (C), whereas another participant felt comfortable and safe with me because "my brother and sister and my mom was here" (B) and his mother was attentive. A participant also seemed to feel more at ease and safe with familiar people around, "when there's like other people in the room…in the group therapy or when someone else was there" (D).

Feelings and Experiences with Trust

In this section, participants described how they experience trust, the risk involved in trust, and how it feels when they do trust others. Participants explained that "if someone tries to tell you something…you might think it might be a lie but you gotta trust them that it could be true" (A), "trust is like believing what's someone's saying or…doing" (A), and "you feel safe" (D) when someone you trust is around. One participant explained that "when I trust someone, I felt all good, no bad at all" (A), and that it "felt good" (A) to trust herself. In terms of their feelings towards me, participants stated, "I trust you, believe you, and am comfortable with you" (A), "now I do trust you" (B), "I feel a lot more comfortable…'cause like I've been here for a while"

(D) as they continued working with me. One participant appeared to have no fear of retribution once trust was maintained since they agreed that they felt frustrated by the questions being asked of them during this interview. Participants also described trust as a reciprocal experience, in which "they opened up, and we opened up" (D) and new friends "trusted me too" (A).

Builds Over Time

Participants expressed that relationships take time by "getting to know the person better" (C), and "getting more comfortable with you…and I got used to you, seeing you" (A). One participant stated that she has "a hard time getting like really comfortable with people" (D). Positive experiences in the past also lead participants to have more trust with peers, as one participant stated, "you can trust them because they've been nice to you and did everything that they could to make you want to be their friend." Trust in the therapy relationship led participants to feel "more happy when I'm playing [an instrument] and I know what we're doing" (A). With trust, participants stated they can "talk and am comfortable, I would say a big speech about something" (A), they feel comfortable to share "the mean moments and the good moments" (A) as well as "talk about…things that have been happening" in their lives (A). Over time in therapy, participants explained that they have been "taking more risks" (A), "[singing] is not a normal thing I really do…especially with people I'm not that comfortable with" (D), and "[singing with the microphone] helped me to like learn how like if I were like on a stage singing by myself and all the people were like watching me do it…it helped me not to be nervous when I do it" (C). In general, trust leads participants to do "what [others] told me to do" (A), share more information than before, build friendships, and have more honest communication. Trust also leads to vulnerability, as one participant stated, "when I open up to someone and you kinda share your experiences, it feels like you can trust that person a lot" (D).

Qualities of Music Therapy Experiences

Participants shared various aspects of experiences during music therapy sessions that helped to increase their trust such as (1) autonomy and choice, (2) familiarity and predictability, (3) types of instruments, (4) types of experiences, and that (5) music contains a wide range of expression.

Autonomy and Choice

Some participants explained that having autonomy over their experiences and having freedom to make choices were important for them to build trust, as they said, "doing things that you like…here" (C), making music "how I want to" (A), and "when you ask me what I want to do today" (A). Another participant explained that "decision-making" (D) made her feel more nervous and uncomfortable during sessions.

Familiarity and Predictability

Familiarity and predictability helped participants feel safe. One participant said they like "more slower songs" (D). Another participant explained, "I would just…try to stay on beat with you" (A), and "I'm more happy when I'm playing [an instrument] and I know what we're doing" (A). One participant also described additional comfort playing the drums because she "used to play them" (D). Feeling relaxed and calm due to predictability increased trust. One participant stated that it is the "beat of the songs…it makes me feel more relaxed. Just listening to it makes me feel relaxed" (A) regarding several songs that help her feel safe, and that she was "so relaxed and I feel safe, and I feel like I'm at home and laying down and trying to relax" (A) as she played calming instruments during previous sessions.

Predictability in structure during sessions helped to build trust. One participant mentioned that "our hello song" (A), which was implemented during every session, helped her to feel better.

Another participant explained that, during prior sessions "[you] helped me answer questions…[by] giving me more to work with for the questions" (D) that were prompted. Structure also allowed for individuation, as one participant explained she is "taking more risks now and playing in a different beat" (A), which was yet another aspect of a participants' experience indicating they had more trust.

Types of Instruments

Feelings of safety were increased when participants had opportunities to play certain instruments that they may have had prior experience with, such as the "drums" (D). On the other hand, one participant mentioned how unfamiliar instruments and certain sounds, such as the "autoharp" (C), can be scary and lead to distrust.

Types of Experiences

Various types of experiences during music therapy sessions that helped build trust were described. Participants said that "playing music" (A, D) was a positive experience. One participant stated that she enjoyed "playing instruments" (C), such as the "guitar and piano" (C), and that she also liked "singing" (C) during sessions. Drawing to music was another way that participants could release challenging emotions. Participants alluded to the relational aspect of "playing some music together" (B) as an experience that leads to trust. Also, feeling supported during improvisational instrument playing experiences, as one participant stated, "when we played the piano together, like free play" (A) increased trust for them as well. Participants seemed to enjoy doing "arts and crafts" (C) and mentioned how games increased rapport and "made me feel better and get used to being with you" (A), specifically by using the "parachute" (A), bouncing a soft ball back and forth on a gathering drum, and "the bean bag game into the drum" (A) in which clients take turns tossing bean bags into drums. Several participants seemed

to appreciate when I played and incorporated several of their preferred and familiar songs into sessions, and then explained that being able to listen to these songs "makes me feel more relaxed" (A). Participants mentioned that "learning new things that I've never done before" (C) and "learning new instruments that could help" (A) gave them opportunities to achieve new things, which likely made them feel good about themselves. Another participant stated that "singing" (C) was a vulnerable experience for her and increased feelings of safety during music therapy.

Participants also described positive music associations that led to an increase in comfort and trust – "when I tapped [the cowbell], it kind of sounded like the Jingle Bell song" (C), as well as being able to play familiar and their preferred instruments, such as the "drums" (D) and "guitar" (C). They talked about having opportunities to play and listen to their preferred tempos and styles of music, which included "fast" (B), "soft" (C), and "slower beats…slow types of songs" (D). One participant mentioned that taking deep breaths while slowly opening and closing the "breathing ball" (C) (otherwise known as Hoberman's Sphere) increased relaxation, and another explained she felt safe as I continued introducing her "to the calm instruments…because playing the calm thing just gets my mind off the whole bad thing" (A). Several participants agreed that "I don't think there was ever a type of music that made me feel not safe" (A) and that "any type" (D) of music implemented into music therapy sessions was helpful.

Music Contains a Wide Range of Expression

Music seems to support all states for these participants, as it's an outlet for different parts of themselves in which they can express in ways that are appropriate for them.

One participant stated:

> *When I play loud, it makes me feel better because I'm listening to something loud and I'm actually making it myself. When I do something quiet…it feels more like safer when I'm doing something quiet because it's relaxing and my body's relaxing when I'm going quiet…calm is good sometimes when my body just wants to relax because when my body doesn't like…if I don't want it to relax, I just want to go like crazy*. (A)

Similarly, another participant stated, "if I got…angry…and I thought with drawing, I thought it would help me with, like I could like, draw…if I was feeling mad and calm down" (C).

There is a lot of overlap between these three main aspects: (1) qualities for trust and distrust, (2) process of developing trust and what that trust then leads to over time, and (3) qualities of music therapy experiences that help to build trust. This demonstrates that trust is dynamic, and that developing trust is a non-linear process that can change and evolve over time in both good and bad ways.

Discussion

The present study aimed to explore and understand children's varying degrees of trust during music therapy sessions after they have witnessed domestic violence. Research questions focused on how child participants understand and experience trust, and how trusting relationships with a therapist are developed and maintained. This study also explored kinds of qualities in a person and aspects of music therapy sessions that lead to trust, how trust changes over time and what contributes to this change, as well as if and how the sociocultural locations of the therapist and child influence trust.

Throughout the findings section, child A was quoted the most out of all four participants, while child B was quoted the least. Child A appeared to be the most comfortable throughout the interview, perhaps because she consistently attended 19 individual and six weekly group sessions

prior to the interview. This was the second interview I conducted. Also, she may have developed more trust with me and openly answered questions because of her consistent attendance.

I conducted my first interview for this study with child B. He appeared to be the least comfortable out of all the participants, and although he attended 20 individual sessions and two group sessions prior to the interview, his attendance was inconsistent and sporadic throughout the program. Because of this, he may have felt less trust with me compared to child A, which may have also affected how he answered the questions. Questions were possibly worded in ways that were too abstract for child B to understand, as he stated several times throughout the interview that the questions were too hard and asked if there were any easier ones.

The third interview was conducted with child C after having attended 17 individual sessions and no group sessions. She attended the program on a semi-consistent basis, and may have also only trusted me so much, compared to child A, at the time of this interview. Due to this child's neurodivergent status, it's possible that some questions were again worded in ways that she may have not fully understood.

Child D's interview was conducted last, so by then, I had more time to practice asking the questions in various ways depending on the child's developmental and chronological age. Child D attended 16 individual sessions and three group sessions on an inconsistent basis prior to the interview. She also was the oldest participant and appeared to be self-conscious while answering questions. Due to these factors, child D appeared to be somewhat uncomfortable and may have felt less trust with me at this time compared to child A.

It should be noted as well that these interviews took place during the COVID-19 pandemic when staff and clients were mandated to wear masks, and children were likely engaging in minimal social interaction with others outside of the family members in their home.

This could have also influenced children's levels of trust with me as well as how open they were in answering questions for this study.

Participants portrayed that the notion of trust is complex and nuanced. Participants defined trust as a natural process that typically begins with initial distrust due to unfamiliarity and potential insecurities and fears from past experiences. As participants become more familiar with and get to know a person better over time, the relationship develops and in conducive contexts (ones in which they have grown to believe in what the person says and does), trust develops. They feel safe and comfortable enough around a person to be honest, vulnerable, and are more willing to take risks. Participants explained that they trust those who are close and familiar to them, such as friends and family, and that they can more easily trust a person if there is a known connection to a participant's family member. Participants identified certain qualities that help them to have more trust with a person, and qualities that may decrease their trust.

For the participants in this study, a trusting relationship is built on reciprocity and engaging in shared and relational experiences together. They described the overall consistent and predictable structure of music therapy sessions, as well as structure during music experiences that led to increased trust. Participants mentioned that engaging in a variety of music, art, and relaxation experiences as well as games that they both enjoyed and were familiar with led to them feeling more trusting. Participants reported feeling further trust when familiar and preferred songs and instruments were incorporated into sessions. They appreciated having control over what they did in sessions, having opportunities to make choices, and feeling supported. With trust, participants could express all moods and feelings through a variety of music experiences. Participants reminded me how trust within a therapeutic relationship can change and evolve over

time. I was further reminded that trust is fragile and multifaceted and that it can also be enhanced or diminished over time depending on many factors.

I engaged in a process of reflexive journaling throughout this research. I wrote down my own thoughts and feelings about varying levels of trust I felt from the beginning to the end. Some excerpts from my first interviews reflect the anxiety and self-doubt I felt, and demonstrate the lack of trust I had in myself since it was my first time actually asking these questions, interviewing clients, and conducting research in this way.

After my first interview with child B, I explained that:

It was chaotic trying to ask these questions to my client…I was expecting more answers from him…It's definitely difficult being the researcher, interviewer, and therapist…I think some of my bias and feelings definitely got in the way throughout the interview. I was anxious, too, going into it…I tried to relax and stay present with him but noticed myself very much in my head for the first half of the conversation. It wasn't until about halfway through that I told myself everything that's happening is completely okay and he doesn't have to answer a certain way for this research to be effective.

For my second interview with child A, I wrote:

I was nervous going into it and started setting expectations for how it would go and was hopeful that [the client] would answer the questions in ways that were helpful for the research. I told myself to let go of these expectations after several moments because I didn't want to ask questions in a way or respond to her in ways that might sway her answers…I'm still trying to figure out how to respond to these clients in ways that will help them elaborate on what's important for the research and when they've said enough, and I can move on to the next question.

With my third interview with child C, I explained:

I feel like I was more present during the session today compared to the last two times I've done this. I tried my best to stick to only asking open-ended questions with this client, but I'm still struggling to pull out the most important parts of what the client is saying as I reflect something back to them…the parts that I am trying to encourage them to expand on. The client was sometimes taking a while to respond to the questions and I felt like I had to "save" her at times…I really did feel like I was more present and engaging with the client as a therapist rather than just a researcher and interviewer…I was worried that she would be uncomfortable with the silence for too long or that she would just say "I don't know" again so I would try to keep prompting her with other thoughts and questions.

For my last interview with child D, I wrote:

I felt like I was expecting [the client] to say more and elaborate because she's older and that was probably being communicated to her which I think she picked up on. I think I was too pushy at times with encouraging her to share more information and give more of a response to a question. She was really anxious, which I felt too, and made me feel more anxious. This likely helped her to have less trust with me, which is the exact opposite of what I would want from a research study about trust. I need to let go of my expectations for this research and just be open to discovering whatever comes out from it.

I think the progression in my own journal entries demonstrates similar themes from what was identified in the research about the overall process of trust. I experienced initial distrust in myself, as conducting this kind of research and interviewing clients were both new experiences for me. I also experienced distrust with clients regarding how they would answer the questions, and worried whether their responses would provide helpful information. My clients' demeanors

also affected my own level of trust; if they seemed to be uncomfortable, anxious, relaxed, etc. I felt those emotions as well and it affected the interview. My trust in myself and with my clients started to build over time, as I became more comfortable and familiar with the process of asking the questions during the interviews. I had to work to let go of my expectations and accept the interviews for what they were and the information gleaned from the study. Ultimately, I had to trust that my results and findings would be important information for other music therapists in the field. However, it was difficult to trust the process of this research from start to finish.

Revisiting the Literature

Participants in this study identified important therapist characteristics and *qualities that increase trust*, which is substantially supported by many researchers (Augsberger & Swenson, 2015; Campbell & Simmonds, 2011; Cossar et al., 2016; Edwards & Karnilowicz, 2013; Geller & Porges, 2014; Graham & Johnson, 2021; Pinkney, 2013; Rotenberg et al., 2008; Sapiro, 2020; Valenti et al., 2020). This finding, specifically as it relates to the qualities of the music therapist (helping clients answer questions, giving advice, and supporting them musically by maintaining a beat for them to follow), is lacking in music therapy literature. Participants described more easily trusting a person who shares the same gender, which supports the findings of Moore & McAuthor (2017).

Participants described *qualities that decrease trust*, such as a therapist's inexperience with trauma or being unable to relate to a child's experience, pressuring a child to share information about their history of abuse or adversity, withdrawing activities if they missed sessions, and discontinuing care once their treatment ended, which was also acknowledged by Graham & Johnson (2021). This finding, however, is also hardly discussed across music therapy literature. The Music Therapy and Harm Model (Murakami, 2018, 2021) begins conversations

around the various ways in which harm can be caused in music therapy that could also then lead to distrust, but further research in this area, especially by the clients themselves, is necessary. It's important for music therapists to be mindful of the qualities they bring in and embody during sessions with clients, as this could affect clients' experiences of trust. It may be worth asking clients how they perceive the therapist and how sociocultural identities, such as race, class, gender, and religion may be affecting their perceptions. For example, I might ask a client of color, "How is it for you that I am a white woman in this space?" Music therapists should learn to expect that clients may not trust them initially, that this is okay, and that it may be in the client's best interest to not trust the therapist at that point. The therapist should come from a place of understanding and knowing that they need to earn the client's trust. Additionally, the therapist needs to consider how the client's sociocultural identities and location may be affecting their own perceptions of the client and the overall therapeutic relationship as well.

Participants described the *process of developing trust and overall evolution*, which was consistent with findings from previous literature that emphasized time as an important aspect in developing trust between a professional and a child, and that identified trust as a process that builds over time (Graham & Johnson, 2021; Pinkney, 2013; Sapiro, 2020). Graham and Johnson's (2021) study participants also agreed that a trusting relationship is "the initial starting point to facilitate effective trauma treatment" (p. 9). Participants in this study further clarified that they experienced *initial distrust/trust* with me as their therapist at the beginning of therapy. *Insecurities and fears from participants' past* were also explained as variables impacting trust in the therapeutic relationship. These findings are beneficial for therapist's working from a trauma-informed lens and could be motivation for other therapists/helpers to actively consider client's trauma history in their work with them. Integrating a trauma-informed approach is important

with survivors of domestic violence because individuals experience lasting impacts on their brains from prolonged stress and trauma in their childhood according to Perry and Szalavitz (2017). This means working from a frame that asks, “What happened to you?” rather than “What’s wrong with you?” (Perry & Winfrey, 2021), always holding a client’s past traumatic experiences in mind, showing compassion and empathy towards them, and being mindful of their vulnerabilities and triggers (NCTSN). Just as Herman (2023) suggested that trauma-informed trainings be held out in communities to facilitate compassion for survivors, both trauma and multiculturally informed training during music therapy undergraduate programs are also necessary. Students should be aware of the many reasons why clients may not demonstrate trust initially and that it could take a significant amount of time to develop.

Undergraduate and graduate programs could spend time focusing on domestic violence and it’s prevalence amongst many populations with which music therapists work and help students learn ways of building rapport with clients at various developmental stages. Colleges and universities need to integrate multicultural knowledge throughout their entire program, instead of having one class on cultural competence, and address ways in which sociocultural identities are going to affect and influence trust with clients. Music therapists should be thinking of the ways in which clients’ past experiences and worldviews shape how they present during therapy and how they interact and develop trust with them. Supervising music therapists could also emphasize this idea during supervision and remind supervisees how challenging it may be for clients to develop trust with someone unfamiliar to them.

Participants explained that *familiarity leads to trust* and increases feelings of safety, which correlates to the findings in previous literature (Jobe & Gorin, 2103; Moore & McAuthor, 2017). Specifically, Moore and McAuthor (2017) learned that if a child’s parent displayed trust

towards a helping professional, then the child would be more likely to trust the professional as well. Similarly, Campbell and Simmonds (2011) found that if a parent is reluctant to engage and develop a trusting relationship with the therapist, this can also affect the child's relationship with the therapist. The findings in this study support this prior research, as participants stated that simply knowing that a family member is in the same building or room with them, they feel more comfortable and can more easily trust the therapist. This *connection to family/friends* seemed to be a significant aspect for these participants in whether they felt safe to trust someone and/or a therapist. If the client feels close to and supported by a sibling or family member, music therapists could facilitate sibling therapy and/or family therapy sessions with them as they are getting comfortable in the space and with the therapist. These findings demonstrate that there is a need for more training in music therapy graduate programs as well as CMTE trainings that focus on implementing family/sibling sessions and/or with individuals from the client's support system. One participant mentioned feeling more comfortable in group therapy. This relates to the findings in Callaghan et al.'s (2019) study, in which child participants explained feeling more connected to others and less isolated by being able to express themselves in a group format. Therefore, music therapists should remember that some clients may feel safer and more trusting of a therapist when they are in a group with other peers. This may be because the attention is not all on them as it is during an individual session or because there are others to witness anything that may feel threatening. With others present, there is less risk of one person's word over another's.

Participants shared their *feelings and experiences with trust*, specifically stating feelings of safety and comfort, and this was also mentioned in previous articles (Graham & Johnson, 2021; Jobe & Gorin, 2013; Moore & McAuthor, 2017; Sapiro, 2020; Valenti et al., 2020). In the

music therapy literature, Bensimon (2020) and Lai et al. (2020) described similar feelings associated with trust for clients. Participants in this present study also described trust as a reciprocal experience, which was conveyed in the findings of a study by Cossar et al. (2016). These findings, however, are lacking in the music therapy literature in general and specifically with survivors of trauma. Music therapists need to be mindful of this finding as well in that trust works both ways. Therapists have to trust their clients in the same way they expect clients to trust them.

Additionally, participants explained how trust *builds over time* and that because they know a person better, they are more likely to do things they probably would not have done without that trust, which is acknowledged significantly in the literature (Augsberger & Swenson, 2015; Callaghan et al., 2019; Graham & Johnson, 2021; Jobe & Gorin, 2013; Pinkney, 2013; Rotenberg et al., 2008). As trust continued to evolve, these participants were more willing to take risks. This is significant for music therapists, as they can implement new and unique experiences and encourage clients to go beyond their comfort zones as the therapist perceives them to be more trusting and comfortable in the space. This, of course, will vary from client to client so therapist awareness is key.

Participants expressed certain *qualities of music therapy experiences* that led to further trust in the therapist-client relationship. They appreciated having *autonomy and choice* during sessions, which several music therapy researchers (Kim, 2015; Lai et al., 2020; Pasiali, 2013; Purdon, 2006) also noted as being important during music therapy. This finding also supported previous literature outside the music therapy field (Callaghan et al., 2019; Graham & Johnson, 2021; Pinkney, 2013; Sapiro, 2020; Valenti et al., 2020). Implementing experiences that give clients autonomy and allow them to make various choices during sessions is important,

especially for those who have experienced trauma and potentially isolation. Participants reported feeling more trust when there was *familiarity and predictability* with the overall structure as well as with structured experiences during sessions, which reinforced prior findings in music therapy (Bensimon, 2020; Kim, 2015; Lai et al., 2020) as well as outside the field (Cohen et al., 2012; Valenti et al., 2020). This finding, however, signifies that music therapists should implement more familiarity and predictability into their sessions, and that more music therapy research is necessary on understanding how these session components and overall structure lead to further trust when working with survivors of trauma.

Researchers focusing on music therapy with survivors of domestic violence often suggested the importance of incorporating familiar and preferred songs into sessions (Bensimon, 2020; Fernández de Juan, 2016; Kim, 2015; Pasiali, 2013; Schulze, 2018; Teague et al., 2006), and this was also emphasized by participants in this study. Additionally, participants explained that they felt more trust and safer with opportunities to play and engage with their preferred *types of instruments*. This finding, however, is understated in music therapy research, but is significant for music therapists because clients feeling safe with their preferred or familiar instruments is like feeling safe with people. During music therapy education and training programs, students are often taught to immediately learn client's favorite songs and genres of music so that they can be incorporated into future sessions. While this is important, there is much less focus on client's preferred instruments and how implementing instruments with which they are already familiar is helpful to them and the therapeutic relationship. Music therapists could ask about familiar instruments on their initial assessments with clients. We saw from this study that certain instrument sounds and ways of playing could be scary for children and potentially lead to distrust, which also supports Bensimon's (2020) findings. This finding has strong implications

for music therapy practice, as music therapists need to pay attention to how various instrument sounds, dynamics, and styles of playing may affect clients and their level of trust, and then adapt these musical elements accordingly to support them.

Participants emphasized various *types of experiences* they enjoyed and that helped them to develop and maintain trust within the therapeutic relationship. Previous research in music therapy has found that various kinds of music experiences, such as implementing familiar songs with repetitive lyrics, melodies and predictable structures, musical validation, musical witnessing as a self-object, and attuned musical involvement with the therapist (Bensimon, 2020) could lead to feelings of trust and safety for clients, in addition to drumming and musical games (Lai et al., 2020). In this study, participants noted that singing, playing instruments, improvising and making music together, learning new and calming instruments, playing various games, engaging in arts and crafts, and practicing breathing exercises led to feelings of trust and safety. Researchers both within and outside of the field alluded to this general concept that specific experiences during therapy sessions, such as drawing and talking about feelings (Grocke & Wigram, 2007; Malchiodi, 2015; Malchiodi, 2020), music-assisted relaxation (Grocke, 2015; Grocke & Wigram, 2007), listening and dancing to music (Grocke & Wigram, 2007; Malchiodi, 2015), engaging in drama therapy (Callaghan et al., 2019; Malchiodi, 2015), integrating expressive arts therapy with child and adult survivors of trauma (Malchiodi, 2020), and joining the child's world through play and imagination (Campbell & Simmonds, 2011) can influence trust as well.

Participants shared that when they achieved success in an experience and when they successfully learned new instruments, songs, etc., this increased positive feelings and self-confidence. It seemed that this may have increased their trust not only in the therapist, but also

trust within themselves. Similar to what Bensimon (2020) alludes to in his research, participants in this study explained that being able to play and listen to their preferred tempos, dynamics, and styles of music when they wanted to increased feelings of trust. This finding, however, appears to be underrepresented across music therapy literature. This could be something music therapists assess in the beginning of their work with a new client and throughout treatment, whether by asking them directly what they like and prefer and/or observing how they engage with various musical elements.

Lastly, participants conveyed that *music contains a wide range of expression*, which is supported extensively in music therapy literature with survivors of domestic violence (Fairchild et al., 2016; Fairchild & McFerran, 2019; Fernández de Juan, 2016; Hernandez-Ruiz, 2020; Kang, 2017; Kim, 2105, 2017; Purdon & Ostertag, 1999; York, 2006). Music has the potential to express that which cannot be explicitly stated for survivors of trauma.

Study Limitations

One limitation is that this was my first experience conducting qualitative research, interviewing child participants, and analyzing this form of data. Several interview questions may have been difficult for some participants to understand, and questions needed to be slightly adjusted in between participant interviews depending on their chronological and developmental age. The concept of trust may have also been challenging for participants to put into words. Another limitation is that I already had a relationship with participants as music therapy clients before they engaged in this research. It is likely they may have agreed to participate in the research to avoid disappointing me, and answered questions during the interviews in ways to please me as their therapist.

Given the nature of this research methodology, the findings are not generalizable across all child survivors of trauma, although my hope is that they are transferable. The generalizability and transferability of the results is limited by the small sample size of only four child participants with similar sociocultural identities. I only interviewed these participants one time after they were working with me for four months and asked them about how trust in our relationship may have developed and changed since the beginning of their time in therapy, which could have influenced the results. Additionally, the bias I hold due to my own sociocultural location in terms of my race, class, and lack of personal experience with domestic violence, in addition to my experience working with these children in music therapy may have been another limitation, as it affected how I interacted with them during the interviews and how I analyzed and interpreted their responses. However, our ongoing relationship may have had a positive influence on the research process because it helped me to know when they may have needed a break, and it enabled them to communicate their needs during the process.

Recommendations for Future Research

Participants in this study highlighted that various musical aspects, including types of familiar instruments in addition to familiar songs, increase trust. Further research could explore the aspects and qualities of preferred and familiar instruments identified by clients that help them to feel more comfortable and safer during therapy, as well as ones that they may be familiar with but that lead to distrust. I would be curious to learn *how* or *why* certain familiar instruments help clients to develop more trust with a therapist. Maybe there are certain instruments that are more vulnerable to play, and possibly some instruments that are "safer" to play for children. Some timbres may feel safer than others. Bruscia (1987) notes that timbre can represent characteristics of a person, the "who-ness," and so some instruments may remind them of significant people in

their lives. How an instrument is played may be a factor in creating a feeling of safety and trust, that is, whether they are struck, hit, or not. Another factor could be whether they are primarily melodic/harmonic or rhythmic. Bruscia (1987) discusses these elements in terms of their psychodynamic implications for emotional (melodic/harmonic) and physical (rhythmic) holding environments. Future research could also explore client's past experiences with familiar instruments and learn about their positive and/or negative associations with them. It would be important to include a larger sample size of participants in future studies with a wider range of sociocultural backgrounds to gain a broader array of responses, richer information, and potentially more patterns across participants. This type of study could include both quantitative and qualitative components.

A similar study to this one could be repeated but using a repeated measures approach, with participants being verbally interviewed and responding to a quantitative assessment around trust at the start of therapy and then again six months later when they graduate from the program. Researchers could explore how participants' answers change over an even longer period. They could ask clients questions about how they may trust people more when they feel safe versus how they may not trust people when they feel unsafe, looking at the difference between these times, and how clients trust themselves.

Conclusion

The present research study explored how child survivors of domestic violence understand and experience trust in general and with their music therapist, as well as how trust changes over time. The kinds of qualities children look for in a therapist and aspects of music therapy sessions that lead to trust were important findings from this research.

Findings from this research have underlined ideas and examples of ways in which music therapists could increase feelings of trust and safety in the therapist and the music therapy experiences with their clients. An unexpected finding was related to the idea that types of instruments participants may already be familiar with could increase feelings of trust with the therapist. The theme *familiarity leads to trust* came up frequently in this study in various ways, including that participants had more trust the more familiar they were with me, as they came to sessions weekly, and as they had opportunities to engage with familiar songs, instruments, and music experiences. Also, once trust was established, participants could take more risks. Being able to take risks and being successful at achieving new tasks were also really important indicators for these participants that there was trust in the relationship. These ideas are imperative to keep in mind for practicing music therapists as well as for music therapy supervisors while discussing aspects of the therapeutic relationship when working with child survivors of domestic violence. Therapists should consider ways of relating to and forming healthy connections with clients, as well as providing a safe container for them not only in the music, but also in the session overall. Incorporating familiarity and predictability into sessions may be key to client's success in therapy.

Parents and caregivers who are considering enrolling their children in music therapy sessions may find the information gathered from this study useful in making their decision to enroll them. Organizations and communities that are thinking about adding music therapy programs for survivors of domestic violence will likely benefit from the findings of this research. Programs may be encouraged to place more of an emphasis on establishing trust and ways to approach this for children at the beginning stages of the therapeutic relationship. This knowledge and the amount of time it may take for children to develop trust during experiences in music

therapy may support a rationale for sessions to take place over a longer period, instead of just three to six months, which is often the case in existing programs.

There needs to be more training for students and practicing professionals on (1) the overall topic of domestic violence so that there is a better understanding of how this form of trauma could present in clients and affect their levels of trust, (2) ways of establishing trust within sessions with clients from various backgrounds in relation to the therapist, (3) and on trauma-informed care and what this looks like across settings and populations. Additionally, there is a need for more research and literature on experiences of trust within the therapeutic relationship during music therapy, specifically from children's perspectives. As demonstrated in this study, as well as in the literature cited throughout this paper, trust in the therapeutic relationship is important for clients to feel safe. Therefore, to ensure that all clients, even our youngest ones, feel safe, supported, and respected, we must remain committed as music therapists to develop trust through the qualities we bring in as therapists, the aspects of music we introduce, and how we structure the experiences implemented in the therapy sessions.

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Appendix A

Parent/Guardian Consent to Participate in Research Form

Experiences of Trust in Music Therapy: Perspectives of Child Survivors of Domestic Violence

Ashley Doron, MT-BC axd1065@sru.edu (856) 824-0599 Ext. 8619

Susan Hadley, Ph.D., MT-BC susan.hadley@sru.edu (724) 738-2446

What is a Consent Form?

A consent form provides information about a research study to help you make an informed decision about your participation. It describes your responsibilities and any known risks or inconveniences. We encourage you to take your time with your decision and contact us at any time with questions. If you decide to give your child permission to participate, you will be asked to sign and submit this form. You will be provided with a copy for your records.

Invitation to be Part of a Research Study

Your child is being invited to participate in a research study. For your child to participate, they must have witnessed domestic violence and be between the ages of 8 and 12. Participation in this research is completely voluntary.

Important Information about the Research Study

Things you should know:

- The purpose of the study is to explore and understand children's varying degrees of trust during music therapy sessions after witnessing domestic violence in their family to improve quality of future music therapy services. If you choose to allow your child to participate, they will be asked to respond to open-ended questions during an individual interview with the co-researcher after they've completed at least four months of music therapy. They will also be asked to participate in a follow-up meeting to collaborate with this co-researcher to check their interpretations of their responses and create music with their responses from the study. These meetings will take place for approximately 30 to 45 minutes at the Counseling Center.
- There are no foreseeable risks or discomforts from participation in this research. However, as your child will be sharing their experiences of trust and safety within the session and perhaps information about the domestic violence they witnessed, they may experience sadness, discomfort, or embarrassment.
- There will be no direct physical benefits from this study, but your child may experience emotional benefits.
- Taking part in this research project is voluntary. Your child does not have to participate if they don't want to and can stop at any time.

Please take time to read this entire form and ask questions before deciding whether to allow your child to take part in this research project.

What is the Study About and Why are We Doing it?

The purpose of the study is to explore and understand children's varying degrees of trust during music therapy sessions after they have witnessed domestic violence to improve quality of future music therapy services. I define *trust* as an interpersonal experience of confidently believing that someone is safe, reliable, and honest. I believe the results of this study will provide information on how children understand and experience trust during music therapy, and how trusting relationships are developed and maintained with a therapist through a long-term program. The results may provide an understanding about how music therapists might be able to develop more trust and provide safety in the music and in their sessions according to children's needs and past experiences.

What Will Happen if Your Child Takes Part in This Study?

If you agree to allow your child to take part in this study, they will first be asked to participate in an in-person individual interview, which will include open-ended questions of their experiences in relation to trust and safety, after they've completed at least four months of music therapy.
An in-person follow-up meeting will also be conducted where your child will have an opportunity to collaborate with the co-researcher to create a piece of music with their responses from the study, which will also be presented in the final report if given consent. These meetings will take place for approximately 30 to 45 minutes at the Counseling Center and will be videotaped.

How Could Your Child Benefit From This Study?

Although your child will not directly benefit from being in this study, they may experience emotional benefits, such as feelings of empowerment and autonomy as they share their experiences of trust in music therapy and collaborate with the co-researcher to accurately portray and create music with the results. This information will likely benefit others participating in music therapy, as music therapists will gain a better understanding of how trust is developed and maintained by clients after they have witnessed domestic violence. Music therapists will also learn more about what they can do to increase feelings of safety and comfort and minimize trauma responses during sessions with future clients.

What Risks Might Result From Being in This Study?

We don't believe there are any risks from participating in this research. Your child may experience feelings of sadness or loss if they share their stories in relation to the domestic violence they witnessed. They may have feelings of discomfort while answering questions about their experiences with the music therapist who also is the co-researcher and interviewer.

How Will We Protect Your Child's Information?

We will protect the confidentiality of your child's research records by keeping all hand-written documents and notes in a locked filing cabinet, and all typed information, documents, and videos of meetings stored in a password-protected folder on a password-protected computer(s). They will be

transcribed and then destroyed. Interview transcriptions will contain your child's demographic information but not their name. At the conclusion of this study, we may publish the results, but no names will be included in publications. Your child's demographic information may be included but will be combined with the demographic information of other participants to further conceal their identity.

What Will Happen to the Information We Collect About Your Child After the Study is Over?

We will not keep your child's research data to use for future research or other purposes. Your child's name and other information that can directly identify your child will be kept secure and stored separately from the research data collected as part of the project. Research materials will be kept for two years and then destroyed.

What Other Choices does Your Child Have if They Don't Take Part in this Study?

If you choose to not permit your child to participate, there are no alternatives at this time.

Your Child's Participation in this Research is Voluntary

It is completely up to you and your child to decide to be a part of this research study. Participating in this study is voluntary. If you decide to have your child participate in this study now, you both may change your minds and stop at any time. Your child does not have to answer any questions they do not want to answer. If your child decides to withdraw before this study is completed, any data collected during their participation will be destroyed.

Contact Information for the Study Team and Questions about the Research

If you have any questions about this research, you may contact *Susan Hadley* at susan.hadley@sru.edu or *Ashley Doron* at axd1065@sru.edu. We are happy to answer any questions you have about the study, including background and rationale, procedures, and implications.

Contact Information for Questions about Your Child's Rights as a Research Participant

If you have questions about your child's rights as a research participant, or wish to obtain information, ask questions, or discuss any concerns about this study with someone other than the researchers, please contact the following:

Institutional Review Board
Slippery Rock University
104 Maltby, Suite 008
Slippery Rock, PA 16057
Phone: (724)738-4846
Email: irb@sru.edu

Your Consent

By signing this document, you are agreeing to allow your child to be in this study. Make sure you understand what the study is about before you sign. Please print this email attachment, sign, and scan this document and return it via email to the co-researcher, Ashley Doron. We will give you a copy of this document for your records and will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact us using the information provided above.

I have read this consent form and I understand what is being requested of my child as a participant in this study. I freely consent for my child to participate. I have been given satisfactory answers to my questions. The investigator provided me with a copy of this form. I certify that I am at least 18 years of age.

_____
Name of Child (Printed)

_____	_____	_____
Printed Parent/Guardian Name	Signature of Parent/Guardian	Date

By signing below, I indicate that the parent/guardian has read and, to the best of my knowledge, understands the details contained in this document and have been given a copy.

_____	_____	_____
Principal Investigator's Printed Name	Principal Investigator's Signature	Date

Audiotape/Videotape Release Form:

We request the use of audiotape/videotape material of your child as part of our study. We specifically ask your consent to use this material, as we deem proper. Regarding the use of your child's likeness in audiotape/videotape, please check one of the following boxes below:

☐ I do…

☐ I do not…

give unconditional permission for the investigators to utilize audiotapes/videotapes of my child.

_____	_____	_____
Parent/Guardian's Printed Name	Parent/Guardian's Printed Name	Date

Appendix B

Volunteer Assent to Participate in Research Form

Experiences of Trust in Music Therapy: Perspectives of Child Survivors of Domestic Violence

Ashley Doron, MT-BC axd1065@sru.edu (856) 824-0599 Ext. 8619

Susan Hadley, Ph.D., MT-BC susan.hadley@sru.edu (724) 738-2446

We want to tell you about a research study we are doing to see if you want to take part in it. Research is a way to learn more about someone's thoughts and feelings from something they take part in by asking questions.

The name of this study is: Experiences of Trust in Music Therapy: Perspectives of Child Survivors of Domestic Violence.

The researchers are: Dr. Susan Hadley (principal researcher) and myself, Ashley Doron (co-researcher) who will be interacting with you.

It is okay to ask questions about what we are telling you. You can circle or highlight things on this paper you want to know more about. If you don't understand something, just ask us. We want you to ask questions now and anytime you think of them.

We are wanting to learn more about how you understand and experience trust as you participate in music therapy sessions.

You are being asked to be in this research study because we want to hear about the qualities you look for in a therapist to trust them, and what helps and does not help you to feel safe during music therapy sessions.

For you to be in this study, both you and your parent or guardian must agree to you being in it. It is the adult's job to make sure being in this study is okay for you. But it is still up to you if you *want* to do it.

Parents and children say "no" for different reasons. It may be that you would miss other activities. Whatever the reason, it is your decision. You will not be treated any differently if you say "no."

If you decide to be in this research and your parent or guardian says yes, this is what will happen:

- We will start by playing some music together, and then the co-researcher will ask you some questions about trust during your music therapy sessions in one-to-one/individual meetings.
- In the next visit, we will create a song about your responses from this study.
- This research will take two visits that each last about 30 to 45 minutes.
- These visits will be videotaped.

Some of the ways you could be helped are:

- To feel proud of yourself for sharing your experiences.
- To help therapists understand ways to make music and a space that is comforting for other children.

We do not know for sure if being in this study will help you, however, we could also learn about what may help other children feel safe and have trust during music therapy.

There is a chance that during the research you may feel uncomfortable or sad. We will take steps to help you with these feelings or discomforts. And you can stop at any time if you want to. Some of these risks are:

- You may feel tired during the meetings. Short breaks will be provided if necessary.
- Sometimes the questions we ask may make you feel sad, uncomfortable, or embarrassed. If this happens, you can tell us and you do not have to answer any questions you don't want to.

You don't have to be in this study if you don't want to. Nobody will be mad at you. You can say okay now and then change your mind later. Just tell us or your parent/guardian if you want to stop at any time.

Signature:

I have read this form or someone has read it to me. If I did not understand something, I asked the researcher to explain it to me. I can always ask a question about the study if I don't understand something. I will be given a copy of this form.

Please check one box:

- ☐ **YES,** I want to be in this study and I know I can change my mind later.
- ☐ **NO**, I do not want to be in this study.

Child's Name (print legal name): _____

Child's Signature: _____

Date of signature: _____ _____

The following should be completed by the Principal Investigator conducting the assent process if the child agrees to be in the study. Check all that apply.

- ☐ The child is capable of reading and understanding the assent form and has signed above as documentation of assent to take part in this study.
- ☐ The child is not capable of reading the assent form, but the information was verbally explained to him/her. The child signed above as documentation of assent to take part in this study.
- ☐ The child had ample opportunity to have his or her questions answered.

Printed name of Principal Investigator:	
Signature of Principal Investigator:	
Date of signature:	

Audiotape/Videotape Assent Release Form:

We would like to record your voice/video tape you as part of our study. We ask for your permission to do this. We may use this for displays related to our study. For us to record your voice/video tape you, please check one of the following boxes below:

☐ I do…
☐ I do not…

Give permission for the researchers to use my voice recordings/videotapes of me.

_____	_____	_____
Print Child's Name	Child's Signature	Date

Appendix C

Interview Questions

1.) Describe for me what it means to feel trust.

2.) Tell me about a time you felt you could really trust someone.

    a. What makes you really trust someone?

3.) Tell me about a time you felt you couldn't really trust someone.

    a. What makes you not trust someone?

4.) Tell me about the difference between these times.

5.) When you first meet someone, how do you know you can trust them or not?

6.) With all of these things in mind, remember back to when we first met, what were the things you were feeling?

7.) Tell me about what we did in here that made you feel better or more safe (safer/secure).

8.) Was there anything we did that made you feel scared or nervous? Tell me about that.

9.) Do you feel different now than when we first started in terms of trust?

    a. Tell me about that difference.