The Experiences of Women in Substance Use Disorder Treatment Engaging in Parent-Child Music Therapy Groups

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Presented to the

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Abstract

This thematic analysis explores the experiences of women in substance use disorder treatment who have participated in parent-child music therapy groups ("Mommy & Me Music Therapy") and how these groups may contribute to parent-child bonding, parental self-efficacy, and social support among parents. Five women with substance use disorders who resided at the participating facility and engaged in at least six weeks of Mommy & Me Music Therapy groups took part in semi-structured interviews. Interview content was transcribed, analyzed, and coded. Themes that arose include improved parenting skills, parent-child relationship, feelings about self, community support, and outside uses of music. Throughout these themes, participants acknowledged how these groups impacted them in terms of bonding with their child, connecting with other women in the group, and striving to be the best possible parent for their child. Implications from the research include the importance of allowing a space for verbal processing within music therapy and including systems and family-based therapy training in music therapy education.

Keywords: parent-child attachment, family music therapy, parental self-efficacy, substance use disorders

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Introduction

Motivation for the Research

The impetus for this research began when I started a new music therapy position in August 2020, serving as primary therapist for women in a residential substance use disorder facility. The facility serves both single women, in its Halfway House program, as well as pregnant and parenting women in the Family House program and is celebrating its 50th anniversary this year. Substance use disorder treatment programs for pregnant women and women with children are quite rare, and I found this niche offering to be very special and important.

The facility has many services available to the women who live there. Women who have their children in treatment with them at the facility are provided free daycare, so they are able to focus on their treatment during the day and obtain employment. There are also several educational groups focused on parenting that are open to all women with children of certain ages, regardless of whether or not they have their children with them. There are frequently special events for the women and children, such as a yearly petting zoo, holiday gifts and activities, and monthly parent-child events. When I started in my role as music therapist, I was approached by the director of social services and asked about my comfort level with running a weekly group for the women and children, which would be called “Mommy & Me Music Therapy”. I enthusiastically agreed, as many of the mothers had made comments during music therapy groups that I ran for the adults about how much their children would enjoy using the instruments and singing.

Wanting to provide the best group possible for the moms and their children, I started to collect any resources that I could find on parent-child music therapy groups. I was disappointed

to find that any of the specialized trainings that exist for running these kinds of groups cost a significant amount of money, and I was also disappointed at the lack of music therapy literature available. I was fortunate that a portion of my undergraduate music therapy internship was focused on young children and family engagement and that I had begun the Master of Music Therapy program at Slippery Rock University, which provided education on families as a system in music therapy. Using the knowledge that I had and the resources I could find, I created a basic structure for my groups and began to run them.

Each session of Mommy & Me Music Therapy begins with a "hello" song, which welcomes each child and parent by name and allows for independent self-expression using developmentally appropriate instruments. From there, familiar children's songs are sung with guitar accompaniment that focus on a variety of goals, such as movement to music, choice-making, vocalization and speech, and with an over-arching goal of creating moments for bonding and attachment between the women and their children. Throughout the group, the parents will engage in connection as well, through discussion of their challenges, needs, and successes. The group concludes with a "goodbye" and "cleanup" song to support the transition out of the space and to the next portion of the day. The groups meet for an hour each week in the facility's "music room" which is a bright space with many windows and with a wide variety of instruments available, including hand drums, egg shakers and maracas, xylophones, keyboard, boomwhackers, cabasa, and more. I began to receive positive feedback from the women, who would call the group the best part of their week.

After about a year of running this group, the county drug and alcohol commission observed Mommy & Me Music Therapy during a site visit and requested that pre- and post-test surveys be conducted with women engaging in the groups. These brief surveys ask about

feelings of support as a parent, feelings of bonding with one's child, and use of music with one's child and use a rating scale of 1-10. Women who completed both the pre- and post-test consistently demonstrated an increase in their self-reported feelings of parental support, bonding, and comfortability using music with their children. I therefore wondered what it was about these groups that was contributing to these positive changes, and I wanted to find out from the women who participate in them each week.

Positioning

I am a white, non-disabled, neurotypical, cisgender, middle class, bisexual woman. I do not have a substance use disorder, and I am not a parent at this time, both aspects of my identity that are frequently asked about by the women that I work with. Many of my intersecting identities are privileged in ways that the women in this study are not, and I strive at all times to defer to their knowledge and expertise on their lives and especially on their relationships and interactions with their children.

Review of the Literature

Attachment Theory

Developed in the 1970s by Mary Ainsworth and John Bowlby, attachment theory refers to the security of the relationship between a child and their primary caregiver. This first relationship is incredibly important, as "much of a child's social, emotional, and cognitive development depends upon the quality of this attachment relationship" (Stubbs, 2018, p. 72). Ainsworth described three possible attachment styles: secure, anxious-avoidant, and anxious-resistant. Later, attachment researcher Mary Main added another anxious attachment style, which she termed disorganized-disoriented (Flaherty & Sadler, 2011, p. 4). Infants give cues, such as "crying, cooing, grasping, and smiling" (Teggelove, 2017, p. 158) which are understood as innate attachment behaviors. Healthy attachment patterns are developed based on a parent's

"emotional availability, responsiveness, and sensitivity" (Teggelove, 2017, p. 158). Secure attachment "is developed when the relationship between child and caregiver is "good enough" to enable a feeling of safety and the possibility to explore the world" (Tuomi, 2017, p. 176). The caregiver responds consistently to the child's cues in a way that is both timely and sensitive, giving the child a feeling of security, safety, and eventually confidence to explore their world (Teggelove, 2017; Tuomi, 2017). When a parent responds inconsistently, unemotionally, or insensitively to a child's attachment behaviors, it is likely that the child will develop an insecure or anxious attachment style. Insecure attachment to the primary caregiver can have a lasting impact on a child's development and lifelong mental and behavioral health. There are many possible reasons a caregiver may be less responsive to a child's attachment behaviors. This could include the parent's own attachment style from childhood, trauma history, mental or physical health issues, and certainly active substance use. Individuals who become dependent on substances often have a trauma history or other negative emotional experiences that substance use can temporarily alleviate, so parents with substance use disorders (SUDs) may be additionally predisposed to poorer attachment outcomes with their children.

A potential risk factor that may further complicate attachment between a parent with a SUD and their child is the possible presence of neonatal abstinence syndrome (NAS) or neonatal opioid withdrawal syndrome (NOWS). Both NAS and NOWS can occur when a child is exposed to substances perinatally, though not every child born to a substance dependent parent will experience one of these conditions. Symptoms of NAS and NOWS include "difficulty feeding, irritability, high-pitched cry, problems with calming/settling, and difficulty sleeping which may last from days to weeks" (Denten et al., 2015, p.1). Typical treatment begins in the neonatal intensive care unit (NICU) with many hospitals mandating a slightly longer hospital admission

for monitoring and the possibility of medication administration to ease withdrawal symptoms (Moreland et al., 2019, p. 427). This initial separation of parent and child can decrease valuable time for initial bonding and attachment through skin-to-skin contact and feeding, which can have a lasting effect on the parent-child bond. Additionally, "these infant behaviors can be challenging and lead to increased stress" (Moreland et al., 2019, p. 427). These stressors may be particularly challenging for parents with SUDs to manage and respond to in a manner that supports a healthy attachment with their child.

Parenting is a stressful and challenging experience for nearly everyone, but there are additional barriers and stressors for pregnant and parenting women with substance use disorders. The literature indicates that parents with SUDs report daily stress, parenting-related stressors due to engaging in substance use treatment, and substance use-specific stressors, all of which parents must cope with and which can lead to difficulties in responding consistently and effectively to their child. Additionally, because of chemical changes in the brain resulting from substance use, for women with SUDs who are parenting "behaviors such as caregiving that are ordinarily reinforced with intense experiences of pleasure are now experienced as neutral or stressful" (Suchman & DeCoste, 2018, p. 17). Negative reactions to one's child and decreased motivation to respond can result in inconsistent responses which can translate to insecure attachment styles in the child. Positively, many parents surveyed in the literature did identify their children as a main source of motivation to remain sober (Moreland et al., 2019; Panchanadeswaran, S., & Jayasundara, D., 2012). This indicates a desire to maintain their identity as parents and to develop a parent-child relationship rooted in secure attachment. There is therefore an important role for substance use treatment facilities to support parents in their recovery through supporting parent-child (re)unification and through providing parenting interventions and supports.

A final potential barrier to secure attachment for substance using parents is that of being physically absent from the child or children. This may occur when the parent is actively using substances, as well as in early recovery if they choose to enter a rehab or psychiatric treatment facility, most of which do not allow children at the inpatient level of care. Because "attachment disruptions appear to have consequences for functioning and development that are not confined to the domain of close personal relationships, including behavioral maladjustment and cognitive development" (Schuengel et al., 2009, p. 2), programs that allow for parents to reside with their children are incredibly important, though they are considered niche and are quite rare at this time. In removing the barrier of physical separation from their child, we can help parents with SUDs and their children have the best chance at optimal outcomes.

Parenting and Substance Use Disorder Treatment

Substance use disorders are a group of diagnoses in the DSM-5, the essential feature of which "is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems" (American Psychiatric Association, 2013, p. 483). According to SAMHSA, the Substance Abuse and Mental Health Services Administration, 5.6% of Americans over the age of 18 have a substance use disorder, which includes 34.3 million American women (SAMHSA, 2020). Treatment for SUDs commonly starts with a short (3-7 day) stay in a detoxification unit, followed by inpatient rehabilitation, which typically lasts between 28 and 60 days, depending on a person's insurance and progress. Inpatient rehabs include daily group therapy, as well as individual and family therapy as appropriate. From there, an individual may transition to a halfway house or similar residential program, which is funded by insurance providers and features additional longer-term treatment (90+ days), or a recovery house, which is paid for by

the individual and is less structured. They may also return to their home or to reside with family or friends and have the option to attend intensive outpatient or outpatient treatment programs. In all of the above settings, recovery is prioritized and celebrated, and focus tends to be on relapse prevention and the development of a healthy sober support network, in addition to identifying and treating underlying trauma and mental health needs. Many individuals also choose to participate in 12-step groups, which are mutual-help groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Celebrate Recovery, or Recovery Dharma within a community. While there is still much stigma surrounding substance use and addiction, there are also fortunately large recovery-based communities available almost anywhere.

Music therapy has been found to be a supplementary treatment modality for individuals in SUD treatment settings. A systematic review of studies on music therapy and music-based interventions with individuals in treatment indicated that music therapy research has demonstrated the efficacy of music therapy in addressing a variety of aspects of SUD treatment, including depression, motivation, withdrawal and craving, and coping skills (Hohman et al., 2017). These research studies comprised a wide variety of treatment settings, involved men-only, women-only, and mixed gender groups, and utilized a wide variety of music therapy and music-based interventions. Gardstrom et al. (2017) engaged in qualitative research to understand women's perception of music therapy's usefulness in their recovery treatment. The researchers found meaningful themes from study participants, including the instillation of hope, group cohesion, universality, and catharsis, that indicated why women found music therapy groups to be a helpful and efficacious part of their treatment. Literature is also available regarding group music therapy with the children of women in SUD treatment (Pasiali et al., 2022), which indicated that the children involved demonstrated improved peer relationships and self-

management, but the music therapy literature does not include group music therapy with parents in SUD treatment and their children together, a gap in the literature that led to this study.

We have all heard the saying "it takes a village to raise a child". This may be doubly true for women with substance use disorders who are parenting, as, "often, parenting while abstinent is uncharted territory for mothers (and their children), and everyone in the family needs adequate support" (Chou et al., 2020, p. 1115). For women in residential substance use treatment, their 'village' may be comprised of external supports, such as their "parents, partners, and children" (Panchanadeswaran & Jayasundara, 2012, p. 982), as well as "treatment staff and other mothers" (Chou et al., 2020, p. 1121) within the treatment facility. In a popular TED Talk, Johann Hari (2015) draws the conclusion that "the opposite of addiction is not sobriety, it is human connection." This sentiment is echoed in the SUD literature, which reflects the importance of support and connection amongst mothers in SUD recovery and treatment.

Several studies which incorporated the personal perspectives of pregnant and parenting women in SUD treatment indicate how critical the development of supportive relationships is for women in recovery (Chou et al., 2018; Chou et al., 2020; Panchanadeswaran & Jayasundara, 2012). As Chou et al. (2020) states, "forming peer relationships may reduce the risk of isolation as women recognize similar struggles among one another—as mothers with SUDs—while also providing a sense of belonging and support for one another" (p. 1121). The women in the above studies describe various ways in which they developed rapport and a sense of community with each other, which included parenting groups and classes, engaging in group parent-child activities, as well as interacting with other parents in unstructured settings. Women with SUDs often enter treatment lacking natural supports, so it is incredibly important that pregnant and

parenting women in SUD treatment can develop a recovery support network and receive support around their parenting abilities.

There are a range of existing programs and interventions that are designed to support and enhance parent-child attachment. One such evidence-based intervention is Mothering from the Inside Out (MIO), "a 12-session individual parenting therapy for mothers with histories of substance abuse that was developed to address the psychological deficits associated with addiction" (Suchman et al., 2020). MIO focuses on the parent's ability to manage the strong emotions that arise when parenting in both oneself and one's child. A benefit of MIO is that clinical addiction counselors can be trained to deliver the intervention, making it more broadly available for various treatment locations. Multiple randomized controlled trials have been conducted using MIO which have found a clinically significant increase in participating mothers' reflective functioning and higher levels of mother-child engagement than mothers participating in a psychoeducative intervention (Lowell et al., 2023; Suchman et al, 2016; Suchman et al, 2017; Suchman et al., 2020). Significantly, Suchman et al. (2017) found that mothers engaging in MIO had a lower rate of relapse on heroin than mothers in the parent education group.

Another broadly applicable parenting intervention is the Circle of Security-Parenting group intervention (COS-P). COS-P is an attachment-based intervention that seeks to address families that are designated as "at-risk" to enhance "caregivers' sensitivity, while also attending to parents' understanding of their own growing up experiences and how these may influence their current parenting behavior" (Kim & Dai, 2018, p. 1324). Benefits of this program include its presentation in a group format, so that more families can participate at one time, and the fact that it is video-based and overall quite simple to implement. A multi-site non-randomized controlled trial found that parents who completed the COS-P intervention showed "improved

parental mentalizing and parenting self-efficacy" (Maxwell et al., 2021). The intervention was also effective in reducing parents' negative feelings about their child and reducing self-reported symptoms of post-partum depression in participating mothers.

Fostering Mindful Attachment (FMA) is a final specific attachment intervention that incorporates infant massage with mindfulness and parent education. FMA is targeted specifically for substance-using parents to encourage mindful attending to attachment cues from infants (Clausen et al., 2012). A main limitation of FMA is the need for advanced training by the facilitator in attachment, infant behavior, and infant massage, which may make this intervention less likely to be utilized by substance use treatment programs. Participants in the pilot study reported "lower parenting stress after completion of the intervention" (Clausen et al., 2012, p. 383).

Each of the above interventions specifically target the goal of enhancing parent-child attachment through dyadic parent-child interventions, demonstrating the need for various creative ways in which to address this goal with the population of parents with SUDs. An additional benefit of these interventions is also the support the parent will receive from the facilitator, adding another member to their 'village' who is able to specifically support them through parenting stresses. This sense of support and assistance in having positive parent-child interactions can lead to an "enhanced sense of competency" (Chou et al., 2020, p. 1125) as a parent, which in turn can reinforce the parent's motivation for recovery, leading to positive outcomes for the family as a whole.

In addition to the importance of enhanced support networks for pregnant and parenting women with SUDs, it is of equal importance that feelings of self-efficacy as a parent are developed and supported in this population. Self-efficacy refers to a person's belief in their own

ability to achieve in a certain area, and when "applied to parenting, self-efficacy refers specifically to the sense of feeling capable in the parenting role, a parent who believes that his or her efforts to soothe or discipline his or her child will result in successful outcomes" (Brown et al., 2016, p. 228). Parental self-efficacy is an important aspect of parenting, as "studies show that mothers who feel a high sense of self-efficacy in their functioning as a parent are likely to successfully establish a warm and harmonious relationship with their infants" (Calderon-Noy & Galboa, 2021, p. 8562). This demonstrates the importance of supporting parents to feel efficacious in their parenting so that they are more naturally inclined to be responsive and engaged with their children. Additionally, qualitative research with women in residential substance use treatment indicates that "higher levels of social support and family empowerment were related to increased parenting self-efficacy" (Chou et al., 2018, p. 2253), suggesting that "improving parenting support may improve both parenting efficacy and parenting behavior" (Brown et al., 2016, p. 234). Parents with higher levels of parental self-efficacy are likely to respond to their children in ways that effectively foster secure attachment between themselves and their children (Kern et al., 2004).

Treatment providers for women with SUDs who are pregnant and parenting can help to create the best possible outcomes in attachment for parents and children by fostering both a supportive environment and parental self-efficacy. Parents with SUDs may experience feelings of guilt and shame due to a societal stigma surrounding addiction, which may lead to increased isolation for the parent. Therefore, "a critical part of recovery is to assist women to see themselves as separate from their addiction" (Chou et al., 2020, p. 1126), which the treatment team can instill and model for the women in treatment through any number of parenting interventions and systems. Parent-child music therapy may be one approach to doing so.

Communicative Musicality

There are several concepts which help to explain the efficacy of parent-child music therapy and how it may support positive bonding and attachment between young children and their caregivers. One such concept is communicative musicality. This term was coined by Stephen Malloch, an Australian music therapist, and Colwyn Trevarthen, an English psychologist (Klempe, 2009) and defined "as an innate ability of a mother and child to engage in meaningful bidirectional musical interactions" (Pasiali, 2012, p. 329). This definition operates under the assumption that communication is innately musical and "focuses on the role of music as a necessary condition for communicative behavior in every human being" (Klempe, 2009, p. 260-261). Beyond musicality, this concept also "is a theory of how human vitality acts, regulates itself, forms intimate relationships, and grows in friendships" (Trevarthen, 2008, p. 37), which points to the great value of parent-child interactions in supporting all aspects of a child's social and emotional development.

There are clearly many benefits of engaging in musical communication and bidirectional interactions for both the parent and the child. One such benefit in infants is "enhanced smiling" (Haslbeck, 2017, p. 37) during musical interactions, which can lead to parents feeling "more fulfilled and motivated to interact with the infant, as opposed to situations in which the infant is aroused and distressed" (Haslbeck, 2017, p. 37). While the case vignette being described by Haslbeck involved premature infants in the NICU, the benefits of communicative musicality between parents and children can certainly also be applied to parents with SUDs and their children. Communicative musicality is incredibly important for many reasons, including music being "essential for early childhood development" (Alessandroni et al., 2017, p. 1555), as well as by allowing the parent and child to "communicate and co-regulate themselves psychologically

through musically organized signs" (Alessandroni et al., 2017, p. 1555). For children, engaging in positive, attuned, musical interactions with their parent, additional benefits include an enhanced "ability to modulate feeling states … and to express a range of emotions" (Malloch et al., 2012, p. 387). Parents who are less comfortable engaging in musical interactions with their child may be educated on the benefits and given basic guidance in doing so by a music therapist, and this "education and support may help those mothers who lack self-efficacy and provide opportunities in which to develop it" (Malloch et al., 2012, p. 395). All of these elements of interaction and self-efficacy can lead to better attachment outcomes through consistent, positive responses from the parent to the child.

Parents may also interact musically through infant-directed speech, also known as "motherese" or "parentese". Infant-directed speech "has its own particular articulation, intonation, punctuation, pauses, repeated words, … and musical prosodic aspects" (Suvini et al., 2017, p. 153). Parents tend to naturally speak to their infant children with a higher pitch, slower pace, more repetitively, and in a much simpler form than they would speak to older children or other adults. Likewise, infants "produce rich, music-like vocal utterances which delight their parents" (Edwards, 2014, p. 39) and which encourage bidirectional engagement in infant-directed speech from the parent.

Another crucial component of parent-child interactions that may be enhanced through music therapy is affect attunement. Affect attunement, a concept identified by Daniel Stern, "can be described as a matching of mental states" (Tuomi, 2017, p. 178) between a parent and child. This allows for emotional matching and regulation in the child and an understanding from the parent that both they and their child are having simultaneous unique experiences (Stern, 2010, p. 98). In attuned interactions, "the parent lets the infant know that his or her feelings are

recognized, and that the parents feel the same way" (Jacobsen, 2017, p. 206). Affect attunement is therefore closely related to attachment theory, as this consistent emotional response to a child's emotional cues is a crucial component of a secure attachment style. Musical interactions between parent and child naturally allow for emotional matching at a nonverbal level (Jacobsen, 2017). Parent-child music therapy can provide a parent who is less attuned with their child with opportunities to engage and attune through musical play, which may include matching, imitation, and synchronicity (Stern, 2010). With time, these musical experiences of emotional matching and affect attunement can translate and generalize to daily interactions between parent and child.

Parent-Child and Family Music Therapy

While parent-child and family music therapy is still a developing area in the music therapy literature, there are existing studies which indicate the value of music therapy in family work (Creighton et al., 2013; Guerriero & Blank, 2018; Ettenberger et al., 2017; Jacobsen et al., 2014; Reilly et al., 2018; Teggelove et al., 2019). Overall, these studies do not explicitly name approaches or interventions used by the music therapist, demonstrating that what matters is the family's engagement in music therapy, rather than what exactly occurs in the music therapy session.

Several studies have focused on parent-child work in music therapy. A randomized controlled trial conducted by Jacobsen, McKinney, and Holck (2014) found that participation in a dyadic music therapy intervention demonstrated significantly improved parent-child nonverbal communication and parenting competencies in families in which a child had experienced emotional neglect. The parents in this study also reported perceiving their children's mood as less stressful than the control group. As stated above, parents with SUDs tend to experience more

stress from their children's negative mood states than do non-substance using parents, so the results of this study are particularly applicable and relevant to parents in this population.

A qualitative study by Creighton et al. (2013) found that mothers who engaged in dyadic singing with their infant had positive attachment outcomes for the mother-child dyad "by creating a variety of positive emotional and mental states" (p. 27). The researchers point to a cycle that occurs when a mother is singing in an infant-directed manner with her child. Through singing, the mother may be calmed and have positive experiences and experience herself as a good mother, which leads to her being better able to calm her baby. Having a happy and calm child leads back to the feelings of calm and self-efficacy in the mother. Reilly et al. (2018) found that women with severe perinatal mental illness who sang with their babies for one hour "reported feeling significantly more relaxed, more cheerful, and more clear-headed than they did just before the session began" (p. 124). Music, and specifically singing with one's child is a simple, accessible, and effective way to boost one's mood. This is particularly important for mothers of young children, as infants are attuned to their primary caregiver's mood and benefit developmentally from their parent demonstrating a consistently calm emotional presence.

In addition to improving a parent's emotional state, other goals for parent-child music therapy may include improving parental responsiveness (Teggelove et al., 2019) and increasing parental confidence and competence in using music to support their child's development (Guerriero & Blank, 2018). Because music-making can be an intimate and vulnerable means of interaction, parents may benefit from support and encouragement, as well as education, regarding the impact and importance of engaging in musical interactions with their children. Palazzi et al. (2017) refer to this process as "empowerment of the mother" and in their case study they found that positive outcomes for the mother after engaging in a music therapy intervention

with her premature infant were a sense of increased relaxation, autonomy, and feeling of competence as a mother (p. 6-7). These feelings are then generalized or transferred outside of the music therapy session environment to other interactions occurring between parent and child, thereby enhancing the parent's feelings of self-efficacy in both parenting and the use of music with their child and providing additional opportunities for positive, attuned, and musical interactions.

In addition to parent-child work, there are various studies focused on "family-based" and "family-centered" music therapy. According to Pasiali (2013) family-based music therapy refers to clinical work in which "the primary therapeutic focus is facilitation of interaction and communication between family members aiming to strengthen relationships" (p. 250). Rather than the focus being on one identified member of the family, the entire family is the focus, with a goal of enhancing family relationships as a whole. Family-based music therapy "addresses family challenges and needs while tapping into family resources and strengths" (Nemesh, 2017, p. 168). This systems perspective of families engaging in music therapy can allow for music therapists to address a wide variety of therapeutic goals which can benefit every member of the family. According to Shoemark and Dearn (2008), the goals of family-centered music therapy are family "collaboration, empowerment, and education" (p. 4). Such resource-oriented and strengths-based approaches to treatment seem to be common in the literature on music therapy with families.

A mixed methods study in Colombia which studied family-centered music therapy with parents and children in a hospital NICU found themes of parental well-being, bonding, and fostering child development in its qualitative results (Ettenberger et al., 2017). Ettenberger et al. (2017) point to the role of music therapist as "facilitator, who works *with* the parents" (p. 13),

rather than that of an all-knowing expert who is conducting music therapy sessions *for* their child. In engaging the entire family in the music therapy interventions, the parents can take on the role of expert in caring for their child and feel supported in their parenting practices during a stressful time in the life of their family. Jacobsen and Thompson (2017) recommend that music therapists working with families "adopt an "ecological intention" where they strive to support and/or guide the family to build their capacity, resources, and self-efficacy to be able to find their own solutions to support their health and wellbeing well into the future" (p. 321). While traditional models of service delivery tend to focus on an identified 'most vulnerable' member of the family, taking a systems perspective can allow for the entire family to be fully engaged and supported by the music therapy intervention.

As stated earlier, much of the music therapy literature on work with families does not describe specific interventions that are used. However, there are exceptions to this statement, as there are writings on specific music therapy programs that are somewhat more prescriptive. Two examples that are dominant in the music therapy literature are Sing&Grow and Music Together within Therapy. Sing&Grow is an Australian music therapy program in which providers work with families with a variety of needs. Sing&Grow "is grounded in theories of attachment and self-efficacy" (Teggelove, 2017, p. 159), and has indicated positive parenting outcomes in a variety of studies in the music therapy literature. Sing&Grow group music therapy sessions follow a session structure that includes a greeting song, action songs, hand percussion, dancing, drumming, movement with props, cuddle time, and a farewell song (Teggelove, 2017). On the other hand, providers who offer Music Together Within Therapy "work within their scope of practice to craft interventions that address the assessed needs of their clients" (Guerriero & Blank, 2018, p. 4). These interventions may include "experiences of rhythm, singing, rhythm and

tonal pattern recognition and repetition, instrument play, chants, and movement to music" (Guerriero & Blank, 2018, p. 3) with select songs provided by the Music Together curriculum. Major strengths of these programs are the structure and ideas that are provided, as well as the evidence base that demonstrates their efficacy, but a drawback is the cost to become certified to provide either of these programs. This financial barrier to specific certification is one of the reasons I was drawn to conduct more research on best practices for parent-child music therapy service delivery outside of these particular programs.

Purpose Statement

As a music therapist working with parenting women with substance use disorders and their children, my intention is to provide the most effective services possible. The current music therapy literature regarding this specific population is quite limited, and this study aimed to add to the research base regarding enhancing parent-child attachment through music therapy groups, as well as developing parental self-efficacy, and support for parenting women with SUDs. Jacobsen and Thompson (2017) stated that "working with families in music therapy is still evolving, and we need to know more about the experiences of all family members, as well as how music therapy works" (p. 326). The purpose of the present research study was to understand how the experiences of women in substance use disorder treatment engaging in parent-child music therapy groups contribute to enhancing bonding and attachment between the parent and child. The study aimed to give voice to women in substance use disorder treatment to share their experiences and perceptions of a parent-child music therapy group program. The research questions included: What aspects of group parent-child music therapy sessions, if any, contribute to an increased sense of parent-child bonding and attachment? How might these groups allow for

the development of social support among mothers in the group and an increased sense of parental self-efficacy?

Method

Theoretical Framework

This study is grounded in a constructionist knowledge framework (Matney, 2019). Constructionist research is rooted in the ontological understanding "that reality and truth are multiple human constructions rather than objective absolutes" (Wheeler & Bruscia, 2016, p. 41). Epistemologically, the constructionist framework posits 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. 41). Other tenets of constructionist research include: a focus on subjective human experience, a goal of understanding how humans make meaning, naturalistic data collection methods, reflexivity of the researcher, and contextualization of the results (Wheeler, 2016).

Research Methodology

Thematic analysis refers to a qualitative research methodology that is flexible and often applied to narrative research strategies. This method of data analysis "entails searching across a data set to identify, analyze, and report repeated patterns" (Kiger & Varpio, 2020, p. 2). Data sources for thematic analysis are most often semi-structured interviews and focus group research, and "when thematic analysis is used in narrative research, it is more often focused on the content of participant stories than on the manner of telling" (Hoskyns, 2016, p. 1358). The process of thematic analysis involves familiarizing oneself with the data, generating an initial set of codes, identifying themes across the codes, reviewing themes, defining and naming themes, and producing the final report (Hoskyns, 2016; Kiger & Varpio, 2020).

Rationale for thematic analysis. Thematic analysis was chosen to address the research questions in this study because of its flexibility, accessibility for novice researchers (Kiger & Varpio, 2020), and its suitability for "seeking to understand a set of experiences, thoughts, or behaviors across a data set" (Kiger & Varpio, 2020, p. 4). Thematic analysis was also chosen due to its focus on phenomena and its goal of understanding experiences across a data set, as well as the potential it offers researchers "to engage in emancipatory investigations that value the voices of oppressed populations" (Kiger & Varpio, 2020, p. 2), as the women with SUDs in this study have previously been marginalized and disempowered in many areas of their lives.

Data Collection Procedures

Recruitment Procedures

In order to participate in this study, the women involved had to have participated in at least six sessions of Mommy & Me Music Therapy during the course of their treatment at the participating facility. This facility provides services for women with SUDs. Mommy & Me Music Therapy meets weekly and is an assigned group for women with children at the facility. This group is an opportunity for the parenting women to pick their children up early from daycare and engage in musical interactions and play with their child, while also interacting with other parents. The number of participants in the group varies from week to week and may be as few as two families to as many as five parent-child dyads. The ages of the participating children may also vary widely, from as young as 1 month of age to as old as 5-7 years of age. Based on these different presentations, the group activities also vary from week to week to best meet the needs and developmental levels of the families present. The stated goals of the group are to promote positive parent-child interaction through music, allow the women to develop support

networks with other mothers, and to provide musical skills that can be generalized to use with their children outside of the group setting.

Pre-interview Procedures

Women who met the six-session requirement of participation in the group were then verbally asked if they were interested in engaging in an interview about their experience in the group. I met individually with each woman who agreed in my office to review the IRB-approved informed consent form and audio recording release form (see Appendix A) and to answer any questions they had. After this, a time was scheduled for the interview to occur that aligned with their treatment and work schedules, as well as my own availability. This was therefore a convenience sample, as several women who were interested in the study and who met the six-session criteria were unable to participate due to time constraints and scheduling issues.

Participant Demographics

The study took place in a women's residential substance use disorder treatment facility located in a suburb of a large Mid-Atlantic city in the United States. The women in this study were all residing in the "Family House" program, which requires that they have at least one child, under the age of 10, in their care for at least 50% of the time. To receive treatment at this facility, women must have at least one substance use disorder diagnosis. Additionally, all clients at the facility are considered "low income" and must have Medicaid insurance to fund treatment at this level of care. All participants in this study identify as cisgender women. See Table 1 for additional demographic information.

Table 1

Participant Demographics

Pseudonym	*Race*	*Age*	*Sexuality*	*Age of Child*
Kelsey	White	29	Pansexual	9 months

Maya	Native American	31	Heterosexual	2 years
Michelle	Multi-Racial	35	Bisexual	5 months
Millie	White	35	Heterosexual	4 months
Rachel	White	38	Pansexual	4 years

Interview procedures

Each interview took place in my private office within the facility. In an attempt to make the interviews as comfortable as possible for participants, fidget toys were provided, and several of the women can be heard commenting on them and engaging with them during the interview. Interviews were audio recorded using the Protect+ application on my laptop and then transcribed verbatim using Transcribe by Wreally. The interviews were semi-structured and followed an outline of questions to be asked (see Appendix B), while still allowing for the participants to share organically about thoughts regarding Mommy & Me Music Therapy, as well as parenting in general, that arose for them throughout the course of the interview. Following each interview, I journaled about my impressions and personal reflections in an effort to cultivate reflexivity.

Ethical considerations

This research protocol 2022-068-56-B was approved by the SRU IRB on May 31, 2022. Due to the nature of the facility and my role there, there were multiple ethical considerations that were attended to throughout the course of data collection. The primary concern was the dual relationship I had as both music therapist and researcher. While a benefit of this was the rapport I was able to develop with the participants through the groups and my daily interactions with them and their children as a staff-person, there was the possibility of individuals feeling obligated or coerced to participate in the study. Participants were made aware that they could decline participation in the study without this affecting their participation in Mommy & Me Music Therapy groups or any other aspect of their treatment. Due to the possibly sensitive nature of discussing parenting and separation from their children, participants were also made aware that

they could speak with their primary therapist at the facility or the facility's Clinical Director if they did experience any emotions due to the interviews. Additional ethical concerns include maintaining participant confidentiality, which was achieved through assigning each individual a pseudonym, which they were able to choose. The pseudonym was affixed to each audio recording and transcription, and transcriptions were saved to a password-protected folder on my personal computer. The audio recordings were then deleted, while the transcripts will be stored for two years before being deleted.

Data Analysis and Interpretation Procedures

I began the analysis process by reading and re-reading each transcript "in order to gain more and more familiarity with the texts, a process that opens up new possibilities of recognizing something missed, something anew" (Hadley & Edwards, 2016). In doing so, I also attempted to engage in reflexivity through journaling regarding my own feelings and memories of each participant's participation in Mommy & Me Music Therapy group with me. The transcripts were uploaded into Atlas.ti, a qualitative data coding software, which was utilized to highlight significant quotes and emerging codes and themes. Through additional re-readings of the transcripts and additional coding, as well as consultation with my advisor, relationships between codes were identified, and themes and sub-themes were created and solidified.

Member checking. Following the final identification of all themes and sub-themes, the findings were sent to each research participant for member checking. Four of the five participants responded and confirmed that my interpretations of their narratives were true to their original intentions.

Findings

The purpose of this study was to develop a deeper understanding of the experiences of women with substance use disorders engaging in parent-child music therapy. All five of the participants indicated in pre- and post-test questionnaires that they felt an increased bond with their child, used more music with their child following participation in the group, and felt more supported as a mother. Semi-structured interviews were used to explore what the group experience was like, including specific experiences of music-making with their child as well as interacting with the other parents, skills that they have noticed an improvement in, how they notice the bond with their child manifest outside of group, and the degree of self-efficacy they feel as a parent.

Five themes with 23 sub-themes emerged from the data. The five main themes were (a) improving parenting skills, (b) parent-child relationship, (c) feelings about self, (d) community support, and (e) outside uses of music. Each theme and sub-theme will be explored in detail in this section, with direct narrative quotes from the participants used to enhance the richness of detail. See Table 2 for a preview of the themes and sub-themes.

Table 2

Preview of Themes

Theme a: Improved Parenting Skills
Sub-Theme 1: Acting as a role model
Sub-Theme 2: Openness to growth
Sub-Theme 3: Change in perspective
Sub-Theme 4: Improved patience
Sub-Theme 5: Seeing child's progress
Sub-Theme 6: Taking child's perspective
Theme b: Parent-Child Relationship
Sub-Theme 1: Parent-child separation
Sub-Theme 2: Goals for child

Sub-Theme 3: Bonding
Sub-Theme 4: Having fun
Theme c: Feelings About Self
Sub-Theme 1: No perfect parent
Sub-Theme 2: Feeling overwhelmed
Sub-Theme 3: Parental self-doubt
Sub-Theme 4: Parental self-efficacy
Theme d: Community Support
Sub-Theme 1: Advice from other moms
Sub-Theme 2: Encouragement from other moms
Sub-Theme 3: Sense of community
Theme e: Outside Uses of Music
Sub-Theme 1: Clean-up song
Sub-Theme 2: Music for bath time
Sub-Theme 3: Music for soothing
Sub-Theme 4: Music for sleep
Sub-Theme 5: Music for daily activities
Sub-Theme 6: Music for self-expression

Improved Parenting Skills

This theme and its sub-themes were endorsed by the participants, the number of which is represented in parentheses. The six sub-themes in this category included: acting as a role model (2), openness to growth (2), change in perspective (4), improved patience (5), seeing child's progress (3), and taking child's perspective (4).

Acting as a Role Model. Two of the participants described opportunities in which they were able to "show" and "guide" (Maya) their child during the group, as well as outside of the group. This was highlighted by several participants as something important to them and a priority as a parent. It also seemed to contribute to a feeling of confidence in oneself as a parent. Maya stated that this ability to model behaviors translated to a sense of calm for both herself and

her child, commenting: “I’ve noticed, when I stay calm, and I am like the stable adult, I can handle the situation, and [child’s name] knows that, like, I’m the mom that she needs, and she can stay calm as well.”

Openness to Growth. Two women in the study discussed how remaining open to learning new skills and being “adaptable” (Kelsey) has contributed to their abilities as a parent. Participants shared that being open to learning and gaining perspective ultimately allowed them to be more present with their child, put their child’s needs before their own, and be the best parent possible for their child. Michelle shared that: “Before, I thought that being a mom was instinctual…you just had a baby and knew what to do. I was so close-minded about learning new stuff. And now that…I’m remaining teachable, you know, I just feel like I can give her so much more of myself and just give her a better version of myself too.”

Change in Perspective. Participants were able to notice the ways in which their perspectives on parenting have shifted. This included realizations about their responses to and connection with their child, putting their child’s needs ahead of their own, and being able to take a broader look at the change in relationship with their child and at the changes within themselves over the six weeks they were in both Mommy and Me Music Therapy and the substance use treatment program as a whole. Millie spoke to her ability to tend to her child’s needs when sick and her perspective on doing so, stating: “I now keep reminding myself that I'm creating a connection and like a bond with him, that he has more needs at that time, that soothing, that love. And it takes the time and energy really, so whenever he cries, even whenever I'm not wanting to pick him up…I still take that time to connect.”

Improved Patience. A common way in which the participants identified their improved parenting abilities was through an improvement in the patience they were able to exercise with

their child. Participants spoke to both their ability to be patient and how this has improved "with age and experience" (Michelle), as well as the importance of learning to be more patient and the need to be aware of one's impatience when it arises with their child. Rachel commented that she needs to "check herself in her older age," as she finds herself less patient with her son than she would like to be. Maya commented that it is important to tend to her daughter's needs and "not get frustrated with her."

Seeing Child's Progress. Participants spoke about being able to observe their child's progress through the course of the group as some of their favorite aspects of being in the group. Several comments were made regarding seeing their children hit developmental milestones and being able to track their child's progress through their involvement with the instruments in the group, as well as being able to compare their child with other children in the group and see what they have to look forward to as their child continues to grow. Kelsey's daughter has a developmental disability, and when asked about her favorite memory from the group, Kelsey stated: "being able to watch her progress, because she does have her disability, and you know being able to see her reach certain milestones during the group, like being able to hold the shaker on her own, and then progress to sitting up was very rewarding."

Taking Child's Perspective. Several participants indicated their ability to take their child's perspective into consideration both in and outside of group. The ability to do so gave participants insight into their child's feelings about them, their relationship, and the experiences that they had together. Maya shared how this realization transformed the way she parented her daughter: "So, I realized that I'm having an experience here… with [child's name], we're having an experience together, and she's also having her own experience being raised by me. You know,

it just really set a perspective that like she has her own feelings and thoughts and needs. She needs me to have patience and love just as much as I need her."

Parent-Child Relationship

This theme had four subthemes endorsed by the participants. The sub-themes included: parent-child separation (2), goals for child (2), bonding (5), and having fun (4).

Parent-Child Separation. When discussing the ways in which their relationships with their children have evolved, several participants identified the impact of previous separation from their children. The parents recognized that these periods of separation had played a role in temporarily altering their bond. Rachel commented: "With me going away, that's time and it's emotions that I'm inflicting on him that are confusing, and hurtful, so we had to get back to that strong bond that we had before I went away."

Goals for Child. The participants' goals for their children and being able to use music to support these goals was also discussed. Education and learning were primary goals that participants named for their children, and Kelsey explicitly stated, "I want her to be smart," when discussing her daily use of the ABC song with her daughter. Rachel also shared many goals that she has for her son and stated that it is important to her that he learn an instrument, which he was able to explore during the groups: "I'm excited because now he plays the piano on his tablet whenever I give it to him, since he got to play a real one."

Bonding. Many of the parents in the study mentioned that they felt that they had a strong bond with their child and that their bond had increased since their admission to the program. Several of the women described the group itself as "a good bonding experience" (Maya and Rachel) and expressed gratitude for the time they were able to spend with their children in the group setting. Participants discussed knowing that they had a strong bond with their child

through seeing “the smile on [my son’s] face” (Millie), “his happiness” (Rachel), and “being able to soothe her” (Michelle). Several participants stated that their bond had “grown a lot” (Millie and Kelsey) and Michelle described her bond with her daughter as “healthier” than the bond she established with her older child due to the one-on-one time she was able to spend with her youngest.

Having Fun. Several participants described the importance of getting to have fun with their child in the group. Kelsey compared the low stress environment of Mommy and Me Music Therapy to her daughter’s other appointments where “there is a lot of pressure,” and stated that in group “everyone is just happy to see her play with the instruments and clap.” When asked about being in group with the other parents, several of the women also mentioned that they were able to let go of daily stressors to be present and have fun with their children. Millie stated about the group: “It was fun. It made me feel like it was okay to break it down, kid-style, and get goofy. We didn’t have to be an adult right then, we could all be kids…I learned you can make anything into a fun experience. I mean, what’s life if you’re not having fun and making it enjoyable?”

Feelings About Self

This theme was comprised of four sub-themes: no perfect parent (3), feeling overwhelmed (3), parental self-doubt (2), and parental self-efficacy (5).

No Perfect Parent. When asked to rate their confidence as parents on a scale from 1-10, participants rated themselves highly, but most did not give themselves a 10. Maya commented that, “there’s no such thing as a perfect parent, but I am a perfect parent for [child’s name],” a sentiment echoed by several of the other woman as well. When asked about rating herself as a 9, Millie commented*:* “it doesn't matter if anyone judges me or not [as] long as I am getting a

connection with my kid. That's all that matters. And I think that can be especially easy to forget in this setting where you're parenting under such a microscope that you feel like you have to be this, like, yeah, mature, perfect parent and really the perfect parent is you, you know, for your kiddo."

Feeling Overwhelmed. A common feeling that emerged was that of being overwhelmed with the responsibilities of parenting. Maya was able to notice a difference in her experience of being overwhelmed from when she first arrived at the program, stating "I was extremely overwhelmed. There were a lot of tears…but over time I've become a lot less overwhelmed, I know that I can go to staff or to people from group to get help if I need it." Some women voiced that the day-to-day stressors of parenting left them feeling overwhelmed, while Michelle commented that specifically financial concerns leave her "a little overwhelmed, you know, and not feeling confident in that area, even though otherwise I really truly feel like a good mom."

Parental Self-Doubt. In addition to feeling overwhelmed with their parental responsibilities, many of the participants also spoke to doubting their parenting abilities in certain aspects of raising their children. Separation from their child played into this, as well as the concept of parenting out of guilt due to their absences while in active addiction. Rachel commented: "So, I'm really hard on myself. Like really hard on myself. Yeah, so just the littlest things I make the biggest deal out of… Like I take care of his well-being, I pay attention to him, we have a good bond, he can talk to me, he's smart, but like, there are certain things I do that make me think, when I'm laying in bed, that I'm a shitty mom, and sometimes that guilt runs me as a parent."

Parental Self-Efficacy. Each of the women described feeling like a good and efficacious parent at some point in their interview. For several of the women, this was due to their ability to

meet their child's needs and to respond to their child consistently. Michelle stated that her daughter "feels safe and knows that I'm going to take care of all of her needs, we have such a good bond, I really love her." Millie stated that as her bond with her son grew, so did her self-confidence, and that she is "believing in [her]self and [her] abilities a lot more".

Community Support

This theme had to do with the role that engaging in groups with other moms had on the parents in the study feeling supported as parents. This theme had three subthemes: advice from other moms (3), encouragement from other moms (2), and sense of community (3).

Advice from Other Moms. Several women spoke to the value of having a space that allowed them to give and receive advice from other parents. This came from several different sources, such as observing how other women interact with their children (Maya and Millie), tangible support through sharing baby items and caring for one another's children when needed (Michelle), and through verbal advice and support about parenting (Michelle, Kelsey, and Maya). Michelle expressed her appreciation that the group: "set a platform for us [moms] to have somewhere to talk, and ask questions…if I have any questions about anything or if I need help with something, it's not only advice, it's also tangible support, and I'm very thankful for that."

Encouragement from Other Moms. Beyond giving advice, some of the participants also highlighted the encouragement that their peers offered both them and their children. Michelle commented that her daughter has "so much love and support," while Kelsey stated that "the other moms would encourage me when I felt I couldn't do it." Maya also shared about the positive experience she had in the group when she got to take an encouraging role for another mom, saying "by the end of group, she was laughing and smiling, and that felt good, to get to pick her up like that."

Sense of Community. Many of the women described particular benefits they experienced from developing community support with other women in the program through the group. Michelle stated that she "didn't realize how [the group] would open up certain conversations, and having a group of just moms is very reassuring." Kelsey and Michelle also spoke to the sense of togetherness that emerged due to everyone having the same goal of "being a better, sober parent." Millie stated that: "the group kind of brings out the best in everyone because we get to see this like pure joy in each other and to experience that together. And, you know that we don't always get to see again with like the pressures of parenting and life."

Outside Uses of Music

The final theme comprises discussion around the ways the women were able to generalize musical skills learned in group to their parenting outside of group. There were six subthemes found across the interviews: clean-up song (2), music for bath time (3), music for soothing (4), music for sleep (2), music for daily activities (5), and music for self-expression (2).

Clean-Up Song. A "clean-up song" was used in Mommy & Me Music Therapy group to cue the end of group time and to support the transition out of the group. Several participants indicated that they now utilize this song with their children on a regular basis as a way of making cleaning and organizing an enjoyable and age-appropriate task. Maya commented that her daughter "is very aware of the clean-up song. Make a mess, and she knows, alright we have to clean up, she's learning that through music."

Music for Bath Time. Several of the women discussed using music when they are bathing their children as a way of making this daily task more pleasurable for the child. When discussing this use of music, most of the participants called it "soothing" for their children, and

Kelsey in particular stated that her daughter "normally hates the bath, but if I sing to her, she does a lot better and screams a lot less."

Music for Soothing. A frequent comment made by participants was that they utilized music as a primary means of soothing their children when they were upset. Maya, Kelsey, and Michelle described incorporating music on a daily basis that they utilize when their children become upset. Michelle stated that music is "incomparable to any other soothing technique I have" and that music gives her daughter a feeling of "calm and serenity." Maya shared that for her daughter, music "helps her calm down and wind down from the day, and it's become a big part of her routine." During her interview, Rachel sang a song that she had created for her son earlier in the day to help him relax when his arm hurt and said that as she did so, "he stopped crying, he forgot that he was even crying, because he got into the music."

Music for Sleep. As a calming strategy, music was also utilized by participants to help their children sleep at night. Lullabies are often discussed in group, and the moms are encouraged to sing or hum familiar songs with their children as they are putting them to bed at night, as sleep issues are frequently identified as a stressor for parents in the group. Kelsey shared that she uses her daughter's favorite music to soothe her to sleep "every night," and Rachel shared that "even going to sleep, I sing him a Bible song."

Music for Daily Activities. Each of the participants mentioned times throughout the day that they utilize music with their children. Maya and Kelsey spoke to the "structure" and "routine" that music adds to their days and to each of the daily tasks that need to be completed to care for their children. Millie, Rachel, and Michelle discussed making up their own songs to communicate to their children what they are doing. Millie shared that for: "any kind of like daily

activity, I'll kind of like do a little sing along with him, so that he kind of correlates it with the activity…he definitely enjoys it a lot more, things like getting dressed, if I make it into a song."

Music for Self-Expression. Several of the women discussed the importance of their children having access to music as a means of expressing themselves. Rachel referred to music as a "key to the soul" when describing her desire for her son to develop a passion and enjoyment for music. Michelle shared her own experiences with music as a means of expressing herself and her desire for her daughter to also have this: "I just remember music getting me through a lot of hard times and I want to make sure, you know, I want to make sure that she has that outlet. That platform. You know, sometimes music can explain, you know, what you can't say out loud. I just want her to have that."

Discussion

The purpose of the present research study was to understand how the experiences of women in substance use disorder treatment engaging in parent-child music therapy groups contribute to enhancing bonding and attachment between the parent and child. The study aimed to give voice to women in substance use disorder treatment to share their experiences and perceptions of a parent-child music therapy group program. Research questions focused on exploring what it is about these groups that may be contributing to an enhanced parent-child bond, as indicated by women on pre- and post-tests, as well as exploring what may contribute to parental self-efficacy and social support among women in the groups.

During the semi-structured interviews, participants shared about their experiences of bonding, both with their children and with other women in the group with whom they were able to develop a sense of community. Women discussed their perceptions of themselves (both positive and negative) as parents, as well as ways that theyve noticed change in both themselves

and their children over the course of the six weeks in which they participated in the groups. Some of the changes that participants were able to notice were attributed to the ways in which they had come to use music outside of the group setting. Participants noted many ways in which they now use music with their children on a daily basis and how helpful this is for them to be able to access. An increased sense of parental self-efficacy was also notable across all of the interviews.

Revisiting the Literature

An important question in this study is *why* music therapy, and music in general, is an effective way to enhance the parent-child bond. According to Williams et al. (2014), family music therapy is a "non-threatening, informal, play-based, relationship-based, and a strength-based approach" (p. 153) and Pasiali (2013) describes family-based music therapy as "silly, playful, and creative" (p. 253). Participants in the study spoke to each of these components throughout their interviews, specifically noting the relationship-based and play-based elements as being important in their relationship with their child. Participants commented on the relaxed atmosphere of the groups, as well as the opportunity to interact with their child with minimal pressure or judgment. Feeling self-confident and calm in this space may have allowed for the positive benefits of parent-child singing interventions found by Creighton et al. (2013), which indicated that by achieving a calm state, the mothers in the study could respond to their child in more positive and effective ways. Participants in the study spoke to the joy that they found as they engaged in musical interactions with their children, which echo Pasiali's (2012) findings regarding mutually responsive orientation between parent and child in which parents found "delight in watching their children participate" (p. 304). By providing a space for joyful interactions, parent-child music therapy groups can set the stage for parents to intentionally

nurture the bond that they have with their child and additionally gain skills and insight into ways to use music outside of the group to improve their bond, which parents in the study also described.

Secure attachment between a parent and child requires consistent emotional responsivity from the parent. Essential to attachment is the "emotional self-regulation of the parent, including recognizing and experiencing a wide range of emotions as well as cognitively understanding the mental state and the needs of the child" (Jacobsen & Killen, 2015, p. 149). Parents in the study described how having access to music interventions that were learned in the group contributed to their enhanced ability to respond to and soothe their children when they were upset, as well as their own increased ability to be patient with both themselves and their children. The self-expressive nature of music was also mentioned as important by several participants, and may contribute to emotional regulation for the parents, though this aspect is beyond the scope of this study.

An interesting and, for me, unexpected concept that emerged during the interviews was the theme of "no perfect parent." Participants in the study explained this idea to mean that although they are not and cannot be perfect as a parent, they are the perfect parent for their child because they know their child best and are able to meet all of their child's needs. This idea is similar to Donald Winnicott's idea of the "good enough parent." Winnicott "raised the idea that perfectionism should not be the basis upon which a parent should be judged, because it is unattainable" (Choate & Engstrom, 2014, p. 369). Winnicott instead asserted that a parent who is warm, loving, and responsive toward their child is "good enough" to create a secure attachment and develop a sense of support and nurturing for the child. This theme of "trying to do what is best" can be found throughout the parenting and substance use disorder literature (Ali et al.,

2022; Rockefeller et al., 2019) in which the idea is often addressed in relation to themes of guilt and shame. While guilt and shame were not explicitly discussed by the participants in this study, a level of self-doubt was expressed regarding at least one aspect of parenting by all of the participants. It is interesting that this theme of being "good enough" arose naturally and without prompting. It may have come from a place of self-doubt and seeing one's imperfections as a parent, but there is also a great sense of parental self-efficacy located in this sentiment, as there is confidence in one's ability to be the absolute best parent for one's child, even in the absence of achieving perfection. A commonly used phrase in substance use treatment and in "the rooms" of 12-step meetings is "progress not perfection," which also aligns with this idea of doing the best one can as a parent and continually striving to be better, while accepting where one is at today.

An aspect of the study that is not typically addressed in the music therapy literature is the role of verbal processing. Most music therapy research, for obvious reasons, focuses on the specific role of music and music therapy interventions being used. In the Mommy & Me Music Therapy groups that I run, we typically spend about 75% of the time engaging in active music-making and music therapy interventions. The other 25% of the time is spent in supportive dialogue. These discussions often arise naturally and focus on any pressing topics in the women's lives, such as their children's fathers, their concerns about housing post-discharge, items needed for their child, parenting issues such as sleep training, and many, many other topics. At times, I will offer a more didactic response, such as providing musical suggestions for sleep, while often, other women will give suggestions, offer advice and support, and at times even provide tangible help by giving each other items that their children no longer use. There are very few groups or scheduled times at the facility that are reserved for only moms, and participants commented on how valuable this space was for them. This feeling is echoed in the

substance use disorder and parenting literature, which describes the importance of women with SUDs being able to develop a network of supports while in treatment (Chou et al., 2018; Chou et al., 2020; Moreland et al, 2020; Panchanadeswaran & Jayasundara, 2012; Sieger & Haswell, 2020). It is possible that the supportive conversations that take place in Mommy & Me Music Therapy could take place in another group setting. However, several participants mentioned ways in which the music opened the door for them to feel comfortable with one another and to see each other in the best possible light. While many of the women's other treatment groups are focused on trauma, relapse prevention, and similarly heavy topics, these groups are one hour out of each week in which a lightness and silliness is acceptable and welcomed. There is a level of vulnerability that is required to engage in active music-making, and this vulnerability seems to have led to an enhanced connection with one's child as well as with her peers.

Based on these findings, there are potential implications for music therapists and music therapy educators. In my own undergraduate music therapy education and internship experience, music therapy interventions were taught by age group brackets with little overlap between them. While much of the music-making in Mommy & Me Music Therapy is focused on the children and provided at a developmentally appropriate level, education on ways to engage both parents and children simultaneously to promote joint attention, attachment, and bonding would be very beneficial to clinicians. Additionally, further education on verbal processing skills at the undergraduate level could be of benefit for clinicians who may go on to engage in similar parent-child music therapy groups. As the literature on family music therapy expands and these types of groups increase in popularity, it will become increasingly important for music therapists to be familiar and comfortable with facilitating parent-child music therapy groups.

Limitations

Limitations that are considered in this study include the dual relationship of the researcher with the participants and the researcher's inexperience in conducting research interviews and analysis. The first consideration refers to my role as both researcher and music therapist/group facilitator. I also run additional groups for the facility outside of Mommy & Me Music Therapy and spend much of my week interacting with the women in the study and their peers in a multitude of ways. It is quite possible that because of this, participants in the study felt an obligation to be complimentary towards me and the groups, rather than expressing all of their true feelings about the group. Each participant was asked about helpful and unhelpful aspects of the groups, and each participant gave only positive feedback. Because of my relationship and rapport with the women in this study, I know that they are caring people who would want to avoid hurting my feelings and therefore may have edited their responses in an effort to be kind to me.

Additionally, in my role as music therapist, my way of engaging in music and therapy had an impact on this study. In my clinical work, I tend to lean more heavily into verbal processing than other music therapists may choose to do or feel comfortable doing. While the verbal processing and support that was engendered in the groups was frequently mentioned by participants as a positive for them, this also impacts the usefulness of the findings in this study, particularly for other music therapists who incorporate discussion to a lesser degree.

A final limitation of the study is the researcher's inexperience with conducting research, as this is my first attempt at engaging in research. Because of this, it is likely that interviews and my analysis and interpretation of the results are biased towards my own perspective and ideas about the research. In an attempt to mitigate the effects of my positioning and biases, I engaged in reflexivity through journaling during all stages of the research process. I also went through the

coding procedures with my research advisor, to mitigate the effects of my biases. My research advisor, while much more experienced in research, does share many of my sociocultural identity markers and so this may have also been a limitation. The process of member checking also allowed me to ensure I was not misinterpreting or misrepresenting what the participants had wished to communicate during the interview process.

Recommendations for Future Research

There is much space for research on a variety of topics related to the present study. Family-based and parent-child music therapy remains an area of the music therapy literature in which research is limited, particularly research that centers the voices of clients, rather than that of music therapists engaging in this type of work. Larger studies involving the same population of parenting women with substance use disorders could inquire into the experiences of women at multiple treatment sites engaging in parent-child music therapy groups. This could allow for more rich data collection and may lead to greater trustworthiness or generalizability in determining what it is about these groups that may contribute to parent-child bonding. Qualitative studies could focus in more detail on one aspect of what was learned in this study, such as the role of peer support in groups with this population, specific music approaches in parent-child music therapy groups, or ways to enhance parental self-efficacy through music therapy groups that provide a more didactic element. Additionally, research which centers the voices of the children who are participating in music therapy groups with their parents who are in recovery could also be very enlightening in uncovering what the experience was like for them.

Positivist research could utilize quantitative evidence-based tools for assessing parent-child bonding and interactions, such as Jacobsen's (2015) Assessment of Parenting Competencies (APC) or the Parenting Sense of Competence Scale (Pasiali 2012). Treatment

studies using an experimental research design could also compare the efficacy of standardized parent-child music therapy groups with another one of the attachment interventions mentioned earlier (Mothering from the Inside Out, Circle of Security-Parenting, or Fostering Mindful Attachment). Future research could also involve combining music therapy with one or more of these interventions to determine whether or not this would be feasible, effective, or beneficial to parents with SUDs.

Conclusion

Parent-child music therapy groups for women with substance use disorders are a meaningful opportunity for women to engage and bond with their children, as well as a means of enhancing social support and parental self-efficacy. This study aimed to attend to the voices of women who have participated in such groups, in order to determine what it is about these groups that allows for each of these aspects to develop. The findings indicate that elements of play, musicality, opening a space for discussion, and having opportunities to practice parenting skills all contribute to positive parenting practices and feelings of confidence in one's parenting. This study arose due to a personal desire to improve my practice and has implications for others in the field working in a similar capacity, as well as for music therapy educators preparing students for the possibility of working with groups like this. I hope that this work might inspire others to seek out ways to support families impacted by substance use through music therapy.

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Appendix A

CONSENT TO PARTICIPATE IN RESEARCH

The Experiences of Women in Substance Use Disorder Treatment Engaging in Parent-Child Music Therapy Groups

Susan Hadley, Ph.D, MT-BC; susan.hadley@sru.edu
Halley Cole, MT-BC; hec1005@sru.edu

Invitation to be Part of a Research Study

You are invited to participate in a research study. In order to participate, you must be a woman over the age of 18 with at least one child. You must be in residential substance use disorder treatment at the participating facility, have completed 6 weeks of Mommy & Me Music Therapy, and be proficient in English. Taking part in this research project is voluntary. You can withdraw at any time without penalty.

Important Information about the Research Study

Things you should know:

- The purpose of the study is to understand how the experiences of women in substance use disorder treatment engaging in parent-child music therapy groups contribute to enhancing bonding and attachment between the parent and child.
- If you choose to participate, you will be asked to participate in an approximately one-hour long interview with the researcher about your experience in the music therapy groups.
- While we don't anticipate risks or discomforts associated with this study, you may experience some discomfort related to questions regarding your relationship with your child.
- You may experience emotional benefits from participating in this study, such as experiencing enhanced feelings of parental self-efficacy and recognition of the strength of your bond with your child(ren).
- Taking part in this research project is voluntary. You do not have to participate, and you can stop at any time without it negatively affecting your treatment at the facility or your participation in Mommy & Me Music Therapy.

Please take time to read this entire form and ask questions before deciding whether 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 understand how the experiences of women in substance use disorder treatment engaging in parent-child music therapy groups contribute to enhancing bonding and attachment between the parent and child. The intention of the study is to give voice to women in substance use disorder treatment to share their experiences and perceptions of a parent-child music therapy group program.

What Will Happen if You Take Part in This Study?

If you agree to take part in this study, you will be asked to participate in an approximately one-hour long individual interview with the researcher, which will include open-ended questions regarding your experiences of bonding with your child and your interactions with your child and other parents in Mommy & Me Music Therapy group. This interview will take place after you have completed at least six weeks of Mommy & Me Music Therapy groups.

How Could You Benefit From This Study?

Although you will not directly benefit from participating in this study, you may experience emotional benefits, such as improved self-esteem and self-efficacy in realizing your strengths and connections as a parent. This information will likely benefit others participating in parent-child music therapy, as music therapists will gain an understanding of what is valued by the participants of these groups and how they can best support participants.

What Risks Might Result From Being in This Study?

While we don't anticipate risks or discomfort, you may experience some feelings of sadness or disappointment when describing your relationship with your child. You could also experience discomfort when speaking about your experiences in group with the music therapist who is conducting this research. If you do have an emotional reaction, the music therapist will process this with you. Additionally, your primary therapist will be available to speak with you following the interview as well if needed.

How Will We Protect Your Information?

We plan to publish the results of this study. To protect your privacy, we will not include information that could directly identify you. You may choose a pseudonym, or one will be given to you by the researcher(s). Transcriptions of the interviews will be kept in a password-protected folder on the password-protected computer(s) of the researcher(s).

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

We will not keep your research data to use for future research or other purposes. Your name and other information that can directly identify you 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.

How Will We Compensate You for Being Part of the Study?

There is no compensation for this study. It is completely voluntary.

What are the Costs to You to be Part of the Study?

There are no costs associated with participating in this research study.

What Other Choices do I Have if I Don't Take Part in this Study?

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

Your Participation in this Research is Voluntary

It is totally up to you to decide to be in this research study. Participating in this study is voluntary. Even if you decide to be part of the study now, you may change your mind and stop at any time. You do not have to answer any interview questions you do not want to answer. If you decide to withdraw before this study is completed, any data collected during your participation will be destroyed. Declining to participate or withdrawing from participation will in no way negatively affect your participation in Mommy & Me Music Therapy or any other aspect of your treatment.

Contact Information for the Study Team and Questions about the Research

If you have questions about this research, please contact Susan Hadley at susan.hadley@sru.edu or Halley Cole at hec1005@sru.edu. We are happy to answer any questions you may have about this study.

Contact Information for Questions about Your Rights as a Research Participant

If you have questions about your rights as a research participant, or wish to obtain information, ask questions, or discuss any concerns about this study with someone other than the researcher(s), 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 be in this study. Make sure you understand what the study is about before you sign. We will give you a copy of this document for your records. We will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I understand what the study is about, and my questions so far have been answered. I agree to take part in this study. I understand that I can withdraw at any time. A copy of this signed Consent Form has been given to me.

Printed Participant Name	Signature of Participant	Date

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

Printed Name of Investigator	Signature of Investigator	Date

Audiotape Release Form:

We request the use of audiotape material of you as part of our study. We specifically ask your consent to use this material during the study, as we deem proper, specifically to analyze participant experiences of Mommy & Me Music Therapy. Your interview with the co-researcher will be recorded, transcribed, and then the recording will be destroyed. Regarding the use of your likeness in audiotape, please check one of the following boxes below:

☐ I do…

☐ I do not…

give unconditional permission for the investigators to utilize audiotapes of me as described above.

Printed Participant Name	Signature of Participant	Date

Appendix B

Semi-structured interview questions for "The Experiences of Women with Substance Use Disorders Engaging in Parent-Child Music Therapy Groups".

- What was it like to be in Mommy & Me Music Therapy with your child(ren)?
  - What thoughts, feelings, and physical sensations come to mind when thinking about these groups?
  - What was it like making music with your child(ren)?
  - How much did you use music with your child(ren) before starting the group and how much do you use music with your child(ren) now?
  - What aspects of group were helpful to you as a parent, if any? What aspects were unhelpful, if any?
- On your pre- and post-test, you indicated that you felt an increased bond with your child since starting this group six weeks ago. Please share what factors helped you to feel more bonded with your child.
  - Describe some of your experiences in the group in terms of bonding with your child(ren).
  - What was it about the music, the group, the experiences, etc. that helped you to bond with your child(ren)?
  - Please share a specific memory of a time you felt the strongest connection with your child(ren) during the groups.
  - How have you noticed this change in bond presenting itself in your relationship with your child(ren)? (Ex: Are you more patient with them, better able to communicate, able to be more present or intentional, etc.)
  - How do you imagine you might use what you learned in the group with your child(ren) after your time in the program?
  - Are there specific skills or ideas that you got from the group that you might implement with your child(ren), and if so, what are they?
- What was it like to be in group with the music therapist? The other moms?
  - How, if at all, do you feel that these relationships are helpful to you as a parent?
- On a scale of 1-10, how confident do you feel in yourself as a parent?
  - Has this changed over the six weeks? In what ways?
  - What factors contribute to you feeling more or less confident about your parenting?
  - How has participating in Mommy & Me Music Therapy contributed to feeling more confident as a parent?