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Child Advocacy Centers in the United States and Music Therapy: Relationships in the Making

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Abstract

In the United States, children who suffer trauma or abuse receive services through Children's Advocacy Centers (CACs). Over 800 CACs provided treatment and services to nearly 325,000 children in 2016 ([National Children's Alliance, 2016b](#)). CACs coordinate the work of multidisciplinary teams (MDT) including law enforcement, mental health, medical, and social service personnel to help children and families heal. CACs are autonomous groups made up of affiliations with many local agencies. This article provides a description of the National Children's Alliance (NCA) standards for implementing treatment, including the state of music therapy implementation in CACs. The literature has shown that music therapy can be helpful to address needs of children and families who have experienced trauma, suggesting that this may offer a helpful treatment modality in CACs. However, music therapy is rarely available in CACs. This may be, in part, a result of the lack of randomized controlled trials, a key determining factor for inclusion in the annotated bibliography that accompanies the NCA Standards ([National Children's Alliance, 2013](#)). Music therapy practice has addressed the clinical needs of children and teens who have been abused. This work is often presented in clinical reflections, not randomized controlled trials. Music therapy is currently not included in the treatment modalities utilized by CACs because of a perceived lack of evidence base. This article attempts to synthesize the information available to provide CACs with the current state of research in music therapy with children who have been abused. This article also provides music therapists with a depth of information about the structure and function of CACs, including a synthesis of the NCA Standards of Practice. The article presents a description for the implementation of music therapy services in a CAC in New Jersey and includes recommendations for music therapists who wish to seek out opportunities for clinical practice at CACs.

Keywords: *music therapy, Children's Advocacy Center*

Introduction

In 2015, four million referrals alleging maltreatment were reported to Child Protective Services (CPS). These referrals involved 7.2 million children (U.S. Department of Health & Human Services, 2015). In the United States, the National Children's Alliance

(NCA) is a member organization that accredits Children's Advocacy Centers (CACs) (National Children's Alliance, 2017). The NCA is a large network of providers with a defined standard of care that attends to a clinical population (children and their non-offending parents/adult caregivers) that can benefit from the unique services that music therapists can provide. The NCA supports the work of CACs by providing advocacy, training, and quality assurance on a national level. Children who suffer trauma or abuse receive services through local CACs. In 2017, Over 850 CACs provided treatment and services to nearly 334,000 children (National Children's Alliance, 2017). CACs coordinate the work of multidisciplinary teams (MDT) including law enforcement, mental health, medical, and social service personnel to help children and families heal. CACs are autonomous groups made up of affiliations with local agencies across the United States. This enables the structure of the local agency to reflect the needs of the community for intervention and treatment. This article provides a description of the NCA *Standards* for implementing treatment, including the state of music therapy implementation in CACs. Suggestions for increasing access to music therapy at CACs are included as well as a description for the implementation of music therapy services in a CAC in New Jersey.

Structure of Children's Advocacy Centers

Children's Advocacy Centers can be structured in a variety of ways, in accordance with the needs and strengths of the local community (National Children's Alliance, 2017). CACs are non-profit organizations that function independent of, but in close collaboration with, other agencies including law enforcement, mental health, medical, and social service agencies. CACs may be housed within hospitals or governmental agencies. The core function of the CAC is to coordinate the work of the multidisciplinary team (MDT) to help children and families heal. The MDT is comprised of representatives of the aforementioned disciplines.

Accredited CACs have shown compliance with the *Standards* developed and maintained by the National Children's Alliance. These *Standards* provide a structure by which CACs provide high quality services to children and families.

Description of Standards

The *Standards* are published by the National Children's Alliance each year. A supplemental document, *Putting standards into practice* (Fine, Marlar, Rioth, & Mullen, 2016), provides member organizations with guidance for member organizations with necessary information for evidence-based treatment. The NCA's *Ten Standards of Practice* are to be implemented by CACs in "creatively adapted and operationalized ways" (Fine et al., p. 6). The NCA *Standards* are a set of guiding principles that Children's Advocacy Centers (CACs) adhere to in order to obtain and maintain accreditation through the NCA (National Children's Alliance, 2017). The purpose of the *Standards* is to "ensure that all children across the U.S. who are served by Children's Advocacy Centers receive consistent, evidence-based interventions that help them heal" (p. 6). The *Standards* undergo a process of revision every 5 years during which time new research is evaluated. The research that informs the development and revision of the *Standards* is published in the annotated bibliography of the empirical and scholarly literature supporting the ten *Standards* for the accreditation by the National Children's Alliance. The most recent publication of the annotated bibliography was published in 2013 (National Children's Alliance, 2013).

The Ten *Standards* are identified as follows: 1) multidisciplinary team; 2) cultural competency and diversity; 3) forensic interviews; 4) victim support and advocacy; 5) medical evaluation; 6) mental health; 7) case review; 8) case tracking; 9) organizational capacity; 10) child-focused setting. A brief summary of each standard follows.

Multidisciplinary team. The MDT is a group of professionals (i.e. law enforcement, CPS workers, medical providers, mental health providers, victim advocates, and prosecutors) who collaborate on the care of the child and family throughout their involve-

ment with a CAC. The purpose of the MDT is to facilitate interagency communication. Each profession represented by the MTD benefits from the shared information, which, in turn, leads to coordinated care for the child and family.

Cultural competency and diversity. In this context, NCA defines cultural competency as “the capacity to function in more than one culture, requiring the ability to appreciate, understand, and interact with members of diverse populations within the local community) (National Children’s Alliance, 2017, p. 17). NCA accredited CACs exhibit cultural competency and diversity by proactively engaging in training and outreach to a variety of communities including degree of acculturation, ethnicity, religion, socioeconomic status, disability, gender, gender identity and expression, and sexual orientation. Awareness of the aforementioned guides the approach care and treatment of a child and family at all levels of their healing experience.

Forensic interviews. A key function of CACs is to conduct a forensic interview of the child about abuse allegations in a manner congruent with evidence-based guidelines. Quality forensic interview impact the CAC’s/MDT’s ability to pursue justice while providing the necessary information with which to frame treatment options. The *Standards* on forensic interviews include education and training of interviewers, protocol for information sharing, and case acceptance criteria, among other criteria.

Victim support and advocacy. According to the *Standards*, “victim-centered advocacy is a discipline...that coordinates and provides services to ensure a consistent and comprehensive network of support for the child and the family” (National Children’s Alliance, 2017, p. 25). Victim advocates provide a variety of services in accordance to the individualized needs of the child and family. The services offered by victim support advocates includes facilitating concrete support (i.e. housing, transportation, domestic violence intervention), presence at interviews or meetings to support and inform the family about the MDT process, plan and coordinate services for the child and family, and coordinated case management (National Children’s Alliance, 2017).

Medical evaluation. The *Standards* ensure that health care professionals with additional training in child sexual abuse complete medical evaluations of children who are suspected victims of abuse.

Mental health. According to NCA *Standards*, effective therapeutic intervention is best achieved through the implementation of “evidence-based treatments and other practices with strong empirical support” in order to “reduce the impact of trauma and the risk of future abuse” (2017, p. 36). Mental health professionals must undergo 40 contact hours of license-specific continuing education, evidence-based treatment for trauma training, and clinical supervision hours by a licensed clinical supervisor. Mental health providers must be master’s level, “licensed, certified or supervised by a licensed mental health professional” (National Children’s Alliance, 2017, p. 37), be license-eligible, or a student intern in an accredited mental health graduate program under supervision of an appropriately credentialed mental health professional (Criteria A.2.). Other criteria include: continuing education on child abuse (Criteria B); the implementation of evidence-supported, trauma focused mental health services (Criteria C); access to services regardless of ability to pay (Criteria D); interagency agreements to include access to appropriate services for all CAC clients (Criteria E); guidance on the roles and responsibilities of the mental health professionals (Criteria F); management and sharing of health protected data (Criteria G); the provision of supportive services to caregivers (Criteria H); and clinical supervision (Criteria I).

Case review. Case review is a “formal process in which multidisciplinary discussion and information sharing regarding the investigation, case status, and services needed by the child and family must occur on a routine basis” (National Children’s Alliance, 2017, p. 40). This collaborative information-sharing and decision-making process ensures efficient and effective handling of the children’s and families’ needs. The *Standards* criteria for case review include statements regarding the frequency, duration, participation in, and coordination of care following case review.

Case tracking. Evaluating outcomes of treatment and investigation/intervention outcomes is a process covered under the NCA *Standards*. Accredited CACs have estab-

lished protocols that include identifying the personnel responsible for keeping detailed records of cases served by the CAC, the interventions utilized, the outcomes of all investigations and interventions, and collecting client feedback to inform service delivery (National Children's Alliance, 2017). The *Standards* on case tracking also includes protocols for including coordinating of information gathered by MDT partner agencies for shared cases.

Organizational capacity. CACs are structured differently according to the needs and capacities of their local community. This plurality of organizational structures allows for the most flexibility in service design and delivery. The NCA *Standards* for accredited CACs require "a designated legal entity responsible for the governance of its operations" (National Children's Alliance, 2017, p. 48) whose responsibility to ensure that all the legal, financial, and regulatory functions of running a service organization (independent non-profit agency or affiliated with an umbrella agency) are followed. The organizational capacity standard also includes criteria regarding staff development, including the effect of vicarious trauma and resiliency in MDT members.

Child-focused setting. CACs are required to structure their physical places and spaces in a manner that is safe, child-friendly, and accessible to children their families from diverse populations (National Children's Alliance, 2017). CACs ensure that children who have been abused are safe preventing alleged offenders from entering the CAC, and that children and non-offending family members are supervised while inside the CAC. The child-focused setting criteria also include components of physical and psychological safety: cleanliness, childproofing, and physical accessibility.

Evidence-Based Treatment Available at CACs

In a document based on the 2016 survey of accredited CACs, NCA reported on a variety of evidence-based treatments (National Children's Alliance, 2016). Trauma-focused cognitive behavior therapy is offered at 73% of the responding CACs. Parent-child interaction therapy (PCIT) and eye movement desensitization and reprocessing (EDMR) the next most frequently indicated (17%) evidence-based practice offered by CACs. Child and family traumatic stress Intervention (CFTSI) is offered by 13% of CACs. Problematic sexual behavior cognitive behavioral therapy (PSB-CBT) is offered by 12% of CACs. Other evidenced-based interventions offered at CACs include child-parent psychotherapy (CPP, 9%), alternative for families cognitive behavioral therapy (AF-CBT, 6%), and none (14%). Of interest is the inclusion of the category: "other" treatments offered at CACs (9%). Further query to NCA revealed that music therapy was not recorded as an intervention reported by CACs in the 2016 survey (B. Warenik, personal communication, December 28, 2017).

Brief Music Therapy Literature Review of Relevance to CACs

An understanding of the evidence-base for music therapy with children who have been abused is required for music therapists who seek to become part of CACs/MDTs. This article provides a framework for reviewing music therapy literature with a focus on clinician reflections, theoretical papers, and empirical studies addressing music therapy with children who have been abused that may be of interest to CACs and music therapists wishing to partner with CACs. For example, Table 1 provides one format for how information can be arranged to assist the music therapist or CAC clinician in accessing the right study to support the inclusion of music therapy in the treatment programming. This author found the following information important to know immediately: age range of the children, group versus individual therapy, and type of music therapy intervention. This information was crucial in articulating the rationale for the music therapy program proposal detailed below. However, the review of the literature needs to be thorough and on going and may need to include relevant music therapy research in trauma with populations beyond childhood in order to establish some clinical relevance. For example, reduction of PTSD symptoms as a result of music therapy

has been studied in the adult population (Carr, d'Ardenne, Sloboda, Scott, Wang, & Priebe, 2012), but a similar study with children is not available.

Music therapy with teens who have experienced abuse

Research in music therapy with adolescents who have been abused exists. Gonsalves (2007) articulated the importance of maintaining a developmental treatment focus when providing individual music therapy treatment to an adolescent girl who sustained sexual trauma as a child. Music therapy interventions that address trauma from a somatosensory clinical perspective provided a young teen the opportunity to develop the capacity to manage her anxiety increase resilience. Hasler (2017) discussed the neurobiological pathways responsible for self-regulation and the healing potential of music therapy, with particular attention to rhythm, to promote and support the communicative musicality between people (including parent-child dyads).

Song writing and lyric analysis are frequent interventions to address clinical concerns for this population. Adolescents who had been sexually abused reported improvement in self-confidence and self-esteem after participation in group music therapy (Clendenon-Wallen, 1991). Songwriting and lyric analysis positively impacted self-esteem and coping skills for youth who were homeless and had experienced trauma (Jurgensmeier, 2012). Curtis (2007) presented a music therapy approach for women and teen girl survivors of childhood sexual abuse. Situated in feminist music therapy theory, Curtis outlined the therapeutic use of songs by women and teen girls for empowerment and voice reclamation. Henderson (2012) described the application of music therapy interventions of song improvisation, play therapy, and other psychotherapeutic techniques to address the therapeutic needs of a 13-year-old girl who was a victim of sexual abuse.

Sekeles (2012) described a music psychotherapeutic approach in her work with a hospitalized adolescent that highlights the role of relaxation in the process of recovery from abuse. In this case, music therapy served to lessen the adolescent's anxiety and allowed her to engage in the therapeutic process.

Music therapy with children who have experienced abuse

The literature suggests a different set of music therapy interventions for children who have been abused. LaVerdiere's model (2007) provided a therapeutic rationale for the use of the following interventions with this population: singing, improvisation, composition, role-play, and listening to music. It should be noted that LaVerdiere's model is for children, though the age range is not specified. Robarts (2012) described the role of spontaneously improvised songs in the treatment of an 11-year-old girl who had sustained sexual abuse and familial trauma throughout childhood. A combination of improvisation with verbal reflection was an approach used by Rogers (2012) in her work with an 11-year-old girl referred for treatment as part of a child protection plan. Schönfeld (2012) described a 6 year course of music therapy with a female child who had been sexually abused, who was conceived as the result of incest, and who had co-occurring medical concerns requiring prolonged hospitalizations.

Individual music therapy cases with male children who have experienced abuse are infrequently addressed in the literature. Wesley (2012) described a case of a 10-year-old boy for whom singing, relaxation, and imagery to music were used to develop self-monitoring skills and to decrease explosive behavior.

Table 1 organizes the above literature in a fashion that is relevant to music therapists working, or wishing to work, for a CAC. Note that studies on music therapy abuse recovery that addresses child victims (birth through adolescence) are included.

Theoretical Foundations for Music Therapy with Children and Families

Music therapists, wishing to work with children who have been abused, need to understand the theoretical underpinnings of treatment for complex trauma, neglect, and

Table 1.

Music Therapy Literature in the Treatment of Abuse with Age Group Relevant to CACs

Reference	Summary of intervention (Age group)
Clendenon-Wallen, 1991	<i>Group (Teens)</i> Improvement to self-confidence and self-esteem
Curtis, 2007	<i>Group (Teens)</i> Therapeutic use of songs for empowerment and to reclaim voice
Gonsalves, 2007	<i>Individual (Teen)</i> Therapeutic use of musical story-telling, improvisation, and client-driven session design
Hasler, 2017	<i>Family Group (Children and Adults)</i> Overview of music therapy interventions appropriate for families with children recovering from trauma
Henderson, 2012	<i>Individual (Teen)</i> Improvised songs to address effects of sexual abuse
Jurgensmeier, 2012	<i>Group (Teens)</i> Therapeutic song writing and lyric analysis to improve self-esteem and coping skills
LaVerdiere, 2007	<i>Group and Individual (Children)</i> Therapeutic use of singing, improvisation, composition, role-play, and listening to music
Robarts, 2012	<i>Individual (Child)</i> Spontaneous improvised songs for integrative, healing potential
Rogers, 2012	<i>Individual (Child)</i> Improvisation and verbal processing
Schönfeld, 2012	<i>Individual (Child)</i> Puppets, improvised songs, instrument play to support ego development and process effects of trauma and medical procedures
Sekeles, 2012	<i>Individual (Teen)</i> Music to promote physical and mental relaxation and address emotional problems
Wesley, 2012	<i>Individual (Child)</i> Singing, music relaxation and imagery to develop self-control and decrease explosive behavior.

abuse. What follows is a brief introduction to several foundational theories that frame trauma work both within and outside of music therapy.

Schore and Schore (2008) provided a summary of constructs and processes related to attachment and how to support attachment in service of affect regulation. At the core of attachment is the psychobiological processes that mediate interactive regulation. According to Schore and Schore, emotional regulation is the outgrowth of the ability of the primary caregiver to co-regulate with an infant. This co-regulation is a rhythmic process that Schore and Schore asserted is replicated within the parent-child dyad and between helping professionals and those receiving assistance. Sena Moore and Hanson-Abromeit (2015) extended the discussion of regulation in their work on the therapeutic function of music to promote self-regulation skills in preschoolers. Jacobsen (2017) characterized neglect as the failure of the parent-child relationship to consistently co-regulate. Jacobsen described the impact of neglect on the child within a family and provided justification for family music therapy interventions to remediate the effects of neglect on the child's development.

Perry (2008) provided a full explication of the neurobiological effects of trauma; Gaskill and Perry (2014) described the importance of developmental approaches to play in the healing of neurobiological trauma sustained in childhood. Roberts (2006) connects the music therapy intervention of improvisation to theoretical foundations of treatment of children who have been abused. *Creative therapies for complex trauma: Helping children and families in foster care, kinship care or adoption* edited by Hendry and Hasler (2017) provided several theoretical frameworks through which trauma recovery can occur through participation in creative arts therapies. Hendry's (2017) chapter "Creative therapies for complex trauma: Theory into practice" explicitly outlined the links between neurobiological research and current trauma theory and the link between these theories and music therapy practice. Trauma therapists, who are not music therapists, may be familiar with the research by Schore (2001), Siegel (2001), and Perry (2008), and van der Kolk (2014) as foundational to their own approaches to trauma recovery treatment, which are clearly outlined by Hendry (2017). Hendry drew together the work of these theorists through the lens of music therapy clinical interventions to provide a framework from which music therapists can work to support positive growth in families after trauma.

Jacobsen and Thompson (2017) expanded on the broader area of theoretical underpinnings of clinical work of music therapy with families by drawing together theories of attachment, family systems, resource-oriented approaches through the lens of interpretive and effect studies. This chapter, co-written by Jacobsen and Thompson (2017), also elucidated emerging characteristics of working with families with young children that music therapists seeking to work within CACs may find helpful. These characteristics included the need to be explicit about the focus of the music therapy intervention (is the child, the parent, or the dyad the focus of therapy) and transparency regarding the role of the therapist (guide/facilitator, directive/supportive).

Table 2 summarizes the theoretical foundations of music therapy treatment for children who have been abused. Taken together, the review of the literature may assist in future efforts to request that NCA include relevant research in music therapy for consideration in the NCA's annotated bibliography.

A brief review of music therapists working in CACs

It is useful to understand what is known about the presence of music therapists in CACs. I used a three-pronged approach to gathering what was known about the state of music therapy in CACs. First, I requested information regarding what was known about music therapy by NCA. NCA conducts a survey of interventions used by CACs (*How CACs are Healing Kids*, 2016). The type of professions responsible for implementing the interventions is not represented in the survey. It is reasonable to infer the types of professions based on the interventions reported in use in the survey: clinical psychologists, licensed professional counselors, and social workers are likely the majority of mental health workers responsible for intervention implementation. Two reasons may exist for the lack of inclusion of music therapy listed as a treatment offered at CACs: 1)

Table 2.
Theoretical Foundations of Music Therapy Trauma Treatment for Children

Reference	Summary
Jacobsen & Thompson, 2017	Synthesis of theories from within and outside of music therapy to provide foundation for music-based interventions for families
Gaskill & Perry, 2014	Provides theoretical framework for developmental approach to play in the treatment and remediation of children who have suffered brain trauma due to abuse or neglect
Hendry, 2017	Links current research in neurobiological processes and trauma recovery with music therapy interventions to address negative effects of trauma on the family unit
Pasiali, 2012	Connects music therapy interventions to literature on resilience and mutual regulation orientation to support music therapy with parent-child dyads
Perry, 2008	Describes the neurobiological processes that are disrupted as a result of abuse in childhood.
Robarts, 2006	Connects music therapy interventions to neurobiological theories of trauma recovery for children who have been abused.
Schore & Schore, 2008	Summary of attachment theory and its role in self-regulation
Sena Moore & Hanson-Abromeit, 2015	Provides theoretical justification for music therapy interventions to increase self-regulation skills in preschoolers

the lack designation of music therapy as an evidence-based treatment, and 2) the infrequent hiring of music therapists to provide treatment at CACs. It is likely that one reason influences the other: the lack of awareness of the efficacy of music therapy in the treatment of children who have been abused leads to the infrequent implementation of music therapy in CACs; the relatively few numbers of music therapists adequately trained in trauma-informed music therapy interventions (and other trauma-informed treatment modalities) results in the paucity of music therapists employed by CACs/MDTs.

Next, I attempted to make connections with music therapists working in CACs through the CAC member listserv hosted by the NCA initiated by the executive director of the New Jersey CAC. This resulted in connection with one music therapist. Finally, I utilized social media to find music therapists working in CACs. Together, the two efforts (the CAC member listserv and the social media effort) revealed the number of music therapists working at CACs in a clinical capacity in the single digits. Two music therapists that I spoke with worked full-time as music therapists in CACs¹ as mental health professionals and offered group and individual services. The two music therapists worked primarily with early-elementary aged children through adolescents (approximately 7–18 years). This age range is consistent with the adoption of trauma-focused cognitive behavior therapy as the primary treatment method in CACs across the country (National Children's Alliance, 2016). The music therapists ran group and individual sessions and were considered part of the treatment team within the CAC that employed them. A third music therapist was in the process of being hired by a CAC in New Jersey. However, the clinical responsibilities of that therapist are unknown at the time of this writing. One of the music therapists I spoke with created a Facebook group to encourage clinician collaboration and information sharing.

Neither music therapist that I spoke with consistently provided music therapy services for children under 7 years old. The lack of availability of music therapy did not reflect clinical need: the clinicians felt that there was need for services for very young children seen at the CAC, particularly services that included the non-offending parent. Rather, the lack of services offered to children less than 7 years seemed to be a reflection of the choice of treatment models adopted by the CACs. What follows is a description of a small group music therapy approach to fill a need for family-services for children under 5 years and their non-offending parents. The CAC identified this need and approached a local music therapy private practice with a request for proposal for clinical services.

Proposed Music Therapy Services for a CAC in New Jersey

A proposal to offer music therapy has been accepted by a CAC in New Jersey; the CAC is actively seeking funding for the project to go forward. The CAC requested a proposal to implement music therapy services for the children they serve under the age of 5 years and their non-offending parent/caregiver. The CAC identified a lack of services for this population of clients.

The proposal includes the implementation of group music therapy, using the Music Together Within Therapy®² framework to support parent-child music-making both within the music therapy session and to increase the likelihood of family music-making outside of music therapy. The Music Together Within Therapy® (MTWT) program is a set of materials that individual clinicians can obtain the trademark license to use in their clinical work. These materials provide the clinician with developmentally appropriate music suitable for use with children birth through early elementary age (7-8 years of age) and additional materials for parents/adult caregivers. MTWT providers design interventions according to the assessed needs of the parent-child dyad. The goals of the proposed program include improving parent-child interaction and bonding and supporting parents with additional parenting tools as they move through the healing process after a traumatic incident has occurred. The decision by the music therapy practice's clinical director to implement the Music Together Within Therapy program is supported by the combination of the therapist's clinical judgment, prior experience offering Music Together for a population in crisis (see Guerriero, 2018 in this issues of *Voices*), and the alignment of Music Together's philosophy with parenting programs to support the parent-child relationship (Music Together LLC, 2012a) and alignment with the Strengthening Families Program (Music Together LLC, 2012b). Strengthening Families Program is a parenting curriculum designed to increase parental competence in five areas: 1) resilience, 2) social connections, 3) concrete support in times of need, 4) knowledge of parenting and child development, and 5) social and emotional competence (Center for the Study of Social Policy, 2018).

Weekly small-group music therapy sessions will be offered at no cost to families identified by the CAC. The program is designed to function under the victim advocacy services and is offered to families seeking services for their young child has been a victim of abuse. This family-based model is designed to include all children in the family and non-offending adults. Program evaluation, including an analysis of the response to the music therapy intervention on parenting stress, children's level of engagement in developmentally appropriate music-making, and evidence mutual parent-child regulation are planned to inform the development of a model of group music therapy treatment for families with very young children.

Recommendations to Music Therapists

Music therapists in the United States seeking to serve needs of clients through CACs will need to be well versed in the mission and philosophy of NCA and have a working knowledge of the role of the CACs and MDT. Music therapists outside of the US seeking to establish a working relationship with an organization similar to the NCA may find the literature review offered here helpful, in addition to country-specific resources and

research on abuse and neglect. In this author's experience, a deep knowledge of the relevant research in trauma-informed therapy, including trauma-informed music therapy, is important.

The following recommendations are offered based on the author's experience interfacing with the New Jersey Children's Alliance and the CAC that requested the music therapy proposal. These recommendations are offered as "lessons learned" and should be filtered through the lens of the specific local organization providing treatment for children who have been abused and their families. One hurdle in the establishment of the music therapy program was to provide a comprehensive literature review specific to music therapy with very young children and their non-offending parents where abuse was the central therapeutic focus. It is also clear, from discussion with the CAC decision-making staff that the strength of the music therapy proposal rested in the clear articulation of how this proposal could assist the CAC in meeting their strategic objectives for providing evidenced-based treatment. In the case of the aforementioned proposal, the strategic objectives of the CAC were aligned with those of the NCA.

Music therapists must also be well versed in the primary evidence-based trauma-informed interventions employed by mental health professionals at CACs or their local organization charged with treating children who have been abused and the members of their family who did not abuse them (also known as "non-offending family members"). For example, a review of NCA's yearly outcome report³ is a useful first step. Additional information on treatment options were described by the National Child Traumatic Stress Network⁴. While the NCA *Standards* state that mental health professionals must be appropriately licensed or certified, it is likely that NCA accredited CACs will opt for master's level clinicians over bachelor's level clinicians to ensure compliance with the mental health standard.

Music therapists who are not employed by the CAC but are members of the partnering MDT agencies should be able to follow the requirements of the *Standards* regarding case review and case tracking; this is a requirement of the current NCA *Standards* (2017). While there are currently no known music therapists who contract independently with CACs as members of the MDT, the impact of these two standards (in addition to the requirement to be appropriately licensed with preference for master's level clinicians) must be considered. The extent to which music therapy private practice owners can ensure that they have the ability to meet the NCA *Standards* may impact the ability of a music therapy practice to be considered an appropriate partnering agency.

NCA's commitment to excellent treatment of children who have been abused and their non-offending family may be another point of philosophical congruence and clinical collaboration that music therapists can pursue. The NCA measures outcomes of MDT coordinated efforts through a yearly retrospective process. At the time of this article's writing, the NCA's *National Report on Outcomes for Children's Advocacy Centers*⁵ (2016) indicated a high level of agreement among MDTs and families on the high level of care children and families received at CACs. The presence of music therapy at CACs may contribute to the high level of satisfaction experienced by families.

The NCA is a large network of providers with a defined standard of care that attends to a clinical population that can benefit from the unique services that music therapists provide. The few music therapists that currently work for CACs report that young clients and families value their work. CACs desire to provide evidence-based treatment options for their clients and currently do not include music therapy among the treatment interventions in their annotated bibliography that drives their *Standards* for member organizations: a review of the NCA's (2013) annotated bibliography for the keywords "music", "rhythm", "song", and "melody", revealed no results.

The literature on music therapy with children who are victims of abuse exists, but there is no availability of a fact sheet or bibliography currently available on the American Music Therapy Association (AMTA) website to share with CACs or NCA. The presence of a bibliography on this topic would empower music therapists seeking to make their services available to CACs/MDTs. Further, the lack of randomized controlled tri-

als on music-based interventions for children who are victims of abuse and their families may contribute to the relative paucity of music therapy services available at CACs. The above brief review of the existing music therapy literature on the topic reveals a predominance of literature focused on the treatment of adolescents but a paucity of literature on music therapy with children under 7 years of age who have been abused and their non-offending parents.

Consistency of treatment implementation is a primary driver of evidence-based treatment; as yet, a standard of music therapy practice for the treatment of children who have been abused does not exist. The reader is encouraged to further review the work of Cordobés (2012) for an example of treatment planning for a child victim of abuse.

Clinician isolation may be a factor in the transmission of best practices between and among music therapists. There are relatively few music therapists in the continental US; the number of music therapists who report working with populations who have experienced abuse may not be sufficient to meet future demand for service. According to the AMTA 2017 workforce analysis, 84 music therapists reported working with individuals who have been abused, including sexually abused; some of the 27 newly created positions and 5 private practices created in 2016 served the abused/sexually abused population. Some of the 47 new positions within existing programs serve individuals who have been abused, including sexually abused populations (AMTA, 2017). Deeper analysis of the workforce data may reveal greater specificity of the positions. Music therapists interested in connecting with a community of music therapists to share best practices in music therapy with trauma, child abuse, neglect, and domestic violence can connect in a closed Facebook group.

Music therapists and other members of society can lend their combined advocacy to the work of the National Children's Alliance by following the legislation on the Victims of Child Abuse Act, the primary NCA's primary source of federal funding) and contacting their federally elected representatives to request its reauthorization.

Notes

1. To see public testimony regarding the importance of music therapy services in a TX CAC, please watch the public testimony here: https://youtu.be/RC9_jvG-5jg
2. <https://www.musictogether.com/parents/special-needs/within-therapy>
3. Available at <http://www.nationalchildrensalliance.org/measuring-cac-outcomes/>
4. Available at <https://www.nctsn.org/treatments-and-practices>
5. <http://www.nationalchildrensalliance.org/wp-content/uploads/2018/02/OMS-National-Report-2016-1.pdf>

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