

The Effects of Music Therapy-Based Bereavement Groups on Mood and Behavior of Grieving Children: A Pilot Study

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The purpose of this study was to measure the effects of music therapy-based bereavement groups on mood and behavior of grieving children. Eighteen subjects were assigned to one of two groups: experimental (8 sessions of group music therapy) or control (no group music therapy). All subjects participated in a battery of psychometric tests which measured behavior, mood, and grief symptoms for both pretests and posttests. Statistical analysis indicated a significant difference among subjects in the experimental group for the Behavior Rating Index for children in the home environment and the Bereavement Questionnaire for Parents/Guardians. Although there were no statistically significant differences, mean scores on the Depression Self-Rating Index and the Behavior Rating Index for children in the school environment of the experimental group dropped following treatment. The investigator concluded that participation in music therapy-based bereavement groups served to reduce grief symptoms among the subjects as evaluated in the home. Teacher and self-evaluations were less conclusive. Further research studying the effects of music therapy on grieving children is recommended.

Adults who have experienced the death of a loved one often face intense challenges in the grieving process as they learn to cope with denial and isolation, anger, bargaining, and depression (Kubler-Ross, 1983). Although the bereavement process is similar

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for children, behaviors and coping styles are different among children and adolescence (Black & Adams, 1993). Children may regress developmentally, experience physiological and social changes, display caregiving behaviors, and change eating and sleeping patterns. They may have explosive emotions, disorganization and panic, fear, guilt, self-blame, regret, emptiness, and sadness. In some children, school grades decline and acting-out behaviors increase (Wolfelt, 1983).

Research related to grieving children focuses on four main areas: understanding reactions and responses to loss, intervention techniques, curriculum guides, and support for parents/guardians. Zall (1994) found that bereaved subjects who experienced the death of a loved one as a child showed more severe symptoms of depression and suicidality in adolescence. Understanding grief reactions is complex, and clinicians need to be aware of the type of death, developmental age of the child, cultural issues, and existing coping mechanisms (Aronson, 1996; Balk, 1996; Cerel, Fristad, & Weller, 1999; Charkrow, 1998; Middleton, Burnett, Raphael, & Martinek, 1996; Silverman & Worden, 1992). Families need assistance in helping children understand death, and it is important to communicate openly and honestly with a grieving child in a developmentally appropriate manner (DeMaso, Meyer, & Beasley, 1997; Hare & Skinner, 1988; Nickman, Silverman, & Normand, 1998).

Because some children may lack the verbal skills needed to express their emotions and cope with grief or may find difficulties in using verbal skills for emotional expression, it is important for symbolic and non-verbal means of expression to be used in the treatment of grieving children (Bright, 1986). Successful interventions with bereaved children address the use of play, story telling, fairy-tale reading, and art in helping children understand the loss and express their feelings (Angell, Dennis, & Dumain, 1998; Guy, 1993; Lamers, 1995; Seager & Spencer, 1996; Tamm & Granqvist, 1995; Webb, 1993). Tramonte (1996) describes the need for clinicians to be sensitive to the multicultural issues in treating grieving children. Multiple curriculum guides are available for clinicians and teachers which describe support group structure and goals for bereaved children (Aspinall, 1995; Black & Adams, 1993; Cassini & Rogers, 1994; Goldman, 1994; Housley, 1996; Knope, 1989).

Much of the research is descriptive and qualitative, and few quantitative articles are available in the field of children in be-

reavement. Tonkins and Lambert (1996) published an empirical article studying the outcomes of psychotherapy-based bereavement groups on grieving children. Children in the treatment group participated in an 8-week psychotherapy group, and parents and teachers reported a significant decrease in overall symptomatology of the children who received treatment. Dependent variables were mood and behavior as they related to the loss.

Music therapy can be a powerful tool for behavior modification with children. It has been used successfully with children on school buses (McCarty, McElfresh, Rice, & Wilson, 1978), developmentally delayed children (Underhill & Harris, 1974), with behaviorally handicapped children in public schools (Presti, 1984), and in the treatment of children with attention deficit disorder (Cripe, 1986). Emotional health of children has been treated successfully with the use of music therapy in elementary schools (Giles, Cogan, & Cox, 1991), homeless shelters (Staum, 1993; Staum & Brotons, 1995), children's hospitals (Froelich, 1984), within families (Hibben, 1992), and in psychiatric, community mental health centers, and residential treatment facilities (Cassity & Cassity, 1994; Friedlander, 1994; Hong, Hussey, & Heng, 1998).

The purpose of this research study was to ascertain if there was a significant difference in grief symptoms among the subjects receiving music therapy as reported on the psychometric tests. For the purposes of this study, grief was viewed as a normal reaction to a loss (death) and children were offered education regarding grief, means of emotional expression, clarification, and normalization of the grieving process. The music therapy group sessions were designed to assist children work through their grief in a nurturing environment and learn healthy means of coping with their losses.

Method

Subjects

Subjects, aged 6 to 11 years, had experienced the death of a loved one within the past 2 years. Although symptoms may manifest themselves differently at different times after the death, the overall presenting grief symptoms were measured at the time of the study. A terminal illness accounted for 61% of the deaths and included diagnoses such as cancer, AIDS, and congestive heart failure. Sudden death accounted for 39% of the deaths and included

suicide, drowning, and SIDS. Race was nearly equally divided between Blacks (55%) and Whites (44%). The socioeconomic range of the subjects was from upper-lower class to middle class.

Design

This study utilized a pretest/posttest design and included both an experimental group and a no-contact control group. All subjects received the pretest battery of psychometric tests. The experimental group participated in an eight-session music therapy-based bereavement program, whereas the control group did not. Subjects in both groups received the posttest battery of psychometric tests.

Measures

Because grief symptoms vary in children, a battery of four psychometric tests were utilized. The Behavior Rating Index for Children (BRIC) was used in two environments: home (evaluated by parent/guardian) and school (evaluated by teacher). The BRIC measures the degree of children's behavior problems which have been identified in the research literature. The frequency in which the child loses his/her temper, hits or pushes others, says or does strange things are examples from the test. The BRIC has a 0.60 to 0.70 alpha range for reliability when used with children and is considered to have good concurrent validity with a correlation of 0.76 ($p < .001$) between BRIC scores and scores on the Child Behavior Checklist (Stiffman, Orme, Evans, Feldman, & Keeney, 1984). The Depression Self-Rating Scale (DSRS) was designed to measure depression in children ages 7 to 13 and was completed by the subjects. The frequency in which the child feels sad, bored, like crying are examples from the test. The DSRS is considered reliable with reported alphas ranging from 0.73 to 0.86 and has good concurrent validity with a 0.81 correlation with the Children's Depression Inventory (Birleson, 1981). The Bereavement Group Questionnaire for Parents/Guardians (BP) was designed to detect the type and severity of grief symptoms among children. Four areas of evaluation included: emotions (guilt, anger, sorrow, anxiety, etc.), behaviors (overactivity, withdrawing from others, avoiding reminders of the deceased, etc.), thoughts (disbelief regarding death, panic, sense of presence of deceased, etc.), and physical symptoms (headaches, stomach aches, lack of energy, etc). The BP also rates the parent/guardian's perception of the effectiveness of treatment

and therapist. It is considered a reliable testing instrument with a reported alpha of 0.74 (Tonkins & Lambert, 1996). In all the tests used, higher scores indicated a more severe problem.

Procedures

The Caring Tree, a child and adolescent bereavement program offered by Big Bend Hospice, provides free, time-limited bereavement groups in the Leon county public schools for children who have experienced the death of a loved one. The researcher worked under the auspices of the Caring Tree program while conducting the research. On a rotating basis, the Caring Tree serves children in the schools where there is a need for bereavement counseling. Three schools were included in this research study. Guidance counselors and other school professionals identified grieving children and formed a list for assessment. Two school groups served as the experimental groups (total $n = 9$) and one school group served as the control group ($n = 9$). Groups were held at two schools because there was a limited number of grieving children in the school district, and there was not one school with enough grieving children to support this study.

Home visits were provided for the children identified, and the parents/guardians received assistance in completing the Bereavement Group Questionnaire for Parents/Guardians and the Behavior Rating Index for Children (home environment). Assistance was provided in the form of giving behavioral examples of questions asked to help parents/guardians better understand what was being asked. Each child completed the Depression Self-Rating Scale, and the children's teachers completed the Behavior Rating Index for Children to assess school behavior. The criteria for acceptance into the study were an overall bereavement score of two on the Initial Bereavement Group Questionnaire for Parents/Guardians, parent/guardian consent, and at least one specific behavioral or emotional problem exhibited by the child believed to be related to the loss. Of the 43 children referred, 19 were accepted into the study. One child transferred to another part of the state after the third session of treatment, therefore, the total log number of subjects was 18. Many children referred did not meet the criteria stated above and seemed to be coping well with their grief. Of the children not accepted into the study, several had already participated in previous bereavement groups offered by the Caring Tree Pro-

gram and others were receiving support through their religious organizations. Two sets of parents decided not to allow their children to participate in the groups although their pretest scores indicated there may be a need for additional support.

The group sessions were all held at the public elementary schools during the school day. Sessions were 1 hour in length and were facilitated in a private room with table and chairs. The experimental group consisted of 9 children who were of the middle and lower-middle socioeconomic standard. The no-contact control group consisted of children in a public elementary school where the socioeconomic standard was upper-lower class and lower-middle class. Random assignment of subjects to groups was not possible due to school needs and policies of the Caring Tree program. However, schools were randomly assigned to be either an experimental group or a control group, and subjects, parents/guardians, and school personnel were not aware of which group was the experimental or the control group. All children in the control group participated in the music therapy-based bereavement groups after the study was completed.

Therapy Groups

Grief therapy consisted of 8 music therapy sessions and utilized a systematic approach to assist children understand and cope with death. Based on previous work experience and a review of the literature, the investigator devised a music therapy group manual which included session themes and comprehensive session plans. Techniques included: singing, song-writing, rap-writing, rhythmic improvisation, structured drumming, lyric analysis, and music listening. The theoretical approach was cognitive-behavioral music therapy which focused on behavior modification, the identification and expression of emotions, the intellectual understanding of grief, and challenged cognitive distortions while assisting with cognitive reframing and reshaping. The following illustrates the music therapy group sessions in an abbreviated format.

Session 1 assisted in the development of trust and therapeutic rapport, established group guidelines (confidentiality), and the common bond of the group (all participants have experienced the death of a loved one). The session began with an ice-breaking, cohesion building activity. Subjects sang "Shake, Rattle, and Roll" (Bernstein & Johnson, 1995) using egg shakers (rhythm instru-

ments similar to a maraca) and movement led by subjects. Group guidelines were established, with subjects choosing their own guidelines. The "Confidentiality Rap" (Jull, 1996) was sung and a confidentiality discussion ensued. Each person shared why they were in a group together and named the person who died. For closure, the group members engaged in a drumming exercise which included improvisational opportunities. Before returning to class, subjects participated in deep breathing and were asked to recall appropriate classroom behavior.

Session 2 focused on basic death education concepts to clarify confusion or myths, offered a time to share each individual's death story, and promoted emotional expression. The group began by singing "Shake, Rattle, and Roll" (Bernstein & Johnson, 1995) with egg shakers and movement, and group guidelines were reviewed. The topic was introduced by therapist saying, "It can be hard to understand death, and today we are going to try to do just that." The group sang "While I'm Sleepin'" (Alsop, 1994) and engaged in a lyric analysis discussion. Myths of death were clarified. Each subject shared how their loved one died and received validation.

The group sang, "Where Will I Go?" (Alsop, 1994) and engaged in a lyric analysis discussion. Each subject shared what happened to the body and to the spirit of the person who died. All beliefs regarding spirituality were validated, and any confusion regarding burial or cremation was clarified.

Session 3 normalized death as a change and a natural part of life, provided an opportunity to share about the funeral or memorial service experience, clarified myths, and promoted emotional expression. "Shake, Rattle, & Roll" (Bernstein & Johnson, 1995) was sung with egg shakers, and the previous session was reviewed. The topic (death as a change) was introduced, and the group sang "Seasons" (Justice, 2000). The group discussed the song and identified how their lives have changed since the death of their loved one. The song provided opportunities for each child to fill in words describing the changes experienced, and the song was sung again using words from the discussion about change. A drum was passed around and each subject verbally identified an emotion felt since the death and then played the emotion on the drum. The group sang "'Til we Meet Again" (Justice, 2000) which encouraged subjects to identify a supportive person in their lives whom they could turn to if needed until the group meets again.

Session 4 assisted in identifying causes of sorrow related to loss and the development of healthy coping mechanisms. Subjects sang "Today" (Justice, 2000), and each subject identified an emotion felt that day within the song. A review of the previous session and introduction of the topic of this session (expressing sorrow) followed. The group sang, "I Cried" (Alsop, 1994) with adapted lyrics related to sorrow from the death of a loved one. A lyric analysis discussion followed, and the feeling of sorrow was normalized. Using a poster board, the word "grief" was written in the center by the therapist. An educational discussion which included previous session's work followed, and subjects were taught the definition of the word "grief". Each subject wrote emotions felt during their grieving experiences. The ocean drum was introduced, and the therapist, while playing, demonstrated how grief is like waves in the ocean: sometimes the emotions are very subtle and other times they are quite strong. Each subject then played how their grief experience has been using the ocean drum. The song, "Until we Meet Again" (Justice, 2000) was used for closure.

Session 5 assisted in identifying causes of anger related to loss and the development of healthy coping mechanisms. The session opened with singing the song, "Today" (Justice, 2000) and emotions were identified. The previous session was reviewed, and the new topic (coping with anger) was introduced. The group sang Boldt's (1993) version of "I Can See Clearly Now" which identified the various physiological changes while getting angry and healthy means of coping with anger. A lyric analysis followed, and subjects shared changes they felt in their bodies as they became angry. Anger as an emotion was validated and normalized. A poster board was used to assist with discussion, and subjects identified ways in which people express anger. Each way of expressing was placed by subjects into one of two columns: helps us/does not help us. Discussion of consequences of expressing anger in harmful ways followed. Music techniques (listening, drumming, singing) were identified as healthy means of expressing anger. The session ended with rhythmic improvisation.

Session 6 focused on the retainment of memories of the person who died. The session began by the group singing "Today" (Justice, 2000), and a brief emotional check-in followed. The previous session was reviewed and the new topic (keeping memories alive) was introduced. Using the melody of "Kum Bah Yah", the group

engaged in a song parody. The original lyrics were replaced with memories of the people who died. Verse 1 focused on naming who died, Verse 2 focused on emotions felt, Verse 3 focused on what the subjects learned from the people who died, and Verse 4 included favorite memories. The song of remembrance was sung together, and copies were provided for each subject. For closure, subjects chose songs to sing using egg shakers.

Session 7 assisted in the reinforcement of objectives through previous sessions through behavioral contracts and a rap-writing exercise. Group members chose an opening song, and any new concerns were addressed. The previous session was reviewed, and the new topic introduced (goal reinforcement). The rap-writing was introduced by the therapist providing the rhythmic foundation for the rap. Each subject participated in composing a rap using the following basic format: Verse 1 focused on the loss; Verse 2 expressed emotions, Verse 3 identified healthy coping skills, and Verse 4 contracted each subject to employ healthy means of coping. Each subject agreed to try to employ the healthy ways of coping at home and at school. Differences in the environments and unique challenges were discussed. For closure, the group sang the rap again, and each subject received a copy of the rap.

Session 8 promoted continued use of support and healthy coping skills while encouraging continued forward movement through grief; evaluation and closure of group were included. Rhythmic improvisation began this session. The seven sessions were reviewed, and an emotional check-in followed. Group evaluations were completed. Each subject was invited to bring recordings of their favorite music to this session. The playing of favorite songs followed, and each subject completed the statement "What I hope to accomplish next . . ." after the song. The group concluded with the singing of the two songs written in previous sessions.

Results

Due to the small n , the statistical test used to compare data between experimental and control groups was the Mann-Whitney U at the 0.05 alpha level for two-tailed tests (Madsen & Moore, 1978). There was a significant difference between the pretests of the experimental and control groups for the Behavior Rating Index for Children in the school environment (BRIC-S) ($n_1 = 9$; $n_2 = 9$; obtained $U = 14.5$; critical $U = 17$; $p < .05$), but there were no signifi-

TABLE 1
Means Scores by Group and Test

	Experimental pretest	Experimental posttest	Control pretest	Control posttest
DSRS	12.44	11.78	13.33	14.00
BRIC (home)	25.33	18.11	27.33	28.78
BRIC (school)	20.55	16.11	27.67	26.67
BP	37.00	14.89	39.00	38.00

cant differences for the Behavior Rating Index for Children in the home environment (BRIC-H) ($n1 = 9$; $n2 = 9$; obtained $U = 39$; critical $U = 17$; $p < .05$), the Depression Self-Rating Scale (DSRS) ($n1 = 9$; $n2 = 9$; obtained $U = 34.5$; critical $U = 17$; $p < .05$), or the Bereavement Group Questionnaire for Parents/Guardians (BP) ($n1 = 9$; $n2 = 9$; obtained $U = 38.5$; critical $U = 17$; $p < .05$) on pretest comparisons of the groups. Because there was a significant difference on the BRIC-S, the difference of pre and posttest scores were used in statistical analysis. The data were analyzed by comparing the pre and posttest differences of the control group to the pre and posttest differences of the experimental group.

The BRIC-H indicated a significant difference between the pre and posttest difference scores of the experimental and control groups ($n1 = 9$; $n2 = 9$; obtained $U = -5$, critical $U = 17$; $p < .05$). Table 1 shows that the mean score on the posttest for the experimental group was 7.22 points lower than the pretest, and the control group posttest was 1.45 higher than the pretest.

The Bereavement Group Questionnaire for Parents/Guardians (BP) analysis indicated a significant difference between the pre and posttest difference scores of the experimental and control groups ($n1 = 9$; $n2 = 9$; obtained $U = 14.5$, critical $U = 17$; $p < .05$). The mean score of the experimental group lowered 14.89 points after group participation whereas the control group mean lowered one point.

The Behavior Rating Index for Children in the school environment (BRIC-S) showed no significant differences between pre and posttest difference scores of the experimental and control groups ($n1 = 9$; $n2 = 9$; obtained $U = 34.5$, critical $U = 17$; $p < .05$). The mean score following participation in the experimental group was reduced by 4.44 whereas the control group posttest mean was reduced by one point.

On the Depression Self-Rating Scale (DSRS), statistical analysis indicated no significant differences between the pre and posttest difference scores of the experimental and control groups ($n1 = 9$; $n2 = 9$; obtained $U = 34.5$, critical $U = 17$; $p < .05$). The experimental group showed little change on the DSRS, with a drop in score of .66 from the pretest whereas the control group showed an increase on the posttest of .77.

Parent/guardian's perception of the effectiveness of the treatment as measured on the BP indicated that 56% viewed it as "extremely effective," and 44% viewed it as "moderately effective." None of the parents/guardians reported that the treatment was "not effective" or "slightly effective." Eighty-eight percent reported that they would "strongly recommend" the treatment, and 12% reported they would "recommend." "Strongly not recommend" and "not recommend" were not indicated. As for the work of the therapist, 78% reported that it was "above average" whereas 22% reported it was "average." "Poor" and "fair" were not indicated regarding the therapist's work.

Discussion

Subjects participating in the music therapy groups showed significant reductions in grief symptoms as captured by the BP (emotions, thoughts, physical complaints, behavior) and a reduction in behavioral problems as captured by the BRIC in the home environment.

Statistical analysis indicated no significant differences following treatment for self-rated depression or school behavior, although there were reductions in the mean scores for the experimental group following participation in the music therapy groups for both tests. The DSRS mean showed a minimal drop from 12.44 to 11.78, and the BRIC (school) showed a more substantial drop from 20.55 to 16.11.

Birleson (1981) cites a cut off score for 13 on the DSRS, therefore, subjects scoring below 13 were not considered depressed. Four of the nine subjects in the experimental group scored 13 or higher on the DSRS. Of those four, three of the scores dropped following group participation, therefore, only 25% of the subjects who were depressed in the pretest remained depressed in the posttest. Five of the nine subjects in the control group scored 13 or higher on the pretest, and six scored 13 or higher on the posttest, therefore, the number of depressed subjects in the control group increased by one from pre to posttest. These results indicate that

50% of the children in the study were depressed on the pretest, per self-report. The experimental groups may not have focused enough on the elevation of mood, or depression may not have been a prevailing sign of grief for the children in this study.

The BRIC (school) was completed by the subjects' teachers in an effort to assess behavior in the school environment. The experimental groups stressed the need for transfer through a variety of means, and change in behaviors across settings was important in evaluation. Stiffman et al. (1981) cite a rough cut off as 30 for the BRIC, therefore subjects scoring below 30 show little need for intervention. One of the subjects in the experimental group scored 31 on the BRIC (school), and the remaining subjects scored below 30 on the pretest. All the subjects in the experimental group scored below 30 on the posttest. Two subjects in the control group scored 30 or higher on the pretest, and one scored 30 or higher on the posttest. These data seem to indicate that behavior was not a significant problem in the classroom. Altogether, there were four sets of siblings in the study. In those cases, behaviors at home were reported as a problem due to sibling fighting. In the school, siblings were not in the same classes, and therefore this separation during the school day may account for differences in evaluation of behavior between home and school. The behaviors at home did improve following participation in the music therapy groups as previously stated, and subjects appeared able to transfer learned skills to the home environment.

The significant differences in scores on the BP are substantial (40% reduction in posttest grief scores), and it is important to note that the BP is the only test that measures grief comprehensively. Grief is a complex phenomena to measure as it encompasses multiple aspects of emotions and behaviors. The BP measured these aspects in four areas: emotions, thoughts, physical complaints, and behavior.

Overall, the BP results indicated that parents/guardians found the treatment to be effective, would recommend others to music therapy groups, and the work of the therapist was above average. Several teachers and school personnel reported that the children participating in group treatment were highly motivated to attend groups, and that the children often verbalized their enjoyment in participating in groups. Music therapy seems to provide a positive

medium through which children can work through the bereavement process.

Future studies which include several follow-ups of the subjects over their childhood/adolescence would be helpful in knowing if success achieved in music therapy group participation is sustained over time. This study was limited by the number of subjects because a comprehensive grief program existed within the county's school system. Further research that focuses on a population that has not received grief counseling and has a larger number of subjects would be beneficial. Furthermore, the therapist lacked input in evaluation of subjects in this study because a reliable tool for therapist's evaluation is not present in the literature. Perhaps the creation of a therapist's evaluation may be utilized objectively if the music therapy groups were videotaped and evaluated by a therapist not facilitating the groups. Research in the future should include a reliable therapist's evaluation of mood and behavior of the subjects. The no-contact aspect of the control group was a limitation of this study, and future studies may want to compare various types of interventions such as psychotherapy-based groups with music therapy-based groups. The lack of randomization of subjects to groups was another limitation since policies of the Caring Tree program and the Leon County Schools prevented randomization of subjects. Schools, however, were randomly assigned to be experimental or control. The subjects attending the schools were then placed in the groups, and subjects, therefore, were not randomized. Future studies would be strengthened by subject randomization.

In conclusion, this study serves as a pilot study for designing research with grieving children being treated by music therapists. A variety of creative music therapy interventions were utilized, and many more possibilities exist for treating grieving children with music therapy. The study demonstrates that research is possible with this population and encourages future research.

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