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Singing an Imaginal Dialogue: A Study of a Bereavement-Specific Music Therapy Intervention

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Singing an Imaginal Dialogue: A Study of a Bereavement-Specific
Music Therapy Intervention

A DISSERTATION

Yasmine A. Iliya

In partial fulfillment of the requirements
for the degree of
Doctor of Philosophy

LESLEY UNIVERSITY
May 17, 2014

(This page will contain the signed Dissertation Approval form)

STATEMENT BY AUTHOR

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“You would know the secret of death.

But how shall you find it unless you seek it in the heart of life?

Only when you drink from the river of silence shall you indeed sing.

And when you have reached the mountaintop, then you shall begin to climb.

And when the earth shall claim your limbs, then shall you truly dance.”

- Khalil Gibran, “On Death”, *The Prophet*

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ABSTRACT

The purpose of this research was to understand the experience of singing an imaginal dialogue with a deceased loved one. This bereavement-specific music therapy intervention was an adaptation of Shear, Frank, Houck, and Reynolds' (2005) imaginal dialogue intervention and was heavily influenced by Austin's (2008) method of vocal psychotherapy. Following Shear's (2006) use of the spoken imaginal dialogue with therapists, the guiding question of the present study was: What are creative arts therapists' experiences of singing the intervention? The sample consisted of nine female creative arts therapists with a minimum of three years of clinical experience. It included women who identified as minorities in the realms of race, culture, ethnicity, and/or sexual orientation. Participation entailed one music therapy session with a music therapist who was not the researcher. After the session, participants completed a questionnaire and were interviewed about their experience by the researcher. Distress levels during and after the intervention rated on a scale of zero to 100, and these quantitative data were analyzed using descriptive statistics. The qualitative data were analyzed using inductive thematic analysis (Braun & Clarke, 2006) and six themes were found: (a) I cried the whole time - Elicitation of profound emotional expression; (b) I was scared to sing - Discomfort, nervousness, and anxiety; (c) I felt safe - Containment and support; (d) I felt his/her presence - Emotional and spiritual connection to the deceased; (e) I'm finally grieving and have greater acceptance - Helpful opportunity for grief resolution; (f) It bypassed the intellectual - More effective to sing than speak. These findings support previous research on grief therapy and imaginal dialogue and contribute to the field of expressive arts therapies by deepening our understanding of the applications of singing an

imaginal dialogue with a deceased person. More research is needed to gain an understanding of grief-specific music therapy interventions for adults.

CHAPTER 1

Introduction

Grieving the death of a loved one is a universal human experience that most people will encounter numerous times. Grief is the “emotional response to loss” (Muller & Thompson, 2003, p. 107). Though many individuals will successfully cope with their grief without seeking grief-specific mental health treatment, others will experience more intense grief reactions and/or may need professional support to integrate and make meaning of the loss (Neimeyer, Burke, Mackay, & van Dyke Stringer, 2010).

The secondary costs of grief can be seriously detrimental to a person’s health and quality of life. In addition to the emotional suffering, individuals with prolonged grief reactions are also at higher risk for physical illnesses such as cancer, heart disease, and hypertension (Prigerson, Bierhals, Kasl, & Reynolds, 1997; Utz, Caserta, & Lund, 2012). Women who experienced high levels of traumatic grief symptoms six months after a loss were more likely to experience a physical health event such as heart attack or cancer by 25 months post-loss (Chen et al., 1999). Men who experienced high levels of anxiety symptoms six months after a loss were more likely to experience suicidal ideation by 25 months post-loss. Impairments such as lower quality of life, sleeping problems, and poor social functioning have been found in numerous studies (Boelen & Prigerson, 2007; Ott, 2003; Prigerson et al., 1997). Boelen and Prigerson (2007) concluded that prolonged grief was “predictive of reduced quality of life and mental health” (p. 444).

Considering the prevalence and poor health outcomes associated with prolonged grief, the question of whether bereaved individuals are motivated for counseling and/or therapy services is important to consider. Johnson et al. (2009) found that 98.3% of

participants without *complicated grief* (CG), a prolonged grief reaction, and 100% of the participants with CG were receptive to receiving mental health services. The implication of this research is that bereaved individuals, especially those with CG, seek mental health services, which must therefore be made accessible. Although bereaved adults are prone to emotional, physical, and social suffering, they seek services to help them cope with their grief, making them a population simultaneously at-risk and motivated for treatment.

Fortunately for these adults, therapeutic interventions may be able to alleviate their pain (Wittouck et al., 2011). Researchers have found a positive relationship between bereavement-related distress and successful outcomes through grief therapy interventions (Currier, Neimeyer, & Berman, 2008). In an important contribution, one grief therapy intervention was developed and researched by Shear, Frank, Houck, and Reynolds (2005). A novel CG treatment protocol was developed and compared with interpersonal therapy in a groundbreaking randomized controlled trial. The protocol included an intervention known as the *imaginal dialogue*. This intervention consisted of asking the participants to have an imaginary conversation with a deceased person, speaking to the person who died and then responding to themselves from the role of the deceased. The imaginal dialogue has been called “one of the most powerful and widely used of the gestalt techniques” (Wagner-Moore, 2004, p. 184). The intervention procedure was outlined as follows:

The patient was asked to imagine that he/she could speak to the person who died and that the person could hear and respond. The patient was invited to talk with the loved one and then to take the role of the deceased and answer. The therapist guided this “conversation” for 10 to 20 minutes. (Shear et al., 2005, p. 2604)

In addition to the imaginal dialogue intervention, this protocol also included asking participants to tell and tape-record the story of the death, and then listen to the tape throughout the week. Results demonstrated that CG treatment was more effective, especially in combination with anti-depressants. However, 10% of the sample refused to participate in these interventions, considering them “too difficult” (p. 2606).

Furthermore, there was an attrition rate of 26%. Although the authors did not detail the reasons for these dropout rates, it appeared that the interventions were too emotionally overwhelming and painful. Participants did not feel that the potential or experienced discomfort and agony of doing the interventions would yield treatment benefits.

Nevertheless, Shear, Gorscak, and Simon (2006) identified the imaginal conversation to be “a powerful component of [their] treatment” (p. 168), and recommended further research on the use of this intervention for bereaved individuals.

In addition to the aforementioned treatment protocol for CG, incorporating imaginal dialogue (Shear, 2006; Shear et al., 2005; Shear et al., 2006), the imaginal dialogue technique had been previously studied in the context of bereavement (Field & Bonanno, 2001; Field, Bonanno, Williams, & Horowitz, 2000; Field, Hart, & Horowitz, 1999; Field & Horowitz, 1998). In all the studies conducted by Field and colleagues, researchers asked participants to speak to their deceased spouses using this intervention in order to study its applications in assessing feelings of unresolved grief following loss. For example, in the study by Field and Horowitz (1998), the participants were instructed to speak to their deceased spouses for approximately five-minutes. The directive was as follows:

You will be asked to speak to your deceased spouse as though he/she were here with you right now. Think of what you would say to him/her if you had an opportunity to take to him/her one more time. This may involve telling him/her things that you didn't say to him/her or things you didn't have the opportunity to say that you would have liked to have said to him/her...Or you may want to express to him/her how you feel about him/her and how his/her death has affected you. Whatever you decide to say, try to think of something that would be most meaningful for you knowing that you only have this one opportunity to speak to him/her again. (p. 281-282)

These research studies demonstrated that while the intervention may have applications for bereaved individuals, more research was needed. Several questions remained, such as why the treatment may be more beneficial and engaging for some individuals more than others. Furthermore, the clearly high attrition and rates of refusal in Shear et al.'s (2005) study beg the question: why is the treatment too distressful for some individuals? If individuals find the imaginal dialogue intervention too painful to utilize, the potential benefits of the intervention are unseen. Therefore, those individuals may continue to emotionally, physically, and psychosocially suffer. Considering the high attrition and refusal rate of Shear et al.'s (2005) study, as well as the limited research on the intervention's application for bereaved adults (Field & Bonanno, 2001; Field et al., 2000; Field et al., 1999; Field & Horowitz, 1998), further examination was warranted.

It seemed there was a need for the intervention to be emotionally less painful and more tolerable, so that individuals would remain engaged in treatment. Could a modification of the intervention keep the principles of the imaginal dialogue but without

the high level of distress? The creative arts therapies, including music, art, drama, and dance/movement therapies, have been shown to increase individuals' motivation for treatment (Mössler, Assmus, Heldal, Fuchs, & Gold, 2012; Persons, 2009; Solanki, Zafar, & Rastogi, 2013). Indeed, Persons (2009) found individuals were more motivated for art therapy because it was even perceived as enjoyable, at times. Even more, the creative arts therapies have long facilitated the expression and process of challenging emotions like sadness and anger (Erkkilä et al., 2011; Gold, Solli, Krüger, & Lie, 2009). The arts have been named effective 'containers' for expressing and processing these deep emotions, making them more manageable by allowing the content to be processed in an externalized form (Rabiger, 1990; Springham, Findlay, Woods, & Harris, 2012; Twemlow, Sacco, & Fonagy, 2008). Therefore, difficult and painful material can become more tolerable and workable when done so in an art form as compared to exclusively cognitive and verbal realms.

Knowledge of the potential held by creative arts therapies to make distressing material more palatable led to the question: Could modifying the imaginal dialogue into a music intervention make it less painful and more tolerable? A review of the literature found that while many studies have demonstrated the effective use of music therapy with bereaved children and teenagers (see, for example, Dalton & Krout 2005; Hilliard, 2001), there was a gap in empirical research focusing on music therapy with bereaved adults. However, one qualitative study conducted by Smeijsters and van den Hurk (1999) used music therapy with a bereaved woman. Their research found improvised piano playing and singing were useful interventions for expressing feelings of grief.

Consequently, an exploratory study was conducted to research music therapy for bereaved adults (Iliya, 2013). This randomized controlled mixed methods study was conducted with adults with CG and mental illness. Among individuals with serious mental illness, the prevalence of those experiencing CG has been found to be as high as one-third (Piper, Ogrodniczuk, Azim, & Weideman, (2001). Participants were diagnosed with severe mental illness such as bipolar disorder, major depressive disorder, schizophrenia, schizoaffective disorder, and/or substance abuse disorder. Concurrently, participants met the proposed criteria for CG (Appendix A) and scored a minimum of 25 on the Inventory of Complicated Grief – Revised (ICG-R; Prigerson & Jacobs, 2001; Appendix B). Participants in the experimental group received 10 weeks of individual music therapy focused on their grief symptoms, while all participants received standard of care treatment consisting of weekly verbal therapy or a day treatment program. Using a pre and post-test design with the ICG-R as the measure, the study demonstrated that those who received music therapy had a significantly greater reduction of grief symptoms. The study demonstrated music therapy to be an effective and promising treatment, but the small sample size must be considered.

Importantly, this study facilitated the first music therapy adaptation of Shear et al.'s (2005) imaginal dialogue, where the dialogue was sung instead of spoken. The intervention was influenced by Austin's (2008) method of vocal psychotherapy, which focuses on the use of the voice. The experimental research sessions in the exploratory study were qualitatively analyzed, and participants identified that singing the intervention was helpful and beneficial in increasing emotional expression (Iliya, 2013). Furthermore, results demonstrated no attrition or refusal. These findings were surprising, as adults with

severe mental illness are typically lower functioning and in need of increased structure in treatment. And yet, the experimental intervention was not only tolerated, but also found to be effective for these individuals.

From the limited sample size ($N=10$) and findings of the preliminary research, the intervention appeared to be more tolerable when sung instead of spoken (Iliya, 2013). These unanticipated findings yielded the obvious question: Why was the intervention perceived as more bearable and helpful when sung instead of spoken? Theoretically, Austin (2008) identified that singing in music therapy is a powerful experience because “our voices resonate inward to help us connect to our bodies and express our emotions” (p. 20). Austin argued that working with the voice holds immense therapeutic potential. Research supports these theories. A literature review found several research studies supporting the therapeutic potential of singing (Busch & Gick, 2012; Gick, 2011). For example, participants described “singing as a way of releasing emotions, which they had felt unable to express fully in talking therapies” (von Lob, Camic, & Clift, 2010). Moreover, a qualitative study on music therapy with bereaved adults illustrated that singing to the deceased “elicited a feeling that [participants] could communicate with their relatives” (O’Callaghan, McDermott, Hudson, & Zalberg, 2013, p. 113).

Shear (2006) introduced experiential exercises for therapists as part of the training to conduct CG treatment. Shear hoped that practicing the imaginal dialogue would activate therapists’ own unresolved feelings of grief to gain personal insight and determined that “the imaginal conversation is similarly powerful and helpful for most therapists” (p. 222). Following Shear’s (2006) use of the spoken intervention with

therapists, it was consequently questioned how singing the intervention would be experienced by therapists, and creative arts therapists in particular.

Therefore, the guiding question of the present study was developed: What are therapists' experiences of singing an imaginal dialogue with a deceased loved one? Additionally, if the intervention is more endurable, as results demonstrated in the pilot study (Iliya, 2013), why is this so? To help the researcher learn about the experience of singing an imaginal dialogue, creative arts (i.e., music, dance/movement, drama, art, poetry, and expressive) therapists with a minimum of three years clinical experience were purposefully selected as participants in the present study. The rationale behind selecting creative arts therapists for participants was based on: (a) Shear's (2006) suggestion of asking therapists to experience the intervention; and, (b) the single-session design of the study. Although the intervention would typically be used in multiple sessions during ongoing treatment, in this research it was studied in a single-session. The rationale behind this design was to focus on participants' initial experiences of the intervention, and to examine any potential attrition or refusal of doing the intervention. The single-session was extracted from the larger context of treatment to examine the intervention with more focus and specificity. In only one session using a creative arts therapy intervention, participants needed to have some sort of familiarity of using the creative arts in a therapeutic way. While not all creative arts therapists may be familiar with singing, these professionals are familiar with using the arts in therapy. In a single-session, some basic understanding of how a creative intervention might be used was necessary, and it was thought that creative arts therapists would possess this knowledge. Furthermore, the intervention was thought to potentially bring up intense feelings, thoughts, and insights.

Therapists were also purposefully selected in order to minimize psychological and emotional risk as much as possible. The rationale was that experienced clinicians might have better coping skills in knowing how to emotionally take care of themselves. As a further safeguard, participants were required to be concurrently engaged in ongoing psychotherapy treatment.

Operational Definitions

The intervention in this study will be referred to as the *imaginal dialogue*. In reviewing the literature, the intervention is also referred to as the *empty-chair dialogue* (ECH). According to *Merriam-Webster Dictionary* (n.d.), the definition of *imaginal* is “of or relating to imagination, images, or imagery.” The word *imaginary* is defined as “existing only in imagination: lacking factual reality.” Although the definition of *imaginary* more accurately describes the intervention, the word *imaginal* will be used throughout this study to keep in line with previous research on verbal variations of the same intervention (for example, Shear et al., 2005).

Research Design

To understand participants’ experiences of singing the imaginal dialogue, the present study employed a mixed-methods design for data collection and analysis. The qualitative component was rooted in a constructivist epistemology, which depends on the participants’ views and experiences of the situation being researched. Theory or hypothesis was not established before the research was conducted. In qualitative research, “the role of the researcher as the primary data collection instrument necessitates the identification of personal values, assumptions, and biases at the outset of the study” (Creswell, 2014, p. 207). The researcher in this study fully acknowledges a personal

history of grief and loss, which undoubtedly influenced the choice of topic. The researcher's experience of loss both creates a bias but also gives the researcher a greater sensitivity to the topic. Furthermore, the researcher is a singer and a music therapist with advanced training in Austin's (2008) method of vocal psychotherapy. Positive professional and personal experiences of singing also influenced the choice of topic. The researcher employed bracketing and reflexivity to become more aware of personal values, assumptions, and biases that have a potential for influencing data collection and analysis. Study design, data analysis approaches, and researcher reflexivity will be discussed in more depth in Chapter Three.

Anticipated Contribution

It is anticipated that this research will contribute to the field of expressive arts therapies by deepening our understanding of singing an imaginal dialogue with a deceased person, which is a bereavement-specific music therapy intervention. Singing may help make Shear et al.'s (2005) intervention more tolerable, and therefore more effective, for bereaved adults. The aim of this research was to help close the gap in research on music therapy for bereaved adults, and offer greater treatment options for many adults who need support with their grief and loss.

Chapter Two will discuss the current state of research related to grief, grief therapy, imaginal dialogue, and vocal expression. It will examine current creative arts and music therapy research for bereavement, as well as for disorders with related symptoms such as depression, anxiety, and post-traumatic stress disorder. Finally, Chapter Two will present a rationale for applying this music therapy intervention with bereaved adults.

CHAPTER 2

Literature Review

The aim of this literature review is to explore the existing literature on bereavement and grief counseling from the fields of music therapy as well as the other creative arts therapies, psychology, and mental health counseling, thereby establishing a foundation for future research. This chapter reviews the following aspects of bereavement and therapy: (a) symptoms, prevalence, and outcomes of prolonged grief reactions, including complicated grief, (b) bereaved individuals' receptivity to services and research, (c) experiences and coping strategies of grieving adults, (d) non-music interventions for grief and related symptoms, and (e) of music-based interventions for grief and related symptoms. Research designs, findings, and interventions are examined. The studies reviewed support the use of music therapy for bereaved adults and demonstrate the need for future research.

Prolonged Grief Reactions

Diagnostic Criteria

Bereavement, which is the state of experiencing the death of a loved one, is considered a natural part of life. However, sometimes individuals experience a more prolonged and severe grief response. One proposed diagnosis for a prolonged grief reaction has been termed complicated grief (CG) disorder. CG has been defined as “persistent intense symptoms of acute grief” (Shear et al., 2011, p. 108) coupled with perseverating thoughts and feelings regarding the loss. CG was controversially proposed to be included in Section III of the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; APA, 2013) as persistent complex bereavement-related

disorder. The proposed diagnostic criteria for CG are listed in Appendix A. It was proposed for Section III because this diagnosis requires further research. Proponents stated that CG met *DSM-5* inclusion criteria as a diagnosis because it is “associated with clinically significant distress and impairment including impairment in work and social functioning” (Shear et al., 2011, p. 105). However, the diagnosis was ultimately not included in the *DSM-5*, due to an ongoing controversy regarding its distinctness from other psychiatric disorders (Hogan, Worden, & Schmidt, 2003; Hogan, Worden, & Schmidt, 2005; Prigerson & Maciejewski, 2005).

To inform the symptom profile of CG, Simon et al. (2011) used the Inventory of Complicated Grief (ICG; Prigerson et al., 1997) scale with 782 bereaved adults ($M_{age}=47.0$; $SD=14.6$ years), of which 288 were found to have CG. The ICG scale is a common tool for measuring grief and CG symptoms, and although it has been used in a number of studies, findings were measurement-dependent by the questions asked in the scale itself. In spite of the limitations, this research offers important diagnostic criteria for CG. Six symptom clusters emerged:

- (1) yearning and preoccupation with the deceased,
- (2) [feelings of] anger and bitterness,
- (3) [feelings of] shock and disbelief,
- (4) estrangement from others,
- (5) hallucinations of the deceased, and
- (6) behavior change, including avoidance and proximity seeking [of memories of deceased]. (Simon et al., 2011, p. 124)

These symptoms persisted for at least six months following the death. Examples of avoidance and proximity seeking behaviors include, respectively, avoidance of certain places that carry memories of the deceased or compulsively viewing photos. The wide

range of ages and racial/ethnic diversity in the sample strengthened the study's credibility. The findings were limited by the questions used in the ICG scale.

Grief symptoms persisting more than six months have been established as the distinguishing factor between normal and pathological, prolonged grief (Prigerson & Jacobs, 2001). The authors revised the popular ICG scale (ICG-R; Appendix B), but both versions continue to be commonly used for clinical and research purposes. Criteria for CG were grouped into separation distress and traumatic distress. Separation distress includes symptoms such as “distressing preoccupation with the deceased person” (p. 623). Traumatic distress includes symptoms such as “a sense of numbness or detachment resulting from the loss; feeling shocked, stunned, or dazed by the loss” (p. 623).

A prolonged grief reaction like CG has been demonstrated to be uniquely different from other related psychiatric diagnoses and symptoms such as depression, anxiety, and post-traumatic stress disorder (PTSD) (Dell'Osso et al., 2012; Prigerson & Maciejewski, 2005; Shear et al., 2011; Simon et al., 2007). For example, the principal characteristic of PTSD is fear, while the principal characteristics of CG are “sadness and yearning” (p. 107). In one study by Golden and Dalglish (2010), participants ($N=223$) completed the ICG scale as well as scales to measure depressive, anxiety, intrusion, and avoidance symptoms. Using principal components analysis, researchers examined how symptoms clustered together. Results demonstrated differentiation of CG from all other disorders, supporting the consideration of CG as a distinct bereavement diagnosis. In addition, descriptive statistics demonstrated 17.5% of the sample fulfilled diagnostic criteria for CG.

However, while CG may indeed be a distinct diagnosis, robust research has demonstrated overlapping symptoms between CG, depression, anxiety, and PTSD (Schaal, Dusingizemungu, Jacob, Neuner, & Elbert, 2012). Symptoms of CG are collectively distinct from these related psychiatric disorders, but there may be individual symptoms of these disorders present in grief. Boelen (2013) demonstrated that correlations between CG, depression, and adult separation anxiety disorder scores were moderate to large, “indicating that the symptom clusters represent distinguishable, but related constructs” (p. 71).

Later research has supported the hypothesis that a prolonged grief reaction, like CG, is an intensity issue rather than a symptom issue (Holland, Neimeyer, Boelen, & Prigerson, 2009). The structure of grief was examined by studying 1,069 bereaved individuals. The ICG-R was administered over the Internet to participants who had lost a first-degree relative more than 6 months earlier. The mean age of the participants was 38.5 ($SD=11.0$) years and most (74.1%) were female. From the scores on the ICG-R questionnaires, participants were classified as either having CG or normal grief. The data were analyzed using taxometric methodology. This analysis searched for connections among variables that are unique to the categories of CG and normal grief. Results showed that “normal and prolonged grief [CG] simply fall along different ends of the same continuum” (p. 198). However, the authors strongly emphasized that despite these findings, CG should still be considered as a diagnosis for the *DSM*. The study’s findings were limited by the young age of the sample, as the results may not be generalizable to older adults. Notwithstanding this limitation, this study adds valuable literature on the conceptualization of CG. While the controversy surrounding its distinctness persists,

research demonstrates that a prolonged grief reaction, such as CG, may be defined by the severity of its symptoms rather than by the symptoms themselves. These symptoms overlap with those of depression, anxiety, and PTSD, and studies examining the treatment of these conditions will be discussed. First, to understand the severity of prolonged grief, the prevalence and risk factors of these reactions must be considered.

Prevalence and Risk Factors of Prolonged Grief Reactions

Despite the fact that death is a natural part of life, prolonged and complicated grief reactions are prevalent. Among other factors, older adults and females are at greater risk. Kersting et al. (2011) surveyed a general population sample in Germany ($N=2,520$) and found that 57.3% had experienced bereavement within the past 10 years. The prevalence of CG within the general population was 3.7%. Among participants who were grieving, the prevalence of CG was 6.7%. The prevalence dramatically increases in older adults. Newson et al. (2011) sampled adults aged over 55 years ($N=5,741$). The prevalence of CG among older adults was 4.8%. Among participants who were grieving, the prevalence of CG was a staggering 25.4%. One in every four bereaved adult over the age of 55 met the criteria for CG. These findings suggest a higher prevalence of CG than found by Kersting et al. (2011). The death of a loved one was not an inclusion criterion in either study; therefore, the results provide realistic estimates of the prevalence of CG in the general population. Importantly, these findings suggest that CG is a more prevalent disorder among older adults.

Other risk factors contributing to a prolonged grief reaction have been studied. Research has demonstrated that African-Americans have significantly higher rates of CG than Whites, when controlling for other factors such as education and rates of sudden

death (Goldsmith, Morrison, Vanderwerker, & Prigerson, 2008). Bereaved adults ($N=538$) were given the ICG-R to assess for grief symptoms at 6 months post-loss. Mean participant age was 59 years. Eighty-eight percent of the participants were White while 12% were African-American. Results showed the overall prevalence of CG to be 13%. However, the prevalence of CG in African-American participants was higher at 21.2% as compared with 11.6% in White participants. If the loved one's death was unexpected, the risk of developing CG was higher. Furthermore, all participants who reported a sudden loss fulfilled the criteria for a diagnosis of CG. In terms of prevention, the study found that interpersonal support and religious coping strategies were not effective. The limitations of the study include a small number of African-Americans and lack of information regarding income status. However, this research adds important knowledge regarding the high prevalence of prolonged grief reactions for African-Americans, which has clinical implications in securing availability of services for this population. Investigating the prevalence and risk factors of prolonged grief in other minority groups is needed.

Additional risk factors for developing prolonged grief reactions include female gender, lower income, age above 61 years, and losing a child or spouse (Kersting et al., 2011; Newson et al., 2011). Understanding the factors associated with poor bereavement experiences like CG may help professionals offer earlier interventions and ensure access to services for those who need it. Van der Houwen et al. (2010) investigated the following risk factors: (a) bereavement-related predictors (i.e., kinship, cause of death), (b) intrapersonal predictors (i.e., age, gender, previous significant losses, religiosity/spirituality, attachment style), (c) social predictors (i.e., social support, living

arrangements, professional help seeking), and (d) environmental predictors (i.e., financial situation, medication use, other significant events around time of death). The intrapersonal predictor of attachment style refers to the individual's secure or insecure attachment patterns (i.e., anxious or avoidant attachment styles) in relationships with others. The four dependent variables were grief symptoms, depressive symptoms, positive emotions, and loneliness. Participants ($N=195$) were bereaved adults aged 19 to 79 years. Questionnaires were completed three times: at the start of the study, then three and six months later. Researchers found that intrapersonal predictors, like anxious attachment style, most predicted bereavement outcome. Surprisingly, bereavement-related predictors such as cause of death least predicted bereavement outcome. Poor social support and a poor financial situation predicted higher grief symptoms.

The prevalence of prolonged grief reactions has been found to be as high as 6.7% in bereaved adults (Kersting et al., 2011) and 25.4% in older bereaved adults (Newson et al., 2011). As the above studies indicate, the risk factors for developing CG include female gender, older age, poor social support, and low income (Kersting et al., 2011; Newson et al., 2011). In addition to the emotional distress, prolonged grief reactions have also been correlated to quality of life impairments and poor mental and physical health (for a review, see Stroebe et al., 2007). To understand the full impact of such grief reactions, these impairments must be taken into account.

Quality of Life Impairments of Prolonged Grief Reactions

The association of prolonged grief reactions like CG with physical illness and other quality of life impairments has been well-documented (for a review, see Stroebe, Schut, & Stroebe, 2007). Prigerson et al. (1997) studied mid-to-late-life ($M_{age}=62.4$; SD

= 8.3 years) bereaved adults ($N=150$) and developed the ICG scale to assess CG symptoms. Results demonstrated that individuals with a high ICG score not only had CG but were also “found to be at significantly heightened risk for a variety of poor health outcomes” (p. 621) such as cancer, heart disease, and hypertension. In addition, the findings suggested a link between CG symptoms and increased use of substances. G. K. Silverman et al. (2000) extended the research done by Prigerson et al. (1997) by interviewing 67 widowed individuals at a median of four months after their loss. Higher CG symptoms were associated with lower quality of life indicators such as social functioning, energy level, and mental health. Limitations of this study included a relatively small sample size and interviewing at only four months after the loss, which may be too early to determine both CG symptoms and quality of life.

Bereaved females have a greater risk for developing physical health symptoms in association with their grief (Chen et al., 1999). In a study of 150 grieving adults who lost a spouse, women ($n=92$) were found to experience more emotional distress than men. Women showed higher levels of anxiety, depression, and traumatic grief (i.e., CG) symptoms. In addition, Chen et al. found gender differences in the effects of bereavement-related emotional distress on physical and mental health. At the 25-month follow-up, women who had reported high levels of traumatic grief symptoms six months after the loss were more likely to experience physical illness such as cancer or a heart attack, and men who had reported high levels of anxiety symptoms six months after the loss were more likely to experience suicidal ideation. The study’s findings highlight serious outcomes of grief that are in addition to emotional suffering. However, the

study's credibility was impaired by its small sample size and the rarity of physical illnesses such as cancer.

Boelen and Prigerson (2007) discovered that CG was “predictive of reduced quality of life and mental health” (p. 444). The authors measured quality of life, suicidal ideation, sleeping problems, and CG, depression, and anxiety symptoms in 96 bereaved adults ($M_{age}=45.90$; $SD=14.46$ years). Quality of life was measured using the Rand Health Survey and included questions regarding physical functioning, social functioning, pain, energy, and general health perception. Participants were enrolled between six months and two years after the loss, and the average time since death was 9.27 months ($SD=1.98$). Measurements were taken three times: after signing consent (T1), at 6 months (T2), and at 15 months (T3). Results supported higher CG symptoms at T1 predicted suicidal ideation and depression symptoms at T2. One limitation of the findings was that authors did not have measurements of quality of life at baseline, before the death. Future research could follow adults longitudinally over time to better assess for health and quality of life impairments. The authors maintained that the CG diagnosis is “needed to identify a subgroup of mourners at risk for quality of life and mental health impairment, that would go undetected with an exclusive focus on depressive and anxious syndromes and symptoms” (p. 451).

Other research on the impact CG on physical health has been less conclusive. Ott (2003) found no statistically significant differences in physical health between those with and those without CG. However, those with CG demonstrated consistently and significantly lower mental health scores lower than the participants without CG. Participants were bereaved widows and widowers ($N=112$) who completed

questionnaires at four points in time over 18-months. Grief symptoms (using the ICG), mental health, physical health, and social support were measured by self-report. Those with CG perceived less social support and more life stressors than those without CG. ICG scores were initially high in both groups until 6 months post-loss, when the non-CG group began to show a consistent decline in ICG scores. A prolonged grief reaction is a grief reaction that persists 6-months post loss, as is supported by this data. Over the course of the 18-month study, 20% of those with CG did not demonstrate any improvement in symptoms. Limitations of the study include the nature of using a self-report questionnaire, and a lack of baseline measurements of physical and mental health issues, prior to the death.

However, Ott (2003) also found that the individuals who met the criteria for CG did reach out for professional help; results showed that 41% sought grief counseling and 69% participated in a grief support group. It was surprising to discover such a high motivation for and receptivity to treatment for grief symptoms. After considering the significant prevalence, risk factors, and quality of life impairments, there is a clear need for treatment options for individuals with prolonged grief reactions. A high receptivity to services, as found by Ott (2003), would aid in ensuring these individuals received beneficial treatments for mental and physical health. Therefore, bereaved individuals' receptivity to services must be further examined.

Bereaved Individuals' Receptivity to Services and Research

Considering the prevalence and poor health outcomes associated with prolonged grief, the question of whether bereaved individuals are motivated for mental health services is important to consider. Johnson et al. (2009) conducted a quantitative study

measuring symptoms of CG and the perception of stigmatization and receptivity to mental health treatment. The sample consisted of adults ($N=135$) who had recently lost a spouse. The mean age of participants was 70.0 years ($SD=9.6$). Participants showed positive attitudes about a diagnosis of CG, with 87.5% stating that if they received a diagnosis, “they would be relieved to know that they were not going crazy” (p. 703). Participants did not demonstrate a significant level of concern about stigmatization. Surprisingly, results demonstrated that 98.3% of the participants without CG and 100% of the participants with CG were receptive to receiving mental health services if they were diagnosed with a condition. Although only 16 of the participants fulfilled the diagnostic criteria for CG, the motivation for services was significant for participants with and without CG. However, the researchers did not ask participants if they would be receptive to mental health services even if they were not diagnosed with a condition, which is a limitation of the study. Notwithstanding this limitation, the implication of this study is that bereaved individuals, especially those with CG, seek mental health services, which must therefore be made accessible.

Another study found a rate of receptivity similar to that found by Ott (2003). Bergman, Haley, and Small (2010) found 52% of bereaved spouses ($N=250$) indicated using bereavement services at six months post-loss. Researchers found that higher educational level and elevated symptoms of depression, anxiety, and grief were correlated to increased use of services. African-American participants also used services more than Caucasian participants. The services were mostly provided by primary care physicians and clergy members. The authors noted that there is a wide variation in the level of bereavement training for these professionals, and that greater bereavement

education among these professions may be helpful. One limitation of this study, as with many grief therapy studies, is that the sample consisted of primarily Caucasian middle-aged females. This limits the generalizability of the findings.

In discussing bereaved individuals' receptivity to services, it is also important to consider ethical issues in and receptivity to participating in bereavement research. In a study by Beck and Konnert (2007), bereaved adults ($N=316$) felt positively about bereavement research, with 98.1% stating that it is "worthwhile" (p. 788). Participants were recruited through Internet grief message boards were questioned on the risks, benefits, usefulness, and worth of bereavement research. Participants were also asked about appropriate methods for recruitment, and whether they felt competent to consent to research while in a state of grieving. Analysis found that the benefits of participating in research were helping researchers, professionals, and other bereaved individuals better understand the grieving process as well as "providing hope to other bereaved individuals" (p. 788). The risks of participating in research were "not being able to adequately express experiences or feelings, being misunderstood, and finding the experience to be stressful" (p. 788). There was no consensus on the appropriate timing and method for recruitment, and researchers concluded that participants did not understand the questions regarding competency to consent. The main limitation of this study was that participant self-selection may have biased the results. Despite this limitation, the results may guide bereavement researchers as they consider ethical issues in their study designs. In addition, as previous research demonstrated that most bereaved individuals are motivated for treatment (Johnson et al., 2009), this study demonstrated that most individuals are additionally receptive to participating in research.

In terms of help from others, bereaved individuals are most receptive to another person's offer of "being there" to listen and show care and concern (Rack, Burleson, Bodie, Holmstrom, & Servaty-Seib, 2008). Advice (i.e., "you should keep busy") and the minimization of feelings (i.e., "do not take it so hard") were found to be the least helpful strategies. Other strategies that were found to be somewhat helpful included complimenting the bereaved and deceased, and discussing memories of the deceased. Rack et al. asked good questions regarding the short-term and long-term implications of these strategies. For example, "can providing helpful support to the bereaved influence their long-term coping abilities, perhaps even assisting them to deal effectively with the grief arising from the deaths of others in the future?" (p. 423). Future research that addresses these questions and the receptivity to services would strongly contribute to the field. The findings from these studies have important clinical implications, as those who are at risk for developing prolonged grief reactions simultaneously seek services. Treatment options must therefore be examined and researched in order to best help these individuals.

Experiences and Coping Strategies of Bereaved Adults

Before discussing research on treatment options for bereaved individuals, it is necessary to better understand their grieving experiences and coping strategies. Recognizing these elements of grief can yield to more appropriate and targeted treatments. Indeed, the grief process has been researched using both quantitative and qualitative methods. Muller and Thompson (2003) conducted a phenomenological study to gain insight on the grieving process through first person accounts. Among other findings, participants shared experiences such as "having faith you can deal with it will

get you through it” (p. 188). The participants were adults ($N=9$) who were grieving the loss of a spouse, child, parent, sibling, and/or friend. Participants ranged in age from 44 to 77 years, and the period of time since the death of their loved one widely ranged from one week to 28 years prior to the study. Researchers included such a wide range of time since the loss to encapsulate the various experiences and coping strategies experienced by bereaved adults at several stages of grief. Participants were interviewed with the open-ended statement, “tell me about your experience of grief after the death of a loved one” (p. 186). The interviews were transcribed and coded, and five themes on the experience of grief emerged: (a) Coping, (b) Affect, (c) Change, (d) Details, and (e) Relationships. Within the Coping theme, participants shared strategies for coping with the loss. The Affect theme constituted the emotional response to the loss. The theme of Change described the shifting of life values and priorities after the loss. The theme of Details included recalling the circumstances surrounding the death. Finally, the Relationships theme included descriptions of the deceased individual. The qualitative method used was ideal for gathering information about personal grief experiences because it allowed the phenomena of grief to be studied in context. Member-checking and illustrative quotes preserved credibility. However, the wide range in periods of time since the death of the participants’ loved ones in this study presented a limitation on the findings.

Additional research found similar themes about the grieving experience (Douglas, 2004). Twelve adults aged 32 to 65 years were interviewed on their experiences of loss between 3 to 19 months post-loss. After inductive qualitative data analysis, five themes on the experience of grief emerged: (a) Profound emotional and physical pain, (b) Sense of loss of control and life purpose, (c) Irreversible change required re-identification of the

self, (d) Spirituality and enlightenment about the definition of life and death, and (e) Strong identification with and desire to help others that had lost loved ones. Similar to Muller and Thompson's (2003) study, Douglas (2004) found strong emotional response and shifting life values after the loss. However, Douglas' findings included physical pain as well as identification to help others. Peer debriefing as well as member-checking increased the validity of the findings.

Grieving styles have also been examined using a Delphi method of data collection and analysis (Doughty, 2009). Twenty experts in the field of bereavement counseling were given three rounds of surveys with the aim of gaining a consensus on a model of grief. Questions were asked about observations of grieving patterns, such as "what factors do you believe are involved in creating an individual's unique response to loss?" (p. 467). Participants agreed that grieving is an individual process with multiple influential factors, including internal and external (i.e., culture and gender) pressures. In addition, the panelists observed that individuals most often used both cognitive and affective grieving strategies. These findings are consistent with other grieving strategies discussed in the literature (Muller & Thompson, 2003). However, coping strategies were not discussed, which is a limitation of the study.

Seah and Wilson (2011) conducted a phenomenological study of coping strategies of bereaved university students ($N=6$) aged 20 to 53 years. Participants were interviewed with an open-ended question, and qualitative data analysis revealed six themes of coping with grief: (a) Thinking, (b) Doing, (c) Resting, (d) Feeling, (e) Relating, and (f) Learning. Similar to Muller and Thompson's (2003) previously discussed findings, the coping strategies within the themes of this study included making sense of the loss,

expressing feelings, reminiscing about the deceased, and finding comfort in faith and God (Seah & Wilson, 2011). In addition, the participants identified coping strategies such as resting, exercise, and adopting a positive attitude.

Contemporary psychology theory has suggested that the construction of meaning from loss, as well as the development of continuing bonds with the deceased, are critical aspects of healthy bereavement (Neimeyer et al., 2010). Neimeyer, Baldwin, and Gillies (2006) researched this theory by asking 506 to complete the ICG as well as other measures assessing the strength of their attachment and ability to find meaning. The results demonstrated that individuals who felt a close bond with the deceased but who were unable to make meaning of the loss were at greatest risk for developing CG. The construction of meaning was defined as the “ability to find some form of benefit or ‘silver lining’ in the loss, to experience a progressive rather than regressive transformation in one’s identity, and especially to make sense of the loss in personal, practical, existential, or spiritual terms” (p. 733). The results also showed that African-American participants reported significantly greater grief symptoms than Caucasian participants. This research finding supports previously discussed findings (Goldsmith et al., 2008) that African-Americans are at greater risk for developing CG.

The importance of meaning construction was further researched by quantitatively studying personal strength, meaning finding, religious importance, caregiving strain, and social support in bereavement (Su Hyun, Kjervik, Belyea, & Eun Sook, 2011).

Participants were older adults ($N=101$; $M_{age}=72.23$ (6.39) years) who completed measurements at six, 18, and 48 months post-spousal death. Results demonstrated that personal strength increased moderately over time. In addition, individuals who reported

higher levels of finding meaning or religiosity also reported higher levels of personal strength. One implication of these findings is that “helping people in their quest to find meaning in the death is one of the important interventions in bereavement counseling” (p. 212). In addition, mental health counselors should be sensitive to the potential importance of religious beliefs in the grieving process.

Similar to the concept of personal strength, researchers have also studied the concept of growth and its relationship to bereavement (Currier, Holland, & Neimeyer, 2012). Conventional wisdom supports the notion that a certain degree of suffering can build personal strength. Researchers used a large sample ($N=670$) of bereaved adults who had experienced loss over the previous 2 years. The findings suggested a curvilinear association between grief and growth: participants who reported moderate grief symptoms perceived the highest levels of growth, and participants with lesser or greater grief symptoms reported lower levels of growth. These results have clinical implications for individuals experiencing highly distressed and prolonged grief. It may be helpful for clinicians to understand that for these clients, a perception of growth may develop over time as symptoms are alleviated.

The implication of these research findings is that there are common themes that may arise during bereavement, which could help mental health counselors become more supportive and helpful to their clients (Muller & Thompson, 2003; Seah & Wilson, 2011). Additionally, participants in these studies found talking about their grieving process in the research interview to be helpful, which has implications for service providers. Findings indicated that bereaved individuals benefited from sharing memories and stories of the deceased, as well as talking about the circumstances of the death.

Gaining an understanding of the grieving experience has significant clinical implications: “health care professionals will be more appropriately prepared in assisting the bereaved to avoid the negative physical and emotional effects of unresolved grief” (Douglas, 2004, p. 32).

Non-Music Therapy Interventions for Grief and Related Symptoms

After understanding how bereaved individuals grieve and cope with the loss, treatment can be better formulated for individuals who seek services. In the fields of mental health counseling and psychology, non-music therapy interventions for grief symptoms have been extensively researched. Grief therapy interventions may help individuals better cope with their loss, which may aid in preventing the mental and physical health risks previously discussed. The efficacy of grief therapy interventions has been debated, but meta-analyses discussed below have supported their use, especially for individuals who seek treatment (Allumbaugh & Hoyt, 1999) and have more distressed grief reactions (Currier, Neimeyer, & Berman, 2008).

In a meta-analysis examining the effectiveness of grief therapy, Allumbaugh and Hoyt (1999) included 35 published and unpublished studies ($N=2,284$) of grief therapy. The criterion for inclusion was the examination of any type of grief therapy using quantitative measures. Analysis of variables (i.e., clinician training and type of treatment) demonstrated that the level of clinical training and licensure was a significant factor in determining outcome, with licensed professionals offering more effective grief therapy. Additionally, participants in the studies who had voluntarily sought treatment had better outcomes than those who were recruited, perhaps due to increased motivation and receptiveness. A major limitation of the findings is that all the studies for which

participants volunteered were also the studies conducted by licensed clinicians.

Allumbaugh and Hoyt used multiple regression analysis to conclude that an increased number of therapy sessions was related to improved outcome. Grief therapy was also more effective when offered closer to the time of their loved one's death. The researchers analyzed standardized mean-change scores and then calculated the difference in outcome between treatment and control groups. Results showed that participants who were in control groups and did not receive any treatment had minimal improvement in reported grief. This has significant implications for mental health professionals, as it suggests that individuals may benefit from grief therapy, especially when offered closer to the time of their loved one's death.

In another meta-analysis of grief therapy interventions for bereaved individuals, Currier, Neimeyer, and Berman (2008) found grief therapy interventions to be significantly more effective when compared to the control conditions. Currier et al. reviewed 61 outcome studies examining the effectiveness of grief therapy, which included 48 peer-reviewed articles and 16 dissertations. Researchers found a slight statistically significant difference between the experimental and control conditions immediately following the grief therapy interventions in the studies reviewed. However, the difference between conditions was no longer evident at times of follow-up, indicating that most participants improved naturally over-time. Some treatments reviewed showed little benefits or negative benefits. It is important to note that effect sizes were larger for the studies that restricted inclusion criteria to bereaved individuals having specific difficulties coping with the loss. These findings suggest that there is a positive association between bereavement-related distress and successful outcomes through grief

therapy interventions. Currier et al. also observed that, in the reviewed studies, “it was rare for researchers to describe how the interventions were developed, how they conceptualized the therapeutic process... and how the interventions were linked to previous research on the needs of bereaved individuals” (2008, p. 658). The findings of this meta-analysis support the idea that grief therapy should not necessarily be universally offered to all bereaved individuals, but only to those experiencing maladaptive reactions to the loss.

Of all the treatment interventions, cognitive-behavioral therapy (CBT) has been an increasingly researched method of psychotherapy for bereavement. However, a review of 11 studies evaluating CBT-based interventions for bereavement-related distress demonstrated mixed results (Currier, Holland, & Neimeyer, 2010). In the reviewed studies, CBT was compared with a non-CBT intervention or a no-treatment control group. All but one of the studies used a randomized study design. Initial results demonstrated that CBT was more effective than the other therapeutic interventions. However, when Currier et al. accounted for researcher allegiance, they found that differences between therapeutic approaches were no longer statistically significant. Researchers have found that investigator allegiance can predict the outcome in comparative treatment studies (Luborsky et al., 1999). Therefore, Currier et al. (2010) concluded that “if the researchers were theoretically neutral, there may not have been significant differences for the various bereavement-related outcomes” (p. 88). Results of the review showed that all treated individuals, regardless of intervention, demonstrated improvements in depression, trauma, and anxiety symptoms, as compared to untreated control participants. Therefore, this evidence demonstrates that CBT interventions for

grief work as well as other interventions. Future research is necessary to establish the efficacy of grief therapy treatments.

Grief Therapy for Adults with Prolonged Grief

Researchers have found a relationship between bereavement-related distress and successful outcomes through grief therapy interventions, suggesting that grief therapy may be most effective when treating individuals with prolonged grief reactions like CG (Currier et al., 2008). However, little research has examined treatment approaches for individuals with CG. The most recent meta-analysis of studies examining prevention and treatment for CG reviewed 14 randomized controlled studies in which a grief intervention was compared with a control (non-grief specific) intervention (Wittouck, Van Autreve, De Jaegere, Portzky, & van Heeringen, 2011). Results showed that treatment interventions had a positive effect on reducing grief symptoms in the short- and long-term. However, preventative grief intervention studies were not found to be effective. In total, 1,655 participants were included in the review, consisting of 910 participants who received a grief-specific intervention, 745 who received a control intervention, and 344 who were lost to follow-up. The participants were 70% female, and the interventions were mostly group-oriented. The meta-analysis highlighted several methodological limitations in current bereavement research, such as the underrepresentation of males, lack of ethnic diversity, and lack of randomized designs, which will be further discussed below. Regardless of these limitations, the meta-analysis supported promising findings for CG treatment, and authors suggested future research use larger sample sizes and longer follow-up periods.

In another study comparing standard psychotherapy with grief focused psychotherapy, Cruz et al. (2007) aimed to identify potential differences in treatment outcomes for African-Americans and Caucasians. Researchers compared African-American participants with CG ($n=19$) and White participants with CG ($n=19$) who were matched for other factors such as sex, age, and grief severity. The participants were randomly assigned to receive 16 sessions of standard psychotherapy or 16 sessions of psychotherapy with a focus on grief and loss. Results found no differences in treatment outcome or clinical presentation, regardless of ethnicity or type of treatment received. Limitations of the study include the small sample size. Nevertheless, individuals in “ethnic minority groups are among those least likely to receive services appropriate to their needs” (p. 702). Therefore, research comparing the treatment approaches and outcomes with individuals from different ethnicities adds valuable clinical information to the field of mental health.

As discussed in Chapter One, Shear, Frank, Houck, and Reynolds (2005) conducted the first randomized controlled trial for CG. The researchers compared the efficacy of a novel CG therapy protocol with standard interpersonal psychotherapy for adults with CG. Participants ($N=95$) aged 18 to 85 years were recruited from a university-based psychiatric clinic, as well as a low-income African American community. Treatment was provided in 16 sessions over an average of 19 weeks. Treatment response was measured through the self-report ICG questionnaire completed pre- and post-treatment, as well as the evaluator-rated Clinical Global Improvement scale. The CG treatment approach alternated between focusing on the loss and focusing on restoration from the loss. It included a “revisiting” (p. 2,604) exercise, modified from in vivo

exposure used for PTSD, where participants were audiotaped recalling the details of the death and subsequently asked to listen to the tape throughout the week.

In addition, the aforementioned imaginal dialogue intervention was an important component of the treatment protocol (Shear et al., 2005). This intervention consisted of the asking participants to have conversations with the deceased, speaking directly to the person who died and then taking on the role of the deceased to answer. This intervention was designed “to promote a sense of connection to the deceased” (p. 2,604). Results demonstrated that participants who received CG treatment showed greater improvement of grief symptoms than those who received interpersonal psychotherapy. Furthermore, those who were simultaneously taking antidepressant medication and receiving CG treatment demonstrated an even greater improvement in symptoms. However, 45% of participants were taking psychotropic medication, which was a limitation on the study results. Further research is needed to systemically examine medication and psychotherapy treatment options for adults with CG.

Serious limitations of Shear et al.’s (2005) groundbreaking study included the high attrition rate of 26% and the 10% of participants in the CG treatment group who refused to do some of the specified interventions because they considered them “too difficult” (p. 2,606). Such high percentages of attrition and refusal gravely limit the potential benefits of the treatment protocol. Notwithstanding these limitations, this was the first randomized controlled trial of a specific CG treatment for adults with CG, and the findings were promising. Further research is needed to understand the effectiveness of exposure therapy and imaginal dialogue interventions for bereaved individuals.

Imaginal Exposure Interventions

Research supports the notion that CG is uniquely different from other related psychiatric diagnoses such as depression, anxiety, and post-traumatic stress disorder (Dell'Osso et al., 2012; Prigerson & Maciejewski, 2005; Shear et al., 2011; Simon et al., 2007). However, research has simultaneously shown that symptoms of grief can overlap with those of depression, PTSD, and anxiety (Bergman et al., 2010; Boelen, 2013; Boelen & Prigerson, 2007; Hogan et al., 2003; Schaal et al., 2012). Symptoms of CG are collectively distinct from these related psychiatric disorders, but there may be individual symptoms of these disorders present in grief. In addition, research has supported the hypothesis that CG is indeed an intensity issue along the grief continuum, rather than an exclusive symptom issue (Holland et al., 2009). Therefore, in reviewing bereavement interventions, it is important to also consider interventions for related disorders whose symptoms overlap with those found in grief. Though these interventions have not been exclusively researched with bereaved individuals, they may have clinical and research applications for this population.

One such intervention for grief-related symptoms is exposure therapy, which has been widely researched as a treatment for PTSD and anxiety disorders (Foa, 2011). This behavioral treatment approach is grounded in the theory that “the fear (emotional) structure associated with the traumatic memory is conceived as a specific pathological fear structure that include erroneous associations among stimuli and response that were present at the time of the trauma and their meaning” (p. 1,044). Exposure interventions are divided into three types: in-vivo, interoceptive, and imaginal. While in-vivo interventions expose the individual directly to the feared stimulus, interoceptive

interventions induce the physical sensations of panic, such as hyperventilation. Imaginal interventions ask individuals to revisit and recount traumatic memories. The aims of this exercise are:

to help patients organize the memory, reexamination of negative perceptions about their conduct during the trauma, regain new perspectives about themselves and others, distinguish between thinking about the trauma and re-experience the trauma, generate habituation to the trauma memory so that the trauma can be remembered without causing undue anxiety, and foster the realization that engaging in the trauma memory does not result in harm. (p. 1,045)

Through imaginal exposure, there may be opportunities for new learning and new insights. However, an essential component of exposure therapy is ensuring that individuals are sufficiently emotionally engaged while revisiting the trauma.

A review of research on exposure therapy identified 25 randomized controlled trials supporting its use in reducing PTSD symptoms (McLean & Foa, 2011). These trials compared exposure therapy with a waiting-list control, supportive counseling, relaxation, and standard of care treatment. Exposure therapy was effective for both acute and chronic PTSD, and treatment gains were maintained at follow-ups of one year or longer. Therefore, proponents of exposure therapy have argued that it is the most robust and reliable treatment for symptoms of trauma.

However, a meta-analytic review found no immediate differences in treatment gains between exposure therapy and other active therapy treatments for PTSD (Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010). Researchers reviewed 13 studies with a total sample size of 675 participants. Statistical analyses demonstrated that exposure

therapy was significantly more effective than no treatment and other passive control conditions, such as relaxation. However, there was no statistically significant difference found between exposure therapy and other active interventions, such as cognitive therapy and eye movement desensitization and reprocessing (EMDR). Results did find that there was a significant effect size for participants who underwent exposure therapy at follow-up, suggesting that it has more lasting benefits than other active treatments. The most noteworthy limitation of the review was that Foa was an author for most of the reviewed studies. The researchers analyzed Foa's research with that of other researchers, and no differences were found. However, Foa was also an author of the meta-analysis, which was a bias that was not addressed. Exposure therapy for PTSD may benefit from research conducted by other researchers in order to ensure robust, generalizable, and replicable results.

Other research has also found exposure therapy to equivalent treatment benefits to CBT. Tarrier et al. (1999) conducted a randomized trial of cognitive therapy compared with imaginal exposure in the treatment of PTSD. Participants ($N=62$) were mostly middle-aged, married men whose traumatic histories included surviving crime, accidents, or terrorist attacks. Treatment was either CBT or imaginal exposure therapy that took place on average every 2 weeks over a 24-week period. Pre- and post-treatment scores of stress, anxiety, and depression demonstrated no significant differences between the treatment groups on any of the outcome measures. In this study, unlike the meta-analysis reviewed above (Powers et al., 2010), treatment gains from both treatment groups were maintained at the 6-month follow-up. Participants in both treatment groups had high rates of non-compliance, which resulted in a longer duration of treatment, a longer time

between sessions, and a reduced number of sessions. Authors suggested that non-compliant participants may not have been benefiting from the accumulating effect of treatment sessions, which has implications for clinicians and researchers working with individuals with PTSD. Indeed, previous research has supported that individuals who are highly engaged and experience gradual habituation between sessions may benefit most from exposure therapy (Jaycox, Foa, & Morral, 1998).

As previously discussed, grief researchers such as Shear (Shear, 2006; Shear et al., 2005; Shear, Gorscak, & Simon, 2006) have developed and researched specific CG interventions that include elements of exposure therapy. Shear (2006) started by first reviewing effects of treatments for depression, but found that patients were “only moderately responsive” (p. 218). Shear then added imaginal exposure to the CG treatment, due to the “prominence of trauma-like symptoms” (p. 218) in CG, and the results were more promising (see, for example, Shear et al., 2005). As earlier discussed, one of the elements of imaginal exposure was an imaginal conversation with the deceased. Shear, Gorscak, and Simon (2006) identified the imaginal conversation to be “a powerful component of [their] treatment” (p. 168). The procedure was outlined as follows:

the patient was asked to speak to the person who died and that the person could hear and respond. The patient was invited to talk with the loved one and then to take the role of the deceased and answer. The therapist guided this ‘conversation.’ (Shear et al., 2005, p. 2604)

Shear et al. were the first to research elements of exposure therapy in the context of grief, by understanding that symptoms of CG are similar to those of depression as well as

PTSD. Adaptations of Shear et al.'s CG treatment have been used for returning service men and women experiencing PTSD and CG (Steenkamp et al., 2011). In addition, the imaginal dialogue component has been widely published in the literature as a treatment for symptoms related to grief.

One common criticism of exposure therapy is the high level of distress and resulting attrition it may cause. In Shear et al.'s (2005) randomized controlled trial, the attrition rate was 26%. However, Hembree et al. (2003) evaluated attrition rates of individuals engaged in exposure therapy, cognitive therapy, stress inoculation training and EMDR. The researchers found no significant differences in rates of attrition between these interventions. On the other hand, additional research has found that those who were unfamiliar with exposure therapy rated a description of it to be more distressful than cognitive behavioral therapy (Devilley & Huther, 2008). This research suggests that more public education on exposure therapy and its potential benefits is needed.

Empty-Chair and Emotionally Arousing Interventions

The imaginal dialogue has also been referred to as the empty-chair (ECH) or two-chair dialogue. Among Gestalt interventions, it has been called "one of the most powerful and widely used" (Wagner-Moore, 2004, p. 184). ECH dialogues "are, in fact, a type of imaginal exposure" (Diamond, Rochman, & Amir, 2010, p. 403). Research has demonstrated the ECH technique to be effective for unresolved issues (Clarke & Greenberg, 1986; Greenberg, 1979, 1983; Greenberg & Malcolm, 2002; Paivio & Greenberg, 1995) as well as for issues surrounding grief (Field & Bonanno, 2001; Field, Bonanno, Williams, & Horowitz, 2000; Field, Hart, & Horowitz, 1999; Field & Horowitz, 1998), depression (Paivio & Greenberg, 1995), and unresolved anger

(Diamond et al., 2010). Gestalt researchers have suggested that the ECH technique is effective in part because of its ability to arouse intense emotions (Greenberg, 1979; Greenberg & Malcolm, 2002; Greenberg & Pascual-Leone, 2006; Paivio & Greenberg, 1995).

The intervention consists of inviting a participant to dialogue with a part of him or herself, and has been well documented for adults struggling with conflict (i.e., internal, external, decisional; Greenberg & Malcolm, 2002). The participant may also have an imaginal dialogue with another person to resolve unfinished business by means of “restructuring of the client’s emotional memories and view of self and other. This form of imaginal confrontation with the significant other involves accessing and expressing the previously inhibited painful feelings, and acknowledging and legitimizing previously unmet needs” (p. 406).

Apart from the aforementioned treatment protocol for CG incorporating ECH dialogue (Shear, 2006; Shear et al., 2005; Shear et al., 2006), ECH techniques have been only minimally studied in the context of bereavement (Field & Bonanno, 2001; Field et al., 2000; Field et al., 1999; Field & Horowitz, 1998). Field and Horowitz (1998) studied the ECH intervention with 73 bereaved spouses who identified unresolved feelings regarding their loss. ECH was used as a method of assessing unresolved feelings. The participants were instructed to speak to their deceased spouses for approximately five-minutes. The directive was as follows:

You will be asked to speak to your deceased spouse as though he/she were here with you right now. Think of what you would say to him/her if you had an opportunity to take to him/her one more time. This may involve telling him/her

things that you didn't say to him/her or things you didn't have the opportunity to say that you would have liked to have said to him/her...Or you may want to express to him/her how you feel about him/her and how his/her death has affected you. Whatever you decide to say, try to think of something that would be most meaningful for you knowing that you only have this one opportunity to speak to him/her again. (p. 281-282)

Immediately after the ECH intervention, the participants completed a Likert-type survey regarding the emotions they experienced as well as their feelings of unresolved grief, self-blame, helplessness, and acceptance of the death. The results demonstrated that the survey responses significantly correlated with symptoms of depression and stress at 6-months and 14-months post-loss. A limitation of this study and several of the studies reviewed is that the sample consisted of middle-class Caucasians and therefore limits the generalizability of the findings to other individuals from other cultural backgrounds. However, this study was the first that employed the ECH intervention in the context of unresolved grief. This study was extended several times by the researchers (Field & Bonanno, 2001; Field et al., 2000; Field et al., 1999). In all the studies, researchers asked participants to speak to their deceased spouses using the ECH intervention described above. Researchers also measured blame-related emotions such as anger and guilt in post-ECH surveys. The ECH dialogues were transcribed and analyzed for blameworthiness and results demonstrated that participants who found the deceased to be blameworthy (i.e., responsible for wrongdoing and deserving of blame) experienced more distress at 14-months post-loss (Field & Bonanno, 2001; Field et al., 2000). Although

these studies do not examine the effectiveness of ECH in spousal bereavement, they do study the applications of ECH in assessing feelings of unresolved grief following loss.

Indeed, bereaved individuals may experience unresolved feelings after experiencing a loss. Paivio and Greenberg (1995) conducted a groundbreaking study of ECH dialogues for adults with unresolved feelings regarding issues such as sexual abuse, physical abuse, and/or the loss of a parent. In a randomized, controlled trial comparing ECH dialogue (experimental condition) with a psychoeducational group (control condition), participants ($N=34$) who participated in ECH dialogues reported greater improvements in all measured outcomes. ECH was provided in weekly 50-minute individual therapy for 12-weeks, while the psychoeducational group met three times for two-hour lectures. Participants completed pre and post-tests measuring interpersonal problems, unfinished business, and general symptom distress. ECH was significantly more effective in all measures, and the gains were maintained at four months and one year post-treatment. Researchers maintained “the explicit focus on accessing emotion in the ECH therapy also likely contributed to treatment effects” (p. 424). A small sample size coupled with an attrition of four people from each group limited the findings. Nevertheless, ECH was found to be effective in resolving unfinished feelings, including those of grief and loss.

More recent research by Greenberg and colleagues has examined the process of change for adults who participate in ECH dialogues for unresolved feelings. In a study of 26 participants who engaged in ECH dialogues, results showed that the participants who expressed previously unmet needs underwent a shift in their view of themselves and the other, expressed a high intensity of emotion, and had the greatest resolution of symptoms

(Greenberg & Malcolm, 2002). The study's findings reinforced that there are "those who fully absorb the treatment, by engaging in the change processes the treatment is attempting to promote, and those who do not" (p. 414). Individuals who were fully engaged in the ECH treatment benefited more than those who did not. Therefore, further research is needed to further examine the change process for individuals in ECH treatment, and why the treatment may be more beneficial and engaging for some individuals more than others.

The aforementioned study demonstrated that intensity of emotional arousal in ECH was correlated with better treatment outcomes (Greenberg & Malcolm, 2002). Additional research has refined this finding. Carryer and Greenberg (2010) measured levels of emotional arousal and treatment outcomes for depression, and found that "too much or too little emotion was found to be not as helpful as a moderate amount" (p. 190). The participants ($N=38$) underwent experiential psychotherapy, and results demonstrated that spending approximately 25% of session time expressing emotions was the ideal level of arousal. Therefore, a lack of emotional arousal and/or overwhelming emotional arousal was associated with poorer outcomes. A majority of the participants were female ($n=24$). Although this study was one of correlation and no causality can be inferred, the findings have clinical implications in ideal levels of emotional arousal for improving depression.

Diamond, Rochman, and Amir (2010) furthered this research by conducting the first study specifically examining emotional arousal of ECH interventions. The research question was: what is the efficacy of different interventions, including ECH dialogues, designed to arouse emotions in psychotherapy? Twenty-nine women who identified as

having unresolved anger were enrolled in a single-session consisting of ECH and other emotionally-arousing interventions, including elicitation of and empathizing with the participants' emotions. Results indicated that the interventions did lead to increased emotional arousal, especially with regards to sadness, fear, and anxiety. The imaginal ECH intervention successfully "elicited primary sadness, loss, and longing among individuals" (p. 406). However, the authors did not relate the results to the findings of Carryer and Greenberg (2010), which correlated positive treatment outcomes to an ideal time of emotional arousal. Furthermore, the percentages of time or degrees of emotional arousal were not specified. The methodological limitations also included a small sample size consisting of only females, and a single-session study design. In addition, the study did not measure treatment outcome, but only examined emotional arousal in correlation with ECH techniques. Nevertheless, the intervention of ECH dialogue was found to be emotionally arousing, and researchers recommended the technique for clinicians working with unmet needs and unresolved feelings. These findings support the findings of Greenberg and Pascual-Leone (2006) that "working with aroused emotion is predictive of positive outcome in therapy" (p. 624). For clinicians and researchers working with bereaved individuals, this research supports the potential effectiveness of ECH dialogue and emotionally arousing therapy for grief. Further research on these interventions and other interventions for this population is needed.

Expressive Writing Interventions

A review of the literature demonstrates limited research of music and creative arts interventions for grief and grief-related symptoms. However, there have been a number of studies using expressive writing interventions for bereaved adults, with varying results.

These studies will be briefly reviewed, as they demonstrate the potential of the creative arts with bereaved individuals and can model as research designs for future studies.

Similar to the previously discussed research on grief therapy, expressive writing interventions have been most effective with adults with prolonged grief reactions. In a randomized controlled trial, Wagner, Knaevelsrud, and Maercker (2006) examined internet-based, expressive writing CBT therapy for adults with CG ($N=55$; $M_{age}=37.0$ years). The 5-week experimental intervention consisted of the following writing assignments emailed to therapists: (1) two essays on the circumstances of the death; (2) a supportive letter to a hypothetical friend who experienced the death of a loved one; and (3) reflecting on memories of the deceased, how the loss has changed them, and how they will cope with the loss. Participants in the control group received no intervention. Instead of using the ICG to measure CG symptoms, researchers used a variety of scales to measure depression and anxiety symptoms, general mental and physical health, and intrusion and avoidance behaviors. Results demonstrated that participants in the experimental group showed greater improvement of CG symptoms than those in the control group for all measures except physical health. Limitations of the study included the restrictions of an internet-based study design, such as limited communication with therapists via email only, and limited possibilities for crisis intervention. Not using the ICG, a standard scale, to measure CG symptoms posed an additional limitation. However, this study was the first randomized, controlled study examining such a creative treatment intervention for adults with CG, and the findings were encouraging.

Additional studies using expressive writing interventions with bereaved adults not diagnosed with CG were less promising. Range, Kovac, and Marion (2000) hypothesized

that writing about one's bereavement experience for 15 minutes a day for four days would decrease symptoms of grief, anxiety, and depression, as well as number of health care center visits, more than writing about a trivial subject. Participants ($N=44$; $M_{\text{age}}=20.31$ years) had lost a loved one by accidental or homicidal death. Participants in the experimental group were asked to write about their thoughts and emotions surrounding the death, and participants in the control group were asked to describe their bedrooms. Measures were given pre-test, post-test, and at a six-week follow-up. All participants in the study demonstrated a decrease in grief, anxiety, and depressive symptoms, but those in the experimental group experienced a larger reduction in anxiety symptoms. Those in the experimental group did not experience any difference in grief symptoms. One limitation of this study is that researchers used the Grief Recovery Questionnaire (GRQ), which was designed to only measure grief after loss by a suicide. Therefore, it was found to be a weak measure for the current study, as it did not encapsulate grief following sudden, non-intentional death. The authors did not specify why they selected this measure. Another limitation was that most of the participants were female college students. These are significant limitations.

Further research with bereaved adults also found no effect of expressive writing interventions on grief symptoms (van der Houwen, Schut, van den Bout, Stroebe, & Stroebe, 2010). Participants in the experimental group ($n=460$) were given five highly structured writing assignments that focused on expressing negative as well as positive emotions and to incorporate meaning or lessons gained from the loss. Grief symptoms, depression symptoms, positive mood, and emotional loneliness were measured pre- and post-test, and compared with a control group ($n= 297$) that did not complete any writing

interventions. Findings demonstrated that those in the experimental group had decreased feelings of emotional loneliness and increased feelings of positive mood as compared to the control group. There was no change in depressive symptoms. Limitations in this study include a high attrition rate of 52%, perhaps due to the lack of researcher feedback provided to participants after completing the emotional and time-consuming writing assignments. Researchers collected writing samples without providing feedback to the participants. Although expressive writing interventions did not appear to decrease grief symptoms in the current study and in the aforementioned study by Range et al. (2000), expressive writing did appear to decrease other symptoms, such as anxiety and loneliness.

One study has suggested potential benefits of using writing interventions for bereaved adults in terms of improving self-care activities (O'Connor, Nikoletti, Kristjanson, Loh, & Willcock, 2003). Researchers asked if writing therapy interventions would reduce grief symptoms as well as lead to improved health and self-care. Sixty-nine participants aged 31 to 86 years completed measures regarding their physical health and grief symptoms, and self-care activities. Most of the participants were women who were grieving the death of a spouse. Participants were randomly assigned to the control or experimental group. The experimental participants attended a 1-day writing therapy workshop specifically tailored for bereaved adults. Interventions included asking participants to write a narrative about the death of their loved one while exploring both negative and positive thoughts and feelings. Results demonstrated that participants in both the control and experimental groups improved in physical health and grief symptoms, suggesting natural improvement over time. However, participants in the experimental group demonstrated a slight increase in self-care activities as compared to

the control group, though the difference was not statistically significant. The small sample size limited the statistical power and generalizability of the results. The limitations of these writing studies must be taken into consideration, and further research needs to be done to evaluate the potential role of self-expression and the creative arts in grief therapy.

Creative Arts Therapy Interventions

The aforementioned writing studies demonstrate the potential of expressive, creative, and artistic interventions for bereaved individuals. As previously mentioned, a review of the literature found limited empirical research examining the use of creative arts (i.e., music, dance/movement, art, drama, expressive and/or poetry) therapy interventions with bereaved adults. However, one dance/movement therapy study using artistic inquiry was recently published (Callahan, 2011). The researcher videotaped seven weeks of dance/movement therapy groups for bereaved parents. The research aimed to help participants kinesthetically explore their feelings of loss using dance/movement therapy while also assisting the researcher in more deeply understanding the parents' grief. The culmination of the study was a choreographed piece, *Buried Treasures*, where the parents' losses were performed using words and movements. Audience responses were recorded, and the researcher concluded that the performers were able to successfully convey parental loss through embodied movements. According to Hervey (2004), artistic inquiry is best-suited for research "about inner experiences of clients or therapists, and if the resulting data is . . . rich in emotional, intuitive, imaginal, or embodied content" (p. 191). While Callahan's (2011) use of artistic inquiry met these criteria, there were several major limitations in this study,

including the lack of member-checking and peer debriefing. In addition, although Callahan listed themes that “repeatedly surfaced” (p. 190) during the groups, there is no explanation of data analysis, which is a major shortcoming. Despite these limitations, this study demonstrated that the use of movement, and especially breath-work, seemed to help bereaved parents as well as the researcher explore feelings of grief and loss.

One study of art therapy with bereaved adults was located, and analysis showed improvements in self-expression and self-esteem. Ferszt, Hayes, Defedele, and Horn (2004) conducted a qualitative inquiry on the use of art therapy with bereaved incarcerated women ($N=8$). The treatment consisted of individual art therapy for eight weeks; interventions were focused on allowing participants to grieve their loved ones and included tasks such as making memory collages. The participants were interviewed about their experience post-treatment. The results of the study showed that six women indicated that art therapy increased self-expression, five women had increased self-esteem, and seven women recommended that the program continue. The results demonstrate the potentially promising use of art in the context of bereavement. However, similar to Callahan’s (2011) dance/movement therapy study, there was no description of how the qualitative interview data were analyzed, which impaired credibility of the study (Ferszt et al., 2004). The researchers included a small selection of quotes from the open-ended responses, but there were no themes identified. These are examples of repeated methodological issues occurring across studies examining treatment options for grief and related symptoms. For instance, a lack of data analysis, which poses serious limitations, as it is difficult to apply the findings. It is important to further review methodological issues in these studies, to understand the state of grief therapy research.

Methodological Issues in Therapy Interventions for Grief and Related Symptoms

As discussed in the previously considered studies, a review of the current research on grief therapy interventions indicated several methodological issues. For example, only 14 studies met the inclusion criteria to be reviewed in the most recent meta-analysis on CG prevention and treatment (Wittouck et al., 2011). Included in the review were randomized controlled studies in which a grief intervention was compared with a control or non-grief specific intervention. In addition, the assessments had to measure grief using a standardized quantitative questionnaire pre- and post-intervention. A grief intervention was defined as “any technique or any more extensive intervention for bereaved individuals suffering complicated grief designed to reduce the severity of complicated grief symptoms” (p. 70). Several studies are methodologically flawed by not having control groups or randomization and/or not measuring outcomes specific to bereavement (Jordan & Neimeyer, 2003). By not measuring grief outcomes, it is difficult to find an effect of the research and results in poor internal validity. One suggestion was measuring positive outcomes of grief, and using mixed qualitative and quantitative designs in order to better measure interventions and outcomes.

Another methodological limitation is the underrepresentation of males and minorities in most published grief therapy studies (Allumbaugh & Hoyt, 1999; Currier et al., 2008; Wittouck et al., 2011). There is a common lack of ethnic and racial diversity, as well as a limited age range, in many published studies. A disproportionate percentage of the participants in current grief therapy research have been middle-aged Caucasian females. For example, in Shear et al.’s (2005) randomized controlled trial examining the treatment of CG, the sample consisted of 83 females (87.36%) and 12 males (12.63%).

Of the 14 studies reviewed by Wittouck et al. (2011), 70% of the study participants were female. Six studies enrolled mostly middle-aged Caucasian females, and four studies enrolled middle-aged females but did not report ethnicity. Only one of the reviewed studies enrolled mostly non-Caucasian males. Females have been shown to be at greater risk for CG (Kersting et al., 2011; Newson et al., 2011), but the reasons for the gender disparity could be related to a number of factors. Ultimately, this methodological issue limits the generalizability of research findings to males. More research is needed on the effectiveness of grief therapy interventions for men and women of varying ages.

More of an effort must also be made to study participants from diverse ethnic and racial backgrounds. Knight, Roosa, and Umaña-Taylor (2009) highlighted the unique methodological challenges and best practices that need to be addressed when studying ethnic minority populations. These challenges include methods of sampling, recruitment, and retention. For example, many of the samples in the published studies were recruited through the Internet and other written advertisements. Knight et al. (2009) stressed that these methods of recruitment target mainly middle-class samples, while in-person referrals have been shown to be more effective with some ethnic minority populations. These methodological challenges must be addressed in the research because:

...a better scientific understanding of the psychological or social science issues associated with being a member of an ethnic minority or economically disadvantaged group in the United States is critical to the way researchers will deal with the social and psychological service needs of the future. (p. 26)

Given these methodological concerns with the current research, future research may benefit from including more ethnically and racially diverse individuals in the samples.

Another methodological limitation of grief research is the disproportionate research done in a group setting. In a recent meta-analysis reviewing 61 controlled studies, Currier et al. (2008) highlighted that a majority of the grief interventions used a group modality (63%). Of the 14 studies reviewed by Wittouck et al. (2011), most of the CG interventions used a group modality, while only three studies examined interventions in an individual setting. Individual interventions must be studied as much as group interventions in order to develop greater treatment options for CG.

The lack of a current CG diagnosis presents another methodological issue. Although CG has been recently accepted into the appendix of the upcoming *DSM-5* (5th ed.; American Psychiatric Association, 2013) as *persistent complex bereavement-related disorder*, the lack of diagnostic criteria has resulted in a plethora of inclusion criteria for studies examining effectiveness of grief therapy (Wittouck et al., 2011). The inclusion criteria defining CG and mean time since the death of the loved one varies widely across the current research. Importantly, Currier et al. (2008) found that the more severe the grief reaction, the more effective the grief intervention. Therefore, criteria have an important effect on research outcomes. Jordan and Neimeyer (2003) suggested that researchers study only high-risk mourners. In addition to the variety of inclusion criteria in the reviewed studies, there was also a range of causes of death, even within one single study. Reactions to non-violent versus violent (i.e. homicide, suicide, accident) causes of death may be different, and further research is needed to understand the effects and circumstances of these causes (Wittouck et al., 2011).

Future research could also use larger sample sizes and longer follow-up periods (Jordan & Neimeyer, 2003; Wittouck et al., 2011). In the studies reviewed by Wittouck

et al., the sample sizes ranged from 54 to 261 participants. In addition, the longest follow-up period was one year after starting the treatment. In the meta-analysis done by Currier et al. (2008), sample sizes ranged from 10 to 261 participants ($M = 64.3$). Research has supported the benefits of treatment for CG, but larger sample sizes would methodologically strengthen the research as well as increase the generalization of findings. In addition, longer follow-up periods would allow researchers to further understand the long-term course and consequences of CG. Further methodological concerns regarding recruitment and retention arise in the research conducted with adults with substance abuse issues (Zuckoff et al., 2006). In this study, the sample size was even smaller ($N=16$). In addition, the attrition rate of 50% greatly affected the study design and outcome. Attrition rates in bereavement research could be high due to concurrent issues, such as substance abuse, and/or due to the emotionally challenging nature of grief therapy interventions.

Finally, bereavement research would benefit from more clearly articulated theoretical orientations and treatment protocols (Jordan & Neimeyer, 2003). Both are currently often vague, and understanding how protocols were developed and how they relate to previous research would benefit future studies. Shear et al.'s (2005) detailed explanation of their treatment protocol, including the theoretical foundations and a manual available by request, greatly strengthened the methodological credibility of their randomized controlled study of CG. These steps ensure the sound replication and clinical applicability of research, both of which are necessary.

Music-Based Interventions for Grief and Related Symptoms

The efficacy of grief therapy interventions has been demonstrated (Currier et al., 2008; Wittouck et al., 2011), but little research has looked at the use of creative arts therapies, including music. After reviewing current research on interventions for grief and grief-related symptoms, as well as methodological limitations in that research, this literature review will now focus on music-based interventions for grief and related symptoms.

Music and Grief Rituals

Music is a common, important, and powerful component of bereavement and grief-related rituals, such as funerals (Castle & Phillips, 2003, p. 41). Recent research in Scotland found that music during bereavement rituals can be used as a way of being together with others, “a means of creating or shifting emotion, [and]... as a means of evoking the memory of the deceased person” (Caswell, 2011, p. 319). Researchers conducted 66 unstructured interviews with bereaved individuals ($n=10$) and funeral professionals ($n=56$), asking the participants to speak about aspects of a funeral they considered to be important. All the participants spoke about the importance and power of music in the funeral setting.

The uses of music in grief and bereavement extend after the funeral, as well. Research has demonstrated that listening to music (Vale-Taylor, 2009) and singing or playing music in honor of the deceased (Castle & Phillips, 2003) are considered two of the most important grief rituals. Participants evaluated ritual activities that helped them maintain a bond with the deceased and allowed the deceased to be remembered by others. Listening to music enjoyed by the deceased was found to be particularly helpful in

reminiscing memories and expressing emotion (Vale-Taylor, 2009). The results of these studies have implications in expanding the use and research of music in the context of bereavement, especially as music therapy.

Music Therapy for Grief-Related Symptoms

The research on music therapy with bereaved individuals is limited. Yet, music therapy has been a consistently promising treatment for grief-related symptoms and illnesses, such as depression, anxiety, and PTSD (Gold, Solli, Krüger, & Lie, 2009). Therefore, it is necessary to further examine the literature on music therapy for these symptoms, as these studies support the potential of music therapy with bereaved adults and can model as research designs for future studies.

A meta-analysis of music therapy and mental illness reviewed studies that mainly examined depression and schizophrenia, but still had promising results (Gold, Solli, Krüger, & Lie, 2009). The review consisted of eight randomized controlled studies, three controlled clinical trials, and four studies without control groups. Music therapy was studied in a group setting for two-thirds of those studies, while only three studies exclusively studied individual music therapy sessions. Findings indicated that music therapy, when added to standard care, significantly improved depression, anxiety, and overall functioning. In addition, the effects of music therapy were directly related to the number of sessions provided, considered to be the 'dose' of music therapy. As the dose of music therapy increased, the benefits of music therapy also increased.

Most research on music therapy and mental illness has been conducted in an inpatient setting with acutely psychotic adults. In a review of the literature, only one study was located examining individual music therapy with adults with depression in an

outpatient setting. A recent randomized controlled trial compared individual music therapy plus standard care with standard care alone for adults with depression (Erkkilä et al., 2008; Erkkilä et al., 2011). Participants ($N = 79$) receiving music therapy plus standard care demonstrated greater improvement in depression symptoms, anxiety symptoms, and general functioning. The music therapy approach was improvisational and psychodynamically oriented, consisting of active music making and verbal processing.

A recent quantitative study was located demonstrating the positive effects of individual music therapy for adults ($N=16$) with anxiety in an outpatient setting (Zarate, 2012). The music therapy treatment consisted of 12 weekly sessions using active vocal and instrumental improvisation methods. Anxiety was measured using the Beck Anxiety Inventory, and results demonstrated a significant decrease in symptoms by the sixth week of treatment. The treatment gains were maintained through the end of the study. The strengths of the study included a sample that was ethnically diverse and 44% male. The use of a standard measure for anxiety also strengthened the validity of the results. Despite the small sample size limiting the generalizability of the results, this study supports the use of music therapy, and clinical improvisation using the voice, for symptoms of depression.

While the above reviewed studies look at the benefits of active music making on symptoms of depression and anxiety, a review of the literature demonstrates that music therapy studies commonly used music-listening interventions, and still found promising results. One such study compared daily listening to classical and baroque music with weekly individual psychotherapy for adults with depression (Castillo-Pérez, Gómez-

Pérez, Calvillo Velasco, Pérez-Campos, & Mayoral, 2010). The music listening group had a statistically significant improvement in symptoms. Music listening was also found to statistically reduce symptoms of anxiety in women who had received a radical mastectomy compared to standard nursing care alone (Li, Zhou, Yan, Wang, & Zhang, 2012). These studies demonstrate the therapeutic potential of music for adults with symptoms of depression and anxiety.

Music therapy has also been shown to be beneficial for adults with PTSD. In a mixed-methods, randomized, controlled trial comparing weekly group music therapy with cognitive behavioral therapy, participants ($N=17$) who received music therapy for 10 weeks reported a significant improvement of PTSD symptoms (Carr et al., 2012). Specifically, pre and post-test differences showed improvements in three hallmark domains of PTSD: avoidance of the traumatic memory, hyperarousal (i.e., fatigue, irritability, aggression, hypervigilance), and re-experiencing unwanted memories of the trauma. There was also an improvement in depressive symptoms, though these results were not statistically significant. However, the small sample size hindered the generalizability of the finding. The authors provided sufficient explanation of the interventions for future replication, which was a strength of the study. Qualitative data included analysis of the sessions and open-ended interviews focused on what was helpful and unhelpful in the sessions. Participants appreciated the opportunities for socialization, relaxation, expression, and distraction in the music therapy group, but found the noise from group drumming to be unhelpful at times. Future studies could more closely examine how specific musical elements help with specific symptoms of PTSD.

While group drumming was found to be unhelpful in the aforementioned study (Carr et al., 2012), it was previously shown to help reduce PTSD symptoms in a qualitative study of six soldiers (Bensimon, Amir, & Wolf, 2008). Data were collected from video-recorded music therapy sessions, open-ended interviews with participants, and a self-report of the therapist-researcher. The sixteen 90-minute sessions consisted mostly of group drumming and 10-15 minutes of relaxing music listening. Researchers employed triangulation and peer debriefing to strengthen the validity of the analysis. The drumming was found to help (a) create feelings of group cohesion; (b) process traumatic associations; (c) appropriately express “rage and relief” (p. 40); and (d) increase one’s sense of control and self-confidence. The researcher conducted the sessions, which may have biased the data and findings. Nevertheless, the reviewed studies support further research examining the applications of music therapy for individuals with depression, anxiety, and histories of trauma.

Voice-based therapeutic interventions for grief-related symptoms. Research has shown promising benefits of music therapy and music listening for grief-related symptoms such as depression (Castillo-Pérez et al., 2010; Erkkilä et al., 2008; Erkkilä et al., 2011), anxiety (Zarate, 2012), and PTSD (Bensimon, Amir, & Wolf, 2008). Of the reviewed studies, Zarate (2012) explicitly stated using vocal improvisation to treat anxiety. There is an emerging body of interest and research on the potential health benefits of singing, which may be applicable to individuals with grief and grief-related symptoms.

References to the benefits of singing have been found in literature dating back to the 17th century (Gick, 2011). More recently, Austin (2008) theorized that singing is a

powerful experience because “our voices resonate inward to help us connect to our bodies and express our emotions” (p. 20). Austin’s method of vocal psychotherapy, consisting of mainly improvisational singing, has been cited as an effective treatment for individuals experiencing symptoms of trauma (Orth, 2005). Furthermore, research on vocal expression and music performance supports the theory that singing is emotionally expressive (Juslin & Laukka, 2003). The authors stated “music performers communicate emotions to listeners by exploiting an acoustic code that derives from innate brain programs for vocal expression of emotions...[and] music may really be a form of heightened speech that transforms feelings” (p. 805). While there may be many treatment uses and benefits of singing, including increased self-expression, the emerging evidence may potentially benefit those who are grieving.

Despite strong anecdotal evidence, current research on the effectiveness of therapeutic voicework has been inconclusive due to pervasive methodological weaknesses (Clark & Harding, 2012; Gick, 2011). Gick reviewed thirty-seven published studies on singing and physical, psychological, and social health. The researcher found some support for health benefits associated with singing, such as improved breathing, improved mood and wellbeing, reduced stress, and social benefits. Gick highlighted several concerns regarding quantitative research design, such as lack of control groups, small sample sizes, and sample selection bias. In the qualitative research, methods of recruitment and data analysis were not consistently clear. Gick suggested that future research examine solo singing in addition to group singing, and that researchers try to understand “the mechanisms by which singing may be associated with health and wellbeing” (p. 198). For example, breathing exercises may be beneficial without including

singing. In addition, variables such as “personality, age, gender, culture, socioeconomic status, musical background, amateur vs. professional status, [and] coping” (p. 199) must be more clearly examined in relation to singing and its benefits.

Additional reviews of singing research found the evidence to be inconclusive. Clark and Harding (2012) conducted a systematic review of the literature on the effectiveness of active singing interventions in improving psychosocial measures such as mood and quality of life. Fourteen articles met stringent criteria to be accepted into the review. These criteria were (a) active singing was the primary intervention; (b) participants were in a therapeutic program; and, (c) psychosocial outcomes were measured. Three quantitative studies had results supporting significantly improved psychosocial measures compared with a control intervention, and three quantitative studies showed significant effects for both the singing and control interventions. These results were inconclusive, and the research quality of these studies was found to be low. Limitations included not blinding the therapists administering the interventions and not blinding the participants. The three qualitative studies were of higher research quality, and demonstrated more promising physiological, social, cognitive, and emotional benefits from singing. The authors of the review concluded that psychosocial benefits of therapeutic singing remain primarily anecdotal, and more robust research is needed to support these claims.

Several studies have examined the impact of group singing on mood, and again found inconclusive results. Kenny and Faunce (2004) conducted one study with ambiguous results that was discussed in the previously discussed reviews (Clark & Harding, 2012; Gick, 2011). The researchers studied the effect of group singing on

mood, coping, and pain for individuals with chronic pain. Middle-aged participants ($N=77$) were randomly assigned to either sing in nine 30-minute sessions (experimental condition) or listen to music while exercising (control condition). Data analysis showed that both groups improved in mood, coping, and perceived pain immediately following the intervention. The inconclusive results were limited by sampling issues. An unidentified number of participants who were placed into the experimental group did not attend their singing sessions, which limits the findings. Secondly, exercising may improve mood, coping, and pain in and of itself, and was therefore not an ideal control condition. In addition, the authors did not delineate the gender breakdown of the participants, which limits the interpretation and generalizability of the findings. However, the benefits of group singing in this study support the need for further research.

Other research on singing and mood has yielded more promising results. In another randomized control trial reviewed by Clark and Harding (2011) and Gick (2011), singing was correlated with improved mood (Unwin, Kenny, & Davis, 2002). Researchers recruited a healthy sample of adults ($N=107$) from a community in Australia. The majority of participants were females ($n=84$) aged between 55 and 65 years, and it was unclear whether or not participants had any previous singing experience. A one-time singing exercise consisting of singing two vocal exercises and five songs (experimental condition) was compared with listening to music (control condition). Participants self-reported mood using the Profile of Mood States Questionnaire before the singing session, immediately after the session, and one week after the session. Data analysis consisted of both parametric and non-parametric tests, which strengthened the results. Similar to the previously discussed study by Kenny and Faunce (2004), findings

demonstrated that participants in both the experimental and control groups reported significantly positive changes in mood (Unwin et al., 2002). Therefore, research has supported that singing does elevate mood, but not more than the control conditions against which it is tested. Further studies must examine longer periods of singing compared with more differentiated control conditions.

Research with adults who regularly sing in choirs has generated the most promising results regarding the potential health and wellness benefits of singing. Busch and Gick (2012) asked members of two choirs ($N=59$; $M_{age}=55.92$) to complete questionnaires regarding mood and well-being before and after a two-hour rehearsal. Most of the participants were women ($n=44$) and the study was conducted in Ontario, Canada. Results suggested that a single choir rehearsal was correlated to increases in positive mood, personal growth, and feelings of energy and vitality. Researchers claimed that socialization did not play a role in the improvement of these measures, because one choir had a designated break for social time and the other did not. However, it is difficult to control for the inherent aspects of socialization that are present when singing with a group, and more research is needed to understand the benefits of group singing versus solo singing.

In another study supporting the benefits of group singing, Livesey, Morrison, Clift, and Camic (2012) researched 169 choir members from Australia, England, and Germany. Researchers asked open-ended questions on the impact of choral singing on overall wellbeing. Results demonstrated that participants found social, emotional, physical, and cognitive benefits of singing in choirs. The study was limited by the sample selection: a majority of the participants were female choir singers over the age of

50 from Western cultures. Further studies should examine a more diverse population to gain a more comprehensive understanding of the potential benefits of singing.

Von Lob, Camic, and Clift (2010) specifically examined the benefits of group singing for choir singers who identified as having an adverse event within the past 10 years. Participants ($N=16$; $M_{age}=52$ years) were members of a non-auditioned choir and mostly female ($n=11$), which is a common sampling limitation across singing research. However, the sample was more diverse than in previous research; it included individuals who identified as gay or lesbian. Researchers conducted semi-structured interviews focused on “how individuals use community group singing as a response to adverse life events” (p. 46). Data were analyzed using grounded theory procedures and six main categories were found: (a) collective experience; (b) building relationships; (c) competence; (d) purposefulness; (e) managing emotions and wellbeing; and (f) creating a meaningful life. These results support group singing as a way for individuals to cope and create a sense of community after adverse life events. The study had clinical implications in that “some described singing as a way of releasing emotions, which they had felt unable to express fully in talking therapies” (p. 51).

Evidence inconclusively supports the therapeutic benefits of singing to improve mood and overall well-being (Clark & Harding, 2012; Gick, 2011), but it is nevertheless important to consider whether all people enjoy singing. As Chong (2010) highlighted, “it is assumed that singing, as one therapeutic intervention, brings positive and therapeutic effects for everyone” (p. 123). However, non-vocalists’ attitudes toward therapeutic singing had not been previously researched. Using an open-ended questionnaire, Chong asked university students not majoring in voice ($N=90$) if they do or do not enjoy singing,

and why. The data were analyzed qualitatively and results demonstrated that for those who enjoy singing ($n=80$), “self-expression” was the most frequent reason. Other reasons for enjoyment included stress reduction, interpersonal relationships, a sense of identity, an increased sense of spirituality, and self-actualization. Seven participants identified enjoyment of singing only when alone, and three participants identified singing as a negative experience with no enjoyment. Although most of the participants reported enjoying singing, it is important to recognize that some individuals may be uncomfortable from or dislike singing. Therefore, sensitivity is required. This has important implications for clinical and research work with singing interventions. Nevertheless, for those who enjoy singing with others, it has potential social, emotional, physical, and cognitive benefits (Busch & Gick, 2012; Livesey, Morrison, Clift, & Camic, 2012; von Lob, Camic, & Clift, 2010). Further research is needed on music and voice-based interventions for grief-related symptoms for adults and children.

Music Therapy with Bereaved Children and Adolescents

The efficacy of music therapy for bereaved children and adolescents has been well-researched (Dalton & Krout, 2005; McFerran & Hunt, 2008; McFerran, Roberts, & O'Grady, 2010; McFerran-Skewes, 2000). In a meta-analysis of 27 studies with bereaved children and adolescents ($N=1,073$), researchers demonstrated music therapy to be the “most successful . . . [and] promising venue for grief intervention” of all the interventions reviewed in the meta-analysis (Rosner, Kruse, & Hagl, 2010, p. 130). Fifteen studies had a control group design, and 12 studies had uncontrolled designs. Interventions reviewed included music therapy, talk therapy, psycho-education, play

therapy, and trauma-focused school-based psychotherapy. Researchers recommended further empirical research using music therapy for bereaved children and adolescents.

One of the studies cited in the aforementioned meta-analysis (Rosner et al., 2010) was done by Hillard (2001). The controlled study design measured behavior, mood, and grief symptoms for participants ($N=18$) who either participated in eight sessions of bereavement-focused group music therapy or did not receive any group therapy. The participants were aged six to 11 years and were pre- and post-tested. The researchers employed a cognitive-behavioral approach using music therapy techniques such as singing, songwriting, drumming, and music listening. Participants in the music therapy groups showed significant reductions in grief symptoms and behavior problems at home, as compared to the control group. There was no difference for depression or behavior problems at school. Future studies should compare music therapy bereavement groups with non-music therapy bereavement groups (i.e., verbal therapy). In addition, the results were limited by small number of participants. However, this study showed promising results in using music therapy to treat symptoms of grief.

Voice-based music therapy interventions for bereaved children. Songwriting and singing interventions were used in Hilliard's (2010) study, and further studies have examined these voice-based music therapy interventions for bereaved children. One cited in the meta-analysis of grief interventions for children (Rosner et al., 2010) was done by Dalton and Krout (2005). Also a controlled study design, researchers used songwriting as the experimental treatment in studying teenagers' grief using the Grief Process Scale (GPS). Dalton and Krout (2002) developed this scale after qualitatively examining 123 songs previously written by grieving teenagers and developing 30 self-statements to be

scored on a scale from 0 to 100. In the present study (Dalton & Krout, 2005), participants ($N=20$) ranged in age from 12 to 18 years, and all had experienced the death of a loved one within three years prior to the study. The participants were recruited at a bereavement center, and six of the participants who were on the waiting list for services served as the study's control group. The experimental group received songwriting-based music therapy interventions for seven weeks. The themes for songwriting selected by the researchers were "understanding, feeling, remembering, integrating, and growing" (p. 132). The researchers administered pre- and post-tests of the GPS and compared the results with those of an established grief measure. Due to the small sample size, researchers analyzed the data using only descriptive statistics. Results demonstrated decreases in grief as measured by both scales for the treatment group. The control group did not demonstrate any noticeable change in self-reported grief. Because only descriptive statistics were used, the groups were not statistically tested against each other. This was a limitation of the study. Despite the lack of statistical analysis, these results supported the use of music therapy in bereaved teenagers. Furthermore, to conclude that the scale is not treatment dependent, the GPS must be used in future studies not utilizing songwriting.

McFerran and colleagues (McFerran et al., 2010; McFerran-Skewes, 2000; Roberts & McFerran, 2013) have repeatedly examined songwriting with bereaved teenagers and adolescents. McFerran, Roberts, and O'Grady (2010) used a mixed-methods design studying music therapy with grieving teenagers ($N=16$). The purpose of the study was to (a) gain an understanding of the teenagers' perception of music therapy groups through open-ended interviews, and (b) determine if participation in music therapy groups improved self-perception and coping abilities through pre- and post-test

measures. The mean age of the participants was 14 years. The participants were recruited from a school, and all had experienced the loss of a family member. The teenagers were placed into two music therapy groups that were 90-minutes in duration and conducted weekly for 12 (Group 1) or 14 (Group 2) weeks. The music therapy interventions included songwriting, improvisational instrumental playing, and music listening. Interviews regarding the perceived benefits of the music therapy group were coded, and six themes emerged. The overall theme was “having permission to grieve” (p. 555) and the sub themes were identified as (a) “changes in grieving status” (p. 555), (b) “changes in loss-related feelings” (p. 556), (c) changes in “daily experience” (p. 556), (d) “improving the connection between self and others” (p. 557), and (e) “increased levels of sharing about the loss” (p. 558). The study’s credibility was impaired by its lack of member-checking and peer debriefing. Examining the scores using descriptive statistics suggested a difference in pre- and post-test scores following music therapy. However, statistical tests were not performed, which limited the study’s findings. In addition, because there was no control group, results were not causal.

McFerran-Skewes (2000) also studied music therapy with bereaved adolescents using a phenomenological approach. Six participants aged 13 to 15 years participated in 10 psychodynamically oriented music therapy groups. Group improvisation and group music sharing were two techniques primarily used. The researcher then interviewed the participants on their experience in bereavement-focused music therapy. The themes that emerged were: (a) musical improvisation offered freedom and control, (b) music therapy created an environment of respect and acceptance, and (c) music therapy facilitated emotional expression. Exemplary quotations from participants’ statements provided

thick description of the phenomenon, but lack of member-checking compromised the validity of the study. The study's findings indicated that the participants benefited from the music therapy group experiences.

The reviewed studies of music therapy and bereaved children all employed a group design. However, Roberts, and McFerran (2013) analyzed lyrics written during individual music therapy sessions with bereaved children ($N=14$) aged between 7 and 12 years. The study did not examine effectiveness of songwriting for bereaved children receiving individual music therapy, but rather asked what themes would emerge from using a songwriting intervention. Participants received an average of seven music therapy sessions. Roberts and McFerran used mixed methods content analysis to inductively identify themes in the lyrics and then deductively analyze the prevalence of each theme. Results demonstrated that the children did write songs to help them process their feelings of grief and loss, but also wrote about themselves, their experiences, and their desires. Thirteen of the children were girls, which is a limitation on the results. However, the studies by McFerran and colleagues (McFerran et al., 2010; McFerran-Skewes, 2000; Roberts & McFerran, 2013) have employed both quantitative and qualitative methods, and have been valuable additions to the research on songwriting with bereaved children. The research on music therapy with bereaved children and adolescents is a promising application of how music therapy, and voice-based music therapy interventions, can be used to treat symptoms of grief. Further research is needed on the use of these interventions for bereaved individuals of all ages.

Music-Based Therapy with Bereaved Adults

Despite the discussed research on the use of music therapy with bereaved children and adolescents, a review of the literature located only four empirical studies using music-based interventions to specifically treat bereaved adults. Sung Hyun and Gallant (2010) studied the effectiveness of adding music-listening interventions in 12 bi-weekly grief counseling sessions with bereaved women ($N=21$) in an outpatient rehabilitation program for substance abuse. All participants listened to the same four recorded songs with themes of healing and forgiveness, then related their stories to the lyrics and messages of the songs. Participants were given pre- and post-tests measuring grief and depression; statistical tests indicated that the mean scores on both measures significantly decreased post-test. Despite these promising results, there were several limitations to this study. There was no control group, which weakened internal validity. In addition, the sample size was small, and all participants were Caucasian females, limiting the ability to generalize the findings. However, this study demonstrated the potential of music listening interventions for bereaved adults.

Popkin et al. (2011) used a mixed-methods approach to study a music therapy grief intervention for nurses and staff in a high mortality cancer setting. In this case, the music therapy consisted of listening to live music, but not playing music. The grief intervention consisted of 5 minutes of improvised music on harp and guitar followed by readings, open reminiscing of patients who passed, and a blessing ceremony. Six participants completed surveys about their experiences, which consisted of six questions that were answered on a Likert-type scale and one open-ended question. Using descriptive statistics, it was concluded that 70% of the participants found the musical

component of the intervention to be “highly-effective” (p. 44). There was no description of how the qualitative data were analyzed, which impaired credibility. The researchers included a selection of quotes from the open-ended responses, but there were no themes identified. The lack of data analysis posed a serious limitation to the study, as it is difficult to apply the findings. In addition, the small sample size makes the effectiveness of the intervention difficult to generalize. Yet, this study demonstrated the potential of listening to live music for bereaved adults.

The aforementioned studies demonstrated the potential of music listening for bereaved adults. Active music making has also been studied in this context. Music therapy conducted before the death of a loved one was later found to be beneficial for bereaved caregivers (O'Callaghan, McDermott, Hudson, & Zalberg, 2013). In this qualitative study with eight adults, only four participants had experienced music therapy with their loved one before the death, but all participants identified using music in some capacity in their personal grieving process. Results found that the surviving caregivers believed that music therapy experiences had enhanced the lives of the deceased, which was comforting. Results also demonstrated that music elicited memories and improved mood for the participants. Listening to, playing, and writing music supported the participant's feelings of grief while also strengthening the bond with the deceased loved one. Participants stated that “music...elicited a feeling that they could communicate with their relatives” (p. 113), especially when they sang to the deceased. The study's design was flawed in that participants did not all have experiences in music therapy. Therefore, the study's findings are difficult to interpret. However, the stated benefits of music,

especially in helping participants maintain a connection with the deceased, were encouraging for future research using music therapy for bereaved adults.

Voice-based music therapy interventions for bereaved adults. As reviewed above, singing has been associated with social, emotional, physical, and cognitive benefits (Busch & Gick, 2012; Livesey, Morrison, Clift, & Camic, 2012; von Lob, Camic, & Clift, 2010). Studies researching voice-based music therapy interventions have shown promising results for individuals with anxiety (Zarate, 2012), as well as bereaved children and adolescents (McFerran et al., 2010; McFerran-Skewes, 2000; Roberts & McFerran, 2013).

One empirical study using voice-based music therapy interventions for a bereaved adult was located in the literature. Smeijsters and van den Hurk (1999) conducted a promising qualitative single-case study of music therapy with a bereaved woman. The 53-year old participant had lost her husband three years prior to the study, which consisted of 23 individual music psychotherapy sessions with co-author van den Hurk. Music therapy techniques included improvisational piano playing and vocalizing. Musical and verbal material from the sessions were transcribed and analyzed. Four themes emerged during the course of the therapy: (a) Identity, (b) Self-esteem, (c) Feeling, (d) Contact. For example, the participant was searching for a new identity without her husband, as demonstrated by her verbal reflections as well as her “restless . . . searching” (p. 227) piano-playing. Self-esteem was demonstrated by the participant’s reflections that she and her music were consistently “stupid” (p. 228). The Feeling theme emerged as the participant began to express herself using words and music after suppressing her feelings for most of her life. Lastly, the theme of Contact emerged from

the therapist's countertransference, which was documented in analytical memos on the session. Often the therapist remarked that the participant "is not seeking contact, does not hear what I am playing, as if it does not matter that I am here and how I am playing" (p. 228). Triangulation, member-checking, and peer-debriefing increased credibility. The researchers found processing the participant's grief using music therapy was beneficial, and suggested that the "expression of deep feelings of sorrow by singing can...lead to an emotional shift" (p. 249). Improvisational piano-playing and voice-work were found to be helpful interventions for the participant, and should be further researched with bereaved adults. The aims of the study included developing guidelines and understanding the effectiveness of music therapy with bereaved adults. The researchers provided helpful guidelines as well as a valid foundation for treatment and future research using music therapy with bereaved adults.

Methodological Issues in Music Therapy Research

As reviewed in the literature, there are several methodological issues in current music therapy research. One criticism of music therapy research methodology is its focus on outcomes rather than theory (Robb, 2012). Robb argued that:

although outcomes-focused research provides essential information about intervention efficacy, it does not allow for the examination of questions about how and why the intervention did or did not work and as a result it often falls short of providing clinically relevant knowledge to guide and advance practice.

(p. 3)

Music therapy research would greatly benefit from the inclusion of the theories behind the interventions, such as the theoretical rationale for the use of music and the therapeutic

process. A review of current music therapy and oncology research found that a majority of studies did not provide any rationale or theory for the music therapy interventions, which was a methodological weakness (Burns, 2012). Theory-based research identifies the complex interactions of all variables and would methodologically strengthen music therapy research.

Another frequent criticism of music therapy research is that it does not meet high standards of scientific of evidence (Bradt, 2012; M. J. Silverman, 2010a, 2010b). Meta-analyses are considered to be the highest level of scientific evidence, followed by randomized controlled studies (Fineout-Overholt, Hofstetter, Shell, & Johnston, 2005). A quantity of quantitative studies is needed for a meta-analysis, allowing several studies about a phenomenon to be collectively analyzed and reviewed. However, the researchers determine the quantity of and criteria for inclusive studies in a meta-analysis, which must be considered. The quantity, quality, and criteria of the reviewed studies will therefore limit the findings of the meta-analysis to various degrees. Strong qualitative designs must also be considered and are equally needed. A review of the current literature demonstrates only handfuls of both, which has led to low levels of evidence demonstrating the effectiveness of music therapy with mood disorders and anxiety.

There are several important methodological implications from Gold et al.'s (2009) meta-analysis of psychiatric music therapy. First, although the results demonstrated that music therapy appears effective for psychiatric disorders such as schizophrenia and depression, not all psychiatric disorders and mood disorders have been equally studied. There is a lack of published research on music therapy with other psychiatric disorders that are related to grief, such as anxiety and PTSD. Second, as Gold et al. (2009)

highlighted, two-thirds of the music therapy studies reviewed in their meta-analysis were conducted in a group setting. This constitutes another methodological problem. Much of the published research on psychiatric music therapy has been limited to studying groups, as well as studying participants who were hospitalized rather than in outpatient clinics (M. J. Silverman, 2008, 2010b, 2011; M. J. Silverman & Marcionetti, 2004). This mirrors much of the grief therapy research, which has also been conducted in group settings.

Additionally, there is a notable underrepresentation of males as well as diverse ethnic backgrounds in much of the reviewed music-based research. In the reviewed research on singing, a majority of the samples consisted of middle-aged, White individuals from Western cultures. In addition, most of the participants were female. Again, these limitations are prevalent in the grief therapy research, as well. There is a need for music therapy and grief research that takes these methodological issues under consideration.

Preliminary Study

Considering the concerning lack of empirical research on music therapy for bereaved adults, an exploratory study was conducted (Iliya, 2013). A randomized controlled, mixed-methods pilot study examined music therapy for adults with CG and mental illness ($N=10$). Among individuals with serious mental illness, the prevalence of those experiencing CG has been found to be as high as one-third (Piper, Ogrodniczuk, Azim, & Weideman, (2001). Participants were diagnosed with severe mental illness such as bipolar disorder, major depressive disorder, schizophrenia, schizoaffective disorder, and/or substance abuse disorder. Concurrently, participants met the proposed criteria for

CG and scored a minimum of 25 on the Inventory of Complicated Grief – Revised (ICG-R; Prigerson & Jacobs, 2001; Appendix B).

Participants either received eight to 10 weeks of individual music therapy in addition to standard care (experimental), or standard care alone (control; Iliya, 2013). As discussed in the Chapter One, a music therapy intervention was developed based on Shear et al.'s (2005) previously reviewed intervention of the imaginal dialogue. Instead of speaking the intervention, participants in the experimental group of the preliminary study were asked to sing imaginal dialogues with their deceased loved ones. Grief symptoms were measured using a pre- and post-test of the ICG-R. Statistical analyses demonstrated that participants in the experimental group had a greater decrease of grief symptoms as compared with the control group.

In addition, the music therapy sessions were qualitatively analyzed into six major themes (Iliya, 2013). In order to limit potential bias, the researcher's perspective was identified and the bracketing process was employed before and throughout the study and data analysis. In addition, peer debriefing was used to help reduce bias. The themes were as follows: (a) music therapy helped the five participants accept the reality of the loss (Task I of mourning; Worden, 2009); (b) music therapy helped the five participants express their emotions regarding their grief and lead to a shifting subjective experience (Task II of mourning; Worden); (c) music therapy helped the five participants externally, internally, and spiritually adjust to a world without the deceased (Task III of mourning; Worden) and make meaning from the loss; (d) music therapy helped the five participants find an enduring connection with the deceased while embarking on a new life (Task IV; Worden); (e) symptoms of mental illness and substance abuse worsened after the loss and

were observed in the mourning process; and, (f) the therapeutic relationship developed in music therapy played an important role in helping participants with their mourning.

These results demonstrated that participants identified singing to be helpful and beneficial for emotional expression, and this may be for a myriad of reasons that support the therapeutic use of the voice (Iliya, 2013). The limitations of this study included the small sample size and that the researcher conducted the music therapy intervention. Nevertheless, this was the first mixed-methods randomized controlled study of music therapy as grief therapy for adults with CG and mental illness. Strengths of the study included the ethnic diversity of the sample: eight of the participants were African-American, one was Hispanic-American, and one was Asian-American. The results found that music therapy, in addition to standard of care treatment, was a promising and helpful treatment for this group of adults with CG and mental illness.

Importantly, this study facilitated the first music therapy adaptation of Shear et al.'s (2005) imaginal dialogue intervention, where the dialogue was sung instead of spoken (Iliya, 2013). The results demonstrated no attrition or refusal. These findings were surprising, as adults with severe mental illness are typically lower functioning and in need of increased structure in treatment. And yet, the experimental intervention was not only emotionally tolerated, but also effective for these individuals. These findings lay the groundwork for the present study, which aimed to further understand the experience of the intervention when sung instead of spoken.

Conclusion

While grieving the death of a loved one is a normal part of life, the literature has shown that bereaved adults, particularly those with prolonged grief symptoms, seek

mental health services and participation in research studies (Beck & Konnert, 2007; Bergman, Haley, & Small, 2010; Johnson et al., 2009). In addition to the emotional suffering, individuals with prolonged grief reactions are also at higher risk for physical illnesses such as cancer, heart disease, and hypertension (Prigerson, Bierhals, Kasl, & Reynolds, 1997; Stroebe et al., 2007). Treatment options exist, and grief interventions have been shown to be effective with adults with prolonged grief reactions like CG (Currier et al., 2008; Wittouck et al., 2011). Robust research has supported the use of imaginal dialogues for individuals with unresolved feelings due to loss (Paivio & Greenberg, 1995). The effectiveness of exposure therapy, such as imaginal dialogue, has been well-documented for individuals with PTSD (Foa, 2011), a grief-related symptom. In addition, the experiences and coping strategies of bereaved individuals have been well researched, and talking about grief experiences and feelings was consistently found to be helpful (Muller & Thompson, 2003; Seah & Wilson, 2011).

The literature demonstrates the need and motivation for, as well as the effectiveness of, services for individuals suffering with symptoms of grief, PTSD, depression, and/or anxiety. In light of the above, it can be concluded that empirical studies investigating music therapy with bereaved adults can help expand clinical practice. The research using expressive writing (O'Connor et al., 2003; Wagner et al., 2006), dance/movement therapy (Callahan, 2011), art therapy (Ferszt et al., 2004), and music therapy (Hilliard, 2001; O'Callaghan et al., 2013; Popkin et al., 2011; Rosner et al., 2010; Smeijsters & van den Hurk, 1999; Sung Hyun & Gallant, 2010) demonstrates the potential of creative arts therapies with bereaved individuals. Furthermore, there has been promising evidence emerging on the potential benefits of singing, such as improved

mood and well-being (Busch & Gick, 2012; Gick, 2011). Participants have described “singing as a way of releasing emotions, which they had felt unable to express fully in talking therapies” (von Lob, Camic, & Clift, 2010, p. 51).

Despite the promising results using music therapy with bereaved children and adolescents, there is a significant gap in research in applying music therapy techniques for bereaved adults. Smeijsters and van den Hurk’s (1999) study using music therapy with a bereaved woman demonstrated the use of improvised piano playing and singing to express feelings of grief. Moreover, a qualitative study on music therapy with bereaved adults illustrated that singing to the deceased “elicited a feeling that [participants] could communicate with their relatives” (O’Callaghan, McDermott, Hudson, & Zalberg, 2013, p. 113).

The pilot study of adults with CG and mental illness demonstrated a reduction of grief symptoms after music therapy (Iliya, 2013). These results are promising and need further examination. Furthermore, in an important contribution, the imaginal dialogue intervention utilized by Shear et al. (2005) in their CG treatment protocol appeared to be more tolerable when sung instead of spoken (Iliya, 2013). Considering the lack of attrition or refusal in the study, these unanticipated findings yielded the obvious question: Why was the intervention perceived as more bearable and helpful when sung instead of spoken? Drawing on the findings of the pilot study, the present study involved qualitatively understanding why singing the intervention may be perceived as tolerable and potentially helpful for bereaved adults. The aim of the study was to help close the gap in research of music therapy for bereaved adults, and offer greater treatment options for many adults who need support with their grief and loss.

CHAPTER 3

Methods

Drawing on the findings of the pilot study (Iliya, 2013), the present study was designed to further understand the experience of the intervention of singing an imaginal dialogue with a deceased loved one. Following Shear's (2006) use of the spoken imaginal dialogue intervention with therapists, this researcher questioned how singing the intervention would be experienced by bereaved creative arts therapists. The guiding question of the present study was: What are creative arts therapists' experiences of singing the intervention?

Study Design

This study was approved by the Lesley University Institutional Review Board. After participants were recruited, all gave informed consent (Appendix C). Participation entailed one music therapy session with a music therapist who was not the researcher. After the session, participants completed a questionnaire and were interviewed about their experience by the researcher. All identifying information and data were kept anonymous and confidential. Participants were not compensated for their participation, but the research session was of no cost to them.

The overarching design of this study was mixed-methods: quantitative and qualitative data were collected and analyzed in response to research questions. The qualitative component was rooted in constructivist epistemology, which depends "as much as possible on the participants' views of the situation being studied" (Creswell, 2014, p. 8). In this epistemology, individuals construct meaning from the world as they interact with it (Denzin & Lincoln, 2005). Individuals thus develop subjective meanings

of their life experiences. In addition, “reality is multiple, complex, and not easily quantifiable” (Broido & Manning, 2002, p. 436). Therefore, research conducted with a constructivist epistemology aims to gain multiple and varied meanings yielding a complexity of views about an experience. Furthermore, qualitative constructivist research asks participants general questions so that varied meanings of the situation can be constructed. In line with a constructivist worldview, this study used broad, open-ended interview questions to ask participants about their experiences, and data were analyzed using inductive thematic analysis, which will be further discussed.

Setting

Data for this study were gathered in a private music therapy office in New York City. The music therapy sessions being studied were conducted by a white male board-certified music therapist (MT-BC) and NY State licensed creative arts therapist (LCAT) with advanced training in vocal psychotherapy (Austin, 2008) and over 15 years of clinical and research experience.

Participants

Nine participants were recruited to participate in the study. Participants were recruited until data saturation was reached; a small sample size was used, in line with qualitative research design. Data saturation is a term from grounded theory that implies that data collection can cease when the themes are saturated, and no new insights are revealed (Creswell, 2014). Participants in the study were purposefully selected to best help the researcher understand the experience of singing an imaginal dialogue as a bereavement-specific intervention. To this end, all participants were master’s-level licensed creative arts therapists (music, dance/movement, drama, and art) with a range of

three to 20 years of clinical experience. The rationale behind selecting creative arts therapists for participants was described in detail in Chapter One. All participants identified with having lost a person due to death more than one year prior to the study.

Table 1 outlines relevant information about the participants.

Table 1

Descriptive Characteristics of Participants

	<i>n</i>	<i>M (SD)</i>	<i>Mdn</i>
Age (years)		39.4 (10.7)	39
Years since death		7.1 (5.7)	7
Female	9		
Identify as a minority	5		
Relationship of deceased:			
Spouse/Partner	1		
Parent	1		
Grandparent	3		
Other relative	2		
Friend	2		
Creative arts therapy modality			
Music	3		
Dance/Movement	1		
Drama	3		
Art	2		

The sampling for the study consisted of nonprobability, purposive sampling (Creswell, 2014). The researcher emailed creative arts therapists in the New York metropolitan region on email lists (i.e., The New York Coalition of Creative Arts Therapy (NYCCAT) list-serv) with information about the research study and instruction on how to receive more information from the researcher. As reviewed in Chapter Two, one methodological limitation of published grief therapy research is the consistent underrepresentation of males and minorities (Allumbaugh & Hoyt, 1999; Currier et al., 2008; Wittouck et al., 2011). Therefore, a special emphasis was made to recruit subjects who were male and/or identify as minorities. An individual from a minority culture was defined as anyone who identified him or herself as outside the dominant culture. Five of the participants maintained cultural, racial, and/or ethnic identification as minorities. All participants were females, which will be further discussed in Chapter Five.

Study Protocol

Participants participated in a single-session of music therapy. Although the intervention would typically be used in multiple sessions during ongoing treatment, in this research it was studied in a single-session. The rationale behind this design was to focus on participants' initial experiences of the intervention, and to examine any potential attrition or refusal of doing the intervention. The single-session was extracted from the larger context of treatment to examine the intervention with more focus and specificity.

In the session, participants were first given an overview of the session, which was divided into three parts. The first part consisted of verbally discussing the loss and getting acquainted with the therapist and the space. In addition, this part included vocal warm-ups and grounding exercises, described in more detail below. The second part

consisted of the music therapy intervention, which the participants knew entailed singing an imaginal dialogue to their deceased loved one. The third and final part consisted of grounding exercises, verbally processing the intervention, and achieving a sense of closure regarding the session.

The purpose of the grounding, containment, and vocal warm-up exercises were to help the participants feel more comfortable and safe exploring an emotionally intense subject in a new way, with a new therapist, and in a new environment. Although they were primarily used before and after the intervention, they were also used throughout the session whenever needed to help participants feel safe, held, and contained. Every participant was led through a series of grounding and containment exercises, such as feeling their feet on the floor and the clothing on their body, before and after the intervention. In addition, before singing, participants were led through vocal warm-up exercises. These exercises included slow, deep breathing, and sighing on open vowel sounds such as “oo” and “ah.” Participants were encouraged to breathe and make sounds to become more comfortable with hearing their voices.

The development of the music therapy adaptation of Shear et al.’s (2005) imaginal dialogue intervention was heavily influenced by Austin’s (2008) method of vocal psychotherapy. Within this method, Austin’s intervention of free associative singing entails the therapist playing two chords on piano to provide a simple, repetitive, and predictable structure for the client and therapist to vocally improvise. The essential components of free associative singing are repetition, singing in unison or harmony with the client, and doubling. Doubling is a psychodramatic technique created by Joseph Moreno (1946) where the therapist becomes an extension of the client, using intuition to

express what the client might wish, but is presently unable, to say. Doubling in vocal psychotherapy means that the therapist sings in the first person, giving “voice to feelings and thoughts the participant may be experiencing but is not yet singing” (Austin, 2008, p. 160). This allows clients to hear what they are potentially feeling and thinking, which may encourage them to deeper self-expression.

In the current study, participants were led in singing to the deceased person while being supported by a two-chord harmonic structure on the piano. Participants were asked to focus on creating a sense of connection with the deceased person. After the vocal warm-up exercises, the therapist played various chords on the piano, asking which ones participants preferred. Once two chords were chosen, a repetitive vamp was established, where the chords were played consistently and slowly, back and forth. The participants were asked to sing directly to the person who died, imaging that the person could hear them. While they were singing, they faced an empty chair that was representative of the deceased person. After approximately five minutes, participants were invited to switch chairs and respond to themselves from the role of the deceased person.

Throughout the imaginal dialogue, the participants were encouraged to vocalize whatever thoughts and images came to mind. Following Austin’s (2008) method, the techniques of repetition, singing in unison or harmony with the client, and doubling were employed. Words, phrases, and melodies were repeated and sung together. If the participant became emotionally overwhelmed and stopped singing during the intervention, the therapist continued the music and singing in the first person to double the participant. If participants did not resume singing, they were led in a series of grounding exercises, such as deep breathing. The interventions ended organically after

participants stopped singing, after approximately 10-15 minutes. After the imaginal dialogue, participants verbally processed the experience with the therapist. Without specific prompts, the participants spontaneously shared their feelings, thoughts, and insights. Grounding exercises were also used to help the participants transition from the intervention to the present moment, and to aid in concluding the session feeling emotionally stable.

Immediately following the session, participants completed an open-ended questionnaire regarding their experience (Appendix D). In addition, following the procedure outlined by Shear et al. (2006), participants were asked to rate their distress levels during and after the intervention on a scale of zero to 100. Participants did not complete the questionnaire in front of the therapist who conducted the intervention. Rather, the questionnaire was completed immediately following the session and mailed directly to the researcher in a pre-stamped, addressed envelope. All participants returned the questionnaire. In addition, within three days after the session, participants were interviewed by the researcher about their experience in open-ended, semi-structured phone interviews.

Following the session and interview, the researcher contacted the participants once every week by email for four consecutive weeks. The purpose was to check back in with the participants and potentially provide additional therapeutic support. The researcher debriefed with the therapist after every session to briefly review the study protocol. The therapist did not sign consent and no formal debriefing took place, which is a limitation of the study that will be further discussed in Chapter Five.

Data Collection and Analysis

Quantitative data consisted of participants rating their distress during and after the intervention using a numerical value, on a scale from zero to 100. These data were analysed using descriptive statistics. The mean and median reported distress levels were calculated and reported, along with the maximum and minimum scores.

Qualitative data in this study consisted of the following: (a) transcriptions of music therapy sessions, to obtain information about what themes participants were singing about, which gave a clearer picture about the intervention; (b) transcriptions of post-session interviews, to obtain information about what participants experienced in a phenomenological manner, and how the intervention may or may not have affected feelings and thoughts of grief; and, (c) open-ended questionnaires, to collect initial information about what participants experienced during the intervention.

The research design was emergent, meaning that exact questions asked in the semi-structured interview were modified in order to best learn about the intervention being studied. The focus was on “learning the meaning that the participants hold” (Creswell, 2014, p. 186) about the intervention. In line with a constructivist epistemology, the first interview question was broad: “how was the experience of singing an imaginal dialogue with your loved one?”

The researcher transcribed the sessions and interviews. The transcription process entailed pausing and rewinding the audio file multiple times, allowing for a precise transcription to capture all spoken dialogue and sung lyrics. Musical data were notated in a narrative form using musical terms (i.e., the instruments played, tempo, chords,

dynamics); following a phenomenological description, music was described as heard (Bonde, 2005).

The qualitative data were analyzed using an inductive thematic analysis approach (Braun & Clarke, 2006). Thematic analysis is a method for “identifying, analyzing, and reporting patterns (themes) within data” (p. 6). The utilized definition of a theme was something “important about the data in relation to the research question...[that] represents some level of *patterned* response to meaning within the data” (p. 10). Thematic analysis is not theoretically bounded, and was grounded in a constructivist theory in the current study. Therefore, the analysis examined participants’ experiences of the intervention, which are inherently based on their interpretations of the world. As previously discussed, constructivism maintains that these experiences differ based on individuals’ backgrounds, as well as the social context of their lives.

The sessions, surveys, and interviews were inductively analyzed to understand the themes that emerged across participants regarding their experience of the phenomenon. Inductive analysis is a ‘bottom-up’ approach and consisted of coding the data without trying to fit it into pre-existing theories, coding frames, or preconceptions (Braun & Clarke, 2006). The themes included the feelings participants experienced, the topics they sang about, and the way they interacted with the therapist. A theme was not necessarily dependent on how frequently it appeared across the data but more on how it captured something important about the data.

The researcher analyzed the data using the assistance of HyperRESEARCH software using the following steps of inductive thematic analysis (Braun & Clarke, 2006; Colaizzi, 1978; Forinash & Grocke, 2005):

1. All the transcripts, interviews, and questionnaires were read to get an overall sense of the phenomenon. Memos and an initial list of ideas about the data were noted.
2. The text was then inductively coded by selecting significant statements, phrases, and/or sentences. As many statements as possible were coded.
3. The codes and their text were cyclically analyzed and grouped to create categories.
4. Similar categories, and their texts and codes, were cyclically analyzed and grouped. Overarching themes were created for these categories, and subthemes were created within each theme.
5. The themes and subthemes were reviewed, refined, renamed, and regrouped multiple times to form as much of a coherent pattern and holistic view of the data as possible.
6. Statements to clarify each theme were written and refined to generate clear definitions.
7. Raw data vividly exemplifying the themes were excerpted from the transcripts.
8. The analysis and findings were written-up to “tell the complicated story” (Braun & Clarke, 2006, p. 23) of the data and provide a complex account of the participants’ experiences.

An example of how sections of the data were analyzed can be seen in Table 2.

Table 2

Examples of Thematic Data Analysis: Data Extracts and Applied Codes

Data extract	Coded for
“[I felt] sadness, guilt, helplessness, loss, [and] deep longing.” (Betsy)	Emotion
“Fear of being vulnerable, fear of being judged or yelled at for showing my feelings.” (Erin)	Painful/Awkward/Vulnerable
“I felt really safe. I felt extremely safe.” (Christine)	Containing
“I came to accept a little more fully the method by which she passed. It made a lot of sense.” (Amanda)	Insight

Reliability and Validity

Peer debriefing was used to help reduce bias. A master’s-level creative arts therapist and doctoral student read all of the transcripts and independently conducted qualitative analysis on the data. The peer and researcher then compared analyses. Although most of the analysis was agreed upon, the colleague extended the analysis through suggesting additional ideas to strengthen the themes. The findings were then reanalyzed and written until the researcher and peer were both satisfied that the results accurately represented the data. In addition, the peer also independently agreed that the data were saturated. The data analysis and results were also debriefed with the therapist who conducted the intervention. This was done to ensure as complete and accurate understanding of the data and results as possible.

Member checking was also used to increase the validity of the results.

Participants were emailed the transcriptions of their post-session interviews. They were

invited to make any necessary changes or additions. Transcripts were revised until participants were in agreement with them. Member checking was again employed during data analysis. The results were emailed to the participants, and they were invited to offer their feedback, agreement, and/or disagreement with the themes. All participants agreed with the data analysis and they did not add any themes.

As this was a dissertation research study, the advisor of the study supervised the process of data analysis. The advisor continually challenged the researcher's thinking and impressed the necessity of reflexivity and bracketing. Under this supervision and guidance, the analysis was repeated until it most accurately reflected participants' experiences.

Researcher's History and Reflexivity

The researcher acknowledges a personal history of grief and loss, which undoubtedly influenced the choice of topic. The researcher experienced a traumatic loss of a close family member at the age of 18, and spent years resolving feelings of grief. This experience of loss creates a bias but also gives the researcher a greater sensitivity to the topic. Furthermore, the researcher is a singer and a music-therapist with advanced training in Austin's (2008) method of vocal psychotherapy. Positive professional and personal experiences of singing also influenced the choice of topic.

To develop a reflective stance, a journal was kept throughout the research process, as a way for the researcher to bracket, self-reflect, ask and explore questions, and expose assumptions (Ortlipp, 2008). Bracketing in qualitative research is a method that is used "to mitigate the potential deleterious effects of unacknowledged preconceptions related to the research and thereby to increase the rigor of the project" (Tufford & Newman, 2010,

p. 81). It was used throughout all the phases of study design and execution including topic selection, data collection and analysis, and writing the findings. Bracketing was especially employed because of the emotionally challenging and sensitive aspects of the research material, and the researcher's personal experiences with grief and singing.

One method of bracketing was writing any thoughts, insights, or feelings related to the research process and data analysis in the reflexive journal (Ortlipp, 2008; Tufford & Newman, 2010). Continually writing in this way allowed the researcher to expose assumptions, biases, and preconceptions. Another method of bracketing that was employed was engaging in ongoing discussions with several colleagues who were not involved with the research process. These supportive relationships allowed the researcher to freely discuss thoughts and feelings and led to deeper clarity and new insights regarding themes in the data. In addition, attempts were made to expose unconscious assumptions and biases regarding the research and data analysis, such as using creativity to evoke memories and emotional experiences, taking breaks to gain distance from the data, and continuing to look at the same data from different angles (Meek, 2003).

Sociocultural Perspective

A primary aim of clinical research is to provide evidence leading to improved therapy interventions. Therefore, it is crucial to include women and members of minority groups to determine whether the intervention being studied differently affects these individuals. In the present study, a socio-cultural perspective was met through diverse sampling to include participants who identified outside of dominant cultures, and the grief-specific intervention was examined in a socio-cultural context. The sample

included women who identified as minorities in the realms of race, culture, ethnicity, and/or sexual orientation. The inclusion of women and minorities addressed gaps in knowledge about grief-therapy experiences, and will hopefully bring greater value to the anticipated contributions of the study.

CHAPTER 4

Results

The findings are based on the qualitative and descriptive statistical analyses. They offer a comprehensive picture of the grief-specific intervention, as experienced by nine healthy, female creative arts therapists.

Participants

A brief depiction of each participant, her loss, and her music is presented below. All names have been changed to protect participants' identities. Cause of the death was not explicitly asked, so it was not always ascertained. Participants chose the chords used in the intervention from various chords offered by the therapist. After playing several different major and minor triad chords (i.e., C major, G major, and A minor) as suggestions to the participants, the therapist asked which chords resonated with them, and those were utilized. Lyrics are further examined in the results.

Amanda was a 47 year-old music therapist who identified as a minority. She identified grieving a close friend who had died two years ago, during a time when two immediate relatives died very soon thereafter. Because she was caretaking and then grieving for those relatives, she felt that she had never had a chance to say goodbye to her friend, who was the first of the three deaths. The friend died suddenly despite suffering from a chronic illness for many years. The chords Amanda chose were C major and A minor (chord progression I-vi). Amanda's singing was expansive and strong, and her phrases consisted of repeated, ascending, scale-wise melodies. Amanda sang continuously throughout the intervention.

Betsy was a 30 year-old art therapist who was grieving the sudden death of a sibling. The sibling died four years prior to the study, and it was a complicated and traumatic death for her. She did not reveal the cause of death. The chords Betsy chose were C major and F major (chord progression I-IV). Her singing consisted of short, quiet, almost whispered phrases, staying on one of two pitches. The therapist mirrored her statements and used the technique of doubling, as explained in Chapter Three, when she paused singing. Betsy sang the least and quietest of the participants.

Christine was a 30 year-old music therapist who was grieving the death of her childhood voice teacher, who died one year ago. The teacher, who died in her 70's or 80's, also filled the roles of mentor and grandmother for the participant. She felt that the relationship was complicated, therefore making the mourning process complicated. The chords Christine chose were A minor to F major (chord progression iii-I). Christine's singing included short, wordy phrases with melodic jumps, such as singing the 7th pitch of the chord. She also held long sustaining notes sung in harmony and unison with the therapist. Her singing had dynamic variability; she sang both quietly and loudly, with expansiveness. Her music had a driving, intense quality.

Doris was a 33 year-old drama therapist who was grieving the death of her grandfather 10 years earlier. Her grandfather had lived in a nursing home for 14 years prior to passing away. As a child, she was close to him. Presently, she felt the need to dialogue with him to understand more about his role in current family dynamics. The chords Doris chose were C major and F major (chord progression I-IV). Doris sang short, simple, repetitive phrases of one or two pitches, as well as sustaining a few words

in unison with the therapist. Her singing was quiet and had a melancholy, almost childlike quality.

Erin was a 30 year-old music therapist who identified as a minority. She was grieving the death of her grandfather 20 years earlier. Because she was a child at the time, her family did not tell her when he died. Furthermore, because of cultural influences, she was not permitted to express feelings of grief. Therefore, she never had the opportunity to say goodbye or express her feelings regarding the death. The chords Erin picked were A minor and E minor (chord progression iv-i). Erin's singing had a breathy, melancholy quality, and her phrasing consisted of descending melodic lines in short phrases. Her singing was quiet throughout the intervention.

Fiona was a 41 year-old drama therapist who identified as a minority. She was grieving the death of a grandmother who died 10 years earlier. She had lived with her grandmother, and felt that her grandmother helped raise her. Fiona was present with her grandmother when she died at home. She identified unresolved issues that were related to the death. The chords Fiona used were A major and F major (non-diatonic chord progression III-I). Fiona's phrasing consisted of long, sustained words and phrases, without melodic variability (i.e., melodies of one or two pitches throughout). As the intervention progressed, she used more words in her phrases. Her singing was strong and moderately loud, and had a storytelling quality.

Geraldine was a 39 year-old art therapist who identified as a minority. She was grieving the death of an extended relative who died suddenly after a heart attack seven years ago. The relative had played a significant leadership role in the family and had kept the family together. Since the death, her family has seemed disconnected. The

chords Geraldine used were C major and A minor (chord progression I –vi). Her singing was quiet and consisted of short, simple, and repetitive melodic phrases of three pitches (i.e., 3- 5- 1), which gave it an almost childlike quality. She also sustained some notes to sing in unison and melody with the therapist.

Heather was a 65 year-old drama therapist who was grieving the death of her spouse who died one-year prior to the study. She had been the primary caretaker for her spouse, who was disabled and ill for many years. She identified several unresolved feelings surrounding the loss, such as guilt and shame. The chords used for Heather were C major and A minor (chord progression I-vi). Heather’s singing had a breathy quality, and her melodic phrasing consisted of one or two pitches, at times almost speaking. Her singing was at a moderate volume, but also had a tired quality.

Iris was a 40 year-old dance/movement therapist who identified as a minority. She was grieving the death of a parent who had died from cancer nine years prior to the study. Iris continued to struggle from the loss, particularly because her child would not have the opportunity to know her parent. The chords for Iris were G major and E minor (chord progression I-vi). Her singing had melodic variability; she sang ascending and descending lines consisting of several pitches. She also sang with dynamic variability, singing both quietly and loudly, and at times sustaining pitches in unison with the therapist. Her singing had a driving, expansive quality.

Distress Levels

In the questionnaire given immediately after the therapy session, participants were asked to rate their distress levels on a scale of 1 to 100 both during the intervention and after the intervention. These data were analyzed using descriptive statistics (Table 3).

The reported mean and median levels were over 50 during the intervention, and were lower after the intervention. However, the standard deviation was found to be large, as it was a quarter of the entire scale. Nevertheless, descriptive statistics indicated that participants felt more distressed during the intervention than while verbally processing it afterwards.

Table 3

Descriptive Comparison of Distress Levels During and After Intervention

	<i>M</i>	<i>SD</i>	<i>Mdn</i>	<i>Max</i>	<i>Min</i>
During intervention	53.33	25.93	60	90	15
After intervention	27.55	23.59	20	80	5

Thematic Results

The data consisted of the therapy session transcripts, interview transcripts, and questionnaires. The music was not transcribed but musical elements such as chords, melodic patterns, dynamics, and phrasing were notated using musical terms. The lyrics that were sung were precisely transcribed. The inductive qualitative data analysis as described in Chapter Three revealed six themes from participants' experiences of singing an imaginal dialogue with a deceased loved one. The themes are: (a) I cried the whole time - Elicitation of profound emotional expression; (b) I was scared to sing - Discomfort, nervousness, and anxiety; (c) I felt safe - Containment and support; (d) I felt his/her presence - Emotional and spiritual connection to the deceased; (e) I'm finally grieving and have greater acceptance - Helpful opportunity for grief resolution; (f) It bypassed the intellectual - More effective to sing than speak.

Theme 1: I Cried the Whole Time - Elicitation of Profound Emotional Expression

Tears, sadness, and other emotions. When asked about their experiences of the intervention, data overwhelmingly demonstrated that all participants named feeling “emotional” during the intervention. In the post-session questionnaires and interviews, participants talked about the elicitation of emotional expression as one of the main experiences of the intervention. All participants reflected that they primarily experienced sadness, although the intervention also elicited other emotions, such as helplessness, regret, guilt, and even happiness. For example,

“[I felt] sadness, guilt, helplessness, loss, [and] deep longing.” (Betsy)

“This was a bittersweet interlude. I felt a bit of sadness at the palpable physical loss of my friend. And yet, I was happy to have a personal encounter with her.”

(Amanda)

“[I felt] sadness, anger, love, [and] freedom.” (Christine)

“I think there was sadness. Well, it was meditational, which included different emotions, sadness, loss, love and play.” (Fiona)

Along with naming the experience as emotional and sad, participants also discussed the elicitation of tears during the intervention. All of the participants shared that they became tearful and could be heard crying in the audio recording of the session. Singing the imaginal dialogue was correlated to an increased presentation of sad affect and tears.

For example:

“When we sat down at the piano and I was facing the chair where I would move into my father, it was very emotional. I started having tears come even before I started singing.” (Iris)

“I cried through the whole thing. I cried and cried. It was raw for sure.” (Doris)

“I was surprised that when the music started, so did my tears.” (Geraldine)

Sounds associated with crying, such as sobbing, blowing and sniffing noses, and quivering vocal quality were heard in all of the transcriptions of the sessions. All the participants had to blow their noses at least once during the intervention, and did so at least once when they were invited to switch chairs and sing from the role of the deceased. At times, participants were crying so much that they were unable to sing. When Geraldine sang to her deceased relative, she was crying continuously:

“We’re still lost [crying],

You were the anchor [crying, blowing nose],

What do I do? [crying]”

For these participants, emotional expression was a large part of the experience of the intervention.

Singing to deceased about missing them. All participants expressed feelings such as missing the deceased and wishing that they were still alive. Singing their feelings of missing the deceased directly to the deceased elicited emotional expression such as tearfulness. For example, in her singing, Betsy asked her deceased sibling to return home:

“I miss you,

Come home [crying].”

When Geraldine sang to her deceased relative, she also expressing missing her:

“I miss you,

I miss you [crying].”

Participants expressed missing the deceased using different language, as well. For example, Doris sang to her grandfather using the words “need you”:

“I need you now, she needs you now, we need you now,
 I need you now, she needs you now, we need, we need you now [therapist mirroring and doubling],
 We need you now,
 We need you now [therapist mirroring and doubling],
 We need you now,
 We need you now [therapist mirroring and doubling].”

When participants sang directly to the deceased about how much they missed and needed them, they were emotionally expressive. Expressions of emotion, like tears, were audible in the audio recordings and reflected upon in the post-session data collection.

Role of music in accessing and tolerating emotion. The music played an important role in both accessing and tolerating a wide range of emotions. Eight of the nine participants reflected that the harmony, melody, and act of singing helped to elicit emotions. Being in, creating, and hearing music contributed to participants feeling emotions more intensely while also feeling contained, safe, and tolerant of their emotions.

Harmonically, the therapist used major and minor chords for the structure of the intervention. The specific chords used for each participant were outlined earlier in this chapter, when discussing the participants and their music. The therapist played common chords such as C major, A minor, E minor, F major, and G major, in common chord progressions such as I-IV and I-vi. In Nordoff-Robbins music therapy, which is based in

clinical improvisation, major chords in root position have been equated with characteristics such as “affirmative, strong, [and] declaring” (Robbins & Robbins, 1998, p. 52). These chords and chord progressions are commonly heard in Western popular music, and that familiarity can be comforting. Although some participants identified as minorities, all had been living in America for years and would be familiar with these chord progressions. Additionally, these chord progressions have been more recently adapted to popular music heard around the world. Minor chords are equally familiar but often associated with melancholic sounds and moods, which may have contributed to participants feeling sad and crying during the intervention. However, two participants, Betsy and Doris, chose major chord progressions (i.e., I-IV), and nevertheless cried throughout the intervention. The therapist played the chords in root position, using slow arpeggio patterns, which may have drawn out the sounds and further elicited an association with melancholy.

The melodic shape of the interventions differed among participants, as earlier discussed: some participants sang quiet, short phrases that were melodically simple and repetitive while other participants had more variety in melodic and dynamic phrasing. These musical elements were supported and mirrored by the therapist in the way he played piano and used his voice (i.e., more quietly or loudly to match the participant’s volume).

In addition to the harmonic and melodic components, eight of the participants shared that the act of singing allowed them to emotionally express themselves. Singing helped access and elicit emotions, including painful ones like sadness. In addition,

singing also helped participants tolerate those emotions. Iris reflected on the role of the music in accessing her emotions of grief around her parent's death:

“It was the experience of doing it in a creative way, a musical way, that really allowed me to access the emotion around it... The tone and the pacing was very slow and allowed for a lot of depth.”

Singing made the emotional expression more tolerable, as the participants repeatedly articulated. Singing made the intervention more satisfying and even enjoyable for some participants. For example, Fiona described the relationship between the intervention and emotional expression as follows:

“There was something really enjoyable about singing, laughing, crying, you know what I mean? There was something really satisfying about it.”

Geraldine also articulated that the music and singing aspects of the intervention made it more tolerable and even “fun.” For her, the music also allowed her to feel more comfortable around a therapist whom she did not know prior to the session.

The music provided kind of a, I don't know if the right word is buffer, but some kind of other thing between me and the therapist. It just made it feel more comfortable, that we weren't just talking, but, like a container. So, that made it feel more comfortable because I was focused on the music rather than the therapist. And then, I think when I got into it a little bit, I got into it and it was, I don't know if the right word was fun, but a little, I guess. You're singing about something sad, but it made whatever I was singing about, depending on what I was saying, lighter at times. Like more easy to tolerate, or something.

Singing with a music therapist accentuated these experiences. In response to the question “what was your experience singing an imaginal dialogue with your grandfather?” Erin responded:

“I thought it was very powerful, to begin with. I did go through a range of emotions that I didn’t have the opportunity to feel. I have found that singing has helped me a lot, to not feel alone with my emotions, that I have someone witnessing them, which was a part of my issue.”

By singing the intervention with the therapist, participants were able to access their emotions while feeling supported, heard, and seen. The music played an important role in accessing and tolerating emotions surrounding the participants’ grief.

Importance in the mourning process. All participants noted that the intervention elicited emotions associated with grief that they otherwise had difficulty accessing and feeling. Therefore, the intervention allowed the participants to feel and process these emotions, which was identified as an important part of their mourning process. Results showed that participants found it helpful to feel the emotions elicited by the intervention. For example:

“I have realized that I was not able to feel my feelings...prior to this session.”

(Fiona)

For participants like Erin, who was not permitted to express her emotions of grief over the death of her grandfather due to cultural expectations, the experience in accessing and feeling her emotions was helpful for her mourning process:

“The music helped me to integrate the emotions and actually helped me to name them. It’s actually very important to have that integration, where the mind, the

body [are] connected to emotions on many levels, and the music helped me to integrate [them]. And, to integrate that sense of sadness, as opposed to sadness from my mind and my intellect, [is] feeling on a different level.”

The way in which the intervention offered participants opportunities to access and express their emotions was an important part of their mourning process. All participants verbalized that it was needed and helpful.

Theme 2: I was Scared to Sing - Discomfort, Nervousness, and Anxiety

Performance anxiety. There were several aspects of the intervention that were found to be uncomfortable. The first aspect is that five participants said they experienced performance anxiety, especially because they were in front of a person whom they did not know. The participants knew that they were going to be asked to sing, but they nonetheless verbalized having thoughts such as “I can’t sing” (Doris) and “this isn’t good enough” (Doris), and shared feeling nervous and uncomfortable about singing. For example:

“I was a little scared to sing because I’m not a trained singer, but I love to sing, so that part I was a little nervous about.” (Iris)

“I was a little self-conscious about my singing.” (Heather)

Two of the music therapists had training in vocal psychotherapy and were more comfortable with singing and using their voices. For example, Christine reflected on this in the post-session interview. She stated that she felt “safe” in the session, and when asked by the researcher what contributed to that sense, she responded:

“Having some experience with that approach [vocal psychotherapy], just understanding that it is ok, it is ok whatever comes out. And having done it before, feeling comfortable in trying it out, so that was helpful.” (Christine)

In this sense, music therapists were privileged in this intervention, and this is further examined in the discussion chapter.

General nervousness. In addition to feelings of performance anxiety, all participants identified feelings of general nervousness, fear, and uneasiness. Their discomfort arose because they did not know the therapist, the environment, or the intervention, and because of the potential intensity of a grief-focused intervention. Participants were nervous about singing in front of a therapist whom they did not know and about singing about a topic that is personal. For example:

“I was nervous because I was singing in front of somebody I don’t know, and then singing about something that was really emotional.” (Geraldine)

“I felt a little uneasy. I think, even though there was a targeted purpose for the session, being prepared to open up, it’s a challenge for me.” (Amanda)

Vulnerability. Participants also used words such as “vulnerable” to explain their experiences of discomfort. Five participants stated that they felt vulnerable singing the intervention, perhaps in part due to the unfamiliarity with the therapist and intervention. For example, in response to the post-session questionnaire question, “what uncomfortable feelings or thoughts arose for you?” participants responded as follows:

“Fear of being vulnerable, fear of being judged or yelled at for showing my feelings.” (Erin)

“The experience felt very vulnerable.” (Betsy)

Participants felt vulnerable doing the intervention due to the nature of the relationships they had with the deceased person, as well. For example, Christine had a complicated relationship with her deceased voice teacher and mentor, which created a sense of discomfort during the intervention:

“There was that feeling of vulnerability and a little bit anxiety...about feeling judged by [the therapist], which is a normal thing for me to feel in front of a lot of people. And, I think having the chair there, representing the other person...I did feel a little apprehensive looking at the chair and remembering this person, and just feeling a lot of emotions at that moment when we first sat down. So I just closed my eyes and was still able to imagine the person and be there.”

Participants were vulnerable about opening up in front of a therapist whom they did not know, expressing potentially painful emotions, and trying an intervention that involves an imaginary dialogue with a deceased loved one.

Intensity of experience. Data showed that even with the grounding and containing exercises, five participants were at times overwhelmed by the emotional intensity of the intervention, and may have felt flooded with feelings of grief. For example:

“At times I felt overwhelmed by pain and had to stop singing...It was pretty intense.” (Betsy)

“It was so intense.” (Heather)

When these moments arose, participants were gently guided through grounding and containing exercises, such as deep breathing. Data analysis demonstrated that if the participant became emotionally overwhelmed and paused singing during the intervention,

the therapist continued the music and singing in the first person to double the participant. Participants were never pressured to sing. Adequate containment and holding was a priority of the research design, and as described in the following theme, experienced by the participants.

Theme 3: I Felt Safe - Containment and Support

Despite their discomfort, all participants referenced that the experience was simultaneously containing. Participants stressed that they felt contained by the: (a) knowledge of the session's structure; (b) therapist's presence; (c) predictability of the music; and, (d) the grounding exercises (i.e., breathing exercises) experienced before, after, and sometimes during the intervention. For example, as Doris explained:

“The structure, chords, therapist, those things are so important... I found the grounding to be silly, but at the end...I needed it. So those things are really important, inextricable from it.”

Knowledge of the session's structure. Even though the participants named feeling nervous due to unfamiliarity with the therapist, environment, and intervention, six of the nine participants identified having knowledge of the structure of the session and an explanation of the intervention to be helpful. Participants were given an outline of the session structure and explained the intervention in detail both during the consent process and again at the start of the session. These aspects helped participants feel more contained, supported, and safe during an otherwise uncomfortable and vulnerable experience. For example:

“The atmosphere of the way things were set up and the way he went about preparing me for the session was really, really nice. I think I was still nervous

before we started, but I'm glad that we prepared prior to just 'come sit at the piano.'" (Geraldine)

"I appreciate that [the therapist] gave me a walkthrough about how things were going to unfold in terms of the process, so I think that helped...and like I said, the environment feeling safe was pretty key." (Christine)

The participants commented that knowing what lay ahead helped ease their discomfort.

Therapeutic presence. All participants spoke about the therapist's presence as another important containing factor. The therapist was repeatedly described as "holding," "safe," and "supportive," as well as "guiding." The intervention entailed singing in unison and harmony with the participants, repeating their phrases (i.e., mirroring), and singing in the first person from the perspective of the participant to offer additional phrases and feelings (i.e., doubling). Participants spoke of the process of singing with the therapist, and all participants named his therapeutic presence as a key factor in helping them feel contained and supported in the session. For example:

"Honestly, the presence of [the therapist] [helped me]. I felt really safe. I felt extremely safe." (Christine)

"I felt supported, acknowledged, listened to, guided." (Erin)

"[The therapist] was very present, thoughtful, and I felt fully heard/seen/listened to. Whenever I felt anxious about my singing ability or the process, I looked at [him] and felt he was fully there with me, with no judgment, which made me feel calm and safe." (Doris)

The therapist was perceived as able to both support the participants' process while also sensitively guiding them when needed. Participants felt that the therapist's guiding

support helped contain them. This was demonstrated in the music, when the therapist sang with and for the participants. For example:

“I felt at times the therapist became my voice when it was lost. The relationship was fluid throughout the sessions. At times supportive, at times guiding.” (Betsy)

Participants appreciated the therapist’s vocal techniques of singing in unison, singing in harmony, mirroring, and doubling. The therapist used all these vocal techniques during the course of a session, fluidly interweaving between them. At times, the therapist only played the piano without singing, supporting the participants in either their singing or their silence. These aspects of the intervention were perceived as sensitively supportive and guiding without being overbearing and dominating.

“I think that the therapist was very amenable. He was very supportive. He was very supportive. He just went with what I suggested, and I didn’t feel pressure to be fancy in anyway. He was very supportive, I think, that was my experience of him. Really stayed out of the way [laughter], and just held. There was a very good holding and supporting in the music, and I really felt that.” (Amanda)

“I trusted [the therapist] and I trusted the process, and he was really good at containing the experience...I loved how he reflected my words and built upon them, offering me more than I could have offered myself.” (Iris)

Predictability of music. Seven of the nine participants described the two-chord harmonic structure, as designed and used by Austin (2008), as “holding” and “containing.” There was a predictability and repetitiveness that was containing and supportive. Participants were easily able to grasp the pattern of the two chords. For example:

“There was a very good holding and supporting in the music, and I really felt that.” (Amanda)

“I felt that I was in some form of container that felt safe, but I also felt that as the music was going in a continuous flow. I also felt that many times I wanted to shut down and step back. But the music helped me to continue, to continue expressing my emotions, in a contained way... I did feel like the music opened up the door, and I felt my breath became more regulated, and I did not feel like I was going to fall apart quickly, and I was able to go to the feeling and back, and still remain as my sense of self.” (Erin)

The music, and specifically the harmonic structure, helped participants regulate and ground themselves. The certainty of the music provided a holding pattern that allowed them to safely express themselves, without feeling emotionally overwhelmed.

Grounding exercises. The grounding and containment exercises utilized before, during, and after the intervention were a valuable component of the intervention itself, and cannot be separated from it. All of the participants reflected on the helpfulness of these exercises in the post-session questionnaires and interviews. The participants recognized the necessity of these exercises in helping contain the emotional intensity of the experience. For example,

“We did some breathing exercises and stuff, and then some humming stuff with the piano, and making noise before the piano started, like with your breath.”

(Geraldine)

“[The therapist] had to do, at the end of our session, a containment exercise with me. We built a container, and we put it into a house. I think he probably did that

because I was crying so much and he wanted to make sure that I was ok leaving.”

(Iris)

“[The therapist] spent some time at the beginning doing some grounding and breathing together, and I think that helped me to feel connected with him. Just some simple breathing. And he also really mirrored me. Like physically. He may have had one idea of how to breathe or move, but there would be a couple of times I did this little shake, cause that’s what I do, and he mirrored that right back to me, and that made me feel like, oh, we’re in this together.” (Doris)

Grounding exercises such as deep breathing were audible in all the sessions, as they were a structured component of the intervention. All of the dialogues started with deep breaths that evolved into toning and vocalization on open vowel sounds, such as “ah” and “oh.” In addition, the therapist was heard modeling deep breaths for participants during particular points of emotional intensity, such as if the participants were crying more heavily. The therapist modeled a few deep breaths while continuing to play the piano. This would serve as a non-verbal invitation for participants to take deep breaths along with him, which they did. For example, during a particularly intense phrase of singing to her grandfather, Doris had to pause to take deep breaths amidst her crying:

“Where were you? [taking deep breaths while crying]

Where are you? [therapist mirroring/doubling while Doris breathes]

Where are you? [participant joins back in]”

The therapist led the participants in grounding exercises that helped them feel contained and supported despite the distress they may have simultaneously experienced.

Theme 4: I Felt His/Her Presence - Emotional and Spiritual Connection to the Deceased

Singing greetings, questions, and answers. Analysis demonstrated that the intervention helped facilitate a connection with the deceased person. In the post-session interviews and questionnaires, all of the participants consistently verbalized feeling closer with the deceased during the intervention. Furthermore, this sense of connection lasted after the session was over. One way in which the participants facilitated this sense of connection was by singing greetings and unanswered questions directly to the deceased individuals. These greetings and questions gave the participants a chance to verbalize some thoughts and feelings that may have been lingering or unresolved since the death. Sometimes the lyrics were hopeful and had a more positive note. For example, when Amanda sang to her deceased friend:

“Hello [deceased person’s name],
How are you doing, up in heaven?
What’cha doing up in the sky?
I hope you are doing fine.
I hope you are doing better
Up there with the angels.” (Amanda)

Amanda reflected on singing these questions and how they affected her feelings of grief in the post-session interview:

“I felt greater relief, a resolution of the questions I had in mind on the suddenness of my loved one’s passing. It was very reassuring.”

Other times, the participants asked more desperate, pleading questions. Common questions included asking why the deceased left them and where the deceased went. These were often coupled with statements asking for help, which furthered that sense of connection. For example, Iris asked her deceased parent why he abandoned her:

“Why did you leave?
 Why didn’t you come back, for me?
 Why did you go?
 Why did you go?
 Help me, help me, help me
 Why did you go?
 Why didn’t you take me?
 Where are you now?”

In addition to asking where he went and why he left, Doris also asked her deceased grandfather questions about her mother, seeking help and insight about her mother’s history and behaviors.

“I didn’t know I needed you until you now
 I need your help
 The stories that you know [crying]
 Where are you?
 And where is my mother?
 She’s here but she’s not
 I feel you have a clue
 I feel you know, can you help me?”

Can you help me?

I need you now, she needs you now, we need you now

Where did you go?

Why, why, why did you go?

Why did you leave me?

Why did you leave her?

And now she's leaving me alone

Why couldn't you be there for her?

Why couldn't she be here for me?

I know you know [crying, blowing nose and breathing deeply to ground herself].”

The sense of connection would be deepened when participants switched roles and responded to themselves from the role of the deceased. In these responses, the participants found opportunities to surmise and vocalize answers to those lingering questions. In the above example, Doris switched roles to her grandfather and responded to herself:

“Honey, you're a woman now

You're a mother, you're all grown, you have a family of your own

And, I'm sorry

Look at all you've become

You stay when it's tough

You speak up in your family, you use that voice

You gotta pray

I don't have all the answers for you

You know what you know
You're mom's not perfect, you know that, she knows that
But she loves you
She loves you so fully
I see that
She never loves so fully as she loves you
Try to forgive
I know it isn't easy
She never forgave me
She wasn't able
But she isn't strong like you."

In the post-session interview, Doris reflected on the experience of singing the questions and responses:

This intervention was real, like, I contain the answers. And part of how I contain the answers is because I contain my grandfather somehow in me. And, I think that was a real, like, yeah, I felt like the answers are in here. Because so much of what I was singing for my grandfather, I had questions for him. Like where did you go? And when I was singing them, I really didn't know the answers...And then when I was in his role, I realized, who knows what it is...that insight came from me in the role of the grandfather, I contained that. And it doesn't have to be right or wrong, but I felt content with that answer. Not right, but that's the answer, that's what I needed to know. And I think when people die it's like 'where did you go' and 'what about this' and 'am I going to be ok,' there's so many questions. And

that's part of the hardest part of grieving. In this, I felt like the mystery was allowed to be present, but I also felt tapped into my own inner resources.

By singing an imaginal dialogue with the deceased, participants had internalized the deceased within themselves. Singing greetings, questions, and responses directly to and from the role of the deceased helped the participants establish a sense of deep connection to the deceased.

Feeling presence of deceased. In the post-session interviews, six of the nine participants used the term “presence” when explaining a heightened sense of connection with the deceased during the session. The participants felt that the deceased person was present in the room, listening and speaking to them. For these participants, this was emotional as well as reassuring. Feeling the presence of their deceased loved one was also described as containing and enjoyable. For example,

“I also felt a sense of reassurance, because I feel her presence. I feel that she's around, that she's watching over me.” (Amanda)

“I felt he was in the room with me and that he heard what I had to say.” (Erin)

“I felt I could be close to my grandmother again, feel her presence, which was both comforting and emotional for me.” (Fiona)

During the interviews conducted a few days after the session, participants commented that they had maintained this sense of connection after the session. For example,

“It is like when you call someone up and make contact. It's like ‘oh, I missed this!’ And then I somewhat feel more whole after that, and I will think about them more often, I will try and keep that contact...He's more alive in my life now.”

(Doris)

“She’s been on my mind a little more.” (Christine)

Using the pronoun of the deceased. Six of the participants used the pronoun of the deceased person when explaining the role reversal, especially in the context of forgiveness. Although this was a semantic observation, data analysis showed repeated occurrences of participants using the pronoun of the deceased. For example, using the words “he sang” rather than “I sang to myself from the role of.” This also appeared to deepen the sense of connection that participants felt with the deceased. When invited to switch roles into her deceased sibling, Betsy stated:

“He’ll just say the same thing back to me.”

In addition, in the post-session interview, participants used the following language:

“When he sang back to me, it was clear that he told me to forgive myself.”

(Heather)

“And she apologized, when she sang back to me, she apologized for leaving so suddenly.” (Amanda)

The participants seemed to have experienced the role reversal to such an extent that the pronoun came naturally when reflecting on the intervention.

Theme 5: I’m Finally Grieving and Have Greater Acceptance - Helpful Opportunity for Grief Resolution

Exchanging apologies and forgiveness. Data demonstrated that the intervention offered opportunities for grief resolution. Participants sang apologies to the deceased and to themselves from the role of the deceased, and this exchange of apologies and forgiveness provided opportunities for grief resolution. Seven participants sang “I’m sorry” to the deceased and/or in response to themselves from the role of the deceased.

These participants also forgave their loved one and themselves from the role of the deceased. These exchanges helped participants to move towards resolution of their grief. For some participants, guilt and shame about unresolved issues contributed to a prolonged grief reaction, and exchanging apologies appeared to be very valuable. For example, Heather sang these words to her deceased spouse,

“I’m so, so sorry at the end that I didn’t pay more attention to you

I’m so, so sorry.

I’m trying to forgive myself [crying].”

When she switched roles and sang back to herself from her deceased spouse, she first paused and took a few long deep breaths, as she was heavily sobbing. She then sang an acceptance of the apology, forgiving herself from the role of the deceased:

“[Name of participant], you gave me all that you could,

You created a life that we shared,

You were there,

You helped and saved my life,

Without you I could not have gone on,

Yes, yes, sometimes I was disappointed that I couldn’t have more of you,

But I understood,

I understood,

You had to make your own life, also,

And death is not a punishment,

I’m free,

I’m free of pain,

And I'll always be there for you,
I'll always be there for you [crying; therapist sings by himself, mirroring her words],
Let yourself love and be loved [crying],
Sail away.”

In the post-session interview, Heather reflected on this exchange of apologies and forgiveness with her deceased spouse. After mentioning that she had gained insights during the intervention, the researcher asked her to elaborate, and she responded as follows:

“Well, one of the major ones [insights] was that I couldn't forgive myself for not being perfect, because towards the end of his life, I had kind of like anticipatory grief. I was pulling away a little bit. Not that I wasn't there for him, but I was pulling away a little bit. And, it's hard for me to forgive myself for that. And, I realized that more. And, when he sang back to me, it was clear that he told me to forgive myself.”

For participants that had unresolved issues, exchanging apologies with the deceased was a helpful opportunity to move towards resolving their grief. Christine identified some unresolved issues with her voice teacher, and sang these words to the deceased along with an apology:

“[Name of the deceased],
I have a voice,
Don't judge me,
You were tough,

You were mean,

You were warm,

You were everything,

I'm sorry if I failed you,

Can you hear me?

Can you hear me?

Can you hear me? [intensity of music builds, singing in harmony with therapist]"

Before switching roles to sing back to herself, Christine was audible breathing deeply to help ground herself. From the role of her voice teacher, she sang back an apology, as well:

"I loose my temper,

But I love you, despite that,

And I know that you know that,

I love you, despite that I pushed,

I'm sorry if I hurt you,

I'm sorry,

I loved you,

Ahhhh [singing in harmony with therapist],

I am here with you, right now,

Be bold, be strong, be fearless,

Be bold, be strong, be fearless,

Sing it loud [singing in harmony with therapist]."

Following is an example when Betsy sang to herself from the role of her deceased sibling:

“I’m sorry,
Don’t let it all be about me.”

Exchanging apologies and forgiveness with the deceased in an imaginal dialogue allowed the participants to begin to resolve lingering wounds, and ultimately, begin to resolve their grief.

Singing ‘good-bye’ to the deceased. Four participants verbalized that the intervention gave them opportunities to say good-bye to the deceased person. For some participants, it had been years since the death, and they did not have previous opportunities to say goodbye. They needed to say goodbye to their loved ones as part of resolving their grief. The intervention was an opportunity to gain some closure and resolution. For example, here is an excerpt from the lyrics that Erin sang to her grandfather:

“I want to say goodbye to you [crying],
I’m sorry that I’m crying.”

When she sang back to herself from the role of the deceased, she sang the following:

“Dear granddaughter,
I’m sorry I didn’t say goodbye,
I didn’t want you to see me [crying],
If only I knew [crying more intensely],
How much I hurt you,
I thought it would be better like this...

I want you to know I love you.”

In the post-session interview, Erin explained,

“I was not allowed to feel my feelings, and I was not told when my grandfather passed away, nor did I have a chance to say goodbye... The fact that I was given an opportunity to sing what I actually wanted to say all these years. It was powerful... I realized how important it is for me to sing that to him, because I didn't have the opportunity. I felt a sense of closure, relief of burden, peace.”

In the post-session questionnaires and interviews, participants like Erin reflected on how singing goodbye to their loved one helped resolve their feelings of grief. They had been feeling a prolonged need to say goodbye and gain closure. For example, another participant reflected on how she was not only grateful to say goodbye to her friend, but to also do it through song and music.

“I realized [name of deceased] was the only of the three losses I did not formally say goodbye to. I was glad to be given a chance to say goodbye to her in her modality: song and music.” (Amanda)

Greater acceptance and insight. In the post-session interviews, all the participants verbalized that the intervention allowed the process of mourning to emerge, thereby offering opportunities for insight and resolution. Participants experienced greater acceptance of the death, greater adjustment to their identity and the world after the loss, and a greater understanding of their own coping styles. For example, with regards to the passing of her close friend, Amanda reflected:

“I've come to a greater sense of acceptance... I felt greater relief, a resolution of the questions I had in mind on the suddenness of my loved one's passing.”

The intervention led to helpful insights about the death and the relationship with the deceased person. Participants gained some understanding about their own behaviors as well as those of their loved ones, especially when singing to themselves from the role of the deceased. Commonly used terms included “I never thought of that before.” The insights gained helped the participants begin to process and resolve their feelings of grief. In addition, participants verbalized shifts in desires, such as understanding and loving, again. For example,

“I began to understand a little bit of what her experience was, and understood that the time had come, even though there was no notice.” (Amanda)

“I know that my husband wants me to live fully and love again.” (Heather)

When singing back to herself from the role of her deceased grandmother, Fiona gained some insight about how her grandmother perceived her:

“I liked to hear your footsteps when you came home at night,

For 60 years, that house was empty, I was afraid

And then you came, this wild child

It was an adjustment,

I was 94, you were 24,

But I wanted you with me,

There was a freedom that you had that I never had,

And now I saw a part of me in you,

A freedom that was growing in my house,

And a liveness as I was dying, as my body fell apart,

I was trapped in my body, I hated,

but you brought the outside world to me.”

In the post-session questionnaire, Fiona reflected on how gaining these perceptions of herself from the role of her grandmother was helpful:

“Moving into the chair and becoming my grandmother was a beautiful addition to the process...it allowed me to become less distanced and integrate the various parts of myself, and get in touch with more dissociated material. I also had some insight about the connection between my grandmother and my mother and myself, and the ways that my bond with my grandmother was reparative and the ways that I struggled with some of her harsh and rigid behaviors.”

Participants repeatedly shared that switching roles and singing to themselves from the role of the deceased contributed to greater acceptance and insight. For example,

“I refer to [the deceased] as the sergeant major. She was the person in my family who was in charge. Nobody ever questioned her...She was the one who was in charge of everyone. When I switched places, listening to myself saying that she didn't want that role was really odd. Just having this like, 'oh, I never thought of that before, that she didn't want it.' You know?” (Betsy)

“Having the experience of me singing to the person, imagining, and then from the other person's perspective what they might be feeling, and come to the realization that there might be more similarities than differences. I had viewed this person as very impatient, and I consider myself a pretty patient person, so realizing that the other person might have wished that she had some of the same things that she saw in me that she didn't have. And I didn't really realize that until having that

experience and processing it a little bit. I have a little more empathy for that person.” (Christine)

Participants gained insights about their relationships with the deceased that helped them begin to resolve their feelings of grief.

Observable changes in feelings and behaviors. Participants reflected that the intervention allowed for shifts in behaviors, such as cleaning out symbolic rooms.

Fiona sang about her grandmother’s death. She sang to her grandmother as she was dying, and the room in which her grandmother died had piled up with clutter since the death:

“You left me,

You just died on me

I saw you dying

In my house

I couldn’t make your room my bedroom

That room is filled with clutter, I can’t use it

It’s just that room, papers and papers and shit and bikes and everything [laughing]

You were on the floor, when you died [getting quiet]

And we were singing to you, after you died

We sat with you

And I sang to you

[singing in another language the song that she sang when her grandmother died]

It means, you are my shepherd

And I lack in nothing

I lack nothing
And you walked with me
In the greener pastures of past life.
Even when I walk in the valley of death
You taught me not to fear death as much.”

After singing this intervention, Fiona felt that she could clean out a room filled with her grandmother’s belongings. In the post-session interview, she noted this observable change in feelings and behavior:

“I could also process some of the ways my grief and difficulties in letting go has kept me stuck...A major thing that really helped me that came up in the session that I’ve been talking about in therapy is that I have a fairly big apartment. I inherited my grandmother’s apartment... She died in her bedroom. I have all the rooms very clear, but my grandmother’s room became like the attic...it’s getting more and more filled with shit that you can barely walk in there. And I always feel so much shame for anyone to see it. And in the session itself as I was singing about my grandmother dying in that room and lying on the floor and me singing on the floor when she was dying and about how I couldn’t go in there, I was like ‘and now I fill it with stuff, so I can’t get in there, so I can’t get close to it’. And that really hit me, that in a way, I’m shutting myself from that room and metaphorically moving myself away from some of the feelings. And now, I felt like something actually shifted. I felt this lift. I actually feel like I could clean out that room now. I was cluttering up that room.” (Fiona)

Intervention was helpful and effective. Results demonstrated that the intervention was found to be helpful, informative, and beneficial to all participants in their mourning process. Participants used similar language, and described the intervention as “working” and “effective” in helping them resolve their feelings of grief. For example, in the post-session interview, in response to the question, “how was the experience of singing the imaginal dialogue?” Heather responded:

“It was very informative...I realized some things that were important, like trying to be a perfect wife.” (Heather)

Other participants said similar statements about the effectiveness of the intervention.

“Based on what I experienced, I can tell that it is working. This is working. This is very effective.” (Erin)

“It made me wish for an opportunity to continue this process, which in itself is a positive thing.” (Fiona)

“I think it was effective, and I think that it will create movement.” (Betsy)

“I think it’s something that could be very good and helpful to people.” (Heather)

Participants repeatedly used words such as “profound” and “powerful” to explain the intervention. For example, after singing an imaginal dialogue with her deceased parent, Iris stated,

“It was definitely very deep and profound.”

The researcher received thankful feedback from the participants repeatedly saying that the study and intervention were “important” and “needed.” Three participants also verbalized a desire to continue their grief process using the intervention. Furthermore,

two participants asked to be referred to music therapists after their participation in the study ended. In an email follow-up, Iris wrote:

“I’m so glad I did the research study... The work is so deep and I feel like it’s a gift.”

The participants felt that the intervention was beneficial to their mourning process.

Theme 6: It Bypassed the Intellectual - More Effective to Sing than Speak

Flow of music. Eight of the nine participants stated that they felt singing was more effective than speaking an imaginal dialogue for accessing thoughts and feelings related to their grief. One of the reasons participants cited was the “flow” of the music. All of the participants discussed that music’s ability to continuously move and flow through time helped participants gain access to their feelings in a “freeing” and direct way. Participants stated that the repetitiveness of the music’s harmonic structure put them in a “trance,” which allowed them to feel a sense of flow in their expression. Therefore, they were not cognitively processing or blocking thoughts and feelings, but just letting the words flow with the music. They emphasized that because they were singing and in the flow of the music, they felt that what emerged was more authentic. For example,

“I think using that technique with the voice and having that constant rhythmic and melodic motion going, it just puts you in this trance like state, I don’t know. It just like comes out very fast, and I was really struck by that. I’m always struck by that work and how fast it happens. And form, I can’t hide as much behind it. I know people can, and there is a way to be resistant in everything, but for me, I couldn’t

hide as much behind it...I was very interested in how fast and how immediate I got to the core of what I was feeling.” (Christine)

“[The music] freed up my ability, the singing, it freed up the spontaneity of what he would say back to me.” (Heather)

The flow of the music allowed participants to stay with the emotions and feelings, which they reflected made singing more effective than speaking. For example,

“I think there’s so much more opportunity when you’re speaking to just not connect. In this particular session, I think there’s a lot less opportunity to hide and deflect and dissociate. It’s like the tone is set. When you’re just talking, you can say whatever you want, and there isn’t anything that’s keeping you within that emotional bubble. Then you can kind of *not* do therapy however you want. Like escape therapy, however you want. And if the music is playing, I don’t know, there’s just less opportunity to hide and not do therapy.” (Geraldine)

Music was more direct, less intellectual. Eight participants reflected that the music directly accessed the core of what they were feeling and expressing, and that singing therefore bypassed defensive strategies like intellectualization. After experiencing the intervention, participants repeatedly stated that by contrast, verbal dialogue had the potential to be overly cognitive and intellectual, and may not have as deeply accessed their emotions. On the other hand, singing was viewed as a more direct path to their grief-related feelings that they admitted were difficult to access and/or express. For example,

“I think that the music and the voice bypasses the cognitive formations that are there. For someone like me, who I tend to be overly intellectualized, or in the

head, or analytical, this kind of work is a good fit for me. Someone like me who can talk about things and maybe even be a little bit detached from what I'm saying." (Iris)

"The way I'm accustomed to speaking, it's genuine, but I wouldn't touch on my emotions, especially the painful ones, or those that were not invited to be expressed." (Erin)

"I think the music provides a direct path to whatever it is that you're going to speak about. There's a direct path. And the music is playing so you can't get off the path, unless you leave." (Geraldine)

"I was sharing more directly what are some of ways that her loss has impacted me, in a much more direct, immediate way." (Fiona)

"If I was having a verbal conversation, I probably would be wishing there were a lot of things I wouldn't want to say, or my defenses would be up, so I think using that approach was really cool." (Christine)

Surprise at emerging 'unconscious' content. Results demonstrated that six participants experienced immediate and unexpected access to what they felt were unconscious material and emotions. They felt this access to deeper feelings and unconscious thoughts might not have happened through verbal dialogue alone, and was aided in part by the music. Participants described the emerging content of the dialogue as "surprising" and "unexpected." They had not previously had those thoughts and feelings. For example,

"What came out of my mouth was surprising." (Geraldine)

“I think it does allow for more unconscious material to come to the surface. I was surprised by some of the things that came out of my mouth.” (Fiona)

“Singing tapped into my unconscious and my raw emotions in a way that a dialogue may have but it would have taken longer, and I think I would have put distance to it, because it would have been more words. Singing...was crucial for me in activating the unconscious and the emotions. And I don’t think that would have happened if I was not singing and only having a verbal dialogue. I know it wouldn’t have.” (Doris)

“It did feel very free-flowing, like it wasn’t premeditated, and I was surprised at how fast things were coming out, and some things not very positive about the person, but at the same time, I think I did really speak the truth, so in that sense, it was very freeing.” (Christine)

Therefore, participants were able to gain deeper insights about their loved one, the relationship with them, and the loss. Participants were also able to express more painful emotions, such as sadness, which they admitted they would not have accessed as easily were the intervention using verbal dialogue alone. When compared to verbal dialogue, the musical aspects such as singing and harmonic progression allowed the intervention to be more freeing, expressive, and effective.

Feeling was more helpful than talking. All participants noted that “feeling” rather than talking about their grief during the intervention was more helpful for working towards grief resolution. Despite their concurrent engagement in ongoing psychotherapy, all participants noted that they had not adequately grieved prior to the session. The

intervention was particularly helpful in allowing the feelings, thoughts, and process to emerge. For example,

“When I went through the technique, I found it very effective, because although I talked about grief a lot, but I was actually able to access it and feel it.” (Erin)

There was a difference in singing the intervention rather than exclusively speaking about grief. Participants identified that previously accessing and expressing grief had been difficult for them. For example,

“I’ve never really mourned before.” (Heather)

“I tend to struggle to access my grief...[the intervention] allowed it to emerge.” (Iris)

“I stunt a lot of the emotions attached to my grief. [The intervention can] bring these emotions that I normally try to keep contained out in the open.” (Betsy)

“I do think that the music allowed me to access things that go beyond the verbal. It was more embodied, it tapped more into the emotional experience.” (Fiona)

After the intervention, participants noted that talking about grief and feeling grief were two different experiences. Feeling all the emotions of grief was noted to be a helpful step in beginning to resolve grief.

In conclusion, data analysis found six themes and 24 subthemes from the experiences of these nine participants singing an imaginal dialogue with a deceased loved one. Themes, subthemes, and exemplary quotations are summarized in Table 4.

Table 4

Results of Data Analysis: Themes, Subthemes, and Textual Examples

Theme	Subtheme	Textual Examples
I cried the whole time - Elicitation of profound emotional expression	Tears, sadness, and other emotions	“[I felt] sadness, guilt, helplessness, loss, [and] deep longing.” (Participant B) “I cried through the whole thing. I cried and cried. It was raw for sure.” (Participant D)
	Singing to deceased about missing them	“I miss you, Come home.” (Participant B)
	Role of music in accessing and tolerating emotions	“You’re singing about something sad, but it made whatever I was singing about, depending on what I was saying, lighter at times. Like more easy to tolerate, or something.” (Participant G)
	Importance in the mourning process	“I have realized that I was not able to feel my feelings...prior to this session.” (Participant F)
I was scared to sing - Discomfort, nervousness and anxiety	Performance anxiety	“I was a little scared to sing because I’m not a trained singer, but I love to sing, so that part I was a little nervous about.” (Participant I)

General nervousness	“I was nervous because I was singing in front of somebody I don’t know, and then singing about something that was really emotional.” (Participant G)	
Vulnerability	“There was that feeling of vulnerability and a little bit anxiety...about feeling judged by [the therapist], which is a normal thing for me to feel in front of a lot of people.” (Participant C)	
Intensity of experience	“At times I felt overwhelmed by pain and had to stop singing...It was pretty intense.” (Participant B)	
I felt safe - Containment and support	Knowledge of session’s structure	“...the way he went about preparing me for the session was really, really nice. I think I was still nervous before we started, but I’m glad that we prepared prior to just ‘come sit at the piano’.” (Participant G)
	Therapeutic presence	“Honestly, the presence of [the therapist] [helped me]. I felt really safe. I felt extremely safe.” (Participant C)
	Predictability of music	“There was a very good holding and supporting in the music, and I really felt that.” (Participant A)

<p>Grounding exercises</p> <p>I felt his/her presence - Emotional and spiritual connection to the deceased</p>	<p>Grounding exercises</p>	<p>“[The therapist] had to do, at the end of our session, a containment exercise with me... I think he probably did that because I was crying so much and he wanted to make sure that I was ok leaving.” (Participant I)</p>
<p>Singing greetings, questions, and answers</p>	<p>Singing greetings, questions, and answers</p>	<p>“Hello, [deceased person’s name]; How are you doing, up in heaven?; What’cha doing up in the sky; I hope you are doing fine; I hope you are doing better; Up there with the angels.” (Participant A)</p>
<p>Feeling ‘presence’ of deceased</p>	<p>Feeling ‘presence’ of deceased</p>	<p>“I felt he was in the room with me and that he heard what I had to say.” (Participant E)</p>
<p>Using pronoun of deceased</p>	<p>Using pronoun of deceased</p>	<p>“When he sang back to me, it was clear that he told me to forgive myself.” (Participant H)</p>
<p>I’m finally grieving and have greater acceptance - Helpful opportunity for grief resolution</p>	<p>Exchanging apologies and forgiveness</p>	<p>“You were everything, I’m sorry if I failed you, Can you hear me?” (Participant C)</p>
<p>Singing goodbye to deceased</p>	<p>Singing goodbye to deceased</p>	<p>“I was not told when my grandfather passed away, nor did I have a chance to say goodbye... The fact that</p>

		I was given an opportunity to sing what I actually wanted to say all these years. It was powerful” (Participant E)
	Greater acceptance and insight	“I’ve come to a greater sense of acceptance...I felt greater relief, a resolution of the questions I had in mind on the suddenness of my loved one’s passing.” (Participant A)
	Observable changes in feelings and behaviors	“I could also process some of the ways my grief and difficulties in letting go has kept me stuck...And now, I felt like something actually shifted. I felt this lift. I actually feel like I could clean out that room now.” (Participant F)
	Intervention was helpful and effective	“Based on what I experienced, I can tell that it is working. This is working. This is very effective.” (Participant E)
It bypassed the intellectual - More effective to sing than speak	Flow of music	“[The music] freed up my ability, the singing, it freed up the spontaneity of what he would say back to me.” (Participant H)
	Music was more direct, less intellectual	“I think that the music and the voice bypasses the cognitive formations that are there.” (Participant I)
	Surprise at emerging ‘unconscious’ content	“Singing tapped into my unconscious and my raw

	emotions in a way that a dialogue may have but it would have taken longer, and I think I would have put distance to it, because it would have been more words. Singing...was crucial for me in activating the unconscious and the emotions.” (Participant D)
Feeling was more helpful than talking	“When I went through the technique, I found it very effective, because although I talked about grief a lot, but I was actually able to access it and feel it.” (Participant E)

While the participants experienced discomfort stemming from performance anxiety and vulnerability, they also articulated feeling containment, support, and profound emotional expression. Music and singing helped participants exchange apologies, greetings, questions, and answers with their deceased loved ones. Music and singing allowed participants to experience a sense of flow that bypassed intellectualization while creating feelings of safety and containment. The intervention helped the participants access, express, and tolerate their grief, which they named to be helpful in establishing a bond to the deceased. Participants began to process and resolve their grief, which was identified as an important part of the mourning process. The intervention was helpful and effective, and participants felt that they gained deeper insight, acceptance, and understanding regarding their loss.

CHAPTER 5

Discussion

A mixed-methods study examining a bereavement-specific music therapy intervention was conducted with nine creative arts therapists. The intervention consisted of singing an imaginal dialogue with a deceased person, which is an intervention that was developed and utilized in previous research (Iliya, 2013) based on the work of Shear et al. (2005) and Austin (2008). Participants, who identified as having lost a loved one due to death more than one year prior to the study, attended a single-session of individual music therapy where this intervention was utilized. A trained music therapist who was not the researcher provided the intervention. Participants were not screened for complicated grief (CG), but may have identified with having prolonged grief reactions. After the session, participants immediately completed a questionnaire and, within three days, were interviewed by the researcher regarding their experience.

The inductive qualitative data analysis of the therapy session transcripts, interview transcripts, and questionnaires revealed six themes from participants' experiences of singing an imaginal dialogue with a deceased loved one. The themes are: (a) I cried the whole time - Elicitation of profound emotional expression; (b) I was scared to sing - Discomfort, nervousness, and anxiety; (c) I felt safe - Containment and support; (d) I felt his/her presence - Emotional and spiritual connection to the deceased; (e) I'm finally grieving and have greater acceptance - Helpful opportunity for grief resolution; (f) It bypassed the intellectual - More effective to sing than speak. Descriptive statistical analysis of reported distress levels (on a scale of 1 to 100) during the intervention and immediately after the intervention demonstrated that the average distress level was over

50 during the intervention and almost half of that level after the intervention. Therefore, distress levels were reported to be less after the intervention, perhaps in part due to the grounding exercises and verbal processing provided by the therapist. Participants reported feeling more distressed during the intervention than while verbally processing it afterwards.

The intention of this research was to understand therapists' experiences of singing the imaginal dialogue. Guided by the findings of the pilot study (Iliya, 2013), this study aimed to better understand questions such as why singing the intervention might be tolerable, helpful, or difficult. Study findings demonstrated that the intervention was indeed perceived as profoundly emotional. It elicited profound sadness and tears, as well as other potentially challenging emotions, like helplessness. Indeed, participants identified that the intervention was helpful in working towards grief resolution because it elicited feelings more deeply than exclusively speaking about grief. The emotionally arousing qualities of the intervention support earlier discussed literature on imaginal dialogues. Diamond, Rochman, and Amir (2010) found that the imaginal dialogue intervention was correlated with increased emotional arousal, especially with regards to sadness, fear, and anxiety. Moreover, research on imaginal dialogues has supported the need for feeling versus intellectualizing about grief. Even in a verbal context, there is evidence that the intervention elicits emotions more than some other verbal therapy techniques such as psychoeducation.

The results of the study showed that the intervention was experienced as not only emotional but also helpful in offering opportunities for grief resolution. In fact, the imaginal dialogue's intensity of emotional arousal has been correlated with better

treatment outcomes (Greenberg, 1979; Greenberg & Malcolm, 2002; Greenberg & Pascual-Leone, 2006; Paivio & Greenberg, 1995). Research has suggested that the efficacy of the imaginal dialogue is partially due its ability to arouse intense emotions. Greenberg and Pascual-Leone (2006) suggested that “working with aroused emotion is predictive of positive outcome in therapy” (p. 624). The imaginal dialogue, even when spoken and not sung, has been linked to better treatment outcomes than other approaches such as psychoeducation, likely because of its ability to access emotions. Therefore, the way in which singing the imaginal dialogue elicited such intense emotions may be why participants felt it was beneficial for their mourning process.

As previously discussed, in Shear et al.’s (2005) study of CG treatment, the promising results were plagued by the 26% attrition and 10% refusal rates due to the interventions being “too difficult” (p. 2,606). Indeed, data analysis revealed a fine line between experiencing the emotions at an optimal level and being negatively flooded with emotions. This balance of experiencing optimal arousal was one of the most important findings of the study. While the intensity of the experience contributed to the participants feeling nervous and anxious, they did not stop or refuse the intervention. As indicated by the descriptive analysis of the reported distress levels, the mean and median levels were over 50 during the intervention, and were lower after the intervention. Therefore, participants did feel more distressed during the intervention, but not so distressed that participation in the study was ended. Previous research on the intervention has found that “too much or too little emotion was found to be not as helpful as a moderate amount” (Carrier & Greenberg, 2010, p. 190). Therefore, a lack of emotional arousal and/or overwhelming emotional arousal has been previously associated with poorer treatment

outcomes. An optimal balance of emotional arousal is crucial for successful treatment outcomes, and data analysis revealed that participants in the current study experienced this balance. The intervention was profoundly emotional and intense but not to the degree that its perceived benefits were negated.

The intervention's optimal emotional arousal was demonstrated, in part, by the lack of attrition and refusal in the present study, as well as in the preliminary research (Iliya, 2013). In the pilot study, adults with severe mental illness and complicated grief did not drop out of the study or refuse the intervention, instead demonstrating an unexpected tolerance and benefit from the intervention. In the current study, creative arts therapists equally participated for the entire study. After Shear et al.'s (2005) findings, the lack of attrition and refusal when the intervention was sung plead the question: why? These findings suggest singing rather than speaking the intervention may have made the intervention more accessible and acceptable. These results must be interpreted with caution, however. It is unknown if the creative arts therapists in the current study would have repeated the intervention if they were invited to do so. Furthermore, participants in both studies self-selected for the study, which minimized the potential for attrition or refusal. Nevertheless, this research shows that setting the intervention to music, using singing, allowed participants to experience an optimal level of emotional arousal and tolerate their intense emotions. Through singing the dialogue, participants may have experienced a more optimal level of emotional arousal in the current study than in Shear et al.'s (2005) study.

Understanding this balance of optimal emotional arousal, and why singing the intervention was better tolerated, requires further analysis. Despite the discomfort and

distress that participants experienced, they felt simultaneously contained due to skilled therapeutic presence, grounding exercises, and harmonic musical structure. Austin (2008) discussed all of these elements as crucial components of the intervention. Regarding therapeutic presence, Austin has argued that sufficient clinical skills and training are needed to safely contain the level of intensity. Furthermore, grounding and breathing exercises were designed to create feelings of safety and containment. The participants were continually guided through breathing and grounding exercises, before, during, and after the intervention. Data analysis yielded that participants felt these components were vital aspects of helping make the entire intervention more tolerable.

The music also played a vital role in helping participants feel contained, which helped make the intervention more endurable. The repetitive two-chord harmonic structure, as used in the intervention, was designed by Austin (2008) to create feelings of predictability and safety. The use of two chords creates “a consistent and stable musical environment that facilitates improvised singing within the client-therapist relationship” (p. 146). The music became a container for expressing and processing painful emotions, making them more manageable by allowing the content to be processed in an externalized form. These abstract, transformative qualities of music and the arts have been previously researched and discussed (Rabiger, 1990; Springham, Findlay, Woods, & Harris, 2012; Twemlow, Sacco, & Fonagy, 2008). Music therapy for PTSD has been found to facilitate appropriate expression of emotions like anger and rage (Bensimon, Amir, & Wolf, 2008; Carr et al., 2012). Setting the intervention to music allowed participants to express, process, and reflect upon their grief and pain in a deeper but also

safer way. All of these containing elements helped the participants feel a sense safety needed in order to tolerate an intense level of emotional arousal during the intervention.

The flow of the music also allowed potentially unconscious thoughts and feelings to quickly emerge. Because singing bypassed intellectual processes, participants felt that it was more effective than speaking in terms of accessing their deeply hidden grief-related thoughts and feelings. These findings are again supported by Austin's (2008) theories of vocal psychotherapy. Austin argued that working with the voice holds immense therapeutic potential in accessing the unconscious. In addition, the repetitiveness of the two-chord harmonic structure used in the intervention was intentionally developed by Austin to create a trance-like state and elicit unconscious material. Austin's vocal psychotherapy techniques were designed to "support a connection to self and other and can be used to promote a therapeutic regression in which unconscious feelings, sensations, memories and associations can be accessed, processed and integrated" (p. 146). Participants were often surprised by their gained insights and felt emotions.

Previous research has supported the premise that singing may be more emotionally expressive than speaking (Juslin & Laukka, 2003). In one study of choir singers, group singing was found to be a way for individuals to cope and create a sense of community after adverse life events (von Lob, Camic, & Clift, 2010). The singers in that study felt that singing more completely expressed their emotions than talking in verbal therapy. In addition, bereavement-specific music therapy research using vocal interventions have been previously found to facilitate emotional expression (McFerran-Skewes, 2000; Smeijsters & van den Hurk, 1999). Researchers found processing the

participant's grief using music therapy was beneficial, and "expression of deep feelings of sorrow by singing can...lead to an emotional shift" (Smeijsters & van den Hurk, 1999, p. 249). Previous research on singing inconclusively supports its therapeutic benefits to improve mood and overall well-being (Clark & Harding, 2012), neither of which were measured in the current study.

Conversely, it is unrealistic to assume that everybody enjoys singing and therefore singing the intervention may be universally effective and helpful. As Chong (2010) highlighted, "it is assumed that singing, as one therapeutic intervention, brings positive and therapeutic effects for everyone" (p. 123). Results of the present study showed that participants felt performance anxiety from singing. The non-vocalists (i.e., non-music therapists) particularly verbalized feeling anxious, nervous, vulnerable, and uncomfortable about using their voices, especially in front of a stranger. These findings mirror previous research examining non-vocalists' attitudes towards singing (Chong, 2010). Although most of the participants in Chong's study reported enjoying singing, some individuals were uncomfortable from or disliked singing. As is discussed further below, potential participants who dislike singing may have self-selected to not participate in the study. However, even the non-vocalists in the study who may not have enjoyed and in reality felt anxious about singing did not refuse or avoid the intervention. Even more, the intervention was perceived as in fact helpful and beneficial for music therapists as well as creative arts therapists practicing in other modalities.

Results of the study also demonstrated that all participants felt an increased connection to the deceased person during and after singing the intervention. Participants sang greetings, questions, and answers to the deceased person and felt the 'presence' of

the deceased during and after the session. These findings also mirror those found in the pilot study (Iliya, 2013). Shear et al. (2005) designed their intervention of speaking the imaginal dialogue for the purpose of promoting a connection to the deceased, and it appeared that this was the experience of the participants in the present study. Other research has found that singing or playing music may help individuals maintain a connection with the deceased (Castle & Phillips, 2003). In their study using music therapy with bereaved caregivers, O'Callaghan, McDermott, Hudson, and Zalberg (2013) found that “music...elicited a feeling that [the participants] could communicate with their relatives” (p. 113), especially when they sang to the deceased. These research findings support the use of a music therapy intervention to create and maintain a connection with the deceased, which has been theorized to be a vital component of healthy mourning (Worden, 2009).

Surprisingly, data analysis found that participants often used the pronoun of the deceased person when discussing the process of role reversal during the dialogue. For example, sentences such as “when he sang back to me, he said...” were common. This was a surprising and important finding. Worden (2009) theorized that the technique of talking directly to the deceased in grief therapy was more powerful than talking about the deceased in the third person to the therapist. The intervention is one way in which talking directly to the deceased can be facilitated. The way in which the participants used the pronouns of their loved ones seems to confirm that they were authentically dialoguing with them. They were successful in envisioning the deceased person in the room, sitting in the empty chair. This supports previous research on the imaginal dialogue that has demonstrated a positive relationship between resolution of symptoms and ability to

engage in an imaginary conversation with another person who is not actually present in the room (Greenberg & Malcolm, 2002). Individuals who were engaged in the imaginal dialogue, “who fully absorb the treatment, by engaging in the change processes” (p. 414), benefited more than those who did not. The use of the pronoun is an example of the participants fully engaging in the imaginal dialogue and its change processes.

The verbal intervention has been previously found effective in resolving feelings, including those of grief and loss (Paivio & Greenberg, 1995; Greenberg & Malcolm, 2002). The imaginal dialogue can foster opportunities to verbalize previously unmet needs, as was experienced by the participants in the current study. One important finding was that these participants apologized to their deceased loved ones, and sung apologies to themselves from the role of the deceased. These exchanges of apologies and forgiveness helped the participants begin to resolve unfinished feelings and issues. Participants also said goodbye to their loved ones, which helped provide a needed sense of closure regarding their loss.

Based on the phenomenological experiences of the participants in the present study, the intervention was perceived as valuable, effective, and beneficial to the mourning process. Participants needed to express their grief-related feelings. These findings are supported by previous research on the experiences of bereaved adults indicating that expressing feelings help to make sense of the loss and reminisce about the deceased (Muller & Thompson, 2003; Seah & Wilson, 2011). Talking about grief experiences and feelings has been found to be helpful, and this was replicated in the current study. Furthermore, participants identified greater acceptance and insight regarding the loss, and noted observable changes in their feelings and behaviors. They

gained new knowledge and understanding about the deceased person, their relationship to the person, and how the loss affected their sense of identity. Participants expressed feeling some relief and closure after the research session.

Participants felt that they had not had previous opportunities to grieve as deeply or as purposefully as in the research session. Literature has shown that bereaved adults, particularly those with prolonged grief symptoms, seek mental health services and participation in research studies (Beck & Konnert, 2007; Bergman, Haley, & Small, 2010; Johnson et al., 2009). Bereaved adults want and need to grieve, and are looking for grief therapy and counseling services to help them with their mourning process. Furthermore, grief interventions have been shown to be effective with adults, especially those with prolonged grief reactions (Currier et al., 2008; Wittouck et al., 2011). The findings from the present and previous research suggest that there is both a need for and potential benefit of grief therapy interventions, such as the one utilized in this study.

Limitations, Considerations, and Recommendations

One limitation of the study is that all of the participants were female. Past research has demonstrated that males continue to be underrepresented in grief therapy studies (Allumbaugh & Hoyt, 1999; Currier et al., 2008; Wittouck et al., 2011). The current study's inability to recruit males is representative of several issues. First, previous research has demonstrated that females are more likely to seek bereavement research and services (Bergman, Haley, & Small, 2010). Research also demonstrates that females tend to experience more prolonged grief reactions (Kersting, et al., 2011; Newson et al., 2011). The current study supported these findings, as mostly females responded to the recruitment advertisements. Furthermore, in New York City, although

exact statistics are unknown, it is widely agreed upon that a disproportionately higher number of creative arts therapists are female. Therefore, males were significantly underrepresented in the potential sampling pool. Lastly, one male did respond to the recruitment advertisement, but did not participate in the study because he had a personal relationship with the therapist doing the intervention.

Previous research has also demonstrated that there is a common lack of sociocultural diversity, as well as a limited age range, in many published grief therapy studies (Allumbaugh & Hoyt, 1999; Currier et al., 2008; Wittouck et al., 2011). Despite the current study's inability to recruit males, the study did successfully recruit females from a wide range of sociocultural backgrounds. Five of the nine participants self-identified as a minority with regards to sexual orientation, race, and/or culture.

Furthermore, women of a wide range of ages (30-67) were included in the study, which is an additional strength. Additional strengths of the study included participants that represented four creative arts therapy modalities (art, music, dance/movement, and drama), and a wide range of years since the death (1-10).

It is important to note that the therapist conducting the intervention was male. While the sexual orientations of participants were mixed, some may have experienced feelings of erotic transference that may have impacted the results. Erotic transference is an experience of sexual attraction towards the therapist (Lijtmaer, 2004). Although the participants overwhelmingly stated that the therapist's presence and skill helped contain them, the fact that he was a male may have contributed to their initial discomfort and nervousness. Furthermore, the therapist identified as gay. While participants may or may not have known this, it may have influenced the participants to feel more or less

comfortable. Previous research has suggested that the gender of patients and therapists, whether matched or mismatched, does not affect treatment process and outcome (Zlotnick, Elkin, & Shea, 1998). In the current study, the role of the therapist's gender and sexual orientation on the participants' experiences is unknown. Furthermore, five of the participants were grieving deceased men; singing an imaginal dialogue with a male may have been especially reparative on an unconscious or conscious level.

Chong's (2010) study of non-vocalists' attitudes towards therapeutic singing has important implications for clinical and research work with singing interventions. As Chong's research highlighted, individuals may prefer to sing when alone, or may be uncomfortable from or dislike singing. Therefore, another important limitation in the current study is that participant self-selection may have biased the results. The recruitment email indicated that the research intervention would include singing, and therefore, potential participants who are uncomfortable with singing may not have volunteered to participate. It is important to note that some participants did select to participate despite being uncomfortable with singing. Although the results demonstrated that participants verbalized discomfort during the experience, it is possible that this discomfort would be greater for those who did not self-select to participate in the study. Furthermore, the music therapists were privileged in this study, as due to the nature of their modality, they had greater comfort and familiarity with using their voices. Two of the music therapists had training in Austin's (2008) method of vocal psychotherapy, also giving them some familiarity to the intervention, and further privileging them. These participants verbalized less nervousness due to unfamiliarity with the intervention and singing compared to the other participants. Although all participants verbalized some

discomfort, the music therapists may have experienced less discomfort than the non-music therapists. However, by including music therapists, vocal psychotherapy-trained music therapists, and non-music therapists in the study, a more comprehensive understanding was gained regarding the experience of the intervention for both singers and non-singers.

A further limitation is the single-session design of the study. While participants were able to reflect on their experience of singing the imaginal dialogue after a single music therapy session, additional sessions may have provided opportunities to become more familiar with the intervention and therapist. Participants were not engaged in an ongoing process with the therapist who conducted the interventions, and a certain level of discomfort and anxiety was to be expected. Participants may have been able to reflect more on their experience of the intervention, and how it relates to their grief process, over time, if they were given the opportunity to have several sessions with the same therapist. In addition, the effectiveness of the intervention can be examined by measuring grief symptoms using a randomized, controlled, pre and post-test study design similar to that used in the pilot study conducted by Iliya (2013). Further research could quantitatively examine the relationships between this intervention, emotional arousal, and treatment outcomes.

The intensity of emotional arousal in the studied intervention needs to be taken into consideration by clinicians and researchers. Due to the emotional intensity of the study, the inclusion criteria requiring participants to be in therapy was an ethically sound decision. Participants needed to have those professional resources to process their experiences, especially because of the single-session design. In addition, the researcher

emailed the participants once a week for four weeks after the session. These weekly check-ins offered additional support and resources, as well as time to talk and process with the researcher, if needed. Furthermore, checking in with the participants provided opportunities for the researcher to follow-up and inquire if any new insights or changes occurred since the session. All the participants consistently denied any new insights or changes while thanking the researcher for the opportunity to participate in the study. One participant asked for a referral to continue music therapy for her grief and loss.

The results of the analysis suggest that music therapists should design interventions carefully for bereaved clients. Furthermore, clinicians and researchers who use potentially emotionally intense interventions such as the imaginal dialogue must have sufficient clinical skills and training in order to safely contain the level of intensity. Austin (2008) has cautioned entry-level therapists from using clinical interventions such as free associative singing. Therefore, she developed a two-year advanced post-masters clinical training. Both the researcher and the therapist conducting the sessions completed Austin's vocal psychotherapy training, and therefore had the necessary skills to conduct and understand the intervention with ethical and clinical competence.

The lack of formal debriefing with the therapist was a limitation of this study. Although informal peer debriefing occurred during data analysis to receive valuable feedback and input on the results, the therapist was not consented and therefore his experience was not recorded and analyzed. Future research could more formally debrief with the therapist conducting the intervention to more fully understand the experience from his/her perspective. It would be interesting to consider how therapists experience the intervention, including its components such as grounding, breathing, and containing.

This would give a more comprehensive picture of the intervention as well as the training and supervision required to use the intervention in an ethically responsible manner.

In future research, participants could rate their distress before the session and intervention. This would give a baseline measurement that would contribute to a clearer understanding of the arc of distress over the entire session. Although this study used a scale of zero to 100, modeled after Shear et al. (2006), a smaller range such as a Likert scale could be used in the future to have a more nuanced understanding of the level of distress. Participants could also rate their level of distress during the actual intervention and throughout the session so that it is a more accurate report, rather than remembering their distress only after the session.

Future research could examine variations of the intervention. For example, bereaved adults could bring an object that represented the deceased person to place in the empty chair. The imaginal dialogue has also been studied for other unresolved issues beyond those of grief, such as depression (Paivio & Greenberg, 1995) and anger (Diamond et al., 2010). Singing the intervention can also be studied in non-grief contexts. Furthermore, the intervention could be musically modified and studied. Following the method established by Austin (2008), the piano was the only harmonic instrument used in this study. However, other harmonic instruments, such as the guitar, hammer dulcimer, harp, and xylophone, could also be used and studied. Non-Western instruments and chord progressions could also be used to make the intervention more culturally sensitive and diverse.

Future research could also examine the use of the intervention in a group context. A disproportionate amount of grief therapy research is conducted in a group setting

(Currier et al., 2008; Wittouck et al., 2011), but this may also be because grief therapy is often offered in a group setting. Research is needed to understand the potential benefits of witnessing a group member sing an imaginal dialogue with a deceased loved one, as well as the potential benefits of being witnessed by a group while doing so.

Future phenomenological research can explore the experience of singing the intervention for non-creative arts therapists, as well. Furthermore, it is important to note that music therapy may not be an effective intervention for all adults. The results from this study demonstrated that for nine participants, singing the imaginal dialogue was beneficial. However, qualitative results are not generalizable to the entire population, and this is important to note. More research is needed to understand the limits of music therapy, as well as for whom music therapy may be most helpful.

In summary, a mixed-methods study examining a bereavement-specific music therapy intervention was conducted with nine creative arts therapists. Singing an imaginal dialogue was perceived as emotional and distressing, yet tolerable and even beneficial. The musical qualities of the intervention safely accessed painful emotions, which participants appreciated. Participants valued the opportunities to connect with and mourn for their deceased loved ones. The most important finding was that the intervention facilitated the optimal amount of emotional arousal while providing containment. Containment was provided through the structure of the music and coinciding therapeutic skill and grounding exercises. All participants were able to complete their participation in the research study, indicating that the intervention was not painful or distressing to an unbearable degree. Therefore, this musical variation of Shear et al.'s (2005) intervention might give future bereaved individuals a promising alternative treatment. Ultimately,

singing this intervention might yield lower attrition and refusal rates, and therefore more positive outcomes in therapy.

The findings from this dissertation research contribute to the field of expressive arts therapies by deepening our understanding of the applications of singing an imaginal dialogue with a deceased person, which is a bereavement-specific music therapy intervention. The research findings give us valuable insight into how these nine women experienced the intervention, and why the intervention was perceived as tolerable and helpful. More research is needed to gain an understanding of grief-specific music therapy interventions for adults.

APPENDIX A**Proposed Criteria for Persistent Complex Bereavement-Related Disorder in Section III of *DSM-5***

- A. The individual experienced the death of a close family member or close friend at least 12 months ago. In the case of bereaved children, the death may have occurred at least 6 months ago.
- B. Since the death, at least one of the following symptoms is experienced on more days than not and to a clinically significant degree:
1. Persistent yearning/longing for the deceased. In young children, yearning may be expressed in play and behavior, including separation-reunion behavior with caregivers
 2. Intense sorrow and emotional pain in response to the death
 3. Preoccupation with the deceased
 4. Preoccupation with the circumstances of the death. In children, this preoccupation with the deceased may be expressed through the themes of play and behavior and may extend to preoccupation with possible death of others close to them.
- D. Since the death, at least six of the following symptoms are experienced on more days than not and to a clinically significant degree:

Reactive distress to the death:

1. Marked difficulty accepting the death. (Note: In children, this is dependent on the child's capacity to comprehend the meaning and permanence of death.)
2. Feeling shocked, stunned, or emotionally numb over the loss
3. Difficulty with positive reminiscing about the deceased
4. Bitterness or anger related to the loss
5. Maladaptive appraisals about oneself in relation to the deceased or the death (e.g., self-blame)
6. Excessive avoidance of reminders of the loss (e.g., avoidance of individuals, places, or situations associated with the deceased). (Note: in children, this may include avoidance of thoughts and feelings regarding the deceased.)

Social/Identity Disruption:

7. A desire to die in order to be with the deceased
8. Difficulty trusting other individuals since the death
9. Feeling alone or detached from other individuals since the death
10. Feeling that life is meaningless or empty without the deceased or the belief that one cannot function without the deceased
11. Confusion about one's role in life or a diminished sense of one's identity (e.g., feeling that a part of oneself died with the deceased)

12. Difficulty or reluctance to pursue interests since the loss or to plan for the future (e.g., friendships, activities)

- D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- E. The bereavement reaction must be out of proportion or inconsistent with cultural, religious, or age-appropriate norms.

Specify if:

With Traumatic Bereavement: Following a death that occurred under traumatic circumstances (e.g. homicide, suicide, disaster, or accident), there are persistent, frequent, and distressing thoughts, images, or feelings related to traumatic features of the death (e.g., the deceased's degree of suffering, gruesome injury, blame of self or others for the death), including in response to reminders of the loss. (American Psychiatric Association, 2012, para 1.)

APPENDIX B**Inventory of Complicated Grief-Revised (ICG-R)**

Please mark the box next to the answer that best describes how you have been feeling over the past MONTH. The blanks refer to the deceased person over whom you are grieving.

Almost never = less than once a month

Rarely = once a month or more, less than once a week

Sometimes = once a week or more, less than once a day

Often = once every day

Always = several times every day

1. The death of _____ feels overwhelming or devastating.

Almost never

Rarely

Sometimes

Often

Always

2. I think about _____ so much that it can be hard for me to do the things I normally do.

Almost never

Rarely

Sometimes

Often

Always

3. Memories of _____ upset me.

Almost never

Rarely

Sometimes

Often

Always

4. I feel that I have trouble accepting the death.

Almost never

Rarely

Sometimes

Often

Always

5. I feel myself longing and yearning for _____.

Almost never

Rarely

Sometimes

Often

Always

6. I feel drawn to places and things associated with _____.

Almost never

Rarely

Sometimes

Often

Always

7. I can't help feeling angry about _____'s death.

Almost never Rarely Sometimes Often Always

8. I feel disbelief over _____'s death.

Almost never Rarely Sometimes Often Always

9. I feel stunned, dazed, or shocked over _____'s death.

Almost never Rarely Sometimes Often Always

10. Ever since _____ died it is hard for me to trust people.

No difficulty trusting others A slight sense of difficulty

Some sense A marked sense An overwhelming sense

11. Ever since _____ died I feel like I have lost the ability to care about other people or I feel distant from people I care about.

No difficulty feeling close or connected to others A slight sense of detachment Some sense A marked sense An overwhelming sense

12. I have pain in the same area of my body, some of the same symptoms, or have assumed some of the behaviors or characteristics of _____.

Almost never Rarely Sometimes Often Always

13. I go out of my way to avoid reminders that _____ is gone.

Almost never Rarely Sometimes Often

Always

14. I feel that life is empty or meaningless without _____.

No sense of emptiness or meaninglessness A slight sense of emptiness or meaninglessness Some sense A marked sense An overwhelming sense

15. I hear the voice of _____ speak to me.

Almost never Rarely Sometimes Often Always

16. I see _____ stand before me.

Almost never Rarely Sometimes Often Always

17. I feel like I have become numb since the death of _____.

No sense of numbness A slight sense of numbness Some sense

A marked sense

An overwhelming sense

18. I feel that it is unfair that I should live when _____ died.

No sense of guilt over surviving the deceased

A slight sense of guilt

Some sense

A marked sense

An overwhelming sense

19. I am bitter over _____'s death.

No sense of bitterness

A slight sense of bitterness

Some sense

A marked sense

An overwhelming sense

20. I feel envious of others who have not lost someone close.

Almost never

Rarely

Sometimes

Often

Always

21. I feel like the future holds no meaning or purpose without _____.

No sense that the future holds no purpose

A slight sense that the future holds no purpose

Some sense

A marked sense

An overwhelming sense

22. I feel lonely ever since _____ died.

Almost never

Rarely

Sometimes

Often

Always

23. I feel unable to imagine life being fulfilling without _____.

Almost never

Rarely

Sometimes

Often

Always

24. I feel that a part of myself died along with the deceased.

Almost never

Rarely

Sometimes

Often

Always

25. I feel that the death has changed my view of the world.

No sense of a changed world view

A slight sense of a changed world view

Some sense

A marked sense

An overwhelming sense

26. I have lost my sense of security or safety since the death of _____.

No change in feelings of security

A slight sense of insecurity

Some sense

A marked sense

An overwhelming sense

27. I have lost my sense of control since the death of _____.

No change in feelings of being in control

A slight sense of being out of control

Some sense of being out of control

A marked sense

An overwhelming sense

28. I believe that my grief has resulted in significant impairment in my social,
occupational, or other areas of functioning.

No functional impairment

Mild functional impairment

Moderate

Severe

Extreme

29. I have felt on edge, jumpy, or easily startled since the death.

No change in feelings of being on edge

A slight sense of feeling on edge

Some sense

A marked sense

An overwhelming sense

30. Since the death, my sleep has been...

Basically okay

Slightly disturbed

Moderately disturbed

Very disturbed

Extremely disturbed

31. How many months after your loss did these feelings begin?

32. How many months have you been experiencing these feelings?

33. Have there been times when you did not have pangs of grief and then those feelings began to bother you again?

Yes

No

34. Can you describe how your feelings of grief have changed over time?

(Prigerson & Jacobs, 2001, pp. 638-644)

APPENDIX C

Informed Consent Form

A Phenomenological Study of a Bereavement-Specific Music Therapy Intervention

Principal Investigator: Yasmine Iliya, graduate student, PhD program in Expressive Therapies, Lesley University

Co-researcher: Michele Forinash, Director of the PhD program in Expressive Therapies, Lesley University

You are being asked to participate in this study to examine the experience of a music therapy intervention for bereaved adults. The purpose of the study is to understand how a specific intervention of music therapy is experienced by people processing feelings of grief and loss.

You will be initially interviewed about personal background information that will include past losses in your life. You will then participate in one music therapy session where you will be asked to have an “imaginary dialogue” with a deceased loved one. An imaginary dialogue in this study will consist of singing to the deceased person, imagining that you can sing to the person who died and that the person can hear and respond. You will then respond to yourself from the role of the deceased person. You will be asked to focus on creating a sense of connection with the deceased person. Before and after the imaginary dialogue, you will be lead through a series of grounding and containment exercises.

After the imaginary dialogue, you will verbally process the experience with the therapist.

The session will be audio-taped and 45-minutes in duration.

Immediately after the session, you will be asked to complete a brief questionnaire.

Within three days after the session, you will be interviewed one or two times about your

experience. The interview(s) will be audio-taped and 45-minutes up to an hour in duration.

Following your participation as described above, I will contact you once a week for four consecutive weeks to briefly check-in with you and provide any additional support you may need. You will be personally interacting with Mr. Brian Harris, the music therapist who will conduct the research session, and myself, the researcher.

This research project is anticipated to be finished by approximately July, 2014.

I, _____, consent to participate in “A Phenomenological Study of a Bereavement-Specific Music Therapy Intervention”.

I understand that:

- I am volunteering for one music therapy session involving singing an imaginary dialogue with a deceased person of personal significance
- I will be asked to complete a questionnaire and talk about my experience in one or two interviews
- Sessions will be audiotaped
- My identity will be protected
- Session materials, including reports, transcripts, questionnaires, and audiotapes will be kept confidential and used anonymously only, for purposes of supervision, presentation and/or publication.
- The sessions may include verbal discussion about my present life, childhood, and cultural self-identification

- The session may bring up feelings, thoughts, memories, and physical sensations. Therefore, possible emotional reactions are to be expected, however, I am free to end the session at any time. If I find that I have severe distress, I will be provided with resources and referrals to assist me, and will not lose any benefits that I might otherwise gain by staying in the study. I am encouraged to discuss these feelings with my therapist.
- This study will not necessarily provide any benefits to me. However, I may experience increased self-knowledge and other personal insights that I may be able to use in my daily life.
- The audio recordings, questionnaires, and transcripts will be kept in a locked file cabinet in the investigator's possession for possible future use. However, this information will not be used in any future study without my written consent.
- The therapist is ethically bound to report, to the appropriate party, any criminal intent or potential harm to self
- I may choose to withdraw from the study at any time with no negative consequences.

Confidentiality, Privacy and Anonymity:

*You have the right to remain anonymous. If you elect to remain anonymous, we will keep your records private and confidential **to the extent allowed by law**. We will use pseudonym identifiers rather than your name on study records. Your name and other facts that might identify you will not appear when we present this study or publish its results.*

If for some reason you do not wish to remain anonymous, you may specifically authorize the use of material that would identify you as a subject in the experiment. You can contact my advisor Dr. Michele Forinash at 617 349 8166 or forinasm@lesley.edu with any additional questions.

You will be given a copy of this consent form to keep.

a) Investigator's Signature:

Date	Investigator's Signature	Print Name
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b) Subject's Signature:

I am 18 years of age or older. The nature and purpose of this research have been satisfactorily explained to me and I agree to become a participant in the study as described above. I understand that I am free to discontinue participation at any time if I so choose, and that the investigator will gladly answer any questions that arise during the course of the research.

Date	Subject's Signature	Print Name
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There is a Standing Committee for Human Subjects in Research at Lesley University to which complaints or problems concerning any research project

may, and should, be reported if they arise. Contact the Committee Co-Chairs Drs. Terry Keeney (tkeeney@lesley.edu) or Robyn Cruz (rcruz@lesley.edu) at Lesley University, 29 Everett Street, Cambridge Massachusetts, 02138.

APPENDIX D

Post-Intervention Questionnaire for Participants

1. Please rate your level of distress on scale of 0 (lowest) to 100 (highest) while you were singing an imaginal dialogue with your deceased loved one.
2. Please rate your level of distress on scale of 0 (lowest) to 100 (highest) **after** you sang an imaginal dialogue with your deceased loved one, while you were debriefing with the therapist.
3. How was the experience of singing an imaginal dialogue with your deceased loved one? Please describe the experience.
4. How did the intervention affect your feelings of grief?
5. What thoughts and feelings arose for you?
6. Please describe the role and relationship you experienced with the therapist
7. Please describe any personal insights you may have had.
8. What uncomfortable feelings or thoughts arose for you?

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