THE EFFECT OF MUSIC THERAPY ON THE GRIEF PROCESS AND
GROUP COHESION OF GRIEF SUPPORT GROUPS

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Kenna D. Hudgins
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This thesis titled
THE EFFECT OF MUSIC THERAPY ON THE GRIEF PROCESS AND
GROUP COHESION OF GRIEF SUPPORT GROUPS

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Abstract

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THE EFFECT OF MUSIC THERAPY ON THE GRIEF PROCESS AND

GROUP COHESION OF GRIEF SUPPORT GROUPS (85 pp.)

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The purpose of this study was to investigate whether the grief process and group cohesion were affected by the incorporation of music therapy interventions into grief support groups. An independent groups design with one pre-test/post-test measure and one post-test only measure was used. The participants (n=13) were members of grief support groups who were registered in one of three possible groups. Each group met weekly for six weeks. Of the three support groups, one was assigned as the control group and the other two were assigned as experimental groups. Experimental Group A received music therapy interventions along with the grief counseling programming. Experimental Group B received the grief counseling programming with recorded background music while the Control Group received only the standard support group curriculum without music interventions. A standardized tool, the Hogan Grief Reaction Checklist (HGRC), measured the grief process in pre-test/post-test design through six factors: despair, disorganization, detachment, blame and anger, panic, and personal growth. A post-test Support Group Questionnaire measured group cohesion at the end of the six weeks. The Kruskal Wallis non-parametric statistical test was applied to analyze both the HGRC and Support Group Questionnaire. HGRC analysis revealed no significance on any of the six
factors from pretest to posttest change in grief process. Significant differences were not found in group cohesion among the three groups measured by the Support Group Questionnaire. A linear regression revealed no significance of group cohesion predicting the grief process. Findings suggest that referral-based grief groups will yield a better understanding of those struggling with complicated or unresolved grief.

Approved: ______________________________________________________________

Anita Louise Steele

Associate Professor of Music
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Introduction

Hospice Development

The topic of death and the dying is not a comfortable topic for many. The subject is more approachable today due to the work of two women, Dame Cicely Saunders and Dr. Elisabeth Kubler-Ross. During the mid-twentieth century, these two women were extremely committed to dying patients and to helping these patients gain the most from their last days before death. However, the two women assumed differing roles in the development of hospice. Dame Cicely Saunders, a nurse, first became interested in the dying when she recognized that the needs of her dying patients were different from patients seeking curative treatment. She began to realize the necessity for patient care in the home, family support, and additional research. Her studies led her to recognize that pain and symptom control were of vital importance to end-of-life care (Bennahum, 1996). Saunders’ work in pain control with dying patients was integral to the founding in 1967 of St. Christopher’s Hospice located in London, England. St. Christopher’s Hospice was one of the first modern hospice programs. The endeavors at St. Christopher’s stirred the interest of medical professionals in the United States. Saunders was invited to lecture at Yale University School of Medicine. At Yale, she met and influenced Florence Wald who in 1974 founded the first hospice organization in the United States, the New Haven Hospice in New Haven, Connecticut (Bennahum, 1996).

While Saunders treated dying patients and assisted with the development of hospice programs, Elizabeth Kubler-Ross, a psychiatrist, interviewed the dying in order
to gain knowledge about the dying process. Thinking the interest in the dying to be morbid, nurses and physicians challenged Kubler-Ross (Bennahum, 1996). Kubler-Ross continued her research with passion and perseverance, and in 1969 published her book, *On Death and Dying*. Kubler-Ross stated that the book was “simply an account of a new and challenging opportunity to refocus on the patient as a human being” (Kubler-Ross, 1969, p. 11). In her book, Kubler-Ross described the psychological stages of dying and grieving. Her examination of the human response to death and loss were essential to the acceptance in the United States of the hospice treatment ideas proposed by Saunders (Bennahum, 1996).

Since that time, hundreds of hospice agencies have been established across the United States. As hospice development has increased in this country, the standards of services and philosophies of the programs have been defined. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (2004) defines hospice as “an organized program that consists of services provided and coordinated by an interdisciplinary team to meet the needs of patients who are diagnosed with a terminal illness and have a limited life span” (p.25). JCAHO describes hospice as “a program that specializes in palliative management of pain and other physical symptoms, meets the psychosocial and spiritual needs of the patient and patient families, uses volunteers, and provides bereavement care to survivors” (The Joint Commission on Accreditation of Healthcare Organizations, 2004, p. 25). Services provided by hospice care are offered in
a variety of settings including patient homes and inpatient facilities, such as nursing centers and assisted living facilities.

The National Hospice Organization (1993) expands JACHO’s definition by describing hospice as an understanding and caring entity that provides support and care for persons at the end of life. Hospice focuses on maintaining the quality of a patient’s remaining life while understanding dying as part of the normal process of living. It is not within the hospice mission to postpone death but to promote a caring community through appropriate care for the dying (The National Hospice Organization, 1993). Hospice programs provide in-home comfort care, spiritual support, nursing care, and bereavement services to terminally ill patients. Hospice care also extends to patients who need monitored care in inpatient facilities or do not have adequate caregivers to assist with quality care.

As hospice organizations became more prevalent, the team approach became the standard of care. Hospice organizations utilize an interdisciplinary team model. Martinez (1996) asserts that the goal of the team is to work with patients to identify their specific needs and health goals within a holistic framework (p.21). The team is composed of physician services, nursing services, medical and social support services, and counseling services. At the center of the team are the patient and family. Other services may also be included in the interdisciplinary team, such as therapies (art, music, massage, speech, and physical), financial counseling, or dietary consults. Within the
team system, members contribute to the overall care of the patient through their specialized area of expertise (Marinez, 1996).

In order to provide the most care for the families of the hospice patient, bereavement services are included in the interdisciplinary team. Dame Cicely Saunders believed that an active program of bereavement care for the family after the death of the patient is critical (Bennahum, 1996). Bereavement services are provided up to one year after the death of the patient (Johanson & Johanson, 1996, p.38). Nurses, counselors, or social workers may be educated and trained to become bereavement counselors. Functions of the bereavement counselor include identifying family members of patients at risk for complicated grief and developing or facilitating grief support groups (Johanson & Johanson, 1996).

**Human Response to Loss: The Grieving Process**

Grief and bereavement are often misunderstood as sharing the same or similar meanings. In fact, the terms describe different aspects of loss. Bereavement is the actual objective state of deprivation caused by the loss, while grief is a psychological state characterized by mental anguish or the emotional pain to the loss (Backer, Hannon, & Russell, 1982, p.251). Exploration of the facets and origins of grief and bereavement have been necessary to develop theories regarding these states of human response.

Elisabeth Kubler-Ross (1969) identifies five stages of grief many experience in response to loss: denial, anger, bargaining, depression, and acceptance. Denial is an overall struggle with the disbelief that a person is physically gone forever, including the
initial paralyzing shock and numbness. Anger may be present in several ways: anger at the loved one, God, or the circumstances. Bargaining enters the grieving mind through guilt and “what if” and “if only” statements following a death. The fourth stage of depression brings about the empty feelings and deep, intense sorrow that may be inevitable. The final stage of acceptance has been misunderstood in the sense that it is the point in which the bereaved “feel okay.” According to Kubler-Ross (1969), this stage involves accepting the reality that the loved one is physically gone and recognizing that this new reality is permanent. It is the final ability to reorganize, recollect, and remember even if the death is never truly understood (Kubler-Ross & Kessler, 2004).

Prior to Kubler-Ross’s stages of grief, theoretical writings of grief work origin date back to 1917 and Sigmund Freud’s “Mourning and Melancholia” (Stroebe & Schut, 1999). Freud asserted that the process of grieving allows a person to break ties with the lost object. The libido must be withdrawn from the deceased. However, in order to withdraw, memories of the loved one must surface and be addressed. The survivor is thus able to sever attachment to the deceased. Several decades after Freud’s theories were published, Erik Lindemann (1944) contributed to the understanding of grief by discussing various aspects of the symptomatology and management of acute grief as a syndrome, as well as the course of normal, morbid, delayed, and distorted reactions to loss. John Bowlby was instrumental to grief resolution through his attachment theory explained in three volumes of Attachment and Loss (1969, 1973, 1980). Bowlby’s theory significantly impacted grief work through the theory that early childhood relationships
and attachments affect forming, maintaining and relinquishing relationships. Furthermore, the adaptation, adjustment and coping to bereavement are a result of the dependability and consequent security (otherwise stated as “attachments”) of relationships experienced during childhood. Stroebe (2002), a contemporary grief work theorist, claims that “the attachment theory is the most powerful theoretical force in contemporary bereavement research” (p.127).

Theoretical writings related to grief are essential to the understanding and development of coping techniques and methods. Traditional philosophies of coping with grief include working through and resolving emotions to reconstitute an autonomous individual who can leave the deceased behind and form new relationships (Walter, 1996). Many researchers have written about more contemporary models and methods of coping with grief (Parkes, 1996; Walter, 1996; Stroebe & Schut, 1999). Colin Murray Parkes (1996) has continued exploring the attachment theory through more contemporary empirical research with grieving individuals. Parkes (1996) discusses aspects of grief through a more medical model, emphasizing loss as a stressful event contributing to detrimental health effects. Parkes suggests that to cope with the stressful event and move toward recovery, the grieving individual must identify risk categories more precisely, explore cognitive processes, and investigate effective and ineffective methods of coming to terms with the loss. In contrast to Parkes’ theory, Walter (1996) used personal experience to develop another coping style that emphasizes the process of talking about the loved one. By conversing about his loss, Walter constructed a biography of the loved
one which led to healing. Walter (1996) posits that the expression of feelings and working through emotions is less effective (p. 19). Others challenge Walter’s theory with the suggestion that the purpose of grief work is to support each individual’s unique grief response by allowing the individual to grieve in whatever way is right for that person (McLaren, 1998). It is the counselor’s purpose to enable the bereaved to integrate the loss into their lives in whatever way feels right for them (McLaren, 1998, p.282).

McLaren does not necessarily agree with the conventional models of grief that suggest the bereaved have to relinquish the emotional attachment to the dead person in order to form new attachments. McLaren (1998) states that the method of working through the grief is individualized.

Because there are differing opinions related to coming to terms with loss, Stroebe and Schut (1999) developed their dual process model of coping with bereavement. Their model entails two components: loss-orientation and restoration-orientation. Loss-oriented stressors deal with aspects of the loss experience itself. This grief work focuses on the bond with the deceased person and circumstances surrounding the death. Restoration-orientated stressors focus on the dimension of grief complicated by secondary stressors and how to cope with the stressors (Stroebe and Schut, 1999). “When a loved one dies, not only is there grief for the deceased person (loss-oriented), but one also has to adjust to substantial changes that are secondary consequences of loss (restoration-oriented)” (Stroebe and Schut, 1999, p.214). Secondary losses could be anything from reconstructing finances to dealing with the fear and anxiety of partaking in
a social life without the loved one. Reorganization of life without the loved one is essential to healthy coping (Stroebe and Schut, 1999). Stroebe and Schut (1999) believe that focusing on both components, loss and restoration-orientation, aids the bereaved through more effective grief work.

*Creative Interventions Utilized to Aid the Bereaved*

For decades, counselors and psychologists have taken psychotherapeutic and psychodynamic approaches to processing and working through grief. However, other therapies and interventions have been explored in an effort to maximize therapeutic gain with the bereaved. These include tapestry-making, poetry, drama therapy, and guided visualization techniques.

Reynolds (1999) describes a process of making a tapestry from a photograph to help work through grief. The finished tapestry provided closure with a symbolic function, much like a headstone to a loved one (Reynolds, p.170). Kirk & McManus (2002) used dramatherapy and other creative media to assist children and adolescents in their process of grief.

Another method or system of interventions is called “creative integrationism.” This method is described as a therapy that includes guided imagery, journal writing, and poetry (Edmands & Marcellino-Boisvert, 2002). Evidence of healing is discussed through the client’s ability to confront the deaths of loved ones, as well as a found ability to explore and engage more in life. Salka (1997) also discussed guided visualization exercises as beneficial for bereaved clients.
Grief and Music Therapy

Although creative approaches are documented to aid bereaved individuals, music therapy has been investigated and researched more than any other creative therapy. To understand the relevance between music and the process of grieving, one may turn to Taylor’s (1997) descriptions of the effect of music on the brain and the relationship between music and expression of emotions. The neurological pathway for sound allows music to affect those structures in the human brain most responsible for emotional behavior, the hypothalamus and limbic system. Musical stimuli travel through the outer, middle, and inner ears to the auditory nerve, cochlear nuclei, and inferior colliculus. Sound progresses through the reticular formation, which extends through most of the brain stem up into the thalamus and eventually into the hypothalamus and the limbic system, the center of emotions. This neurological process may explain why couples decide to choose a song as “their song” to remind them of the emotion of love for one another. It may also explain the effect that movies can have on an audience through the use of music to elicit sadness, fear, or joy.

The knowledge of the effect music has on the brain has led many to explore the use of music with grieving individuals of all ages. The use of original therapist-composed song in therapy has been used to decrease the physical grief symptoms during bereavement and to elicit suppressed emotions due to grief in clients (Wexler, 1989). Gallant and Holosko (2001) describe the use of music interventions with grieving clients and explain the difference between music intervention and music therapy. The authors
discuss music intervention used by counselors who are not “music therapists” but who
constructively and responsibly use and adapt music in their practice. From the
counselor’s point, “Music can be used as an adjunct to grief counseling or as an integral
part of the therapeutic process” (Gallant & Holosko, p.119). Lochner (1988) also
describes music as an effective tool that counselors can utilize to help the bereaved work
through grief. When there is a need for more advanced musical interventions and ability,
music therapy by a qualified music therapist is necessary.

Although research on the use of music therapy with grieving adults is limited,
various music therapy studies conducted with grieving children may have relevance to
grieving adults. Hilliard (2001) measured grief symptoms and behavior in 18 grieving
children. The children were placed in either an experimental group, which received 8
music therapy sessions, or a control group, without music therapy. Hilliard (2001) found
that group music therapy could significantly reduce grief symptoms and behavioral
problems in the home environment of grieving children. Music therapy can be a positive
avenue through which children or possible adults can work through the bereavement
process (Hilliard, 2001).

Specific music therapy interventions, such as song-writing, have been effective in
working with older grieving children and adolescents (Dalton & Krout, 2005; Skewes,
positive growth through grief after a loved one had died. Participants who received
music therapy by means of song-writing interventions were more engaged in groups and
better able to process their grief than those without music therapy treatment (Dalton &
Krout, 2005). Through qualitative analysis of music therapy with a group of six bereaved
adolescents, Skewes (2001) examined ten sessions in which group improvisation and
group music sharing/discussion were used as interventions to address grief. The results
indicated that the six participating adolescents were better able to express feelings and
share memories of their loved ones while maintaining developmental needs such as
freedom, control, fun, and group cohesion.

Limited research exists addressing music therapy with individuals or groups of
bereaved adult clients. Smeijsters and Hurk (1999) explored the use of music therapy
with a widow referred after 21 sessions of verbal psychotherapy. The psychotherapist felt
that music therapy might facilitate the patient’s exploration of feelings and needs in the
process of working through loneliness and improving decision-making skills. After the
use of music improvisational techniques, singing, and active music-making, the client
discovered suppressed anger and expressed an element of her personality that she had not
allowed to surface since childhood. Through this process, the client improved her
emotional health (Smeijsters and Hurk, 1999).

Another research study investigated the effect of music therapy on the families of
patients under hospice care. From self-report Likart scale questionnaires with negative to
positive responses, Okamoto (2005) found that those who received music therapy scored
higher in the area related to positively working through their grief issues. This evidence
supports the theory that music has potential to provide positive influence on families experiencing grief due to a terminally ill family member.

*Group Cohesiveness and Music Therapy*

According to Yalom (1995), group cohesion is not only the attractiveness of the group to its members but the primary cause for therapeutic gains within a group. A recent study investigated group cohesion as it relates to curative factors within group therapy (Marmarosh, Holtyz, & Schottenbauer, 2005). Counseling groups from four different university counseling centers participated. A modified Schutz Cohesiveness Questionnaire (Schutz, 1966), used to measure the group cohesion, was completed by group members. Results supported Yalom’s (1995) theory that group cohesion is pertinent to therapy within a group and impacts the collective self-esteem, hope and measure of well-being.

The theory that music therapy experiences impact group cohesion has been a topic of investigation by several researchers. De L’Etoile (2002) studied the effect of music therapy on several dimensions of group participation, including group cohesion. The investigator discovered that group cohesion increased after 6 one-hour music therapy sessions in an adult psychiatric setting. The music therapy techniques included music listening and lyric analysis, music in conjunction with other arts media, instrumental improvisation, song-writing, group singing and music for relaxation. Group cohesion was reported as the largest increase from pre-testing to post-testing.
Results of studies by Cordobes (1997) and Waldon (2001) contradict the effectiveness of music therapy on group cohesion. In Cordobes’ (1997) study, eighteen HIV-Seropositive adults with depression were selected to participate in one group session of either song-writing, game playing, or no treatment control. Subjects completed a questionnaire designed to measure group cohesion after each group activity. No significance was determined among the song-writing, game playing, and no treatment groups. Stronger group relationships and closer bonds among group members were observed in the songwriting group. Waldon (2001) had similar statistical findings when studying the group cohesiveness of adult oncology patients after group music therapy. Two groups received 8 music therapy sessions: four sessions labeled “music-making” and four labeled “music responding.” When measured by content analysis, attendance records, and questionnaires, results showed no statistical effects with respect to group cohesiveness. However, without a control group, the findings may be questioned regarding the effectiveness of music therapy on group cohesion.

Purpose

Research studies have investigated the effect of music therapy on mood, behavior and grief process with groups of bereaved adolescents and children. Similar studies have not been conducted with adults. On the other hand, there is limited research examining the effect of music therapy on group cohesion with groups of bereaved adults. The purpose of this study is to investigate the effect music therapy has on the grief process
and group cohesion in adult grief groups. This study addressed the following three research questions:

1. Is there a difference in the grief process experienced by the bereaved when music therapy interventions are included in the traditional grief counseling support group programming?

2. Is there a difference in the group cohesiveness of grief support groups when music therapy interventions are included in traditional grief counseling support group programming?

3. Does group cohesiveness predict change in the grief process within grief support groups that receive traditional grief counseling combined with music therapy or background music during support group sessions?
Methodology

Setting

FairHoPe Hospice and Palliative Care, Inc. is an agency that serves Perry County, Hocking County, and Fairfield County with offices in Lancaster and Logan, Ohio. The agency provides medical care, spiritual support, and bereavement support for terminally ill patients and their families. The control group took place in the Logan office while the two experimental groups took place in the Lancaster office. The research rooms at both offices were arranged with chairs positioned in a circle. Tables were placed near the chairs for participant comfort when writing and completing forms.

Initial Process

The researcher contacted FairHoPe Hospice and Palliative Care, Inc. to obtain consent to implement the current research study. A meeting was held with the Chief Executive Officer (C.E.O.) to explain and describe the study. An Institutional Review Board (IRB) letter was signed by the C.E.O. giving the agency’s consent and willingness to participate in the study (See Appendix A). University IRB approval was granted and a second meeting was held with the grief counselors who were scheduled to lead the grief support groups. The study was described to the grief counselors and questions or concerns were discussed. The researcher described the music therapy interventions and background music to be used with each research condition.
Participants

Participants for this study were adults ages 18 and older who registered for participation in grief support groups between June and November of 2005 through FairHoPe Hospice and Palliative Care, Inc. The participants were self-referred or referred by the social workers or grief specialists. Because group sign-up was voluntary, the researcher was unaware of the exact number of participants registered for the programs until 1-2 weeks prior to the start of each. Three different 6-week support groups convened during this six-month period. Each group had weekly meetings for the six weeks. Participants who attended the first support group were assigned as the control group. The subsequent two groups were experimental. To be included in the study, group members were to attend 5 of the 6 meetings. All group members who qualified agreed to participate in the study, however the researcher explained that members could participate in the support group without being included in the study. Each participant gave informed consent to participate in the study (See Appendix B).

A total of 13 participants (10 females, 3 males) qualified for the study. Of the 8 participants enrolled in the control group (no music group), 4 withdrew after the first session. Of the 9 participants in Experimental Group A (music therapy group), 3 withdrew after the first meeting. Experimental Group B (background music group) began with 2 participants in the first meeting and gained 1 participant during the second meeting.

The participants ranged in age from 31 to 84 with no more than 3 participants within one age group per research group. The range of losses included the deaths of a
mother, father, spouse, and child. Ten participants experienced the loss of a spouse while two participants lost a mother or father. Only one participant experienced the loss of a child. Length of bereavement for the thirteen subjects is described in Table 1.

**Design**

An independent groups design with specific pretest/posttest and posttest measures was used in this study. The design included one control group and two experimental groups. The independent variables were music therapy (Experimental Group A), no music therapy (Control Group), and background music (Experimental Group B). The dependent measures were the Hogan Grief Reaction Checklist (See Appendix C) and the Support Group Questionnaire (See Appendix D).
Table 1.
Length of Bereavement

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<tr>
<td>0-3 months</td>
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<td>1</td>
<td>0</td>
</tr>
<tr>
<td>3-6 months</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>6 mo.-1 yr.</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>1-2 yrs</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Over 2 years</td>
<td>0</td>
<td>0</td>
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n=4                    n=6                    n=3

Measures
The Hogan Grief Reaction Checklist (HGRC) was utilized to measure the grief process of subjects (See Appendix C). Hogan, Greenfield, and Schmidt (2001), developers of the HGRC, empirically generated categories within the test through
interview and anecdotal data of bereaved adults. Data were analyzed into six categories: despair, panic behavior, blame and anger, disorganization, detachment, and personal growth. A 61-item questionnaire was designed based on the six categories and a factor analysis from interviews and anecdotal data of the grieving adults. Subjects respond to the 61 items by circling one of 5 numbers for each statement: 1- does not describe me at all, 2- does not quite describe me, 3- describes me fairly well, 4- describes me well, 5- describes me very well. Improvements in the process of grieving are demonstrated by a decrease in scores from pretest to posttest in five out of the six factors. Improvement in the factor, personal growth, is demonstrated by an increase in scores from pre-test to post-test. All six factors were proven internally reliable based on alpha coefficients (despair, $\alpha = 0.89$, panic, $\alpha = 0.90$, personal growth, $\alpha = 0.82$, blame and anger $\alpha = 0.79$, detachment, $\alpha = 0.87$, disorganization, $\alpha= 0.84$). Internal consistency for the total instrument was 0.90.

The HGRC is appropriate for the 6-week measurement period of the current study due to its sensitivity to the trajectory of the grief process (Gamino et. al., 2000). The HGRC was selected because of its unique inclusion of the measurement of personal growth. The tool also measures both positive and negative responses to grief (Gamino, Swewll, & Easterling, 2000). The HGRC contains easily-understood items and takes a relatively short length of time to complete. For these reasons, Dalton and Krout (2005) also chose the HGRC over other available tools to compare with their author-developed tool, the Grief Process Scale.
Validity and reliability studies of the HGRC have been conducted to measure reaction to a variety of losses. Hogan et al. (2001) evaluated the use of the HGRC with widows, parents of children who were murdered, and loved ones of victims of suicide. Gamino, Swewll, and Easterling (2000) compared the HGRC with an accepted standardized tool, The Grief Experience Inventory, finding the HGRC to be an effective measurement of grief. Others have chosen and have successfully used the HGRC in studies of the loss of a child. Giaquinto and Sansoni (2001) used the HGRC to measure the reaction of parents to the loss of a preborn child, and DiMarco, Menk, and McNamara (2001) used the HGRC to measure grief reactions of parents who had experienced a perinatal loss. Laakso and Paunonen-Ilmonen (2002) used the HGRC with mothers who had a child die before the age of 7 years to analyze their grief and coping. These studies conclude that the HGRC is an acceptable assessment of the grief process.

To measure group cohesiveness and to obtain possible relevant demographic information, a researcher-developed 10-item Support Group Questionnaire was used (See Appendix D). Other group cohesion measurement tools available were judged by the researcher to be too long and cumbersome for the research setting. The researcher was also sensitive to the intrusive nature of more lengthy and complicated forms. Demographic questions collected included age, gender, ethnic group, current marital status, and length of bereavement. The length of bereavement was categorized into 0-3 months, 3-6 months, 6 months-1 year, 1-2 years, 2-5 years, and more than 5 years.
*Experimental Group A: Music Therapy Interventions*

Three music therapy techniques were used in Experimental Group A. These techniques were chosen from published research and documented clinical applications with clients in many settings. Group drumming, lyric analysis, and song-writing were the techniques in which the researcher felt competent in leading and which others had used with clients having multiple needs. (Watson, 2002; Slotoroff, 1994; Clendenon-Wallen, 1991; De l’Etoile, 2002; Edgerton, 1990; Gallagher and Steele, 2002; Hull, 1998; Silverman, 2003).

Group drumming is an appropriate adult activity and has been reported effective in addressing specific goal areas (Watson, 2002). The technique was chosen for the current study to address group cohesion and to provide a nonverbal assessment of emotions. Slotoroff (1994) described the technique of drumming as an effective intervention with survivors of trauma because it increased their awareness of emotions, thoughts, and coping styles. Emotions may be assessed by observation of the volume, speed of playing, and length of time the individual drums. In group drumming, a leader plays a complicated rhythmic part while the novices play the steady beat or improvise. The leader is responsible for the group maintaining a steady beat. The leader also uses vocal signals and dynamic or rhythmic changes in pattern to conduct the group, which can create an exhilarating event (Crowe, 2004, 299-300). Hull (1998) described drumming as a community experience that contributes to healing and group harmony. According to Hull, “The personal expression of rhythm is a healing experience; therefore, group rhythmical expression is a community healing experience” (p.13).
Lyric analysis has been supported in research as an effective technique when working with adults and adolescents with emotional needs. It is a frequently used music therapy technique to elicit discussion with adults in a variety of settings (Gallagher & Steele, 2002). Wolf (1998) described the process of lyric analysis as listening to a song, analyzing the meaning of the lyrics, expressing feelings, and relating client problems to the lyrics. De l’Etoile (2002) found that music therapy techniques, including lyric analysis, were effective in reducing anxiety and depression in short-term psychiatric patients. Jones (2005) found similar results in the use of song-writing and lyric analysis to evoke emotional change in a single session with chemically dependent participants. The techniques increased joy and reduced guilt, anxiety, and depression (Jones, 2005). Lyric analysis has also been used to influence the self-confidence and self-esteem adolescents clients (Clendenon-Wallen, 1991).

Many researchers have cited song-writing as a beneficial intervention to elicit emotions and discussions with clients. Edgerton (1990) examined song-writing as a therapeutic intervention with emotionally impaired adolescents. He found the intervention to be effective in increasing self-expression, developing group cohesion, and increasing self-esteem. Edgerton asserts that “creative group song-writing can be used with groups at different functioning levels and at different levels of cohesiveness” (p.16). Dalton and Krout (2005) also investigated song-writing with adolescents. Through their research with bereaved adolescents, it was discovered that song-writing engaged adolescents and led to positive growth. Writing songs is also useful for patients in a
palliative care setting to assist with emotional expression and describing relationships with people both living and deceased (O’Callaghan, 1996). O’Callaghan asserts that song-writing is a worthy technique for patients in this setting because the lyrical themes meet physical, psycho-social, and spiritual needs.

Some studies even suggest song-writing as one of the most enjoyable music therapy interventions. Gallagher and Steele (2002) reported song-writing to be a preferred intervention of adult psychiatric clients. Clients used song-writing in treatment to express feelings and tell stories of their own life experiences related to illness. Silverman (2003) also reported this technique as an effective intervention preferred by groups of adults with mental illness in the recovery process.

Procedure

The control and two experimental groups met weekly for six weeks. The grief support group programming common to all research conditions included a video, activities, worksheets, poems and educational materials during six weekly meetings. Two grief specialists presented the experiences and facilitated discussions. Subject matter for the weekly meetings included the stages of grief, secondary losses, processing both positive and negative memories of the loved one, coping methods, and the difficult experiences during the holidays after a loved one has passed away. Experimental Group A received the grief support group programming along with two music therapy interventions each meeting. One intervention addressed group cohesiveness; the second addressed the grief process. Experimental Group B also received the grief support group
programming with the addition of recorded background music throughout each session. The background music ceased during the playing of counseling videos. All subjects completed the prêt-test Hogan Grief Reaction Checklist (HGRC) during the first of six sessions and a post-test HGRC followed by the Support Group Questionnaire at the end of the sixth session.

*(Experimental Group A: Music Therapy Group)*

**Session 1**

During the first session, the researcher began with a drum circle. A drum was placed under each participant’s chair prior to the start of the meeting. When instructed, participants found their drum and were given directions to participate in “Pass the Rhythm” and “Eye Contact/Name Drumming.” Pass the rhythm was conducted with the researcher playing a simple rhythm and allowing each participant to echo that rhythm. Several rhythms were played and various group members were offered opportunities to lead a rhythm. The Eye Contact/Name Drumming allowed for a more socially interactive experience. The leader began the drumming and gave eye contact to another participant. The participant who received the leader’s eye contact then began to drum and continued by giving another participant eye contact. This process continued until all members of the group were drumming. Each participant was instructed to also say the name of the person to which they gave eye contact. Following the drumming experience, the music therapist explained that anger is one of many emotions possibly experienced during the grieving process. While participants held their drums, they were instructed to
individually demonstrate (on the drum) the anger felt during their personal grieving experiences. The grief counselors then discussed the process of “Going Through Grief” as described in the worksheets provided in participants’ packets of information. The researcher followed the discussion by singing, “It’s Never Easy to Say Goodbye” by Kenny Chesney (See Appendix E) with live keyboard accompaniment. After the song was sung, each participant was encouraged to share his/her reason(s) for coming to the grief support group and to whom they were trying to “say goodbye.” Participants shared as much or as little as they desired. The music therapist and grief counselors supported each participant by responding with reflective and encouraging statements reassuring each participant that their responses were welcomed.

Session 2

For the second meeting, the music therapist instructed the participants to find the drums under their chairs. “Pass the Rhythm” was reintroduced and conducted. “Eye Contact/Name Drumming” was also described to participants. Participants took turns leading the drumming with eye contact. The grief counselors followed the drumming experiences with their regular programming and led discussion of the grief process as described by the mourning bridge and grief wheel (See Appendix F) in participants’ packets of information. The music therapist distributed the song lyrics of “I Grieve” by Peter Gabriel (See Appendix G). The music therapist read the lyrics aloud and then instructed the participants to close their eyes and listen to the song as it was played on the CD player. When the song was finished, the music therapist asked the participants to
identify the grief stages of the songwriter. Following the discussion, participants were asked what stage they felt they were currently experiencing in the grief process as well as the stage they wished to be experiencing. To close the session, participants identified their goals for the remainder of the program and their goals for the future.

Session 3

The third session began with participants seated in a circle with the drums located in the center of the circle. The researcher instructed participants to choose their preferred drum. The grief counselors presented cards, each labeled with an emotion. As the counselor displayed each word, the participants were instructed to play drums in a manner reflective of the emotion. The researcher asked processing questions about the drumming such as, “What was it like to drum these emotions? Was it easy/difficult? Why? Which feelings do you most relate too since you lost your loved one?” The grief counselors assisted with a discussion of the normal emotions during the grief process such as guilt, anger, loneliness, and powerlessness. A balloon experience was then used to aid participants in the release of their emotions. Each participant chose a balloon and a marker. They were instructed to identify and write on the balloon those emotions they would like not to experience and what produced the emotions identified. Each participant was instructed to pop their balloon. By popping their balloons, the participants were symbolically eliminating the negative emotions related to their lives.
Following the balloon experience, the researcher sang the song, “Turn, Turn, Turn” by Pete Seeger (See Appendix H) with guitar accompaniment. The participants were prompted to sing along and to select phrase to which they most related. After the song was sung, the participants discussed the lyrics and their personal experiences triggered by the lyrics. If participants did not voluntarily verbalize, the researcher asked questions about particular phrases in the song such as, “a time to laugh, a time to cry.” Participants were asked if they had genuinely laughed since their loved one died and the situation and emotions producing this response. To finalize the experience, the group completed phrases of the song that related to the discussion. The therapist encouraged participants to fill-in the blanks with statements made during the meeting that reflected their feelings and personal experiences. As homework for the fourth meeting, the researcher asked participants to select a recorded song that had been difficult or impossible to hear since the loved one’s passing and to share it in the following session.

Session 4

To begin session number four, recorded sedative music was played as background music while the grief counselors led a group discussion. The coping styles and stress applicable to grieving the loss of a loved one were addressed. Sedative music was chosen based on previous research of new age music (Smith & Joyce, 2004). The music was chosen to elicit a calming response at approximately 60 beats per minute (Barger, 1979; Zimney & Weindenfeller, 1963). The grief counselors educated the participants about
“eustress” (good stress) and “distress” (bad stress) in life. Each participant’s personal coping styles were discussed. The researcher introduced music-assisted relaxation and guided imagery to the participants as a potential coping strategy. The grief counselors also introduced the therapeutic touch specialist and explained “therapeutic touch” to the group. The researcher instructed the participants to move into a comfortable position either in the chair or lying on the floor. With the calming music playing, the researcher led participants through progressive muscle relaxation techniques followed by guided imagery based on a walk through a forest. The therapist began with deep breathing and instructed participants to inhale 3 counts and exhale 3 counts. A tense-and-release pattern of the following muscle groups was presented: facial muscles, shoulders, arms, hands, thighs, calves, and feet. The researcher encouraged the participants to clear their minds and to imagine a forest while the following script was read:

Visualize yourself in a beautiful forest. It’s a crisp, autumn day and the sun reflects gently upon a gurgling stream that runs along the edge of the forest. You walk carefully into the forest, over the crackling red and golden leaves and broken twigs; pinecones are scattered across the ground. A squirrel runs up a tree...you watch the speed with which it moves, swiftly up and through the branches until you lose sight of it.

It’s very peaceful here in this forest, you notice green moss and the bark of the trees. Notice all the scents and colors around you. The deeper into the forest you venture, the deeper into relaxation you fall...you’re falling deeply into a calm and tranquil state.
Watch a leaf as it falls from a tree and dances in the air before fluttering slowly down to rest with the others. You pause for a while and rest against an old oak tree. You can feel the rough bark of the tree against your fingertips. Smell the earthy ground. As you’re resting here against the rough bark of the tree, you feel a deep sense of peacefulness in this beautiful place. Just sit and experience the peace of the woods.

As you listen to the music, I will count backwards from five and when I reach one you may open your eyes and recognize your surroundings in this room. 5..4..3..2..1.

Following the music relaxation and guided imagery experience, some participants chose to have a short therapeutic touch session in a private room with a professional trained in this technique.

The researcher asked the participants who remained to share a song they had brought as a homework assignment. The researcher explained that music can be a coping strategy but can also be a trigger for extreme sorrow and depression that may hinder the grieving process. The participants had the option of ceasing their song at any point if they became uncomfortable. As each song was played, the researcher asked about the details of the songs. The researcher asked why the song was difficult to hear and what memories surfaced while hearing it. Participants discussed feelings, memories, and difficulties experienced while listening to the song during the group meeting. Group members offered support and encouragement. To leave the participants in a positive emotional state, the grief counselors closed the meeting by asking participants to share humorous stories of their loved ones.
Session 5

Beginning the fifth session, the researcher placed choir chimes under each chair before participants entered the room. Once each group member was present, the researcher explained how to play the choir chimes. The researcher demonstrated the technique by grasping a choir chime with the thumb pointed up and flipping the wrist to produce sound. Participants were instructed to find their choir chime and practice the technique. The researcher led the group through the song, “You Are My Sunshine,” and asked group members to guess the song after a few notes. The group played the song two times to develop more connectedness within the group (Gallagher & Steele, 2002).

Following the brief choir chime experience, the grief counselors discussed remembering the good and the bad qualities of loved ones. In the discussion, they encouraged participants to acknowledge the reality of the loss, allow the experience of the pain and separation, and move into new life without forgetting the old.
The researcher followed the discussion by singing “You Are My Sunshine” and led the group in analyzing the song’s lyrics:

You are my sunshine, my only sunshine
You make me happy when skies are gray
You’ll never know dear, how much I love you
Please don’t take my sunshine away

The other night dear, as I lay sleeping
I dreamed I held you in my arms
But when I woke dear, I was mistaken
So I hung my head and I cried.

The researcher passed out song-writing sheets with blanks where the words are underlined above. The participants were instructed to write a few words about their loved one that fit into the blanks. The individual songs were gathered for the next segment of the group meeting.

The grief counselors directed each participant to talk about their loved one to the rest of the group. Each participant introduced their loved one to the group by providing pictures, memoirs, and stories about their loved one. The researcher then sang each participant’s song after he or she shared.
Session 6

The researcher opened the final session with a choir chime ensemble experience with the same procedure as the previous session. “Jingle Bells” was played to replace “You Are My Sunshine”. The grief counselors led a discussion about the holidays and feelings associated with holidays. The researcher had each participant choose a preferred song from a list of Christmas songs. The group sang the preferred songs together while the researcher accompanied the songs on the keyboard. Lyric sheets for each song were provided for each participant.

The memorial portion of the final session began with each participant lighting a candle and speaking briefly about their loved ones. They were encouraged to speak about future hopes for their lives. The researcher provided live background music on the keyboard while the group members participated in a brief memorial segment to honor their loved ones.

(Control Group- No Music Group)

The first session of the control group began with introductions including participants’ descriptions of why they were attending the support group. The stages of grief, expectations, and goals of the support group meetings were discussed during the second session. Participants identified their places on the “mourning bridge” and the “grief wheel” (See Appendix F). The third session addressed emotions during the grieving process. The grief counselors discussed normal emotions during the grief process such as guilt, anger, loneliness, and powerlessness. A balloon experience was
used to aid participants in the release of their emotions. Each participant chose a balloon and a marker. They were instructed to identify and write on the balloon those emotions they would like not to experience and what produced the emotions identified.

Participants were instructed to pop their balloons. By popping their balloons, the participants were symbolically eliminating the negative emotions related to their lives. In session four, the grief counselors educated the participants about eustress (good stress) and distress (bad stress) in life and discussed personal coping styles of each participant. During the fifth session, the participants were encouraged to talk about their loved one. Each participant introduced and described their loved one through pictures, memoirs, and stories. In session six, the discussion centered on the holidays and feelings associated with holidays followed by a brief memorial service.

*(Experimental Group B- Background Music Group)*

The procedure for Experimental Group B was identical to the procedure for the Control Group with the exception of electronically produced background music played throughout each of the six sessions. The researcher played sedative music from an iPod using the speakers of a CD player and an adapter during each of the six sessions. Recorded music was chosen from iTunes based on previous research of new age music (Smith & Joyce, 2004) and music to elicit a calming response at approximately 60 beats per minute (Barger, 1979; Zimney & Weindenfeller, 1963). The recorded music looped to provide continuous music throughout each session.
Results

Analysis of Data

Data collected from the HGRC and Support Group Questionnaire were entered into (Statistical Package for the Social Sciences Version 11 (SPSS) for OSX of Macintosh computers.

Research Question 1

The first research question asked if there was a difference in the grief process experienced by the bereaved when music therapy interventions were included in the grief counseling support group programming. To answer the research question, The Hogan Grief Reaction Checklist (HGRC) in pre-test/post-test form was used to gather the data regarding 6 factors of the grief process. The 6 factors included despair, panic, blame and anger, disorganization, detachment, and personal growth. The change in scores from pretest to posttest was analyzed for the 6 factors. Mean scores and standard deviations are shown in Table 2. Higher numbers indicate positive change for despair, panic, disorganization, detachment, and blame and anger. Lower numbers indicate a positive change for personal growth. Due to the small n, a Kruskal-Wallis test at the 0.05 alpha level was used to analyze the results of the six factors and to compare the control conditions and two experimental conditions. The Kruskal Wallis test is a nonparametric procedure based on a chi-square distribution. Analysis revealed no significant differences in the 6 grief factors when comparing music therapy (Experimental Group A),
background music (Experimental Group B), and no music (Control Group) conditions. Chi-square statistics and p-values for the test are listed in Table 2.

Statistical differences are shown in Table 4. Figures 1 through 6 illustrate the results of pretest to posttest scores for the six grief factors.

Table 2.

Descriptive and test statistics for difference between condition on each of the six HGRC grief factors.

<table>
<thead>
<tr>
<th>HGRC factor</th>
<th>Group</th>
<th>Mean changes</th>
<th>Std. Deviations</th>
<th>n</th>
<th>x²</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Despair</td>
<td>Control (no Music)</td>
<td>11.25</td>
<td>9.57</td>
<td>4</td>
<td>1.88</td>
<td>0.39</td>
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<td></td>
<td>Experimental A (Music Therapy)</td>
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<td>13.75</td>
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<tr>
<td></td>
<td>Experimental B (Background Music)</td>
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<td>23.07</td>
<td>3</td>
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<td>Panic</td>
<td>Control (no Music)</td>
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<td>7.41</td>
<td>4</td>
<td>1.46</td>
<td>0.48</td>
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<td></td>
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<td>6.49</td>
<td>6</td>
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</tr>
<tr>
<td></td>
<td>Experimental B (Background Music)</td>
<td>-6.33</td>
<td>12.66</td>
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Table 2: continued

<table>
<thead>
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<th>Detachment</th>
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<td></td>
<td>(no Music)</td>
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<td>17.47</td>
<td>3</td>
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</tr>
<tr>
<td>(Background Music)</td>
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</table>

<table>
<thead>
<tr>
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<td>(no Music)</td>
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<tr>
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<td>5.42</td>
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<tr>
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<td>8.89</td>
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<table>
<thead>
<tr>
<th>Blame &amp; Anger</th>
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<td>(no Music)</td>
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<td>-0.33</td>
<td>3.88</td>
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<tr>
<td>Experimental B</td>
<td>0.33</td>
<td>14.50</td>
<td>3</td>
<td></td>
<td></td>
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<tr>
<td>(Background Music)</td>
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Table 2: continued

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<td>(no Music)</td>
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<td>4</td>
<td>2.24</td>
<td>0.33</td>
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<tr>
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<td>5.05</td>
<td>6</td>
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<tr>
<td>(Music Therapy)</td>
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<td></td>
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<tr>
<td>Experimental B</td>
<td>-11.33</td>
<td>5.69</td>
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<tr>
<td>(Background Music)</td>
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</tbody>
</table>
Figure 1.

Test comparisons for HGRC factor of despair.
Figure 2.

Test comparisons for HGRC factor of panic.
Figure 3.

Test comparisons for HGRC factor of blame and anger.
Figure 4.

Test comparisons for HGRC factor of disorganization.
Figure 5.

Test comparisons for HGRC factor of detachment.
Figure 6.

Test comparisons for HGRC factor of personal growth.

Research Question 2

The second research question asked if there was a difference in the group cohesiveness of grief support groups when music therapy interventions were included in the grief counseling support group programming. The Support Group Questionnaire was used to gather data regarding group cohesiveness. The mean scores of the three groups are shown in Table 3. A Krusal Wallis test revealed no significance in group cohesion among the support groups ($p = 0.27$). Descriptive and test statistics are shown in Table 3.
Table 3.

Descriptive statistics for support group questionnaire.

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean</th>
<th>Std.deviation</th>
<th>$\chi^2$</th>
<th>p</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control Group (No Music)</td>
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<td>7.77</td>
<td>2.53</td>
<td>0.28</td>
<td>4</td>
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<td>Experimental Group A (Music Therapy)</td>
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<td>7.31</td>
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<tr>
<td>Experimental Group B (Background Music)</td>
<td>48.67</td>
<td>2.31</td>
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</table>

**Research Question 3**

The third research question asked if group cohesiveness predicts change in the grief process within grief support groups that receive traditional grief counseling combined with music therapy or background music during support group sessions. To test this research question, a series of linear regressions were performed. Specifically, group cohesiveness was regressed on each of the six Hogan Grief Reaction Checklist factors. Results are shown in Table 4. Group cohesiveness did not significantly predict change in any of the six factors. However, group cohesion revealed a notable effect on
panic behavior at a level of $p = 0.110$ and disorganization factor at a level of $p = 0.115$.

Even though significance was not found, results did indicate that group cohesion can negatively affect factors of panic and disorganization within the grief process.

Table 4.

Descriptive statistics of linear regression analysis for group cohesion and grief process.

<table>
<thead>
<tr>
<th>HGRC Predicting Factor</th>
<th>b</th>
<th>se</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Despair</td>
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<td>.70</td>
<td>-0.50</td>
</tr>
<tr>
<td>Panic</td>
<td>-0.60</td>
<td>.35</td>
<td>-1.74</td>
</tr>
<tr>
<td>Disorganization</td>
<td>-0.42</td>
<td>0.25</td>
<td>-1.71</td>
</tr>
<tr>
<td>Detachment</td>
<td>-0.14</td>
<td>0.44</td>
<td>-0.33</td>
</tr>
<tr>
<td>Blame and Anger</td>
<td>-0.08</td>
<td>0.32</td>
<td>-0.25</td>
</tr>
<tr>
<td>Personal Growth</td>
<td>0.10</td>
<td>0.24</td>
<td>0.41</td>
</tr>
</tbody>
</table>
Discussion

This study was designed to investigate the effect of music therapy on the grief process and group cohesion in adult grief support groups. Secondary reasons for this study include the examination of group cohesion’s effect on the overall grief process and the effect of musical conditions on the grief process and group cohesion in adult grief groups. It was hypothesized that music therapy would positively affect the grief process and group cohesion in grief support groups.

In respect to the grief process, no significant differences were found among music therapy, background music, and no music conditions as measured through six factors determined by the Hogan Grief Reaction Checklist (HGRC). These findings do not support the hypothesis. In addition, the outcomes of the current study contrast with results of Hilliard (2001), who found that music therapy could significantly reduce grief symptoms. However, Hilliard’s study involved grief of children while this study examined grief of adults. More specifically, explored in the current study were the six factors of the HGRC: despair, panic, blame and anger, disorganization, detachment, and personal growth. The HGRC did not reveal a significant change among the conditions, and actually increased in all five areas of despair, panic, disorganization, blame and anger, and detachment within the Experimental Group B (background music). These results indicate a negative response to not only the background music but also to the support group programming.

These findings may somewhat be explained by the fact that the background music group participated in the support group during the holiday season. The Thanksgiving and
Christmas seasons are particularly challenging for an individual who is experiencing grief. Kessler and Kubler-Ross (2005) explain that for many people, experiencing the holidays is the most difficult part of grieving because it “magnifies the loss” (p. 137). The first holiday season after the loss of a loved one can cause depression, anxiety, and panic. One individual in the background music group was experiencing her first holiday season after the loss of a child. This participant also had the dreaded anticipation of her late child’s birthday and anniversary of his death soon after the holidays. All of these dates were within three months of each other. Since there were only three participants included in Experimental Group B (background music group), one participant’s answers to the HGRC may easily have skewed the group scores. Of the three groups, Control and Experimental A and B, the results indicate that the Control Group benefited from the support group programming.

Similar to the previous findings, the results of the group cohesion measurements do not support the hypothesis. Group cohesion was not significantly affected by music therapy interventions as measured by the Support Group Questionnaire. Results of this study support findings of Cordobes (1997), who did not find significance when comparing group cohesion of groups using specific songwriting and groups with no music conditions. Although empirical data did not indicate significance regarding group cohesion, subjective observation revealed an immediate change in social characteristics when members were engaged in drumming during the first support group meeting. Within each of the three support groups, the participants did not interact with each other
at the beginning of the first session. This lack of interaction continued throughout the first meeting with the control group and background music group, yet within the music therapy group this was not the case. During and after the drumming experience, there was immediate laughing and talking among participants, and the members knew each other’s names by the end of the first meeting. Future research may be designed to study group cohesion within the initial meeting of a grief support group comparing music and no music conditions using behavioral observation methods as well as standardized self-assessment tools.

Several factors may have contributed to the results of music and non-music conditions on group cohesion. One determining factor may have been the types of death experienced by the participants. During the Control Group, 3 of the 4 participating members experienced the loss of a spouse after a lengthy illness and hospice involvement. The music therapy group had the most participants, even though only 6 were included in the research. Of the six, 5 experienced the loss of a spouse and one experienced the loss of a parent. Although each experienced a loss of a loved one, the difference in type of death made group cohesion difficult for the one particular subject who expressed an inability to relate to experiences or emotions shared by others throughout the meetings. A second factor may have to do with the number of individuals within each support group. The researcher observed better group cohesiveness in the groups containing three or four participants. With smaller groups, participants received
increased individual attention pertaining to their grief experiences. As a result, participants interacted and communicated more throughout the sessions.

The third research question asked if group cohesion could predict the grief process. Even though the results were not significant, coefficients were in converse directions reflecting that as group cohesion increases, negative grief factors decrease. To further explain, as group cohesion increases, panic and despair decrease. However hypothesis tests were not significant, therefore no conclusion can be accurately drawn from the analysis.

While the results do not support the use of music therapy utilizing drumming, lyrics analysis, and song-writing with the bereaved within grief support groups, the findings generate conclusions that may contribute to future music therapy research. One conclusion that may be drawn from this research is that with those experiencing a heightened emotional level, music therapy intensifies emotions to the point of an inability to positively improve. The researcher suggests that some applications of music therapy may have negative effects. Ruth Bright (2002) asserted that “there are times when someone is so vulnerable or one’s future seems so fraught with tragedy that looking into the depths of the emotions is temporarily inadvisable” (p. 5). Most participants involved in the music therapy group were able to express their extreme sadness verbally and physically and were further saddened or angered by the processes of music therapy intervention as observed by the researcher. During the second meeting, the researcher implemented experiences with drumming to assess anger within the grief process. After
a brief introductory drumming experience, the researcher instructed each participant to play their anger on the drum that would be passed around the group. The purpose of this task was to assess the intensity of anger more accurately as observed through the volume, speed of playing, and length of time the individual drummed. This experience did assess if anger was present yet elicited an intensity of emotion that was difficult to address within the context of a group. A few individuals demonstrated their extreme anger with loud and hard playing. One individual actually voiced her concern about breaking the drum prior to demonstrating her anger. As these few individuals drummed, their anger emerged and they became enraged during their drumming experience. The grief counselors addressed the anger with these individuals but were unable to provide the most beneficial counseling within the group setting. In preparation for such circumstances, it is essential to have highly trained counselors available for group and potential individual counseling. Upon the introduction of musical interventions designed to assess anger, music therapists would be advised to anticipate intense expression of anger with grieving individuals.

Without the drumming experience, participants were able to express their anger verbally and avoid “feeling” the emotion to the point of needing to escape the group environment. On the other hand with the drumming experience, the music therapist and grief counselors had better insight regarding the level of anger within a few individuals. One may argue that music therapy created the exact response anticipated. Acceptable emotion was elicited from the wounds of hurting and struggling people. Many agree that
emotions should be released regardless of their intensity. The group drumming experiences allowed for these feelings to be expressed in a way that neither participants, nor counselors expected. It is possible that the professionals facilitating the groups were not adequately prepared to process extreme responses in the group setting. Because music therapy interventions had not previously been incorporated into this agency’s support groups, those overseeing the groups had not been exposed to the intense effect music therapy can have. As a positive outcome to the drumming experience, appropriate referrals could be made for individual counseling or individual music therapy sessions to work through grief complications due to anger.

Another conclusion drawn from the present study is the necessity of referral-based music therapy. It is a grand assumption that the experience of a loss in itself is enough to benefit from or “need” music therapy. “Although we [music therapists] depend in part upon referrals for bringing to us people who may benefit from music therapy, we also need an effective method of assessment to decide which people may benefit from our interventions and which approach should be used initially” (Bright, 2004, p. 1). Only after a referral did Smeijsters and Hurk (1999) address grief issues with a widow and found music therapy to improve her emotional health. On the other hand, Krout (2006) incorporated use of general songs pertaining to loss in one-time bereavement support groups without a referral basis. A referral process may have not been necessary for the incorporation of songs into the group since intense music therapy interventions were not used. The use of general song was reported to benefit the
participants, yet Krout did not obtain systematic data for analysis, thereby lacking numerical support for the benefit discussed.

Many factors should be considered prior to engaging the bereaved in music therapy experiences. Designing experiences to elicit strong emotions should be utilized on a case-by-case basis warranting a clear referral process prior to the implementation of music therapy. When persons address and experience their grief in a healthy manner, the coping process may not require additional intervention other than grief support programming. Moreover, those who attend a voluntary grief support group demonstrate a degree of emotional strength by the effort made to seek assistance. When interested in grief research, future music therapists would be advised to consider referral-based groups for research.

Music therapy serves those who have an emotional, behavioral, cognitive, or physical barrier to typical development or emotional well-being. An individual who is seeking assistance for their grieving process and in doing so, recognize their need for help, may not warrant the extra intervention of music therapy. Grieving persons seeking help from a support group, does not qualify as a barrier to emotional well-being. After further assessment of a grieving person through attendance in a support group, a counselor may recognize that music therapy might assist a person to heal. While the process of grief is quite individualized, so also is the response to music and song material making individual music therapy an appropriate avenue for treatment in this case. Individuals who withdraw and disregard the grief symptoms while suppressing emotions
related to a death, are more likely to be appropriate candidates for music therapy interventions. Others who may benefit from music therapy may simply not find the relief they seek from traditional counseling techniques. They may find better emotional release or expression through music therapy sessions designed to address their needs.

Limitations

This study was limited by the small $n$ who participated in the research. Another limitation was the voluntary, not referral-based, participation of the support group. Stroebe et al. (2003) questions the representation of the bereaved who actually participate in research studies. The bereaved withdraw from support groups and research studies for various reasons (Stroebe et al, 2003). These reasons include being too upset to participate or fear that participation in a group may increase their grief. This contributes to one of the challenges of this study because it is precisely this reaction to grief that the researcher is aiming to investigate. The difficulty is that those individuals who are appropriate for music therapy are the very individuals who may not choose to attend a support group.

Future Research

Future research should include a greater number of participants to further understand the effects of music therapy on the bereaved. Based on the increased interaction of support group members after music therapy interventions, future research is warranted to compare music conditions to non-music conditions for measurement of group cohesion within an initial group session. By analyzing a first session, group
interaction and participation may be investigated to identify processes that may contribute to quicker group cohesion. Other music therapy interventions may be specifically investigated or compared to further examine effective techniques with those grieving a loss. To equally examine music therapy and grief, future studies should also avoid the holiday season due to increased intensity of grief during those months. In addition, findings suggest that referral-based grief groups will yield a better understanding of those struggling with complicated or unresolved grief. Referrals made due to unhealthy grieving may increase the likelihood of assigning appropriate candidates for music therapy interventions. Thus, music therapy and grief can be investigated more effectively.
Appendix A

FairHoPe Hospice and Palliative Care, Inc.
1111 East Main St.
Lancaster, OH 43130

Ohio University
Institutional Review Board

April 24, 2005

To Whom It May Concern:

Kenna Hudgins, a music therapy graduate student at Ohio University, has proposed a collaborative research project with us to investigate the effectiveness of music therapy with our grief support groups. We agree to this collaboration and have been informed of the procedures and research involved in the project. Because research is not common within our agency, we do not currently have an internal review board. We invite the opportunity to involve music therapy research, as well as other research, to provide the most beneficial services to the terminally ill and their families and friends.

Thank you for this opportunity. Please contact us with any questions or concerns.

Sincerely,

______________________________
Denise Bauer
CEO
FairHope Hospice and Palliative Care, Inc.
Appendix B

Ohio University Consent Form

TITLE
The Effect of Interventions on the Bereavement Process in Grief Support Groups.

PRINCIPAL INVESTIGATOR
Kenna Hudgins

Federal and university regulations require signed consent for participation in research involving human subjects. After reading the statement below, please indicate your consent by signing this form.

EXPLANATION OF STUDY
My name is Kenna Hudgins, and I am interested in studying how the grief therapy offered in a support group environment helps individuals who are dealing with loss. I will be observing and participating in the group sessions, and would like for you to complete one questionnaire during the first session, and two questionnaires during the last session. Completing the forms will take about 10 minutes each time. Completing the forms for my study is completely voluntary. If you choose not to complete the forms, it will not affect your support group meetings with FairHope in any way.

RISKS AND DISCOMFORTS
No unusual risks or discomforts are expected outside the normal grieving process due to this research.

CONFIDENTIALITY AND RECORDS
In the first meeting, your name will be assigned a code. Each measurement tool has the code on the first page. There will be a code key with your name matched with your code. In the posttest, the researcher will match you with the code assigned during the initial meeting. Your name will not be directly on any questionnaires.

The code sheet and data from the study will be kept in a file box in the locked office of the researcher. The researcher and study advisor will be the only individuals with access to the box. The researcher will share information from the measurement tools with the grief counselors to protect the participants
during the grief period. The researcher will destroy all materials after the completion of the results of the study.

**CONTACT INFORMATION**

If you have any questions regarding this study, please contact:
Kenna Hudgins by email *(kennamiller@yahoo.com)*
OR
Louise Steele by email *(steelea@ohio.edu)* or phone (740-593-4249)

If you have any questions regarding your rights as a research participant, please contact Jo Ellen Sherow, Director of Research Compliance, Ohio University, (740-593-0664).

I certify that I have read and understand this consent form and agree to participate as a subject in the research described. I agree that known risks to me have been explained to my satisfaction and I understand that no compensation is available from Ohio University and its employees for any injury resulting from my participation in this research. I certify that I am 18 years of age or older. My participation in this research is given voluntarily. I understand that I may discontinue participation at any time without penalty or loss of any benefits to which I may otherwise be entitled. I certify that I have been given a copy of this consent form to take with me.

Signature________________________________________ Date ____________

Printed Name____________________________________
Appendix C

**Hogan Grief Reaction Checklist**

*This questionnaire consists of a list of thoughts and feelings that you may have had since your loved one passed away. Please read each statement carefully, and choose the number that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement that best describes you. Please do not skip any items.*

1. My hopes are shattered........................................1 2 3 4 5
2. I have learned to cope better with life................1 2 3 4 5
3. I have little control over my sadness...............1 2 3 4 5
4. I worry excessively........................................1 2 3 4 5
5. I frequently feel bitter....................................1 2 3 4 5
6. I feel like I am in shock....................................1 2 3 4 5
7. Sometimes my heart beats faster than it normally does for no reason.................................1 2 3 4 5
8. I am resentful................................................1 2 3 4 5
9. I am preoccupied with feeling worthless...........1 2 3 4 5
10. I feel as though I am a better person............1 2 3 4 5
11. I believe I should have died and he or she should have lived........................................1 2 3 4 5
12. I have a better outlook on life........................................1 2 3 4 5
13. I often have headaches........................................1 2 3 4 5
14. I feel heaviness in my heart........................................1 2 3 4 5
15. I feel revengeful........................................1 2 3 4 5
16. I have burning in my stomach........................................1 2 3 4 5
17. I want to die to be with him or her........................................1 2 3 4 5
18. I frequently have muscle tension........................................1 2 3 4 5
19. I have more compassion for others........................................1 2 3 4 5
20. I forget things easily (e.g. name, telephone numbers).1 2 3 4 5
21. I feel shaky........................................1 2 3 4 5
22. I am confused about how I am........................................1 2 3 4 5
23. I have lost my confidence........................................1 2 3 4 5
24. I am stronger because of the grief I have experienced.1 2 3 4 5
25. I don’t believe I will ever by happy again.......................1 2 3 4 5
26. I have difficulty remembering things from the past....1 2 3 4 5
27. I frequently feel frightened........................................1 2 3 4 5
28. I feel unable to cope........................................1 2 3 4 5
29. I agonize over his or her death..........................1 2 3 4 5
30. I am a more forgiving person...............................1 2 3 4 5
31. I have panic attacks over nothing........................1 2 3 4 5
32. I have difficulty concentrating...........................1 2 3 4 5
33. I feel like I am walking in my sleep.....................1 2 3 4 5
34. I have shortness of breath...............................1 2 3 4 5
35. I avoid tenderness........................................1 2 3 4 5
36. I am more tolerant of myself..............................1 2 3 4 5
37. I have hostile feelings.....................................1 2 3 4 5
38. I am experiencing periods of dizziness...................1 2 3 4 5
39. I have difficulty learning new things....................1 2 3 4 5
40. I have difficulty accepting the permanence of the death................................................1 2 3 4 5
41. I am more tolerant of others..............................1 2 3 4 5
42. I blame others..............................................1 2 3 4 5
43. I feel like I don’t know myself............................1 2 3 4 5
44. I am frequently fatigued....................................1 2 3 4 5
45. I have hope for the future..................................1 2 3 4 5
46. I have difficulty with abstract thinking...............1 2 3 4 5
47. I feel hopeless.............................................1 2 3 4 5
48. I want to harm others ........................................1 2 3 4 5
49. I have difficulty remembering new information ..........1 2 3 4 5
50. I feel sick more often ........................................1 2 3 4 5
51. I reached a turning point where I began to let go of some of my grief ........................................1 2 3 4 5
52. I often have back pain ........................................1 2 3 4 5
53. I am afraid that I will lose control ..............................1 2 3 4 5
54. I feel detached from others ....................................1 2 3 4 5
55. I frequently cry ..................................................1 2 3 4 5
56. I startle easily ....................................................1 2 3 4 5
57. Tasks seem insurmountable ...................................1 2 3 4 5
58. I get angry often ................................................1 2 3 4 5
59. I ache with loneliness .........................................1 2 3 4 5
60. I am having more good days than bad ......................1 2 3 4 5
61. I care more deeply for others ..................................1 2 3 4 5
Appendix D

Ohio University Support Group Questionnaire

1. What is our age? ___________

PLEASE CIRCLE YOUR ANSWERS

2. Gender
   Male    Female

3. Ethnic group
   Caucasian    African-American    Mexican
   Asian    Hispanic
   Other ___________

4. Current Marital status
   Single    Divorced    Widow/er
   Married

5. Education
   High School    College    Other ___________

6. How long ago did your loved one pass away?
   [0-3 months ago]    [3-6 mo.]    [6 mo.-1 yr.]
   [1-2 yrs. ago]    [2-5 yrs.]    [more than 5 years ago]

FOR EACH QUESTION, PLEASE CIRCLE THE NUMBER THAT BEST DESCRIBES YOU

1  2  3  4  5
Not at all    A little    Somewhat    Mostly Yes

1. Do you trust the majority of the individuals in this group?
   1  2  3  4  5

2. Have you developed a better relationship with others in the group?
   1  2  3  4  5

3. Do you relate to others in the group? 1  2  3  4  5
4. Does this group feel like a second family? 1 2 3 4 5
5. Do you feel that others in this group understand your situation? 1 2 3 4 5
6. Would you arrange to see one or more persons in this group outside of this program? 1 2 3 4 5

FORM Code__________

7. After having time with others in this group, how close are you to them as a whole? 1 2 3 4 5

8. Do you feel close enough to your group to disclose personal information about your situation? 1 2 3 4 5

9. Do you feel that you can be honest and open with the others in your group? 1 2 3 4 5

10. Do you think that others in the group are able to be honest and open with the group? 1 2 3 4 5

IF YOU WOULD LIKE TO PROVIDE ADDITIONAL COMMENTS, YOU MAY WRITE ON THE LINES BELOW.

__________________________________________________________________

__________________________________________________________________

__________________________________________________________________

__________________________________________________________________
Appendix E

It’s Never Easy to Say Good-bye
By Kenny Chesney

Jimmy climbs on board
Of that old yellow bus
Sure looks big in his little eyes
His mamma waves
As the tears kick up the dust
It's never easy to say goodbye

Julie Ray in her pearl white wedding gown
Has found her wings and it’s time to fly
It’s all her dad can do to keep from breakin’ down
It's never easy to say goodbye

CHORUS
It ain't easy to ever say goodbye
It ain't easy lettin' go of the ones you love
But believe me we'll meet again
By and by
If not here somewhere up above

I've had friends
That I lost along the way
They've been called on down the line
Though their time was short
I still think about them everyday
It ain't easy to say goodbye

My time has come
To go our separate ways
And it's alright if you wanna cry
Though I know we'll meet again someday
It's never easy to say goodbye

CHORUS
It ain't easy
To ever say goodbye
It ain't easy
Lettin' go of the ones you love
But believe me
We'll meet again, by and by
If not here
Somewhere up above
10-Mile Mourning Bridge
Appendix G

"I Grieve" by PETER GABRIEL

1. It was only one hour ago
   It was all so different then
   Nothing yet has really sunk in
   Looks like it always did
   This flesh and bone
   It’s just the way that we had tied in
   Now there’s no-one home

2. I grieve for you
   You leave me
   'So hard to move on
   Still loving what’s gone
   They say life carries on
   Carries on and on and on and on

3. The news that truly shocks
   is the empty empty page
   While the final rattle rocks its empty empty cage
   and I can’t handle this

4. I grieve for you
   You leave me
   Let it out and move on
   Missing what's gone
   They say life carries on
   They say life carries on and on and on

5. Life carries on in the people I meet
   In everyone that’s out on the street
   In all the dogs and cats
   In the flies and rats
   In the rot and the rust
   In the ashes and the dust
   Life carries on and on and on and on
   Life carries on and on and on

6. It’s just the car that we ride in
   A home we reside in
   The face that we hide in
   The way we are tied in
   As life carries on and on and on and on
   Life carries on and on and on

7. Did I dream this belief?
   Or did I believe this dream?
   Now I can find relief, I GRIEVE
Appendix H

**Turn, Turn, Turn**

By Pete Seeger

*Chorus:*
To everything, turn, turn, turn,
There is a season, turn, turn, turn
And a time for every purpose under heaven.

A time to be born, a time to die;
A time to plant, a time to reap;
A time to kill, a time to heal;
A time to laugh, a time to weep.

*Chorus.*

A time to build up, a time to break down;
A time to dance, a time to mourn;
A time to cast away stones,
A time to gather stones together.

*Chorus.*

A time of love, a time of hate;
A time of war, a time of peace;
A time you may embrace,
A time to refrain from embracing.

*Chorus.*

A time to gain, a time to lose;
A time to rend a time to sew;
A time to love, a time to hate;
A time for peace, I swear it's not too late.

*Chorus.*
Turn, Turn, Turn

By ____________________

A time to ____________, a time to ____________________;
A time to ______________ a time to ____________________;
A time ________________, a time to ________________;
A time ________________, ____________________________.
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