Family Narrative/Music Therapy: Children Dealing with the Death of a Parent

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FAMILY NARRATIVE/MUSIC THERAPY:
CHILDREN DEALING WITH THE DEATH OF A PARENT

By

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ABSTRACT

The purpose of this study was to examine the effect of a family narrative/music therapy intervention (FNMT) on family functioning in families with children or adolescents who have experienced the death of a parent some time in the two years prior to the study. To accomplish this, two families participated in FNMT within the framework of a nonconcurrent multiple baseline design. Both families consisted of a single parent (one female, one male) and two daughters. Pretest/posttest measures were the Family Assessment Device (FAD) for adults and adolescents and the Children’s Assessment of Family Functioning (CAFF) for children younger than 12. Baseline/postsession measures were a self-rating scale and open-ended questions designed for this study. All family members completed two pretest and one posttest measure and six weekly postsession measures. A random assignment resulted in Family 1 and Family 2 completing baseline measures for six and three days prior to the first session, respectively. In addition to these measures, the therapist completed a behavioral observation form following each session.

FNMT involved the use of music listening, drumming exercises, and drawing to enhance emotional expression and facilitate discussion of loss issues and the writing of a story about each family’s experience of the death. The six sessions took the family through the loss process and included such topics as facts about the death, first hearing about the death, the funeral, memories of the deceased, the family as it is now, and future plans. The primary intention of this intervention was to create an experience through which family members could process their loss experiences with each other and parents could learn about developmentally appropriate responses to loss. This combination was expected to improve family functioning (i.e., decrease parent-child conflict, increase parental nurturance) so that the family units would provide the emotional support necessary for the children to be able to progress in their emotional and cognitive development despite the major loss they had experienced in their family structure.
Data analyses of the different measures showed mixed results. Mean FAD change scores for parents and adolescents showed a trend of improvement in overall family functioning from pretest to posttest. There was, however, no change in the CAFF scores of the younger daughter in Family 1 from pretest to posttest. Interestingly, this same participant who rated no change in family functioning according to the CAFF was the only one whose self-rating scale scores showed significant improvement in parental nurturance during the treatment phase according to the X-moving range-chart analysis. The results for her older sister’s self-rating scale scores showed the opposite effect, indicating a significant increase in parent-child conflict and decrease in parental nurturance. Graphic analyses of the self-rating scales, supplemented by the calculation of an average effect size (ES) for all participants, indicated a small positive effect on parent-child conflict (ES = 0.28) and a small-to-medium negative effect on parental nurturance, as measured by comfort with emotional expressiveness (ES = -0.31) and communicating about death (ES = -0.42). Therapist observations showed no change in the way parents expressed and handled disagreement in sessions but did show positive change in all family members’ emotional expressiveness during sessions. A chi-square analysis of the ethnographic content analysis of responses to the open-ended questions revealed no statistically significant difference in the participants’ description of sessions as being therapeutic or facilitative of therapeutic ends and a statistical significance in the description of behaviors in the family indicative of more nurturance. A discussion of limitations of this study, recommendations for future research, and implications for practice concludes this paper.
CHAPTER 1
INTRODUCTION

Statement of the Problem

The death of a parent is probably one of the more distressing events that can occur in a child’s life. This is true no matter the age of the child. However, the impact on the child is likely to be the most devastating when the child is dependent on the parent for her or his physical, cognitive, and emotional development, also known as the formative years. Understanding this phenomenon would open the door to understanding how to intervene.

The study of the effects of parental death necessarily is preceded by a gathering of information on how extensive and damaging such a death might be to the children and families involved. This chapter will include an examination of the size and potential effects of parental loss on children’s behavior and development. In addition, details are given about the possible influences of the post-death family environment on a child’s ability to grieve. Then, the significance of the problem to the social work and marriage and family therapy professions will be discussed. A discussion of the focus of this study, the limitations inherent in the characteristics of this study, and the research question will conclude this chapter.

Extent of the Problem

Many families with children experience the death of a parent. In the year 2000, there were 231,458 deaths in the age range typical for young families (i.e., 21-50). Of these people, the number of male deaths was almost twice that of females (i.e., 1.9:1; National Center for Health Statistics, 2003). National statistics for 2000 also indicate that 14.7 million people over age 15 are widowed (U.S. Census Bureau [USCB], 2003a). Furthermore, 12 million of the single-parent households contain children between the ages of 6 and 17 (USCB, 2003b). Considering these
data, it seems evident that many families with children are likely to have to process loss issues due to parental death.

**Effect of Parental Loss on Children**

Children in families who have experienced parental loss are in a particularly vulnerable position (Bowlby, 1982/1983; Elkind, 1991, 2001). This type of loss carries with it the potential for adverse effects on children’s psychological development. Bowlby (1982/1983) suggested that loss experiences may create intense fear of abandonment in children or may put the child into the position of having to care for the remaining parent. Elkind (1991, 2001) elaborated on the negative effects of the latter situation. He stated that adults may easily mistake young children’s ability to verbalize at an adult level with an adult-like understanding of the words they use. When this occurs, the remaining parent is more likely to expect the child to act like an adult, including taking on such roles as partner, comforter, and confidante. Whether the loss results in the child fearing abandonment (Bowlby, 1982/1983) or stressing over their newly assigned adult role in the family (Elkind, 1991, 2001), she or he becomes more vulnerable to negative effects in future functioning when experiencing other losses or developing close relations with others, especially if the fear of abandonment becomes intense (Bowlby, 1982/1983).

**Developmental Considerations**

*Behavioral manifestations.* An additional difficulty for children in this situation is that it is not necessarily obvious to the adults in their lives that they are having difficulty because their behavior differs from adult grieving, depending on their level of cognitive and emotional development (Seager & Spencer, 1996). Seager and Spencer noted that children are likely to behave in ways considered immature for their age after experiencing the death of a parent. Infants’ inability to understand the concept of death does not bar them from being aware that something is different in the family emotionally, and when they do, they often act fussy or cling tightly to the remaining parent. Toddlers still cannot grasp abstract concepts and are likely to start having nightmares, acting more aggressively, or being less compliant to parental requests. School-aged children are more able to understand the abstraction of death, but their tendency to think magically (i.e., self-centered thought processing with no apparent logical connection between cause and effect) often results in their blaming themselves for the loss. Their behaviors
may include aggression, but they may also seem compelled to care for others or to hold onto and have control over possessions or other people, exhibit extreme fear reactions, or have physical symptoms (e.g., headaches, stomachaches). Although children in middle school have more ability to verbalize their feelings, they continue to have some magical thinking and may create unique explanations for the loss or view the loss as a punishment. Possible loss-related behaviors in this age group include those exhibited by school-aged children but may also extend to defiance of authority figures. Finally, adolescents have an understanding of and ability to express thoughts and feelings about the loss that nearly equals that of adults, but they may have an intense fear of their own death and of peers seeing them as somehow different. Whereas younger children may ask questions about death and its meaning, adolescents tend to avoid such discussions and may even become obsessed with thoughts or fears of their own death (Matter & Matter, 1982; Seager & Spencer, 1996). Adolescents are also more likely to be aware that they are angry at the deceased and that they fear what may happen in the future. Although they are likely to exhibit behaviors similar to those of middle school children, some additional manifestations of adolescent grief may include such behaviors as getting into fights, engaging in unsafe sex, taking drugs or drinking alcohol, taking risks with their own or others’ lives, or attempting suicide (Seager & Spencer, 1996).

*Conditions for healthy grief experience.* Despite differences in overt behaviors, children (Bowlby, 1980) and adolescents (Christ, Siegel, & Christ, 2002) may experience grief much the same as adults when certain conditions exist in their environments. Bowlby (1980) identified one condition before death that can create a secure base from which a child is better able to deal with the loss as the firm belief that the parents were emotionally available to meet the child’s needs in the past. For conditions following the death, a healthy grief response is associated with a respectful, caring adult presence in the child’s life (Bowlby, 1980; Christ et al., 2002). Behaviors indicative of such respect and caring include discussing facts about the death with children in a timely and accurate manner, answering children’s questions honestly and in developmentally appropriate language, encouraging and allowing children to grieve with the rest of the family while accepting their unique ways of expressing their grief, and providing comfort and reassurance that the surviving parent is not also leaving (Bowlby, 1980).

*Need for emotional support.* Bowlby (1980) and Nolen-Hoeksema and Larson (1999) further suggested that children require emotional support from the surviving parent to allow
them to grieve in a healthy manner. Nolen-Hoeksema and Larson (1999) stated that the death of a parent creates comprehensive change in a child’s life. This change may impact the child’s life directly, as with the loss of attention and care previously provided by the deceased or the disruption of what had been familiar family routines, or indirectly, as with the loss of emotional availability when the surviving parent is depressed or working long hours. Yet children are ill-equipped to cope with such life-altering change because of their emotional immaturity (Worden, 2002). For example, Nolen-Hoeksema and Larson (1999) found that children of elementary school age tend to avoid public display of sadness and preadolescent children tend to express their sadness in the form of anger. They posited that parental understanding of and openness to emotional expression would greatly facilitate the children’s processing of their grief, especially when parents also help the children learn socially appropriate ways to enact such expression.

Adolescents also require a great deal of emotional support from family and friends as they attempt to deal with their grief over a parent’s death at a time in their lives when the developmentally appropriate task is to achieve some sense of self or identity apart from their parents (Erikson, 1963; Nolen-Hoeksema & Larson, 1999). Because of the adolescents’ need to at least appear independent of their parents and their deep-seated fear of being perceived as different from others, this support may only occasionally take the direct forms of verbal and physical comforting so often used with younger children. Instead, adolescents may be more receptive to indirect methods of support, such as encouraging them to actively engage in stress-reducing activities and showing them the positive effects of open emotional expression and social support within the family system (McGoldrick & Walsh, 1991; Nolen-Hoeksema & Larson, 1999). At any age, therefore, children seem likely to become emotionally overwhelmed by the loss of a parent unless the surviving parent is emotionally available to comfort them (Bowlby, 1980).

**Powerlessness.** Additionally, Bowlby (1980) pinpointed children’s inherent lack of control over many aspects of their lives, lack of years of experience in living, and tendency to live in the present moment as exacerbating factors in the grief process. Adults get to decide what to tell the child about the death, how much comfort to give the child regarding their sadness and anxiety, and how long (and whether) they are willing to discuss the death with the child. Thus, the child’s grief process is largely dependent on the ability of the adults in his or her life to tolerate their own sadness and anxiety about the death. This lack of personal power on the part of
the child is exacerbated further during preadolescence and adolescence. Preadolescence is characterized by the tentative beginnings of a sense of independence. Any reminder that children of this age are actually helpless and dependent on their parents, therefore, is likely to produce negative self-talk regarding apparently childish behavior. Adolescents also struggle with this issue, albeit to a lesser degree, because of their still tenuous and incomplete emotional separation from the adults in their lives (Nolen-Hoeksema & Larson, 1999).

**Need for discussions about death.** Nolen-Hoeksema and Larson (1999) also posited that some parents believe they are protecting their children from feeling sad or anxious when they refuse to discuss the death, even though this kind of discussion has been found to help children process their grief. Avoiding these discussions actually increases the likelihood that the child will feel more insecure and abandoned. Piaget’s (1959) study of children provided some support for this belief that adults should discuss death with their children. He found that, between the ages of approximately 7 and 12, children have a strong need to find a reason for everything. Chance has no place in their world. As a result, they will create some kind of explanation for the parent’s death, regardless of how illogical it may seem to the adults around them. These seemingly illogical explanations stem from children’s tendency toward magical thinking (i.e., making causal connections between events simply because they occur at approximately the same time) and egocentrism (i.e., seeing the world from your own point of view and believing that others see the world the same way). The latter condition increases the likelihood that explanations and thoughts about the death will involve some kind of self-blame since egocentrism, by its nature, almost dictates that the child make some connection between his or her behavior and the parent’s death (Piaget, 1959; Piaget & Inhelder, 1966/1969). Such thinking may create even more distress to the child than a clear explanation from an adult.

Worden (1996, 2002) suggested that adolescents also need the opportunity to discuss the death of a parent. In his study of children between the ages of 6 through 17, he found that such discussions tended to increase the children’s ability to cope with their grief. Not only would such discussions provide the adolescents with an understanding of how the parent died, but they would also be likely to provide an opportunity for the adolescent to process feelings and thoughts about the death. Some adolescents in Worden’s (1996) study reported feeling uncomfortable talking to peers about the death because they did not believe that their peers could understand what they had experienced. With their usual source of conversation and information
blocked, the family’s role in encouraging open discussion about the death takes on greater importance.

**Cognitive inability.** Finally, children’s immature level of cognitive development may not be apparent to the adults in their lives. Their lack of life experience keeps them from being able to understand the euphemisms and figures of speech so often used by adults regarding death and grief (Bowlby, 1980). Such understanding requires much more cognitive sophistication than a young child possesses. Miscommunication occurs because the child takes the adult message literally. Thus, a statement that the deceased is “gone” will likely be interpreted by the child as meaning that the deceased might return from the place to which he or she “went.” Another example of children’s lack of cognitive sophistication is their tendency to focus on what is happening in the here and now. This tendency may create the false impression (to adults) that the child does not miss the deceased. To the contrary, children temporarily forgetting their loss in the presence of environmental distractions or exhibiting a wide variation in mood, from extreme sadness to extreme happiness, is consistent with the way they cognitively assimilate loss.

Some theorists (Piaget, 1959; Piaget & Inhelder, 1966/1969) have identified other immature cognitive abilities that are likely to cause surviving parents some consternation if not understood as developmental issues. In the early part of the preoperational stage, which spans the ages of 2 through 7 or 8, children aged 2 to 4 tend to believe that anything that moves is living, also known as animism. Piaget and Inhelder (1966/1969) also discussed the precausal reasoning, or magical thinking, found in 4- to 6-year-olds. Since children have difficulty distinguishing between psychological-emotional and physical phenomena, bereaved children are likely to explain the death as being the result of some negative emotion (e.g., anger) they were experiencing just prior to the death. Even children as old as 6 or 7 often view inanimate objects as being alive and death as a chance happening shrouded in mystery (Piaget, 1959). Children’s inability to understand death often leads them to become preoccupied with the subject, which takes the form of repeated “why” questions to the parent. The result is that children often flood the surviving parent with questions about death and when the deceased will return home. This barrage of questioning may be particularly difficult for a grieving spouse/parent to have to answer.

The concrete operational stage of development encompasses the ages of 7 or 8 through 11 or 12 and is characterized by a need to connect thoughts to physical (i.e., concrete) objects.
Children in this stage cannot truly understand discussions about abstract concepts, such as death (Piaget & Inhelder, 1966/1969). As a result, even though children in this stage are better able to think logically and use language to communicate, some children still personify death as an external entity from which they can escape (Webb, 2002). In this way, their understanding of death as irreversible does not extend to themselves. Magical thinking continues to be somewhat of a problem at this stage, as well (Piaget & Inhelder, 1966/1969). As a result, these children need their parents’ patience and ability to discuss the concrete details of death.

Adolescence involves the development of formal operational thinking, spanning the ages of 11 or 12 through 17 (Piaget & Inhelder, 1966/1969). Abstract thought and the ability to hypothesize about phenomena are some key aspects of this stage of development. Even so, adolescents’ understanding of death may be laced with fantastic notions that protect them from seeing death as a personal reality, retaining some of the tendency of concrete operational thinking about death as escapable (Kandt, 1994). In addition, adolescents often take longer to process their grief than adults because of their tendency to cope with the intense unpleasant emotions inherent in grief through denial and avoidance (Kandt, 1994; Lenhardt & McCourt, 2000). Denial, in particular, is likely to result in the appearance that the adolescent is not grieving. As a result, not only does the adolescent no longer consciously acknowledge that the loss is affecting her or him, but the people around her or him may begin to believe it also. Although the lack of emotional expression that accompanies denial is a useful means of protecting bereaved adolescents from feeling that they are different from their peers or that everyone is watching or talking about them (a common manifestation of adolescent egocentrism), this behavior also promotes the misunderstanding on the part of the surviving parents that the adolescents have no further need for emotional support or help dealing with grief (Kandt, 1994).

Family Influences over Child Grief

**Parental grief response.** It seems evident that the surviving family has a great deal of influence over how well a child processes the death of a parent and its impact on his or her life. Worden (1996) stated that the surviving parents’ grieving behavior is “inextricably intertwined” (p. 35) with their children’s ability to adapt to the loss. He conducted a 2-year longitudinal study of 70 families in which a parent had died. He found a correlation between depression and stress
in the surviving parents and emotional and behavioral problems in the children. Parental depression was also associated with the parent’s inability to accurately perceive how the child was feeling and behaving. In turn, this inaccurate perception was related to the child’s anxiety level and external locus of control (i.e., when people believe that others have more control over their lives than they, themselves, have). These results seem to support the view that the surviving parent’s ability (or inability) to cope with the loss strongly affects the children’s emotional and behavioral well-being.

**Gender differences for surviving parents.** Worden (1996) also delineated specific differences in participant adult responses to the loss of a spouse depending on the gender of the bereaved parent. Where mothers’ overall self-concept was often shattered by the loss, fathers had more difficulty with taking on the role of single parent and organizer of household chores. Mothers tended to be more attuned to their children’s emotional needs than fathers, but fathers were better able to provide for the children financially than mothers. In their 18-month longitudinal study of 455 bereaved individuals, Nolen-Hoeksema and Larson (1999) found that women were significantly more likely than men to experience depression and rumination following the death of a spouse. The level of depression was similar whether the spousal relationship was positive or negative prior to the death. Additionally, these researchers found that children whose parents’ behaviors changed radically (i.e., more withdrawn or more irritable and angry) were severely affected by these changes. Parental withdrawal was associated with children’s feelings of abandonment and sadness, and parental irritability and anger were associated with children’s anxiety, guilt, withdrawal, or compulsive obedience.

These results might partially explain Becvar’s (2001) thesis that a father’s death often results in sons feeling abandoned and responsible for the financial well-being of the household and daughters feeling responsible for the care of their mothers. Such behaviors are likely to occur when the child feels compelled to support a depressed parent (usually the mother) in order to ensure their own continued safety. Worden (1996) reported that 59% of the children in his study expressed concern about their parent’s well-being and the family finances and stated that they tried to behave in such a way that they would not cause the surviving parent extra work or concern. In essence, the parental role was at least partially reversed for these families. Shapiro (1994) posited that such role reversals are bound to occur in single-parent households because of the need to distribute the same number of chores as found in intact households with one less
member and the natural tendency for children to want to comfort and protect their parent. She suggested that such role reversals only become problematic when the surviving parent refuses to seek adult companionship and continues to lean on the child for his or her emotional support indefinitely.

**Family life cycle.** Another factor that influences a child’s ability to process grief is the place the family occupies in the life cycle. Families with nonadult children are more likely to have difficulty than those with adult children (Worden, 2002). For one thing, a parental death during this earlier stage of family development is unexpected, or untimely, because the surviving spouse would normally have anticipated a long life with the deceased, including emotional and financial help in raising the family (Walsh & McGoldrick, 1991). Secondly, the loss of a parent at this time of life is likely to incur multiple life stressors in the surviving family, such as the surviving spouse struggling with her or his grief while trying to parent the children, managing household expenses with a reduced income, and possibly changing living arrangements to accommodate the change in income or the need for extended family support (Walsh & McGoldrick, 1991).

Because of the high level of stress associated with parental death in young families, these families are also likely to quickly and prematurely stabilize the family system to the detriment of the mourning process (Shapiro, 1994). This stabilization may take the form of obsessive preservation of belongings of the deceased (Shapiro, 1994) or total avoidance of any discussion or emotional expression related to the death (Nolen-Hoeksema & Larson, 1999, Walsh & McGoldrick, 1991; Worden, 2002). Children whose families suppress verbal and emotional expressions often communicate their distress through problematic behaviors (Walsh & McGoldrick, 1991; Worden, 2002). These behaviors give the family another outlet for its anxiety by allowing members to identify the “acting out” child as the problem and, subsequently, to suspend further personal reflection and growth on their part (Shapiro, 1994). Another way that distressed families might stabilize the system is by adopting an overly rigid or permissive structure. A rigid structure precludes any form of change to the system, including role reassignment and rules realignment that reflect the loss of the deceased, and a permissive structure precludes any of the true stability or continuity required for the children to be able to cope with developmental challenges (Walsh & McGoldrick, 1991). Finally, families may react to the death by developing overly close (i.e., fused) or distant (i.e., cutoff) relations within the
family. Fusion in a family keeps members from processing their grief fully because such a state is intolerant of any differences, emotional or cognitive, among members. Thus, any expression of personal loss experiences is strictly forbidden. Cutoff also restricts communication, but the mechanism by which this occurs is the isolation of family members from each other. In this environment, children are left alone to try to figure out what the death means (Shapiro, 1994; Walsh & McGoldrick, 1991).

**Family cohesion.** Worden (2002) reported that bereaved individuals in his study appeared to process their grief more fully when their families were cohesive. Walsh and McGoldrick (1991) described family cohesion as a state in which members provide mutual emotional support and respect individual expression of other members’ grief experiences. This type of warm, accepting environment apparently promoted personal growth and progress through the grief process moreso than family environments lacking these characteristics. From all these data, it appears that families may have a positive or negative impact on how well children handle their grief.

**Intervention Development**

**Developmentally Appropriate Practices**

Because of the variance in children’s understanding and processing of the concept of death, specific interventions designed to address loss issues need to take child clients’ developmental levels into account. In particular, younger children (between the ages of 6 and 8) require special consideration due to the large difference in their physical, cognitive, and emotional abilities as compared with adults. Bredekamp and Copple (1997) outlined developmentally appropriate practices for working with children of this age as taken from the current position statement of the National Association for the Education of Young Children (NAEYC). Some of the principles behind these practices that are consistent with Piagetian theory include such concepts as: (a) the interconnectedness of children’s physical, social, emotional, and cognitive development; (b) the sequential nature but irregular rate of children’s development depending on individual child characteristics; (c) the expectation that children’s abilities will become more organized and adult-like with time; (d) the interactional nature of
children’s learning, with children actively participating in this process as the interface with their physical and social environments (i.e., families, school); and (e) the need to work with the children’s families directly. Since children from about 6 to 8 years old are typically in Piaget’s concrete operational stage, developmentally appropriate practices for this age group would include physical activity to promote cognitive learning, concrete experiences through play or drawing to encourage thinking about family interactions and communication patterns, and topics to which the child can relate to facilitate assimilation or accommodation of the information within a caring, safe environment.

Although Bredekamp and Copple (1997) only discussed the use of the above-mentioned principles with younger children, others support similar approaches with children of all ages (Piaget & Inhelder, 1966/1969; Worden, 2002). Piaget and Inhelder (1966/1969) highlighted the importance of developing a safe, respectful, accepting environment in which children may use play as their symbolic language and means of growing socially, emotionally, and cognitively. They proposed that there is no way to separate social, emotional, and cognitive development since these occur concurrently. In their description of the different stages through which children move, they acknowledged that children develop at different rates and that capabilities developed in each stage build on those acquired in previous stages, becoming more adult-like with age. They also identified drawing as a useful medium through which children may express themselves symbolically. The types of drawings produced change beginning at about the age of 8 or 9. Younger children often depict their view of real life in their drawings without consideration for the perspective from which the object is viewed. However, older children’s drawings reflect their ability to understand differing visual perspectives. Worden (2002) also suggested the use of drawing and writing as viable means of allowing children and adults to express their thoughts and feelings without having to filter them through verbalization. Finally, Piaget and Inhelder (1966/1969) and Worden (2002) identified the involvement of other family members in the therapeutic process as helpful in promoting a home environment which promotes further healing as children grow.

**Treatment Modality**

Modality of treatment is an important factor to consider when creating a therapeutic program for grieving families. Rainer (1998) posited that grief work is systemic in nature, which
suggests that working with the whole family in therapy may be beneficial. He stated that the
dearth of a family member throws the family into a state of confusion as the members attempt to
adjust to the loss, both emotionally and physically. Emotionally, the members need to
acknowledge and experience the feelings that arise due to the loss of the physical presence of the
deceased, and then they need to identify the level and type of connection they wish to maintain
with the deceased (e.g., memory review, confidences, family stories). Physically, the family
needs to reassign to other family members those roles previously filled by the deceased and to
adjust to the new family structure. Rainer (1998) suggested that therapists who identify family
rituals and hear all family members’ narratives regarding the loss experience are likely to be able
to assist the family in having a healthy grief experience.

In considering Rainer’s (1998) position and the increasing body of research evidence that
has identified family therapies as more effective than individual child therapy approaches when
addressing family-based issues (Shadish et al., 1993), it appears that a family therapy approach
would be the most useful modality for addressing loss issues. This approach involves as many
family members as possible in the solution because family therapists believe that the “problem”
is a function of family interactions and does not solely reside in the child (Matorin & Greenberg,
1992; Nichols & Schwartz, 1998). Structuring sessions in this way increases the likelihood that
the relationship between the parent and child will be enhanced by the experience. Not only do
family sessions allow for sharing of thoughts and feelings, but they also provide a forum for
giving information to all family members about the grieving process as it relates to the different
developmental stages.

Summary

Interventions with families in this situation, therefore, are more appropriate when they
match the developmental level of participants and include the remaining parent. Moody and
Moody (1991) suggested that developmentally appropriate interventions often include such
additions as music, art, and storytelling. These techniques provide nonthreatening media through
which the children (and the parents) can express distressing feelings and thoughts, which then
allows for improvement in the parent-child relationship. Storytelling also provides an
opportunity for all family members to share their experience of the loss in a more playful
atmosphere than the traditional question-and-answer therapy.
Significance of the Problem

Whether to Intervene

Although Worden (1996) found that 65% of the children in participant families dealing with the death of a parent did not need professional grief counseling to prevent future psychopathology, 23% of the children in this longitudinal study continued to have difficulty talking about the deceased two years after the death. In addition, the researcher’s comparisons between bereaved and nonbereaved children showed that the bereaved children had more social problems and safety concerns and were more likely to have an external locus of control than their nonbereaved counterparts two years after the parent had died. Worden pinpointed these characteristics as problematic for children’s healthy development.

In analyzing the results of their Bereavement Coping Project, a large-scale longitudinal study of the family grief process, Nolen-Hoeksema and Larson (1999) identified several reasons for promoting grief counseling in most situations. First, they found a decided lack of traditional support systems (i.e., extended family, community) for bereaved families and suggested that grief counseling might fill this need. Even though some of the families might be capable of coping with their grief without assistance, these researchers found that specific types of social support (i.e., caring presence, nonjudgmental listening, commonality of experience) ameliorated the grief process. Secondly, there were times when grieving participants were also experiencing other serious emotional problems (e.g., depression) that might be overlooked because of the presence of grieving behaviors. The hope is that a trained professional (i.e., grief counselor) would identify these other problems and would introduce coping techniques designed to handle the other issues. Finally, these authors proposed that grief counseling may promote personal growth in the bereaved. Not only could these people learn how to handle difficult situations in more adaptive ways, but they may also experience spiritual growth and/or a greater appreciation of life as well as of family members and other loved ones currently in their lives. This thesis was supported by the findings that those bereaved participants who found something positive in their loss reported significantly less emotional distress, better adjustment (i.e., coping, problem solving), and more ability to reappraise their situation than those who had not. In essence, Nolen-Hoeksema and Larson posited that grief counseling has the potential for helping any family that
is experiencing grief to improve their adaptation to the loss.

Social Work/Marriage and Family Therapy Professions

It would appear that the provision of grief counseling is important from the grieving family’s perspective. The significance of this work to the professions of social work and marriage and family therapy, however, lies in their missions. These professions share a primary goal of improving the lives of families and individuals within their environment (American Association for Marriage and Family Therapy [AAMFT], 2001; National Association of Social Workers [NASW], 2003). Although this assistance may take the form of changing factors in the larger environment, including laws and social or organizational policies, many of these professionals work with families directly to empower them to better their own lives. When a family is in distress because a parent has died, intervention is likely to focus on family processes.

Considering how damaging parental death may be to the current and future functioning of the surviving family members (Worden, 1996) and the likelihood that front line social workers and marriage and family therapists will encounter this problem as they carry out their work with families, it is very important that professionals in these fields have an understanding of what family grief and bereavement processes entail and of how to effectively intervene. Thus, studies such as this one add important information to the knowledge base available for practitioners as they attempt to provide evidence-based interventions to their clients.

Focus of This Study

This study examined the effect of family narrative/music therapy (FNMT) on participant families’ ability to function in a positive, nurturing manner. FNMT is defined as the combination of cuing memories of the deceased parent and expressing emotions through music and art (i.e., music therapy) and telling and restorying the family’s grief/loss story (i.e., narrative/poetry therapy) in a family therapy modality. This combination may act as the primary intervention for families who, in general, function in a healthy manner (i.e., allow open communication and a full range of emotional expression), have minimal stressors in their lives, and have sufficient social support but who are having difficulty adjusting to the life transition of having lost the presence of the second parent in the household. However, for other families who are experiencing what
Rando (1992-1993) called “complicated mourning” (p. 45) (i.e., unshakable denial of the loss and its impact on the mourner), this intervention may be used as an adjunct, or entry point, to more intensive grief work.

One drawback to using a combination of music, art, and storytelling in a family loss intervention is that there has been only limited empirical research conducted on this particular approach to addressing this issue. Therefore, Chapter 2 begins with a review of existing research regarding the components of FNMT designed to promote improved functioning of families with children who have experienced parental death. This literature review will examine research relevant to the grief process, the family therapy modality, and the use of music and narrative/poetry therapies.

**Delimitations of Study**

Chapter 3 will include an outline of a method for studying the effect of FNMT on families’ interactional patterns. Certain elements of this method have built-in features that limit the ability to generalize study results to people other than the actual participants with any confidence. First, the sample size for this study will be extremely small and drawn from the population of bereaved single-parent households on a voluntary and convenience basis. The small number of participants decreases the probability that this sample will be representative of the target population. In addition, people who volunteer to participate are likely to have systematic characteristics that differ from similar people that would not volunteer to be study participants. For instance, families experiencing a high level of distress and chaos are less likely to voluntarily add one more task to their life than those experiencing less distress. Another possible characteristic in families who would not choose to participate is a parental attitude that the children are the ones with the problem and, therefore, the only ones in need of therapy. Such an attitude would preclude participation in this study because of the eligibility requirement that therapy sessions include the parent and the children. A second potential limitation is that the use of a university clinic may encourage participation from a small segment of the target population that is more comfortable with entering a campus environment. Finally, the researcher will also be conducting the therapy. Although this is a necessary situation for this preliminary test of the intervention, there is the potential for researcher and therapist bias in the results. This use of only
one therapist, in itself, also reduces the generalizability to other therapists.

**Research Question**

Within the limitations of this study, the intent is to investigate to what extent FNMT is effective in alleviating bereaved family members’ difficulties in relating to each other. The research question for this study is, “Will families with children dealing with the death of a parent improve their ability to function as a family as a result of having participated in the family narrative/music therapy intervention?”

**Operational Definitions**

1. Family – nuclear family system consisting of a single parent and at least one child.
2. Child – offspring of surviving and deceased parent between the ages of 6 and 18.
3. Family functioning – the level at which family members interact in general and as a function of problem solving, communication, roles, affective responsiveness, affective involvement, and behavior control (i.e., Family Assessment Device scores) and as a function of emotional expressiveness, conflict, and communication regarding the parental death (i.e., postsession self-rating questionnaires).
4. Family therapy – therapeutic encounter based on the premise that individual behaviors (i.e., functioning) are strongly influenced by family dynamics. The targets for intervention, therefore, are the problematic interactions between family members, with the expectation that change in these interactions will promote long-lasting improvement in individual family members’ behaviors (Nichols & Schwartz, 1998). In this study, family therapy techniques will include working with all family members in joint sessions, fostering acceptance of other family members through normalization of behaviors and feelings, promoting positive communication of thoughts and feelings between family members, and encouraging empathy through circular in reflexive questioning.
5. Music therapy – therapeutic encounter involving the systematic use of music to improve a person’s physical, psychological, emotional, or social functioning. Core aspects of this type of therapy are the provision of emotional support for individuals and families by the
therapist and use of nonthreatening media through which clients may express difficult emotions and thoughts (Davis, Gfeller, & Thaut, 1999). The music may be used by itself, as with relaxation training or music improvisation, or as a cue to create an emotional mindset while expressing thoughts and feelings verbally, through discussion or writing, or pictorially, through drawing (Standley, 1991). Specific music therapy techniques used in this study will include listening to music to evoke memories and drawing to music and playing percussive instruments to promote expression of difficult thoughts and emotions.

6. Narrative/poetry therapy – therapeutic encounter based on the premise that because people develop meaning in their lives through the construction of their life narratives, they are also able to reconstruct, or re-author, these life narratives. The aim of this re-storying is to improve clients’ self-concept and interaction with others (White & Epston, 1990). Poetry therapy, in particular, focuses on the written and spoken word, whether receptive, expressive, or symbolic (Mazza, 1999). In this study, the therapist will use externalization of the problem through storytelling (i.e., participants writing their loss experience and listening to this story being read) and reframing (i.e., therapist introducing alternative stories, or perspectives, for possible adoption by clients in their re-storying efforts).

7. Family narrative/music therapy – the combination of family therapy, music therapy, and narrative/poetry therapy.
CHAPTER 2
REVIEW OF LITERATURE

Introduction

This literature review begins with an exploration of the theoretical underpinnings for doing grief work with families using a systemic orientation. Theories discussed include bioecological, attachment, and family systems. In addition, Worden’s (2002) tasks of mourning are described. Following this presentation of theories is an exploration of nonthreatening media through which people may express their emotions and thoughts. This leads into a review of the literature relative to family therapy, music therapy, and narrative/poetry therapy, the components of family narrative/music therapy (FNMT). The final article reviewed contains information on a multimodal therapeutic approach that combines poetry, music, and drawing.

Theoretical Underpinnings

Bioecological Theory

Family therapists view client issues from a systems perspective to provide a more complete picture of what is happening in the family and to develop a comprehensive intervention more likely to alleviate the family system’s distress. Bronfenbrenner and Morris (1998) identified their bioecological theory as a means of conceptualizing families from this perspective. As its name suggests, this theory includes interpersonal and intrapersonal factors that affect the individual’s cognitive and emotional development. The interpersonal factors include microsystems, or the person’s direct interactions with others; mesosystems, or the influence of interactions in one of a person’s microsystems on other microsystemic interactions; exosystems, or external social systems that affect the person even though he or she has no direct
interaction within them; and macrosystems, or larger cultural systems (e.g., national or ethnic values). The intrapersonal factors consist of the person’s characteristics, such as personality and physical attributes. According to this theory, children’s intrapersonal factors influence how others interact with them and vice versa.

Bronfenbrenner and Morris (1998) also posited that change occurs primarily through proximal processes (i.e., direct interactions between the individual and his or her environment), which are far more influential in the child development than more distant environmental factors. The larger systems influence a child’s growth indirectly, by establishing the context within which the child lives. For instance, a macrosystem that gives value to independence and intellectual strength will devalue dependence and emotionality. In this environment, many families may find themselves isolated from a family support system and embarrassed by displays of emotion. At the exosystem level, a single parent is likely to have a long workday that decreases personal contact with children at home. However, mesosystems and microsystems have a more direct effect on children’s lives because both of these systems involve the children in face-to-face interaction. Mesosystem influence occurs in instances when people transfer behaviors and thoughts learned in one microsystem to their interactions in other microsystems. This is evident in situations such as parents who learn about death and what are considered appropriate responses to it through interactions with their parents or religious leaders and then teach their children these meanings and behaviors through modeling. The latter interactions then influence the children’s thought patterns and behaviors when they encounter death. In this way, the family takes on the function of promoting individual family members’ growth. From this perspective, dysfunction manifests itself as problematic interactions among family members.

**Attachment Theory**

As with bioecological theory, attachment theory views a child’s interaction with significant others as a powerful influence on current and later functioning (Bowlby, 1963/1994, 1980). Bowlby (1980), who based this theory on empirical observations and research, identified attachment behavior as any activity intended to get or stay close to a protective other (i.e., attachment figure). Secure attachment occurs when a person experiences enough continuity in his or her connection to an attachment figure that he or she feels confident in that relationship. However, the loss of a significant attachment figure early in life is expected to disturb a child’s
sense of security such that she or he exhibits problematic interactional patterns. These patterns are based on anxiety and may take the form of a compulsion to keep people close, keep people away, or care for others. He stated that such an experience would have an adverse effect on the child’s future ability to relate to others if he or she was not able to develop a secure relationship with another significant person. Bowlby (1963/1994) also noted this effect when children failed to accept and express the anger evoked by the loss and the extreme desire to have the person back. In this type of situation, the anger may be directed at the absent person, some other person in the child’s life, or the child him or herself.

In the case of parental death, Bowlby (1980) further posited that the surviving parent’s behavior has a major influence on how well a child deals with this loss. To promote optimal processing of the grief experience, the parent needs to model healthy expression of feelings and thoughts about the loss and allow the child to follow this example. On the other hand, disordered mourning (i.e., chronic grieving or long-term absence of grieving) is likely to occur if surviving parents refuse to express their grief and anger in front of their children or refuse to allow the children to express their thoughts and feelings about the death and its impact.

**Systemic Theories**

Several systemic theorists have expressed support for this view of an interactional element to the grieving process (Bowen, 1991; McGoldrick, 1991; Shapiro, 1994; Walsh & McGoldrick, 1991). Shapiro (1994) described the family as being composed of interdependent members whose actions and reactions affect all other members of the system. The family system, as a whole, has to constantly balance the desire to maintain the status quo with the reality of changing circumstances. Meanwhile, individuals in the system are doing their own dance between maintaining their sense of self and their need to be connected to other members in the system. Bowen (1991) posited that the loss of a parent in a family with young children creates an “emotional shock wave” (p. 83) when family members have and deny a strong dependence on each other. He described this shock wave as the occurrence of a series of problematic life events (i.e., physical or emotional symptoms, dysfunctional social behavior such as substance abuse and school failure) throughout the extended family following the death. In such cases, the families exert a great deal of energy to prevent any connection being made between these events and the death.
Walsh and McGoldrick (1991) elaborated on this process by explaining that part of what makes loss a complex process is the interaction among family members and between family members and the larger social context. They further discussed the need for families to achieve nonreactive acceptance of the loss so that family members may begin to live their lives in the present again, as opposed to continually trying to force the family system to function in the same or a completely different way as it did prior to the death or to forget about the death altogether. In order for families to adapt to the death, these authors suggested that all family members need the opportunity to acknowledge and share their personal experiences of the loss and to reorganize the family into a cohesive yet flexible system that meets its members’ current needs. In situations where families do not adapt to the death, McGoldrick (1991) proposed that this unresolved loss will be passed on to the next generation in the form of maladaptive relational patterns.

Coming from a systemic developmental perspective, Shapiro (1994) stated that a child’s ability to grieve is a function of the child’s developmental level, relationship to other family members, and cultural environment. She suggested that grieving families are more likely to exhibit maladaptive family development (as seen in the children’s inability to reprocess grief as their cognitive and emotional abilities develop) when members deny that the family has changed after the death, try to keep the family system from changing or force the system to change in a constrained direction, or refuse to accept that children view death differently depending on their developmental level. Grieving families experience healthy development (as seen in the assimilation of change into the family system) when members explore personal and interpersonal change following the death, maintain emotional connectedness to other family members, and accept developmentally different perspectives on death from its members.

**Tasks of Mourning**

As a means of understanding the grief process more fully, Worden (2002) outlined four tasks of mourning required for healthy progression through the grief experience. Unlike many other theories about the grieving process, this theory emphasizes the active participation of mourners in this process. Similarly to most other theories, the understanding is that these tasks are not completed in any prescribed time period or sequence.

Task 1 involves the bereaved accepting the loss as real and irreversible at an emotional
level. Those who insist on keeping or throwing away all the possessions of the deceased or who deny the significance of the loss are struggling with this task. Task 2 involves accepting and processing the full range of emotions experienced following the death, including the painful ones. Difficulties with this task may take the form of a lack of feeling, substance abuse, or idealization of the deceased. Task 3 involves adjusting to a world without the deceased. The person not making this adaptation may maintain a helpless stance in the face of problems, refuse to learn the skills necessary to adopt different roles, or withdraw from contact with people. Task 4 involves identifying the desired role for the deceased in the life of the bereaved such that they are also able to live their lives fully in the present. The inability to achieve this task is manifested in a lack of intimate relations of any kind (Worden, 2002).

Worden (2002) also outlined tasks for families to achieve in order to adapt to a loss. In the first two tasks, family members accept not only the reality of the loss but also the sometimes widely divergent grief experiences of all family members. For the third task, families redistribute role assignments such that those jobs previously completed by the deceased are adopted by other members or are identified as no longer necessary. This also involves family members learning to accept the reality of family life without the deceased both emotionally and spiritually. The final task involves staying emotionally connected to the deceased in a way that is comfortable for the survivors and still allows family members to connect intimately with others. This ongoing connection to the deceased may take the form of conversations, thoughts, dreams, or sensations of feeling watched. Shapiro (1994) suggested that this latter task takes on different forms depending on the cultural mores of the bereaved.

Nonthreatening Media for Emotional and Cognitive Expression

Music

As Worden (2002) and Shapiro (1994) have suggested, a key part of a healthy grief process is the open expression of a full range of emotions and thoughts related to the death. To assist in the expression of difficult emotions, Skar (2002) posited that clients may access nonconscious material in a nonthreatening manner by selecting music or playing percussion instruments. Her theoretical orientation is Jungian, and she suggested that the playing of music
releases pent-up energy that can then be used to express emotions verbally. Hudson (1973) supported this view from a physiological standpoint. As a result of his study of research on this topic and his object relations perspective, he posited that the rhythm in music has a direct connection to a person’s physiology and that this connection creates a natural bridge to building rapport and initiating communication in therapeutic sessions.

Narratives

Another nonthreatening way for clients to express thoughts and feelings is through storytelling (Blow & Daniel, 2002; Carlson, 1997; Dallos, 2000; Mooney, 2000). Two forms that storytelling may take are narrative (Blow & Daniel, 2002; Dallos, 2000) and art (Carlson, 1997; Mooney, 2000). Coming from a social constructionist perspective, Blow and Daniel (2002) identified parental postdivorce stories as contributing to children’s creation of unhealthy narratives about their lives and the people around them. Stating that these skewed narratives adversely affect children’s future relationships, they encouraged client families to accept the stories of all family members. This often entailed ensuring that the children’s voices were heard without elevating the importance of their voices above those of the parents.

Dallos (2000) approached the concept of family narratives from the attachment theory perspective. He stated that children who were not able to develop secure attachment to a significant other use much of their emotional and cognitive energy trying to get close to or far from significant others. As a result, these children (and later, adults) operate under a life narrative so skewed that they have difficulty communicating openly with significant others, expressing their feelings to anyone, forming truly intimate relationships, and reflecting on their own or others’ emotions and unspoken thoughts.

Mooney (2000) and Carlson (1997) proposed a connection between people’s narratives and art. Working under a client-centered, constructivist perspective, Mooney posited that art offers a unique opportunity to facilitate emotional expression, mastery, and increased awareness of self and others. She identified art as a nonverbal version of a person’s narrative. As such, therapists can focus this medium in such a way that clients can externalize, identify exceptions to, reframe, and find potential solutions for their problems. Carlson also made a connection between theoretical concepts in art therapy and narrative therapy. He equated the nonconscious parts of the self with nonconscious alternative stories, the active role of the therapist in the
therapeutic system with the therapist as a co-creator of the family’s new story, and the inherent creativity of people with people’s tendency to self-heal. As such, art can be used as a medium for assessment, externalization, reframing, finding unique outcomes, and performing before an audience.

The theories reviewed here lend some support for doing work with families to address family system issues and using music and storytelling to facilitate the expression of problematic feelings and thoughts. A study of the effectiveness of these aspects of the FNMT intervention (i.e., family therapy, music therapy, and narrative/poetry therapy) would provide further information regarding this intervention’s potential usefulness.

**Family Narrative/Music Therapy Components**

**Family Therapy**

*Overall effectiveness.* While Shadish et al. (1993) provided a metaview of family therapy effectiveness, Black and Urbanowicz (1987) and Sandler, West, Baca, and Pillow (1992) studied specific elements relevant to family therapy. Shadish et al. did an extensive database and manual search for randomized therapy outcome studies published between 1963 and 1988. Their sample (\(N = 163\)) included 97 journal articles, 69 dissertations, 5 book chapters, and 2 unpublished manuscripts, 71 of which included a control group and 105 of which included a comparison group. The types of therapy outcomes studied were marital (\(n = 62\)) and family (\(n = 101\)). Participants in these studies all reported levels of distress prior to therapy. According to the correlation coefficients of the weighted effect sizes, there was no significantly different effectiveness among the different family therapy orientations. Results also indicated a higher level of positive outcomes after marital or family therapies (62%) than after a no-treatment control group (38%). Although participants in family therapy had worse outcomes than those in individual child and adolescent therapy when the presenting issues were conduct disorder or school problems, they tended to do better when the presenting issue was a family problem.

*Effectiveness with grief.* Black and Urbanowicz (1987) and Sandler et al. (1992) studied the effectiveness of family therapy when dealing with parental death. The purpose of the Black and Urbanowicz intervention was to enhance the children’s understanding of and ability to adapt
to the parent’s death. They worked with 45 families in which at least one child was no more than 16 years old when the parent died. After randomly assigning participants to either the treatment or control group, treatment group families underwent six biweekly family therapy sessions in the participants’ homes. Data were collected through structured interviewing and completion of the Rutter A/B. At the one-year follow-up point, treatment group children exhibited significantly less restlessness and nailbiting than control group children, and treatment group parents experienced less depression than control group parents. Children crying and talking about the deceased the month following the death and parental well-being were associated with positive outcomes (i.e., fewer and less severe problematic behaviors and emotional disturbance). Two years after the study, treatment group parents had significantly fewer health problems than control group parents, but there was no significant difference in the children’s behaviors. The authors suggested that differential attrition might have influenced the results (i.e., control children not completing this study did not cry about the deceased in the months following the death and exhibited more behavior problems at the one-year follow-up; treatment families experienced additional deaths after the parental death).

Sandler et al. (1992) studied 72 families, most of which were female-headed (n = 62) and Caucasian (n = 59). Of the children, 37 were male and 35 were female, and their mean age was 12.39 (SD = 3.19). Researchers separated participants into four cohorts and randomly assigned them from within these cohorts to the treatment and six-month-delayed-treatment groups. The intervention (i.e., the Family Bereavement Program) involved 3 sessions of a psychoeducational grief workshop and 12 sessions of a family adviser/therapy program. Scores for parent-report and child-report measures of the children’s behaviors, family’s interactions, and grief-related issues indicated that the treatment group exhibited significantly higher parental warmth and social support satisfaction and lower child conduct disorder and older child depression than control group participants. In addition, control group participants had significantly fewer grief-related discussions than treatment group participants did. The regression analysis indicated parental warmth, family coping, family cohesion, and parental symptoms were predictive of child symptoms at posttest.

Findings from both of these studies indicate that family therapy may have a positive effect on families grieving the death of a parent. The second element of the FNMT is the use of music listening to promote remembrance and percussive instrument playing for emotional
Music Therapy

Music as cue. One use of music in FNMT is as a cue for memories of the absent parent and for current and past emotions felt by family members. Balch, Bowman, and Mohler (1992) and Kenealy (1997) studied music- and mood-dependent recall, respectively. Participants in both these studies were undergraduate students. Balch et al. used background music (i.e., slow or fast jazz, slow or fast classical) while presenting words to participants. Either immediately or after two days (i.e., retention interval groups), participants were asked to recall the learned words while listening to either the same, different, or no music (musical cue groups). Their second experiment added two different-music groups (i.e., a change in tempo or form) and removed the no-music condition. Although there was a linear trend of increasing the number of recalled items from different-to no- to same-music groups, the only significant effect was for immediate recall in a different-music condition, in which participants recalled significantly fewer items than those in the other conditions. The researchers identified tempo as being more likely than musical form to promote music-dependent memory. Approaching recall from a different angle, Kenealy directly induced moods (i.e., elation/happiness or depression/sadness) through either a reading activity (i.e., the Velten mood induction procedure) or a music listening activity. The day after the memorization task, she induced either the same or a different mood in participants and had them recall the instructions from the previous day. In the second and third experiments, she also introduced a visual cue on the second day to observe how this affected recall. She found that a change in mood negatively influenced the number of recalled instructions. When the visual cue was present, this effect was apparent in all but the happy-sad group, which exhibited significantly lower recall than the other groups. Kenealy concluded that sad moods might impair the ability to use cues.

An extension of these studies involves researching the measurement of music as a cue to emotional induction. Goins (1998) and Lychner (1998) studied university students to study the effect of non-Western music on mood and the relationship among words used to describe the internal reaction to music, respectively. Both of these researchers used CRDI devices to measure the participants’ responses to music. Goins conducted two separate studies, one with two CRDI devices (i.e., aesthetic and mood adjectives) and the other with a paper and pencil test (i.e., mood
adjectives), and compared the two. He concluded that nonverbal and verbal measurement of mood responses produced similar results and made the global statements that music therapists can elicit and explore musically induced moods and use the adjective checklist to explore client values. Lychner had participants listen to four music selections (i.e., vocal/opera, keyboard, symphony, band), using the CRDI dial to measure their response to the music (i.e., aesthetic, emotional, perceived tension, free). Participants also completed a short questionnaire after each selection to indicate whether their CRDI responses reflected the participants’ level of responding to the music. There were significant differences in the responses to the different music selections, but there were no significant differences among the aesthetic, emotional, and free responses. The results from both of these studies, then, showed music as capable of inducing a narrow range of measurable emotions.

**Music as emotional expression.** Another use of music in FNMT is to give clients a chance to express their emotions through the playing of percussion instruments. Some music therapy interventions may facilitate the expression of difficult thoughts and feelings in individuals (Bright, 1999) and in families (Miller, 1994). Bright developed a therapeutic approach to facilitate grief resolution and began therapy with verbal reflection of the clients’ experience, followed by playing or talking about music associated with the absent person to bring nonconscious thoughts and feelings to conscious awareness. She then improvised music to reflect the emotions expressed during the session without identifying what was being reflected to allow clients to interpret from their personal perspective. After the improvisation, the clients shared the thoughts and feelings evoked during the improvisation, and the clients and/or therapist drew sketches of the issues discussed. In some cases, the therapist and/or clients also wrote songs to provide a written product for use by the clients between sessions.

Miller (1994) approached the emotional expression through music more directly in his family systems therapy model of music therapy. He first assessed family functioning via a percussive instrumental improvisation task done by family members. These members then practiced new ways of instrumental expression and interaction in the family to promote self-differentiation (i.e., maintaining a sense of self while staying emotionally connected with significant others). Individual members could also perform solo improvisation and receive family applause to promote the use of “I” statements (i.e., self-assertive statements that do not denigrate others). Pairs of family members were encouraged to play duets and receive corrective
feedback from the therapist to improve dyadic communication. Family members could also echo others’ playing to build listening and responding skills. Finally, parents directed children’s playing or provided a basic rhythm while their children improvised to improve the parent-child relationship or reestablish more appropriate parent-child boundaries (i.e., counteract role reversals). These experiences during therapy were then made conscious through subsequent discussions of the thoughts and feelings expressed.

In an exploration of emotion communication in music performance, Juslin (2000) and Laukka and Gabrielsson (2000) studied university students playing guitar and percussive instruments, respectively, to examine the roles played by the performers’ expressive cues and the listeners’ perception of emotional expression in this process. According to Juslin, successful musical communication of emotions is a function of the performer’s consistent use of cues to express emotion (i.e., encoding), the listener’s consistent use of cues to perceive emotions (i.e., decoding), and the match between these coding mechanisms. In both studies (Juslin, 2000; Laukka & Gabrielsson, 2000), musical selections were performed and prerecorded with clearly identified emotional intentions. Computer analysis of the recorded performances allowed for identification of the performers’ cue utilization. A difference between the studies was that Juslin analyzed all the performances and Laukka and Gabrielssen only analyzed the two performances with the highest agreement between the performer’s intent and the listener’s perception. Juslin defined performance cues as the mean tempo and volume, high or low frequency (i.e., 3,000 MHz cutoff), legato or nonlegato articulation, and articulation variability. Laukka and Gabrielssen also measured tempo and volume in their performers’ cue utilization, but the other elements they measured were tempo variability and timing (i.e., the number of notes deviating < 5%, < 10%, and > 20% from a metronomic performance). As participants listened to the selections, they rated their perceived emotional response to the music on a 10-point scale (0 = minimum, 10 = maximum). In both studies, the researchers found that the performers successfully communicated the intended emotions, but Laukka and Gabrielssen also found that the basic emotions (i.e., happiness, sadness, anger, and fear) were easier for listeners to distinguish than more subtle emotions (i.e., tenderness, solemnity). Successful communication of emotions was associated with close matching between the performers’ use of expressive cues and listeners’ perception of cues in both studies. Laukka and Gabrielssen further reported medium to high effect sizes for their findings (i.e., .30-1.80). They suggested that expressing
emotions with percussive instruments was as effective as with melodic instruments and discussed parallels between musical and vocal expression of emotions (i.e., tempo = speech rate, dynamics = voice intensity).

**Songs as metaphor.** Music may also facilitate the discussion of sensitive information through the use of song lyrics. Mark’s (1988) therapeutic approach included the use of song lyrics as metaphors and opportunities for problem-solving discussions. The first step in her process involved choosing, or letting clients choose, which musical selection to play. Second, clients read the lyrics as they listen to the song. The therapist then facilitated a group discussion on the overall message and the feelings expressed in the song. This discussion led into elicitation of clients’ personal disclosures of life situations in which they have had similar feelings. As specific problematic issues arise, the therapist introduced ways of coping with or solving problems and encouraged discussion of advantages and disadvantages for each action proposed. The author concluded that lyric analysis was a valuable tool in opening communication with adolescents about personal issues and beliefs, which she expected to result in their discovering meaningful roles for themselves in the world.

**Songwriting as personal narrative.** An extension of the use of music to broach difficult topics in a nonthreatening way is the use of songwriting. Coulter (2000) studied four children (ages 9 to 11) and five adolescents (ages 12 to 17) with a history of physical abuse ($n = 2$), sexual abuse ($n = 3$), or both ($n = 4$) to determine if a songwriting intervention would more effectively decrease PTSD symptoms than a recreational music group. Participants were inpatients in a psychiatric hospital and included five males and four females, whose race distribution was four African-American, four Caucasian, and one biracial. Recreational music groups involved singing or signing to songs, tossing a koosh ball to music, and playing rhythm instruments. The songwriting intervention involved the rewriting of a song about abuse that would more accurately reflect the participants’ experience of abuse. Participants completed a self-report instrument as a measure of their PTSD symptoms. The researcher found no significant differences between groups, but there was a trend of PTSD symptoms increasing in the recreational music group and decreasing in the songwriting group.

**Summary.** It appears that music may have a facilitative effect on the therapeutic processes found in FNMT. Music listening is likely to promote remembrance of the deceased and evocation of emotions that have been suppressed; percussive instrument playing is useful in
promoting the expression of difficult emotions; and both of these activities may promote
discussion of the grief process. The final element in FNMT involves clients sharing and
reshaping their family stories around the death of the parent.

**Narrative Therapy**

**Poetry therapy.** In a vein similar to that of songwriting, poetry therapy offers a way to tap
into a family’s narrative more easily than direct questioning. Mazza (1999) based his Receptive-
Expressive-Symbolic (RES) model of poetry therapy on the constructivist stance of narrative
therapy. This approach is useful with families, couples, or individuals, giving it a great deal of
flexibility, by design. The RES therapist takes on the facilitator role. One way to begin this
therapeutic process is to use receptive poetry therapy, in which the therapist uses prewritten
poetry, stories, or lyrics to open discussion of client issues and possible exceptions to client
problems in a nonthreatening way. Once rapport has developed, expressive poetry therapy
begins. In this phase, the therapist facilitates the clients’ expression of their personal narratives
in written or oral form. The author identified specific techniques for assisting clients in this
activity. Finally, he described symbolic poetry therapy as the use of ritualized expressions, either
in session or at home. As the author pointed out, the latter phase is especially helpful when
clients are dealing with loss issues.

**Programmed distance writing (PDW).** An extension of poetry therapy is apparent in
Jordan’s (2000, 2001) PDW, a structured way of allowing families to tell their stories. This
procedure is based on a social constructionist perspective (i.e., a belief that the creation of
knowledge about self and others occurs through interdependent internal and interactional spoken
or written dialogue) and the belief that optimal therapy occurs by processing the problematic
situation with all family members present (Jordan, 2001). The author created workbooks
designed to help families, couples, and individuals understand and cope with problematic
situations they are experiencing. She identified the assessment of clients’ literacy and readiness
for therapy as a first step (Jordan, 2000). Other criteria for potential clients include adequate
social skills, introspective ability, and age (i.e., 12 years or older). When using this approach, the
therapist assigns structured, self-instructional lessons for completion in writing at home, either
individually or together. Families are expected to discuss the lessons at home and then in
therapy, where the therapist assists clients in identifying irrational thinking that may be blocking
progress. Jordan (2001) provided a detailed description of this process using a divorce workbook. In this article, she specified that appropriate clients (i.e., literate and motivated) are introduced to the idea of using PDW workbooks to extend the gains made in therapy to the home and to facilitate the expression of difficult thoughts and feelings. The therapist then gives parents specific information on how to provide feedback to children regarding their workbook answers during the home discussions. Specific topics covered in the divorce lessons are the experience of the divorce and the two-household family, feelings about divorce, custody arrangements, children’s perception of their parents and roles in the family, and changes in the family. After the family has had a chance to discuss the lesson at home, the therapist facilitates family discussion of lesson material and parent-child communication about this material and provides constructive feedback on the whole process.

**Storytelling.** A less structured narrative approach to therapy is the use of storytelling (Carlson & Arthur, 1999). Using humanistic, client-centered, psychoanalytic, and learning theories, Carlson and Arthur developed a therapeutic approach that combines play therapy and therapeutic storytelling. They presented both of these media as metaphors through which clients can externalize their problems and communicate with the therapist and through which therapists can build rapport with clients. Although the authors stated that this approach is primarily used with young children, they also suggested that older children, adolescents, and adults might benefit from this approach with some developmentally appropriate revisions. The procedure involves having toys available that are likely to facilitate communication during free play and either selecting prewritten stories or creating client-tailored stories that provide an example of positive resolution to the clients’ presenting problem. During sessions, the therapist simply accepts, reflects, and validates clients’ emotional distress while setting minimal limits to ensure their safety. Reflection may involve highlighting a child’s apparent ability to cope with the situation, but the therapist allows clients to come up with their own solutions to their problems.

**Art as narrative.** Mooney (2000) added a nonverbal element to the therapeutic process (i.e., art) as a way to facilitate the expression of difficult thoughts and emotions, especially in elementary-school-aged children. She based her intervention on humanistic, client-centered theory and the constructivist perspective. In this six-week program, child clients are encouraged to draw about different aspects of their problematic situation. As an example, the author described the sequence of topics drawn by a child dealing with his parents’ divorce (i.e., the
divorce story, feelings about the divorce, suggested reframes to normalize the divorce experience, anger about the divorce, how to feel better, changes in post-divorce life, blaming feelings, and positive aspects of postdivorce life).

*Storytelling and life roles.* In a study of how the storytelling procedure might relate to reality outside of the storytelling activity, Georgakopoulou (2002) observed three Greek adolescent females in conversation primarily about one participant initiating a relationship with a man. The 18-year-old informant in the group taped eight of these conversations, and the researcher conducted ethnographic, unstructured interviews with the participants before and after the recordings. The result was the identification of three discourse identities (i.e., questioner, event and character evaluator, and paraphraser/elaborator) that closely paralleled the participants’ external social identities (i.e., sexually naive person, expert in male-female relationships, and helper, respectively). Storyteller selection was also based on the participants’ previous interactional history. The researcher checked the validity of the results by comparing participants’ statements about their relations outside of the study to support the validity of the discourse identities found in the study.

*Narratives and therapeutic change.* In an effort to examine change processes in therapy, Coulehan, Friedlander, and Heatherington (1998) studied families with older children (i.e., over age 8) and adolescents to identify the change processes involved in therapeutic narrative transformations. The principal investigator was a staff member of the agency promoting the tested intervention. Study participants lived in a variety of family structures, including intact (n = 2), remarried (n = 1), single parent (n = 4), and grandparent headed (n = 1). Data collection involved videotaping therapy sessions, identifying whether a transformation did or did not occur (by staff and independent observers), and transcribing and coding the sessions (by one and three condition-blind observers, respectively). Coulehan et al. found that all sessions with successful transformations involved a shift in attribution. Three of these transformations involved a change from blaming one family member for the problem to describing the problem as interactional (i.e., between subsystems) or general (i.e., without specifying particular players), and the remaining transformation involved placing the blame on another child. Participants who did not successfully transform their narratives either continued to blame the original child for the problem (n = 3) or did not discuss the problem in session (n = 1). There was modest interrater agreement on coding (r = .72) and acceptable reliability (i.e., consistency of three stages, but not
of substages) and validity (i.e., clinical relevance and internal coherence) of the conceptual model. Stage 1 of the conceptual model involved family members sharing their thoughts about the problem and possible solutions, therapists highlighting interactional aspects of the problem and potential solutions, and family members accepting that they did not have to all agree and/or that there were exceptions to the problem. In Stage 2, the therapist facilitated a shift in family members’ perception to include some positive characteristics in the child previously identified as “the problem,” an expansion of the problem definition to include family history and/or structure, and acknowledgment of family strengths and values that ease the change process. Finally, family members became more empathic and nurturant and expressed hope of positive change in Stage 3. The task analysis resulted in the elaboration of this three-stage conceptual model that was evident in all the sessions with successful transformations and not evident in those that did not include successful transformation of narratives.

**Solution-focused therapy (SFT).** Kogan (1998) also studied the therapeutic change process. He repeatedly viewed a conference videotape of a guest therapist conducting SFT while focusing on the interviewing process to study any possible restraining or political effects this questioning might have on clients’ narratives. Once he formed hypotheses related to the original three 12-minute segments, he selected additional segments as supporting examples of the hypotheses. Participants in this study were a married couple presenting with concern about the husband’s fear of having a heart attack. His definition of SFT was a combination of exteriority (i.e., construction of alternatives meanings by focusing on current contextual meanings of words rather than links to previous experiences), narrative discipline (i.e., redirection of client speech toward more therapeutic verbage), and locality (i.e., confirmation and validation of client statements regardless of the existence of supporting evidence for these statements). Kogan found that the use of these strategies facilitated the evolution of a new story for the couple which gave the husband personal agency. However, interpretation of the results also indicated that the old story (i.e., that the wife was the cause of the husband’s distress) remained intact. Validity checks included alterity (i.e., looking at different interpretations to create alternative views of the situation), political engagement (i.e., considering the political context of the study), and indeterminate social validity (i.e., considering the social context of the study). Kogan concluded that theory in therapy may have positive and negative effects on outcome and that therapists need to maintain a reflexive stance toward stories developed in therapy.
**Narrative therapy and client perception.** St. James O'Connor, Meakes, Pickering, and Schuman (1997) approached the therapy question from a different angle. They attempted to discover what clients find helpful or unhelpful in their experience of narrative therapy. The authors were clinicians on the team that was working with the clients and with each other for more than six years, and they were highly invested in the narrative perspective. St. James O’Connor et al. interviewed five single-parent and three intact families that included children between the ages of 6 and 13 and whose presenting problems involved a child’s problematic behaviors related to a variety of family and interactional issues. Time in therapy for these families was less than three months \( (n = 4) \), between four and nine months \( (n = 2) \), and greater than one year \( (n = 2) \). The ethnographic, semi-standardized interviews were conducted either with the whole family present \( (n = 4) \) or with the parents only \( (n = 4) \). In addition, clients rated their perception of problem reduction/severity from 1 (i.e., *completely reduced*) to 10 (i.e., *very severe*). Using independent professionals to rate the fairness of questions used and an independent ethnographic research expert to check the accuracy of identified codes, researchers identified six content areas in the interviews. The families commented on four narrative therapy strategies (i.e., externalization of the problem \( [n = 15] \), unique events and alternate stories \( [n = 21] \), consulting and reflecting team \( [n = 46] \), and audience building \( [n = 26] \)) as well as what they perceived as helpful \( (n = 101) \) and unhelpful \( (n = 16) \) in therapy. Clients in therapy for more than one year reported the highest reduction in their presenting problem, and those in therapy less than three months reported the least reduction. St. James O’Connor et al. posited that the length of time for the better outcomes was a result of the time it takes for clients to make the cognitive shift necessary to use externalization to its greatest benefit.

**Narratives in therapy.** Levitt, Korman, and Angus (2000) studied the connection between the use of metaphors and positive versus negative outcomes in therapy. They selected the best and worst therapy outcomes from a larger study and analyzed transcriptions of these sessions to identify the metaphors used that reflected either feeling “burdened” or “unloading” a burden (p. 28) and the types of narrative sequences associated with these metaphors (i.e., internal, emotion-related; external, storytelling; reflexive, self-analytical). These researchers reported moderate-to-high interrater reliability \( (Kappas = 71.5-71.8; r = .80-.96) \) and acceptable levels of several validity measures (i.e., content, construct, discriminant) on their two standardized researcher-observation instruments. In general, the good outcome was associated
with a great deal of reflexive speech (67%) and a moderate amount of internal speech (32%), and
the poor outcome was associated with a great deal of reflexive speech (65%), a moderate amount
of external speech (20%), and a lesser amount of internal speech (15%). Furthermore, Levitt et al.
found that while the client with a good outcome used burden metaphors when in touch with
her own emotions (i.e., internal narrative sequence) and shifted her use of metaphor from feeling
burdened to unloading the burden in the course of therapy, the client with a poor outcome was
more likely to use burden metaphors to tell a story (i.e., external narrative sequence) and
continued using a burdened metaphor throughout therapy. Hypotheses generated by these
analyses were that exploration of emotions and meanings in metaphors and encouragement of
emotional connection in expressed metaphors may be helpful for clients.

Besa (1994) and Painter, Cook, and Silverman (1999) studied families to determine if
narrative-related interventions were effective in improving family relations (i.e., parent-child
conflict and child noncompliance, respectively). Both studies involved the use of nonconcurrent
multiple baseline designs. The six participant families in the Besa study came from various
family structures (i.e., two intact, one blended, one divorced/dating, two divorced/single-parent).
The four male and two female children in these families were between 8 and 16 years old. Besa
trained the parents to measure the collaboratively chosen target behaviors. Baseline therapy was
limited to gathering family history, collaboratively defining the problem, and externalizing the
problem. The narrative therapy intervention began with the delineation of a behavioral contract
or the presentation of a challenge to a family member’s behavior followed by the asking of
unique outcome questions. One month after termination, Besa collected three days of followup
data. Five of the six families showed 88% to 98% improvement in targeted child behaviors
following the intervention application.

The four participant families in the Painter et al. (1999) study all presented with a self-
identified noncompliant child. These families were all Caucasian, and the children were all male,
two of whom were 5 years old and two of whom were 6 years old. The intervention for this study
was a combination of therapeutic storytelling (TST) and behavioral parent training (BPT), the
presentation of which was counterbalanced to control for order effects. Painter et al. matched
participants by age and randomly assigned them to the conditions. The parents and therapist
operationalized specific noncompliant behaviors to pinpoint and the therapist showed the parents
how to measure these behaviors before the intervention began. The TST session involved telling
a therapeutic story and having the child retell the story, with standardized prompts used to assist the child in remembering story details. The BPT session involved giving parents the training handbook and assisting parents as they practiced the skills relevant to noncompliance and attempted to integrate the therapeutic story content with the behavioral strategies. Participant children recalled all five points of the therapeutic stories, with and without prompting. Both treatments produced an equivalent reduction in the frequency and the intensity of the children’s noncompliance. These results were supported by the triangulation of the Behavioral Assessment System for Children results, which showed a decrease in externalizing behaviors and an increase in adaptive functioning. TST-BPT parents reported reduced stress at posttest and further reduction at followup. BPT-TST parents also reported reduced stress at posttest, but this increased or remained stable at followup. Parental satisfaction ranged from 4.0 to 5.0 on the 5-point self-rating scale. Painter et al. suggested that this intervention has promise as a treatment because of its apparent equivalence to a previously tested intervention (i.e., BPT).

**Summary.** The use of narratives in therapy appears to have a beneficial effect on some families. For FNMT, this use can take the form of storytelling, where the family members get to share their individual perceptions of the grief process, as well as story writing, where the therapist and family members work together to create a more positive, interactional view of the family’s current and future situation. Of course, since FNMT integrates three therapies (i.e., family, music, narrative/poetry), it is also important to review the potential effectiveness of such integration.

**Integrative Creative Arts Therapy (ICAT)**

Goldstein-Roca and Crisafulli (1994) drew from the constructivist perspective to develop a multimodal approach for brief treatment of individuals in inpatient settings. ICAT begins with a verbal interview to identify clients’ problems as well as their motivation to change, strengths, interests, and future dreams. This interview provides detailed information for use in tailoring the modes of treatment to the client’s needs and current abilities. ICAT therapists take on a facilitative role in the remainder of treatment. To explore client issues further and begin the process of clients discovering who they are and how they can express their thoughts and feelings, the therapist helps them create poetry through such interventions as a fill-in-the-blank activity. The ICAT therapist then uses music and creative poems to encourage clients to feel their
emotions more intensely as a means of promoting greater self-awareness. Once change begins to occur, the therapist introduces a drawing activity to solidify the change and encourage the client to begin thinking of a more hopeful future.

**Discussion**

This review of literature supports the view that the components of FNMT (i.e., family, music, and narrative/poetry therapy) have the potential for effectively assisting families to deal with parental death when presented as separate interventions. All three components have strong theoretical support, and this support is strengthened further for the narrative part through qualitative research. All of the quantitative studies included convenience or purposive samples, though, which prevents direct generalization of results. However, the overall picture of this research seems to indicate some usefulness concerning the different elements of FNMT. There is evidence that family therapy may effectively improve family problems (Black & Urbanowicz, 1987; Sandler et al., 1992; Shadish et al., 1993) and some weak evidence that narrative therapy may effectively improve parent-child relations (Besa, 1994; Painter et al., 1999). Additionally, there is some evidence that music may be a useful medium for expressing emotions (Juslin, 2000; Laukka & Gabrielsson, 2000) and some suggestion that it may facilitate experiential remembering (Balch et al., 1992; Kenealy, 1997) and feeling (Lychner, 1998).

The next question, then, is whether the composite of these elements might produce a positive effect on families with children who are experiencing the loss of a parent due to death. Of the articles in this review, only three directly addressed loss issues due to death (Black & Urbanowicz, 1987; Mazza, 2001; Sandler et al., 1992) and one addressed an integrative intervention (Goldstein-Roca & Crisafulli, 1994). One possible way to begin filling this gap in the literature is to conduct a multiple baseline research design, a fairly rigorous approach to doing a preliminary examination of the possible effectiveness of an intervention.
CHAPTER 3
METHODOLOGY

Purpose of this Study

The purpose of this study was to investigate the effect of a family narrative/music therapy intervention on family functioning with families dealing with the death of the parent. This chapter includes the details of how this study was conducted. Elements discussed are the participants and setting characteristics, instrumentation, research design, study procedure, and data analysis procedures. The research hypotheses provide a frame of reference for analyzing this study’s methodology.

The research hypotheses were as follows:

1. Family functioning will improve from pretest to posttest as measured by parental Family Assessment Device scores;
2. Family functioning will improve from pretest to posttest as measured by adolescent Family Assessment Device scores;
3. Family functioning will improve from pretest to posttest as measured by Child Assessment of Family Functioning scores;
4. Family functioning will show decreased parent-child conflict (i.e., self-reported level of arguments) following application of a family narrative/music therapy intervention (FNMT) as measured by baseline and postsession parent, adolescent, and child responses to self-rating questionnaires;
5. Family functioning will show increased parental nurturance (i.e., self-reported comfort with emotional expressiveness and communication about death and the deceased) following application of FNMT as measured by baseline and postsession parent, adolescent, and child responses to self-rating questionnaires; and
6. Family functioning will improve from pretest to post-intervention as measured by therapist behavioral/interactional observations.

Setting and Participants

Setting

The study took place in a university counseling setting. This agency is a nonprofit organization that is an integral part of a graduate-level training program for marriage and family therapy that also serves the local community by providing relationship therapy services. The mission of this program is to produce family scholars who address the needs of families by developing effective, evidence-based family interventions and improving graduate students’ systemic assessment and therapeutic skills for working with couples and families. Therapy was provided by the researcher, who is a Board Certified Music Therapist and is registered as a Clinical Social Worker Intern and a Marriage and Family Therapist Intern.

Participants

Participant selection involved convenience, purposive sampling. The researcher distributed brochures to local churches, public and private schools and agencies, and private practitioners to establish referral sources for the project. The two families who contacted the researcher after hearing about the study from two of these referral sources agreed to participate in the study and passed the screening (i.e., were not suicidal or severely depressed). Family 1 consisted of a 39-year-old Latino mother and her two daughters, ages 8 and 17. Household income was in the $15,000 to $24,999 range, and the mother had a high school degree. The parents had been married 20 years and the father was 42 years old when he died of a drug overdose, which occurred 8 months prior to participation in this study. Family 2 consisted of a 46-year-old Caucasian father and his two daughters, ages 14 and 17. Household income was in the $75,000 to $99,999 range, and the father had a bachelor’s degree. The parents had been married 16 years and the mother was 44 years old when she died of cancer, which occurred 2
years and 2 months prior to participation in this study. Sessions occurred with families individually. Both families participated in all six therapy sessions and completed all measures (i.e., pretest, posttest, baseline, postsession).

**Instrumentation**

**Pretests and Posttest**

**Family Assessment Device (FAD).** Family members 12 years and older completed the FAD to measure family functioning according to the McMaster model (Epstein, Baldwin, & Bishop, 1983, 2000; Miller, Epstein, Bishop, & Keitner, 1985). FAD contains 60 items, including seven scales that reflect a family’s overall functioning (i.e., General Functioning) as well as their ability to resolve problems (i.e., Problem Solving), communicate clearly and directly (i.e., Communication), delineate and accomplish role assignments that meet the physical and emotional needs of family members (i.e., Roles), express a full range of emotions appropriately to different situations (i.e., Affective Responsiveness), connect with and show interest in each other’s lives without undue intrusion into other members’ lives (i.e., Affective Involvement), and influence members’ behaviors (i.e., Behavior Control). Responses involve rating each item on a 4-point scale (1 = strongly agree, 2 = agree, 3 = disagree, 4 = strongly disagree), with lower scores indicating healthier family functioning.

Miller et al. (1985) conducted psychometric tests on the original 53-item FAD and found that it had adequate one-week test-retest validity ($r = .66-.76$) and good concurrent validity with two established measures of family functioning. FAD subscales also demonstrated the ability to differentiate between clinical and nonclinical families (i.e., discriminative validity). Miller et al. identified subscale cutoff scores to differentiate healthy, somewhat unhealthy, and very unhealthy family functioning as follows: General Functioning – 1.8 and 2.2, Problem Solving and Communication – 2.1 and 2.3, Roles – 2.1 and 2.4, Affective Responsiveness and Affective Involvement – 2.0 and 2.4, Behavior Control – 1.8 and 2.1. In comparing these cutoff scores to family therapists’ clinical ratings of participant families, they found that these scores had low-to-excellent sensitivity in identifying unhealthy functioning (i.e., 31-93% of the time), specificity in identifying healthy functioning (i.e., 36-100% of the time), and diagnostic confidence (i.e., 61-
Kabacoff, Miller, Bishop, Epstein, and Keitner (1990) conducted a psychometric study of the 60-item FAD with psychiatric, medical, and nonclinical samples. They reported poor internal consistencies for Roles (i.e., .57-.69) but adequate internal consistencies for all the other subscales (i.e., $\alpha = .70$ to .86). The General Functioning subscale showed the highest internal consistency, with alphas ranging from .83 to .86. In addition, Kabacoff et al. conducted a confirmatory factor analysis and found construct validity for this instrument as a measure of the theoretical structure of the McMaster model. They further found support for using the General Functioning subscale as a means of measuring overall family functioning.

**Children’s Assessment of Family Functioning (CAFF).** Ridenour, Daley, and Reich (1999) created the CAFF as the child's equivalent of the FAD general functioning scale after having completed a factor analysis of the FAD that identified this scale as the overall assessment of family functioning. Unlike the FAD, higher scores on this 14-item instrument are indicative of healthier family functioning. The CAFF is intended for completion by children between the ages of 5 and 11. Each item consists of a narrative and three cartoons depicting different interactional patterns, from which the child selects the one that most closely resembles his or her family’s interactional patterns around specific scenarios (Daley, Ridenour, & Reich, n.d.). Daley and Ridenour (1999) pilot tested this instrument and found it to have high face and content validity and moderate internal consistency (i.e., $\alpha = .80$) with a sample of kindergartners, aged 5 to 6 years. J. G. Daley (personal communication, October 15, 2003) interpreted these findings as indicating some promise for the use of this instrument to measure children's perception of family functioning.

**Postsession Questionnaires**

**Self-rating scales.** Parents, adolescents, and children rated the level of specific types of family interactions (i.e., parent-child conflict, communication about death and the deceased, emotional expressiveness) on self-rating scales created specifically for this project (see Appendixes A through C). Item 3 measured the level of parent-child conflict; Items 2, 5, and 8 measured the level of comfort with communication about death and the deceased; and Items 1, 4, 6, 7, and 9 measured the level of comfort with emotional expressiveness. Intensity level was measured with 10-centimeter scaling lines anchored with the opposing levels of intensity (i.e.,...
0 = *not at all*, 10 = *extremely*) and containing hash marks at each centimeter point on the line (see Appendixes A and B). There are no numbers on these scaling lines so as to encourage an emotionally based response, as opposed to a cognitive one. The inclusion of hash marks on the line allows for some standardization of participant responses. Children’s scaling lines include emotion faces to assist participants in identifying the intensity of the interactions and related emotions (see Appendix C). A straight-mouthed face is the anchor for *not at all*, a broadly smiling face is the anchor for *lots*, and different levels of smiling faces mark varying levels of intensity between these extremes.

*Open-ended questions.* The researcher asked participants open-ended questions at the end of each session to better understand members’ qualitative experiencing of family interactions at home and during the session. The initial questions were: (a) “What was it like for you doing the activity during the session?” (b) “What, if any, changes have you noticed in the way your family interacts at home since the last session?” and (c) “What, if any, changes have you noticed in how other members in your family have been acting since the last session?” She asked followup questions to clarify responses to initial questions. Clarifying questions took the form of emotion reflection, content paraphrasing, or direct inquiry (e.g., “What does that mean?”).

*Therapist behavioral observations.* In addition to the family’s assessment of their own functioning, the therapist completed a behavioral checklist, created specifically for this project (see Appendix D), immediately following the session. This checklist included interactional patterns in the family, such as the level and type of emotional responsiveness the parent showed to children’s feelings and statements, how conflict was expressed by the parent, how close or distant members were to each other (as evidenced by physical positioning), and the overall emotional expressiveness and types of emotions expressed by the parent and children. As with the self-rating scales, these observations were recorded on 10-centimeter scaling lines anchored with descriptive words and containing hash marks at each centimeter point on the line (see Appendix D). The scaling lines for emotional responsiveness and the dismissive-restrained-open conflict dimension were rated from 0 to 10, with higher numbers indicating healthier functioning. All other lines were rated from -5 to +5, with healthier functioning indicated by more moderate scores (i.e., closer to 0). The behavioral observation sheet includes a list of behaviors associated with the anchor descriptors (see Appendix D). These observations served as an alternate perception of family functioning.
Research Design

The research design used in this study was a nonconcurrent multiple baseline. This type of design is particularly useful in clinical settings because it not only controls for history (Campbell & Stanley, 1963) and allows for causal links and generalizability (Bloom, Fischer, & Orme, 2003), but it is also flexible enough to use in real-life settings (Watson & Workman, 1981). Families are unlikely to reach the appropriate level of readiness for a particular intervention at the same point in time. Thus, a waiting-list approach may entail long spans of time following the initial contact made by the family. This is particularly problematic with grieving families because of the possibility of extreme distress and the reality that they will go elsewhere if necessary. Watson and Workman (1981) suggested that a nonconcurrent multiple baseline design addresses this problem by allowing the researcher to begin the research process as soon as potential participants make contact. In addition, they proposed that the random assignment of participants to predetermined baseline lengths also increases the confidence that the results are not due to chance. As far as deciding what these predetermined baseline lengths should be, Bloom et al. (2003) specified three data points as the minimum length for baseline data collection and the minimum difference between the lengths of the different baselines. By their definition, a multiple baseline design also requires that two or more participants, problems, or settings be studied. This study gathered data on two participant families using predetermined baseline lengths of three and six days, to which participant families were randomly assigned. After the baseline period, data were collected following each weekly session.

Procedure

Screening/Pretests

After approval by the University Institutional Review Board (see Appendix F), screening of participants commenced. A licensed marriage and family therapist interviewed participants to screen out and refer to intensive therapy those who were experiencing severe depression or suicidal ideation. The intent of the FNMT intervention is to help grieving families navigate the bereavement process, not to stabilize families in crisis. After completing the screening interview,
participant parents signed the consent form (see Appendix G) and completed the demographic sheet (see Appendix H), the FAD, and the adult version of the postsession questionnaire. Concurrently, adolescents and children signed assent forms (see Appendixes I and J, respectively) and completed the FAD and CAFF, respectively, and the adolescent and child versions of the postsession questionnaire. Following completion of the pretest measures, the researcher contacted participant families daily to collect baseline data (i.e., postsession questionnaires) on family interactions. Baseline length was determined by randomly assigning each family to have these data collected for three or six days prior to the first intervention session. Parents/adolescents and children again completed the FAD and CAFF, respectively, just prior to participating in the first intervention session.

**Treatment**

The FNMT intervention involved the use of music-making and drawing to enhance the expression of difficult emotions, psychoeducation on the loss process, and story writing to process the individual families’ experience of the death. Treatment sessions required the use of a variety of media. Prerecorded music playing of compact discs and/or audiotapes to trigger memories and feelings about the deceased involved the use of an Aiwa CSD-EX100 compact disc/tape player (see Treatment section for researcher-provided recordings). To initiate awareness and discussion of emotions through percussive instrument playing, participants used a Wellness Reproductions 11 x 17 emotions sheet and various rhythm instruments (see Appendix E). Drawing materials for nonverbal expression of feelings included Crayola washable, nontoxic markers (broad and super tips), crayons, and smooth bright colored pencils; colored and white bond paper; and colored construction paper. To accurately capture the family narrative regarding the death experience and the responses to postsession interviews, the therapist recorded the sessions with a Sony IC digital recorder, model ICD-ST10. Family drawings for use in the family storybook were captured by a Canon PowerShot A80 digital camera and transferred to the storybook file on a Dell SmartStep 100N laptop computer using Canon Utilities ZoomBrowser EX 4.5 and ArcSoft Photo Impression 4 software. The researcher created the family storybooks using Corel WordPerfect 10 and ScanSoft Dragon NaturallySpeaking 7.3 software.

Transcriptions of participants’ stories that had been recorded during the sessions formed the basis for individual families’ storybooks. Families participated in six weekly sessions, each
of which concluded with family members completing the postsession questionnaires and open-ended questions regarding family interactions. The therapist recorded behavioral observations related to family interactions immediately following each session.

**Session 1.** The first session involved the building of rapport by giving family members the opportunity to discuss the behaviors they saw as being problematic in the family and the facts about the death. Participants drew their impressions of how the parent died while listening to Elton John’s performance of “Circle of Life” (John & Rice, 1994, track 1). The researcher selected this song because of its focus on normalizing death as a part of the life cycle. In addition, the therapist introduced the concept of expressing feelings through the use of percussion instruments and encouraged participants to familiarize themselves with the instruments and improvise a percussive “song” for the deceased parent. The therapist set an initial beat to start the improvisational process. Then, she encouraged each family member to join in the playing. Once family members were playing their instruments, the therapist matched their playing to let them take the lead and support whatever they were playing, even if the playing had no particular rhythm. This matching is the musical equivalent of reflecting emotions and, as such, lets the participant know that the therapist understands what they are “saying.” At the end of this activity, the therapist praised family members’ efforts and processed their reactions to the playing activity and reminded the family that there were five sessions remaining. The latter was intended to prepare participants for the inevitable loss they were going to experience at the end of the sessions.

**Session 2.** Session topic for the second session was “The experience of first hearing about the death.” Participants drew while listening to James Taylor’s performance of “Fire and Rain” (Taylor, 1969, track 3) and/or Elton John’s performance of “Candle in the Wind” (John & Taupin, 1987, track 12). The researcher selected these songs because of their focus on the songwriter’s experience of first hearing about the death of a fiancé and an idolized other, respectively. During and following this activity, participants discussed what it was like for them at that time. The therapist normalized the emotions and developmentally appropriate behavior presented and focused the discussion on information for use in the first chapter of the family’s grief storybook, entitled “When I First Heard.” She also asked participants which of the pictures they had drawn during the session they wanted to include in their storybook. When participants had difficulty expressing thoughts or feelings, the therapist encouraged them to “play” these
thoughts or feelings and reflected emotions inferred from the playing to facilitate further sharing. At the end of the session, the therapist started a drumming circle, when participants were amenable to this, and reminded the participants that there were four sessions remaining.

**Session 3.** The third session began with the reading of the storybook chapter from the last session so that participants could change whatever was inaccurate about the transcription. The topic for this session was “The experience of the day of the funeral.” Participants drew what they were doing on the day of the funeral while listening to their choice of Eric Clapton’s performance of “Tears in Heaven” (Clapton & Jennings, 1992, track 4), Elton John’s performance of “Daniel” (John & Taupin, 1972, track 4), and/or Mariah Carey’s performance of “Never Forget You” (Carey & Babyface, 1993, track 6). The researcher selected these songs because of their focus on the loss of a family member or significant other. During and following this activity, participants discussed what it was like for them at that time. A particular concern for the therapist during this session was that the family needed to take the lead in the discussion to promote full disclosure of the family’s unique cultural experience of the death and funeral. The therapist normalized emotions and developmentally appropriate behavior presented and focused the discussion on information for use in the second chapter of the family’s grief storybook, entitled “The Day of the Funeral.” When participants had difficulty expressing thoughts or feelings, the therapist encouraged them to play these thoughts or feelings and reflected emotions inferred from the playing to facilitate further sharing. The therapist requested that participants bring music (i.e., compact discs or audiotapes), pictures, or any other items that reminded them of the deceased to the next session. End-of-session activity involved a drumming circle, when participants were amenable to this, followed by the therapist reminding participants that there were three sessions remaining.

**Session 4.** As with the third session, the fourth session began with the reading of the storybook chapter from the last session to allow for participant amendments. The topic for discussion during this session was “Memories of the deceased parent.” When family members brought music, the session began with drawing to this music and a discussion of the memories it evoked. Otherwise, drawing occurred while listening to participants’ choice of Luther Vandross’ performance of “Dance with my Father” (Vandross & Mark, 2003, track 7), Nancy Griffith’s performance of “Goodnight to a Mother’s Dreams” (Griffith, 1994, track 14), Jim Croce’s performance of “Photographs and Memories” (Croce, 1972, track 3), and/or Nancy Day’s
performance of “Photograph” (Day, 2002, track 2). The researcher selected these songs because of their focus on remembrances of loved ones. Family members shared about the items they brought to the session, and the therapist encouraged discussion of the memories triggered by these pictures. The therapist also focused the discussion on information for use in the third chapter of the family’s grief storybook, entitled “Memories.” When participants had difficulty expressing thoughts or feelings, the therapist encouraged them to play these thoughts or feelings and reflected emotions inferred from the playing to facilitate further sharing. End-of-session activities involved a drumming circle, when participants were amenable to this, followed by the therapist reminding participants that there were two sessions remaining.

**Session 5.** As with the previous two sessions, the fifth session started with the reading of the storybook chapter from the last session. The new session topic was “The family as it is now.” Participants drew a picture of their family as they see it now while listening to their choice of Des’ree’s performance of “You Gotta Be” (Des’ree & Ingram, 1994, track 1), James Taylor’s performance of “Secret of Life” (Taylor, 1977, track 6), Mary Carpenter’s performance of “Why Walk When You Can Fly” (Carpenter, 1994, track 1), and/or Gloria Estefan’s performance of “Abriendo Puertas (Opening Doors)” (Santander, 1995a, track 1) or “Mas Allas (Beyond)” (Santander, 1995b, track 3). The researcher selected these songs because of their focus on positive outcomes. During and following this activity, participants discussed what life is like in the family now and how they want to incorporate the deceased into their daily lives. The therapist normalized emotions and developmentally appropriate behavior presented and focused the discussion on information for use in the fourth chapter of the family’s grief storybook, entitled “Our Family Now.” When participants had difficulty expressing thoughts or feelings, the therapist encouraged them to “play” these thoughts or feelings and reflected emotions inferred from the playing to facilitate further sharing. End-of-session activities involved a drumming circle, when participants were amenable to this, followed by the therapist reminding participants that there was one session remaining. The therapist also discussed whether the family wanted to have refreshments at the next meeting as part of the celebration of graduating from therapy.

**Session 6.** After reviewing the chapter from the previous session to make any necessary changes, the sixth session proceeded with the review of the complete story, with pictures in place when the family wanted to include these pictures. The therapist processed participants’ thoughts and feelings about ending sessions, facilitated discussion of what participants learned during the
sessions, and discussed participants’ future plans (i.e., whether to continue therapy at the referring agency, how to handle expected and unexpected setbacks). As part of this processing, the therapist normalized the experiencing of different emotions (i.e., happiness, sadness, anger) whenever a relationship ends, including therapy. Participants were given the opportunity to play drum-circle style to celebrate their new family. Drum circles often begin with one person (in this case, the therapist) playing a drum to set a basic beat, followed by other members playing their drums with their chosen rhythms. As with the other family playing activity, the therapist matched or complemented family members’ playing after the initial beat had been set. In addition, the therapist stopped playing when the family appeared to have their “song” in motion to allow them to experience the activity as a family.

Posttest

Posttest data were collected following the final intervention session. Participant parents and adolescents completed the FAD, and the participant child completed the CAFF.

Data Analyses

Change scores (i.e., \( \Delta \)Pretest = Pretest2 - Pretest1, \( \Delta \)Intervention = Posttest - Pretest2) were calculated for each participant on the seven FAD scales and the CAFF. Sample size was too small to conduct a test of statistical significance on either of these measures. Therefore, the researcher presented the data as raw score differences and percentages of improvement or worsening occurring during the intervention phase, as compared to the baseline (i.e., \( \frac{|\Delta \text{Intervention}|}{[|\Delta \text{Pretest}| + |\Delta \text{Intervention}|] \times 100} \)). Visual comparison of each participant’s raw FAD pretest and posttest scores to the established cutoff scores for clinical (i.e., moderately to severely unhealthy) versus nonclinical (i.e., healthy) populations was the measure of clinical significance for these scores. The CAFF has no established cutoff scores.

Baseline and postsession data points (i.e., parent-report, child-report, therapist-report) were analyzed graphically to determine if, and at what point, change occurred following application of the intervention. Although participants completed six postsession questionnaires, the researcher did not include the responses that followed the first session in the data analysis for the sake of clarity. These data reflected participants’ experiences during the week prior to the
intervention, which were more clearly delineated by the daily baseline data and were not reflective of post-intervention experiencing. Data overlap in the differing time periods (i.e., daily baseline and weekly postsession) would only add confusion to the presentation of the data; therefore, these data were omitted to allow for a reasonable analysis of the results. The addition of a celeration line, calculated through regression analysis, provided additional descriptive data. The X-moving range-chart (X-mR-chart, also known as the three-standard-deviation-band approach) allowed determination of statistical significance (i.e., \( \alpha = .0027 \), two-tailed test) for each participant (Bloom et al., 2003). Because of the rigorous nature of this test and unique way of calculating standard deviation (i.e., using the ranges between baseline points rather than the mean of these points), Bloom et al. proposed that this method is a valid measure of statistical significance even when there is autocorrelation evident in the data. The researcher used SingWin32 (Auerbach, Schnall, & Laporte, 2003), a software application created to analyze single-subject-design data, to facilitate these analyses and Microsoft Excel 2003, illustrations in Watson and Workman (1981), and a procedure outlined by Carr and Burkholder (1998) to create the multiple baseline graphs. In addition, the researcher used the \( g \)-index to calculate effect sizes for each participant, a recommended procedure for data that reflect a trend, and calculated an average effect size for all participants (Bloom et al., 2003). The sample size was too small to calculate a test of statistical reliability across participants. Participant family feedback during postsession interviews provided the measure of clinical significance.

The researcher conducted an ethnographic content analysis (Newfield, Sells, Smith, Newfield, & Newfield, 1996) of the answers to the open-ended questions with the aid of QDA Miner 1.1/WordStat 4.0 (2004). QDA Miner is software that facilitates qualitative data analysis, and WordStat is an add-on module that facilitates content analysis of data entered into the QDA database. The ethnographic portion of this analysis involved a constant comparative analysis, from which came specific codes for use in the content analysis (Newfield et al., 1996). Content analysis results took the form of frequency counts for codes derived from the original qualitative data. Using QDA Miner 1.1/WordStat 4.0 (2004), the researcher also calculated chi-square statistics on the results to identify statistically significant differences among sessions, family roles of reporters (i.e., parent, older daughter, younger daughter), and families.
CHAPTER 4
RESULTS

Introduction

This chapter contains an outline of the data analysis results conducted to answer the research question, “Will families with children dealing with the death of a parent improve their ability to function as a family as a result of having participated in a family narrative/music therapy intervention?” The independent variable for this study was the family narrative/music therapy intervention (FNMT), and the dependent variables were the various measures of family functioning. There will be a presentation of the results of the hypothesis testing, followed by the results of the ethnographic content analysis of the responses to the postsession, open-ended questions.

Research Hypothesis Testing

Hypothesis 1

The first hypothesis was that family functioning would improve from pretest to posttest as measured by parental Family Assessment Device (FAD) scores. Analysis of the FAD scores involved calculating mean responses separately for parents and adolescents for each administration of the instrument (i.e., Pretest 1, Pretest 2, Posttest). Difference scores provided information regarding change during the two phases (i.e., baseline, treatment), and these data formed the basis for the calculation of the percentage of total change that occurred during the treatment phase. Lower FAD scores indicate healthier functioning.

The trend evident in the mean parental responses to the FAD indicates support for Hypothesis 1 (see Table 1). There was improvement in the mean scores for parental perception
of overall family functioning (i.e., General Functioning scale), problem-solving ability, communication, and affective responsiveness. Percentages of improvement for overall family functioning and affective responsiveness that occurred during the treatment phase were 62% and 80%, respectively. Additionally, the parents’ mean communication scores showed no change during baseline and improvement during the treatment phase, and their mean problem-solving scores worsened during baseline and improved during the treatment phase, with 68% of that change occurring in the latter phase. There were also some results that did not provide support for Hypothesis 1, though. Mean affective involvement scores indicated a worsening in this factor during the treatment phase after improvement during baseline, and mean roles and behavior control scores showed trends of improvement that started during baseline, with less than half of the change occurring during the treatment phase. Positive clinical significance (i.e., lower scores), as indicated by preset cutoff scores, was evident in the mean parental rating of problem-solving, affective responsiveness, and behavior control, although 61% of the change that occurred in the latter was during baseline. However, the change in the mean affective

| Table 1 |
| Mean Parental Family Assessment Device Scores<sup>a</sup> |
| --- | --- | --- | --- | --- | --- | --- |
| PS | CM | RL | AR | AI | BC | GF |
| Pretest 1 | 2.17(0.24) | 2.28(0.08) | 2.55(0) | 2.42(0.12) | 2.43(0.40) | 2.33(0.31) | 2.17(0.12) |
| Pretest 2 | 2.25(0.35) | 2.28(0.08) | 2.45(0) | 2.33(0.47) | 2.29(0.20) | 2.17(0.24) | 2.08(0.35) |
| Posttest | 2.08(0.12) | 2.11(0.16) | 2.41(0.06) | 2.00(0.47) | 2.43(0.61) | 2.06(0.24) | 1.96(0.06) |

<sup>a</sup>Pretest = change during baseline = Pretest2 - Pretest1. <sup>b</sup>Δ = change during treatment phase = Posttest - Pretest2. <sup>c</sup>%Tx = percentage of total change that occurred during treatment phase = (|Δx| / |Δx| + |Δx|) x 100.

Notes. Lower scores indicate healthier functioning. Values enclosed in parentheses represent sample standard deviations. PS = problem-solving scale; CM = communications scale; RL = roles scale; AR = affective responsiveness scale; AI = affective involvement scale; BC = behavior control scale; GF = general functioning scale. Subscripts indicate the following clinically significant changes during specified phases: a = moderately unhealthy to healthy, b = severely unhealthy to moderately unhealthy, c = moderately unhealthy to severely unhealthy. n = 2.
involvement score, though clinically significant in a positive direction during the baseline, was clinically significant in a negative direction (i.e., higher scores) during the treatment phase. In addition, there was no clinical significance in the change of the general functioning or communication scores. Therefore, even though there is some support Hypothesis 1, mixed results of the changes in subscale scores and lack of clinical significance in general functioning prevents a strong statement to this effect.

**Hypothesis 2**

Mean adolescent responses to the FAD also provided some support for Hypothesis 2, that family functioning would improve from pretest to posttest as measured by adolescent FAD scores (see Table 2). As with the mean parental scores, the adolescents’ perception of overall family functioning and communication was that of improvement, with the majority of the change occurring during the treatment phase (i.e., 58% and 61%, respectively). Unlike the mean parental response, adolescents rated problem-solving and affective responsiveness as worsening during the treatment phase. Even so, adolescents perceived improvement in roles and affective

| Table 2  |
|------------------|-------|-------|-------|-------|-------|-------|-------|
|               | PS    | CM    | RL    | AR    | AI    | BC    | GF    |
| Pretest 1     | 2.22(0.19) | 2.15(0.34) | 2.24(0.14) | 2.00(0.17) | 1.90(0.58) | 2.07(0.17) | 1.78(0.25) |
| Pretest 2     | 2.06(0.25) | 2.07(0.17) | 2.27(0.24) | 1.83(0.33) | 1.95(0.08) | 1.89(0.22) | 1.86(0.32) |
| Posttest      | 2.11(0.10) | 1.96(0.17) | 2.12(0.37) | 1.86(0.05) | 1.81(0.59) | 1.81(0.42) | 1.75(0.43) |
| \(\Delta\)Pretest\(^{b}\) | -0.17\(_{a}\) | -0.07\(_{a}\) | 0.03 | -0.17\(_{a}\) | 0.05 | -0.19 | 0.08\(_{b}\) |
| \(\Delta\)Tx\(^{c}\) | 0.06\(_{b}\) | -0.11 | -0.15 | 0.03 | -0.14 | -0.07 | -0.11\(_{a}\) |
| \(\%\)Tx\(^{d}\) | 26% | 61% | 83% | 15% | 74% | 27% | 58% |

*Notes. Lower scores indicate healthier functioning. Values enclosed in parentheses represent sample standard deviations. PS = problem-solving scale; CM = communications scale; RL = roles scale; AR = affective responsiveness scale; AI = affective involvement scale; BC = behavior control scale; GF = general functioning scale. Subscripts indicate the following clinically significant changes during specified phases: \(a\) = moderately unhealthy to healthy, \(b\) = healthy to moderately unhealthy.*

\(^{a}n = 3, \Delta\)Pretest = change during baseline = Pretest2 - Pretest1. \(^{c}\)\(\Delta\)Tx = change during treatment phase = Posttest - Pretest2. \(^{d}\)%\(\)Tx = percentage of total change that occurred during treatment phase = (\(|\Delta\)Tx| / (\(|\Delta\)Pretest| + |\(\Delta\)Tx|)) x 100.
involvement, with a high percentage of the improvement occurring during the treatment phase. The only mean score indicating positive clinical significance from pretest to posttest was that of overall family functioning. A positive clinically significant change in communication and affective responsiveness scores occurred during baseline, and the changes in problem-solving scores went from positive clinical significance during baseline to negative clinical significance during the treatment phase. These mixed results from the adolescent FAD provide only weak support for Hypothesis 2. However, the combination of improved scores and clinically significant change in overall family functioning strengthens this stance somewhat.

**Hypothesis 3**

The third hypothesis was that family functioning would improve from pretest to posttest as measured by the Children’s Assessment of Family Functioning (CAFF). Scores for the one child who completed the CAFF showed little change during baseline (Pretest1 = 2.86; Pretest2 = 3.0) and no change during the treatment phase (Posttest = 3.0). In the second pretest, this participant rated her family at the maximum score possible for this instrument, a score that was maintained at posttest. Therefore, there is no support for Hypothesis 3.

**Hypotheses 4 & 5**

The fourth and fifth hypotheses stated that self-reported parent-child conflict would decrease and self-reported parental nurturance would increase, respectively, following the application of FNMT as measured by baseline and postsession parent, adolescent, and child responses to the self-rating questionnaires. X-moving range-chart (X-mR-charts, or the three-standard-deviation-band approach) analyses, as calculated by the SingWin32 software (Auerbach et al., 2003), provided the basis for determining statistical significance (i.e., $\alpha = .027$, two-tailed test) for each participant (Bloom et al., 2003). According to the X-mR-chart analyses, the only statistically significant improvement in family functioning as measured by the self-rating scales was parental nurturance as rated by Family 1’s younger daughter. Most of the other scores showed no significant change from baseline to treatment, with the notable exception of a statistically significant increase in parent-child conflict and decrease in parental nurturance from the perspective of Family 1’s older daughter. The lack of statistically significant improvement across participants following application of the intervention seems to indicate no support for
Hypotheses 4 or 5.

As suggested by Bloom et al. (2003), however, the X-mR-chart results were weighed against other analyses because of the existence of trend data in this study and the very real possibility that an actual effect would not be revealed by this test (i.e., Type II error) because of its rigor. Visual analysis of the nonconcurrent multiple baseline graphic data and calculation of an overall g-index effect size for each parameter were the alternate analyses used for these data.

Cohen (1969) identified three approximate levels of effect size (i.e., .2 = small, .5 = medium, .8 = large) and stated that the sign of the calculated effect size indicates the direction of change when testing a directional hypothesis. This interpretation of the directionality of change is different for the g-index in that this formula takes into account that improvement of scores may be reflected in either a positive or negative direction. In these analyses, therefore, all positive effect sizes are considered improvements and all negative effect sizes are considered deteriorations.

**Hypothesis 4 (Revisited)**

Visual examination of the parent-child conflict graphs revealed a different picture from that provided by the X-mR-charts (see Figures 1 and 2). Apparently, both parents and Family 1’s younger daughter perceived a sudden drop in parent-child conflict during the week following the first intervention session (Week 2). This effect was delayed in the scores of Family 2’s older daughter, which showed a decreasing trend following the second treatment session (Week 3; see Figure 2). Family 2’s younger daughter perceived a floor effect during baseline, which was maintained through the treatment phase. Only Family 1’s older daughter perceived a sustained worsening in parent-child conflict during the treatment phase. Average effect size for all participants was 0.28, which indicates there was a small positive effect of the intervention on parent-child conflict. These data provide some support for Hypothesis 4.

**Hypothesis 5 (Revisited)**

The picture for parental nurturance (i.e., level of comfort with emotional expressiveness [EE] and death communication [DC] among family members) is not as clear or as positive as that of conflict (see Figures 3 through 6). As with parent-child conflict, both parents reported an increase in both parameters during baseline followed by a decrease the week following the first
treatment session (Week 2; see Figures 3 and 4). During the treatment phase, then, one parent’s scores showed a slightly negative trend and the second parent’s scores showed a positive trend.

The daughters’ perceptions of these parameters were even more mixed (see Figures 5 and 6). Family 1’s older daughter and Family 2’s younger daughter reported a slight decrease in both EE and DC during the week after the first treatment session (Week 2). While the former’s scores continued on this decreasing trend, the latter’s scores gradually rose, with her EE score almost returning to the highest baseline level. Family 1’s younger daughter perceived DC at the highest level possible halfway through the baseline phase and maintained this ceiling effect through the treatment phase. Her EE scores rose gradually through the baseline and treatment. Finally, Family 2’s older daughter perceived a sharp decrease in EE and DC during baseline, followed by a slight increase the week following the first session (Week 2) that was sustained for EE and
Figure 2 Daughters’ perceptions of parent-child conflict in a nonconcurrent multiple baseline graph.
increased for DC during the treatment phase. Although this daughter’s scores showed obvious improvement during the treatment phase, the other daughters’ scores did not indicate any connection between treatment and improvement and even suggested that at least one person (Family 1’s older daughter) actually perceived a worsening of parental nurturance during the treatment phase, especially for communication about death and the deceased (see Figure 6).

The average effect sizes for EE and DC scores of all participants were -0.31 and -0.42, respectively, which further supports the graphic analyses. As a result, there is no conclusive evidence to support Hypothesis 5, that parental nurturance would improve following application of the intervention.

**Hypothesis 6**

The sixth hypothesis was that family functioning would improve from pretest to post-
Figure 4 Parents’ comfort levels with communicating about death and the deceased with their children in a nonconcurrent multiple baseline graph.

intervention as measured by therapist behavioral/interactional observations. Analysis of the behavioral checklists completed by the therapist at the end of each session involved graphing the different interactional patterns observed in the family during treatment sessions. Conflict was measured on two dimensions: level of parental openness to discussing conflictual topics with children and level of collaboration parent used in resolving disagreements. Indications of healthy functioning involved high scores (i.e., approaching 10) on the first dimension and moderate scores (i.e., close to 0) on the second dimension. Parental nurturance was measured on three basic dimensions: level of emotional responsiveness (i.e., empathy) to children’s feelings and statements; level of self-differentiation (i.e., balance between physical closeness and separateness of family members); and overall emotional expressiveness of parents and children. Indications of healthy functioning involved high scores (i.e., approaching 10) on the responsiveness dimension and moderate scores (i.e., close to 0) on the other two dimensions.
Figure 5 Daughters’ comfort level with expressing a full range of emotions with parent in a nonconcurrent multiple baseline graph.
Figure 6 Daughters’ comfort levels with discussing death and the deceased with parent in a nonconcurrent multiple baseline graph.
According to the behavioral observations, the parents’ ways of expressing conflict was primarily open and collaborative (see Figures 7 and 8, respectively). Some notable exceptions were when Parent 1 would not discuss a conflictual matter brought up during the first session and when both parents exhibited tension during disagreements with their children in the fifth session, as evidenced by strained voice tone (see Figure 7). There was little variation in the parents’ ability to remain nonblaming during disagreements (see Figure 8). The former exception seems to support the self-rated parent-child conflict scores as reported by the older daughter in Family 1 (see Figure 2), and the latter exception seems to support the self-rated parent-child conflict scores as reported by the parent in Family 1 (see Figure 1). Even so, these data do not provide any support for Hypothesis 6 because both parents were already functioning at optimal levels on these dimensions prior to application of the intervention.

Parental nurturance behaviors were reflected in observations of the parents’ emotional responsiveness and physical closeness or distance to children and family members’ level of emotional expressiveness during sessions. Both parents exhibited a high level of emotional responsiveness through most of the sessions (see Figure 9). As can be seen by this graph, there was an initial decrease in empathetic responding during the first session and a steady increase of these behaviors as the sessions progressed, with the exception of a decrease in Parent 1’s

**Figure 7** Parental style of expressing conflict (i.e., disagreement) with children during sessions as a function of affect, voice tone, and body language: 0 = dismissive, 5 = restrained, 10 = open

**Figure 8** Parental style of handling conflict (i.e., disagreement) with children during sessions as a function of affect, voice tone, body language, and verbalizations: -5 = other-blaming, 0 = collaborative, +5 = self-blaming

61
responsiveness in the last session. Even with this improvement, however, the final measure of empathetic responding did not reach the initial, pretest level. On the other hand, observations of the families’ levels of differentiation indicated positive relatedness in both families (i.e., scores ≈ 0) at pretest and during the treatment phase (see Figure 10). Therefore, the intervention had no effect on this parameter. The third element used to measure parental nurturance – observed emotional expressiveness during sessions – showed improvement (i.e., became more moderate) in all family members during the treatment phase, albeit in different patterns that apparently depended on their roles in the family (see Figures 11 through 13). Both parents gradually increased their emotional expressiveness from a minimal level, with Parent 2 showing this improvement after a slight delay (see Figure 11). After an initial convergence of the two older daughters’ diametrically opposite levels of emotional expressiveness from pretest to Session 1, the patterns of change in their expressiveness were approximately parallel during the treatment phase (see Figure 12). Their pattern of change was more variable than the parents’, but their expressiveness stayed relatively close to the moderate level, as well. Finally, the two younger daughters, who showed the same initial pattern of change from pretest to Session 1 as the older

![Figure 9](image1.png) **Figure 9** Parent emotional responsiveness (i.e., empathy) to child during sessions as a function of nonverbal, paraverbal, and verbal behaviors: 0 = denigrating, 5 = neutral, 10 = empathetic

![Figure 10](image2.png) **Figure 10** Family level of self-differentiation as a function of physical closeness or distance from each other for 90% of session: -5 = fused, 0 = balanced, +5 = cut off
daughters, showed even more variability than the older daughters and their patterns of change mirrored each other, rather than running in parallel (see Figure 13). Even so, neither reached the same level of effusiveness or minimal expression during treatment as they exhibited during pretest. Based on all these data, it appears that there is only partial support for Hypothesis 6.

**Figure 11** Parental overall emotional expressiveness during sessions: -5 = minimal, 0 = moderate, +5 = effusive

**Figure 12** Older daughters’ (age 17) emotional expressiveness during sessions: -5 = minimal, 0 = moderate, +5 = effusive

**Figure 13** Younger daughters’ (ages 8 and 14, respectively) emotional expressiveness during sessions: -5 = minimal, 0 = moderate, +5 = effusive
Ethnographic Content Analyses of Open-Ended Postsession Questions

Reaction to Session Activity

With intervention research, it is helpful to identify participants’ reactions to the activities employed in the intervention to be sure these activities are not aversive to the participants and to determine whether the activities actually promoted the therapeutic goal of the intervention. Responses to Question 1 in the postsession interviews (“What was it like for you doing the activity during the session?) provided this feedback. According to the results of the ethnographic content analysis of the responses to this question, participants consistently regarded session activities as being therapeutic or invoking responses expected to facilitate the therapeutic process throughout the six sessions (see Table 3). Chi-square analyses showed no statistical significance among sessions for the number of responses identifying therapeutic ($p = .302$) or facilitative ($p = .261$) aspects of session activities. This consistency existed across participant families, as well (see Table 3). Elements of activities considered to be therapeutic included those that promoted comfort with the therapeutic process or memory recall, stress reduction, positive connection to

Table 3
Categories of Responses to Postsession Open-Ended Question #1: What Session Activity Like for Participant

<table>
<thead>
<tr>
<th></th>
<th>Session 1</th>
<th>Session 2</th>
<th>Session 3</th>
<th>Session 4</th>
<th>Session 5</th>
<th>Session 6</th>
<th>$\chi^2$</th>
<th>$p$</th>
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</table>

$\chi^2 = 7.20, p = .302$ for Therapeutic

$\chi^2 = 7.69, p = .261$ for Facilitative of Therapeutic Process

$\chi^2 = 5.00, p = .544$ for Nontherapeutic
the deceased, emotional connection between family members, emotional expression, self-expression, open communication, learning of coping skills, self-reflection, and positive outlook on the upcoming day. Facilitative factors included those that invoked an emotional reaction or memories of the deceased.

**Changes in Family Interactions and Behaviors**

Questions 2 and 3 in the postsession interviews addressed any changes participants noticed in family interactions and behaviors at home the week prior to each session. The only statistically significant result in the chi-square analyses of the categories derived from family members’ answers to these questions was for “more nurturance” (see Table 4). Closer analysis of these data showed that Family 2 disclosed an increase in evidence of nurturance, including emotional expressiveness in front of the parent, empathy and respect for personal space on the part of all family members, and parental support of children’s activities. These data seem to contradict the results of the self-rating scales (Figures 3 and 4) and support the results of the therapist behavioral observation (see Figures 11 through 13). However, there was no discussion in Family 1 interviews about change in these nurturance indicators. This inconsistency between families decreases confidence in the intervention as a factor in these changes.

Another indicator of parental nurturance is the level of open communication among family members. Although the data on open communication did not show any statistically significant change across sessions, there was a trend indicating a gradual increase in open communication from pretest to post-intervention. Participants reported an initial increase during the week following the first session, an increase that was sustained in Family 1 (see Table 4). After the initial surge, Family 2 members reported decreasing numbers of instances where open communication occurred for two weeks, followed by a gradual increase to a level higher than the initial pretest count. Behaviors counted as indicating open communication included discussions about the deceased, open sharing between family members, and self-assertiveness with other family members or peers.

Conflict and other behaviors also showed no significant change across sessions, but there were some trends of possible interest. Reports of lower conflict in the family increased across the six weeks of the intervention (see Table 4). Indicators of lower conflict were statements regarding a decrease in angry interactions or an increase in family closeness, positive or calm
Table 4
Categories of Responses to Postsession Questions 2 & 3: Changes in Family Interactions and Behaviors Since Last Session

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<th>#3</th>
<th>#4</th>
<th>#5</th>
<th>#6</th>
<th>$\chi^2$</th>
<th>$p$</th>
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</tr>
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</table>

*p < .05, two-tailed.

interactions, and child compliance. Discussions about more conflict in the family varied greatly depending on the session and the family (see Table 4). While Family 1 appears to have
experienced a steady increase in conflict during the study, Family 2 only occasionally talked about experiencing heightened conflict. Categories reflecting conflict were angry behavior or interaction, defiance of parent, and parent-child or sibling conflict. There was some reporting of other troubling behaviors, such as depression, worrying, and procrastination, but again these data showed a different pattern for each family (see Table 4). The data show a trend of increased troubling behaviors in Family 2 during the last two weeks of the intervention.

During the postsession interviews, family members also discussed aspects of their behavior that were more directly related to their grief responses. Worden’s (2002) four tasks of mourning provided the framework for discussing these answers (see Table 5). While participants made some pre-Task 1 statements about children not being able to accept the loss of the parent and family members experiencing emotional reactivity to events or objects that reminded them of the deceased during Interviews 4 and 5, they also made Task 1 statements that indicated an emotional acceptance that the loss had occurred and Task 4 statements that indicated movement toward living life fully in the present while maintaining a connection to the deceased beginning as early as Interview 2. There was little discussion of accepting the expression of a full range of emotions, which is considered Task 2 in the mourning process, but there was a statistically significant increase in discussion about adjusting to a world without the deceased (i.e., Task 3) during the third and fourth interviews. Task 3 comments reflected such topics as absence of emotional reactivity to previous triggers, readjustment of roles to compensate for absence of the deceased, and reduced preoccupation with belongings of the deceased. Statements categorized as Task 4 included such topics as actively participating in current events, moving on with life, and thinking or dreaming about the deceased without becoming emotionally reactive.

**Summary of Data Analyses**

These data show mixed results regarding FNMT’s effectiveness in improving family functioning as defined in this study. There was no support for Hypotheses 3 and 5 (child report via CAFF and family report of parental nurturance via self-rating scales, respectively), weak support for Hypotheses 1, 2, and 4 (adult report via FAD scores, adolescent report via FAD scores, and family report of parent-child conflict via self-rating scales, respectively), and partial support for Hypothesis 6 (therapist report via behavioral observation checklist). In postsession
Table 5  
*Categories of Responses to Postsession Questions Related to Grief Response as a Function of Worden’s (2002) Tasks of Mourning*

<table>
<thead>
<tr>
<th>Session</th>
<th>#1</th>
<th>#2</th>
<th>#3</th>
<th>#4</th>
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<th>#6</th>
<th>$\chi^2$</th>
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<td></td>
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</tr>
</tbody>
</table>

* $p < .05$, two-tailed.

Interviews, Family 1 reported a steady increase in conflictual interactions and both families reported an increase in troubling behaviors, such as depression and worrying, which adds to the uncertainty of the usefulness of this intervention. However, analysis of the postsession open-ended questions also showed participants in Family 2 reporting significantly more nurturing behaviors and both families reporting trends of more open communication, more instances of low-conflict interactions, and evidence of progress with the tasks of mourning. As a result, the overall picture of these results shows a combination of improvement and deterioration in family functioning from pretest to posttest. Further discussion of the possible meanings for these results will be addressed in the next chapter.
CHAPTER 5
DISCUSSION

Introduction

The previous chapter included an outline of the data analysis results as they relate to the different research hypotheses. From these data, it appears that there is some support for the overall thesis that families grieving the loss of a parent will experience improvement in some aspects of family functioning while participating in the family narrative/music therapy (FNMT) intervention. This chapter will address possible meanings and alternative explanations for these results. Other topics discussed are the limitations of this study, recommendations for future research, and implications for practice.

Interpretation of Results

This research project included several measures of family functioning, and the analyses of these different measures showed a mixed picture of how participant families responded to the intervention. These different results appeared to depend on which instrument and which reporter was being analyzed.

Overall Family Functioning

*Family Assessment Device (FAD).* Scores from the primary standardized instrument showed the most consistent report of improvement in overall family functioning (see Tables 1 and 2). Some researchers (Kabacoff et al., 1990; Ridenour et al., 1999) have found that the general functioning scale from this instrument serves as an adequate measure of overall family functioning due to its high internal consistency and construct validity. Therefore, scores from
this scale formed the primary basis for testing Hypotheses 1 and 2 in this study, with results from the other scales used for more detailed analysis.

Both the parents and the adolescent daughters scored their families as better in general functioning at posttest than at either pretest. This improvement reached positive clinical significance for the mean adolescent score. On closer examination, it was apparent that parents reported improvement even during baseline and that adolescents reported deterioration during baseline and improvement during the treatment phase. As a result, the improvement in functioning reported by the adolescents provides greater support for the idea that the intervention contributed to this improvement than was evident from the parents’ mean score, even though the adolescents’ mean posttest score was just slightly lower than the mean score for the first pretest.

Of the other FAD scales, the three that were most relevant to this study are communication, roles, and affective responsiveness since FNMT was designed primarily to address blocks to communication about death and the deceased, parental nurturance, and emotional expressiveness in the family, respectively. The communication scale was also relevant because it measures overall parent-child interactions, and another goal of FNMT was to increase the parents’ knowledge of developmentally appropriate responses children may have to grief so that their understanding may translate into less parent-child conflict. Both the parents and the adolescent daughters indicated that their families scored better in communication and roles at posttest than at either pretest (see Tables 1 and 2). Parents also rated affective responsiveness as better after having completed the intervention than beforehand, but the daughters indicated a slight worsening of affective responsiveness after a positive clinically significant change during baseline. Most of the change in these scales started during baseline and continued during the treatment phase, with the exceptions of parent-report of communication, which showed no change during baseline, and adolescent-report of roles, which showed deterioration during baseline and improvement during the treatment phase. The only improvement to reach positive clinical significance during the treatment phase was parent-report of affective responsiveness, but parents also reported a clinically significant improvement in affective responsiveness during baseline.

With the possible exception of the adolescents’ perception of their families’ overall functioning, it appears that these two families began much of their change, as measured by the FAD, without any direct assistance from a therapeutic intervention. One possible explanation for
this seemingly spontaneous change may be a function of testing. Having taken a pretest prior to and repeated measures (i.e., self-rating scales) during baseline, family members likely were sensitized to the issues being addressed in the study. This knowledge may have started the change process even before they had a chance to participate in the intervention. It is also possible that these families were already in the process of making positive change in their families even before completing the first pretest. If this were the case, the measures taken during baseline and after the treatment phase only reflected their continuing growth.

*Children’s Assessment of Family Functioning (CAFF).* When viewing the results of the other standardized test, the participant child seemed to already see her family as functioning at the highest level available for this instrument during baseline. Because of this ceiling effect, there was no way to measure if, in fact, any improvement occurred during the treatment phase. A more sensitive measure of family functioning might have helped in understanding the effect of the intervention. Another factor likely to have influenced this child’s scores is that she was in the concrete operational stage of development (Piaget & Inhelder, 1966/1969) when her father died and when she participated in the study. Children in this stage have a tendency to view or report family functioning in a more positive, even idealistic, light than older children or adults might due to their more egocentric processing of the environment (Piaget, 1959) and the need to see their families as having no problems to protect against their own fears about their surviving parent not being available to them (Shapiro, 1994; Worden, 1996).

**Individual Perception of Change in Family Functioning Dimensions**

X-moving range-chart (X-mR-chart) analyses pinpointed statistical significance for individual participants’ perception of change in the family as reported in the postsession self-rating scales. According to these analyses, FNMT only produced a statistically significant positive change in one participant’s perception of parental nurturance (Family 1’s younger daughter). Of particular interest is that this person was the same child that rated her family as functioning at a high level according to the CAFF. This consistency across measures provides some support for the idea that this child did, in fact, experience an unchangingly high level of this phenomenon with the family. The only other statistically significant change measured by the self-rating scales was an increase in parent-child conflict and a decrease in parental nurturance from the perspective of this child’s older sister, who was firmly established in the formal
operational stage of development (Piaget & Inhelder, 1966/1969) at the time of her father’s death and her participation in this study. As a result of her level of development, this participant’s perceptions of worsened conflict and nurturance may have been at least partially driven by the struggle between her ability to understand the abstract concept of death, along with the distressing thoughts and emotions associated with this understanding, and her need to feel independent from the very person on whom she had to rely for emotional support (Erikson, 1963; Nolen-Hoeksema & Larson, 1999; Piaget & Inhelder, 1966/1969). Although not statistically significant, the parent in this family also reported a decrease in parental nurturance during treatment as compared to baseline. These results show the differing perspectives among members in the same family, with the parent and older daughter apparently perceiving fewer nurturing behaviors than the younger daughter. This stark contrast in perception seems to support the above-mentioned thesis regarding the young child’s need to not see or report problems in family interactions.

As discussed in previous chapters, the X-mR-chart analysis is extremely rigorous and, therefore, prone to Type II errors (i.e., not detecting a change that actually occurred). The discussion for the other analyses conducted to identify other possible changes in the family will be separated into the parent-child conflict and parental nurturance dimensions.

**Parent-Child Conflict**

*Self-rating scales.* Graphic analyses of the self-rating scale scores showed a decrease in parent-child conflict as reported by both parents and younger daughters and the older daughter in Family 2 (see Figures 1 and 2). This decrease occurred during the week following the first intervention for all but the younger daughter in Family 2, who rated conflict at the minimum possible during baseline and maintained this floor effect throughout the treatment phase. In looking at the scores for the older daughter in Family 1, it is apparent that she was experiencing minimal conflict through most of the baseline, as well, which was followed by an increase during the week following the first session and a gradual decrease throughout the remainder of the treatment phase. It would appear that, overall, participating in this intervention did, in fact, have a positive effect on parent-child conflict with these two families. Although this effect was strongest from the parents’ perspectives, as evidenced by both parents experiencing a sense of less conflict during the treatment phase, only one daughter experienced a consistently higher
level of conflict during the treatment phase, and even her scores showed a slight deceleration as treatment progressed.

**Open-ended questionnaires.** One possible explanation for the decrease in conflict experienced by participant families may be the therapeutic nature of the sessions. In postsession interviews, both families consistently reported that they experienced the session activities as therapeutic (see Table 3). These responses included statements about feeling more relaxed or comfortable during and following sessions, more at ease with having memories about the deceased, and more empowered to express difficult emotions and thoughts. Participants also mentioned that the activities helped them understand each other better, think more clearly about their connection with the deceased, understand the meaning for their distressing emotions, and go about their day with a clearer mind. The only response that suggested that the activities were not effective in promoting a therapeutic end was the statement that a participant felt like crying but was not able to do so. Participants also discussed ways that session activities consistently facilitated the therapeutic process (see Table 3), such as invoking emotions that they had difficulty experiencing previously and invoking memories of the deceased. These facilitative factors were not always pleasant for the participants (e.g., invocation of sadness or fear or an unpleasant memory), but the result was that participants were able to process these emotions and memories in a safe environment. Smyth and Pennebaker (1999) posited that putting difficult or traumatic emotional experiences into words, either through speech or writing, reduces a person’s need to exert energy toward avoiding discussion about these issues. The freeing of this energy then reduces the chronic stress reaction inherent in this constraining behavior. From the participants’ comments about this aspect of the intervention, it seems likely that their qualitative experiencing of the intervention was as a reducer of their overall state of tension or conflict in the family.

Participants also responded to direct questions regarding family behavior between sessions that reflected higher and lower levels of parent-child conflict. Although their responses included slightly more discussion about conflictual interactions as the treatment phase progressed, they also discussed an increase in low-conflict interactions in both families (see Table 4). In describing conflictual interactions in the family, participants discussed such topics as sibling conflict, daughters and parents exhibiting angry behavior, and younger daughters exhibiting defiance of parental authority. The report of sibling conflict occurred during the first
postsession interview, which involved behaviors at home prior to application of the intervention. That this behavior was not mentioned in later interviews might be construed as a point of improvement regarding this type of conflict in the family. Angry behaviors exhibited by the adolescents in later sessions could be explained as their initial attempts at coping with the unpleasant feelings evoked by actively working through their grief, rather than pushing it aside (Worden, 2002). Reports of angry behaviors by parents were connected to reports of daughters misbehaving. The anger expressed during these interactions might also have been associated with facing the myriad of feelings related to the loss of the spouse. Of particular interest in one of these instances, however, was the differing perspectives of the two parties involved in the parent-child conflict. Where the parent confessed having to express anger at the daughter, the daughter described the interaction as involving her angry behavior and the parent’s calm approach to the whole incident.

Finally, when considering parents’ reports of younger daughters defying their authority, this behavior, although problematic for the parents at the time, may also reflect positive growth on the part of these children in that they appear to have been more comfortable with stating their minds to their parents – a precursor to open communication between child and parent. Piaget and Inhelder (1966/1969) posited that such behavior heralds the development of autonomy and the thinking that fairness is more important than obedience. Of course, this defiance may also reflect the younger daughters’ attempts to deal with their burgeoning awareness of the pain inherent in facing the loss of a parent or an expression of the tension they were feeling in the family as its members begin to face the unpleasant emotions associated with the loss (Shapiro, 1994). This latter explanation would likely fit the experience of Family 2’s younger daughter, who was transitioning between concrete operational thought at the time of her mother’s death and formal operational thought just prior to participation in this study. As a result, her increased ability to understand the abstract concept of death would also increase her awareness of the pain associated with that loss (Piaget & Inhelder, 1966/1969). Since this behavior began in the fifth session for one family and continued through the sixth session for the other, it is possible that a longer intervention would have been warranted to provide additional support to these families as the younger daughters worked through their grief.

In discussing low-conflict interactions, the younger daughters mentioned such topics as less yelling, more friendliness, fewer arguments and more calmness in the family beginning in
the fourth postsession interview. An older daughter also shared during the sixth postsession interview that she was feeling more at peace at the present time than she had previously. Parents disclosed such phenomena as more positive interactions and closeness in the family as early as the fourth postsession interview. It would appear, therefore, that even though these two families continued to experience family conflict, these less pleasant interactions were increasingly being offset by some more pleasant interactions. Such a change would give the families some positive experiencing to decrease the negative impact of existing conflictual interactions. Gottman (1999) conducted extensive research on marital relations that supports this change as being an important one for the building or maintaining of positive relating in family situations. He found that couples in stable marriages balanced each negative comment with at least five positive comments, on average. Those couples in his study who eventually divorced had a positive-to-negative statement ratio of 0.8 to 1. From these data, it seems that increasing positive relating in a family is likely to provide greater stability for its members, also.

**Therapist behavioral observations.** Finally, parents’ styles of expressing and handling conflict, as observed by the therapist during the sessions, were relatively stable throughout the baseline and treatment phases (see Figures 7 and 8). In fact, conflict was expressed openly and collaboratively, for the most part, from pre-intervention to post-intervention. Parents showed little variation in their ability to remain nonblaming even when they were disagreeing with their children. The only two exceptions noted were one time when a parent would not discuss a conflictual matter in the first session and one time when both parents exhibited some tension (i.e., strained tone of voice) during a disagreement in the fifth session. Even while noting these exceptions, it is important to remember that the first instance occurred before therapeutic rapport could be established and the second instances were minimal, at best. One possible explanation for these positive data may involve a social desirability factor typical in behavior outside the familiarity of the home environment. From the differing perceptions of behaviors considered conflictual mentioned above, it is also possible that the therapist observations were a more objective measure of how parents express and handle conflict in the family. Furthermore, it is possible that their pre-existing high level of functioning in this area precluded any chance of positive change. Whatever the explanation, it is apparent that the intervention had no effect on the observed behaviors related to how these parents handled and expressed disagreement with their children.
**Summary.** From the perspectives of the different client-report measures, the overall picture is that these families did experience some relief from conflictual interactions during the time that they participated in the intervention, whether this relief came from a decrease in actual conflict or an increase in more positive interactions. This positive effect seems to have been most consistent from the parents’ perspectives, but even the daughters reported either almost no conflict (i.e., the younger daughters) or a decreasing trend of conflict (i.e., the older daughters) during the treatment phase.

**Parental Nurturance**

**Self-rating scales.** As with parent-child conflict, graphic analysis of the scores for the parental nurturance factors (i.e., emotional expressiveness and death communication) showed a decrease during the week following the first session for all but the younger daughter in Family 1 and the older daughter in Family 2 (see Figures 3 through 6). An interesting commonality among these scores is that participants who saw parental nurturance as declining during that first week of the treatment phase viewed these parameters as increasing during the baseline, in some cases to the maximum level possible. This was also the case with the scores from Family 1’s younger daughter. The only difference was that her scores attained this ceiling effect during baseline, much as was found in her CAFF scores. The only participant who perceived a change in parental nurturance in the hoped-for pattern was Family 2’s older daughter (see Figures 4 and 6). Even so, Family 2’s parent and younger daughter did perceive a gradual improvement in comfort level both for emotional expressiveness and communication about death and the deceased during the treatment phase.

There does not appear to be enough consistent improvement in the parental nurturance scores across families to attribute the change that occurred to the intervention. It is interesting to note, however, that all participants in Family 2 perceived some positive change in the parental nurturance factors during the treatment phase after the initial decline. Considering how variable perceptions can be, depending on the role a person has in the family (i.e., parent, older daughter, younger daughter) and the differing developmental levels of the children (i.e., advanced formal operations for the older daughter, early formal operations for the younger daughter), this consistency seems to indicate a cohesiveness in this family’s response to the intervention. When looking at the data for Family 1, one possible explanation for the lack of change in comfort with
emotional expressiveness is that these members were already experiencing a high level of comfort in this area (see Figures 3 and 5). It could be that this family had already reached its optimal level of comfort with sharing their emotions openly and had no need for improvement in this area. Similarly, these family members’ comfort level with discussing death or the deceased was relatively high during baseline. For this parameter, however, only the younger daughter maintained this high level of comfort. This lack of death communication may have been due to the existence of anxiety related to the topic of death (Bowen, 1991), especially for the older daughter because of her probable need to avoid seeing death as a personal reality, a tendency of children in the formal operational stage of development (Kandt, 1994; Piaget & Inhelder, 1966/1969).

Open-ended questionnaires. Another possible reason that members of Family 1 expressed less comfort with death communication at home might be found in responses to the postsession questionnaires. According to the ethnographic content analysis of these interviews, the parent in this family appeared to be moving solidly into Worden’s (2002) last task of mourning (see Table 5). She made several comments about moving on with their lives, relocating the position of the deceased to her dream life, and actively participating in current events. Even so, the parent in Family 2 expressed similar thoughts regarding full participation in life events, and his reported level of comfort with discussing the deceased was higher than that of Family 1’s parent.

Despite the lack of support in the quantitative analyses for the thesis that participation in FNMT would improve parental nurturance, chi-square analysis of the ethnographic content analysis category “more nurturance” showed statistical significance (see Table 4). Closer examination revealed that this reported change occurred exclusively in Family 2 during the latter sessions of the intervention. This nurturing behavior took the form of parental support for a daughter with a task she needed to do, displays of empathy within the family, increased allowance of personal space for members to take care of themselves, and more comfort expressing a range of emotions, both verbally and physically (i.e., crying). These disclosures came from all family members, which seems to indicate that this family did experience a qualitative improvement in the parental nurturance dimension.

Although not statistically significant, participant families also discussed many instances of open communication at home the week after they had participated in the first treatment
session, as compared to no discussion relevant to open communication in the first interview (see Table 4). By the third interview, Family 1 members stated that they were better able to talk with each other, in general, and were experiencing more open and balanced communication about the deceased (i.e., less negativity, more positivity). Family 2 members also talked about being able to speak more freely with each other in general and to assert their feelings with family members and peers without fearing negative ramifications beginning the week following the first session. The latter situation is indicative of individual emotional maturity or intelligence (Mayer & Salovey, 1997), which may be a function of greater acceptance of these emotional displays in the family. Such acceptance also points to the very real possibility that this family had grown beyond its need to maintain extreme closeness to protect themselves against their grief, thus allowing its members to have independent thoughts and feelings (Shapiro, 1994; Walsh & McGoldrick, 1991).

Apparently, one participant family experienced higher levels of nurturance and both participant families experienced more open communication on a qualitative level even though these improvements were not reflected in the quantitative measures of these parameters. This would seem to imply clinical significance in these areas. Of course, whenever participants are answering questions in a face-to-face interview, there is the danger that they will give answers that they believe the interviewer wants to hear or that would make them look better (Babbie, 2001). However, these open-ended questions are also likely to reveal more information about the interviewee’s experience of the phenomenon than the closed-ended questions in the quantitative measures because responses are not restricted to one choice from a finite number of choices. In any case, these two families appear to have found more positive ways of interacting during the six weeks that they participated in the FNMT intervention.

**Therapist behavioral observations.** In looking at parental nurturance factors from the therapist’s perspective, the parents’ emotional responsiveness was relatively high and the families’ level of self-differentiation (i.e., balance between physical closeness and separateness of family members) was relatively moderate throughout the baseline and treatment phases (see Figures 9 and 10). As with the observations regarding parent-child conflict during sessions, these data indicate no effect of the FNMT intervention on these measures of parental nurturance.

Observations of emotional expressiveness for each family member showed a different picture, however. These data showed a positive effect on family members’ level of emotional
expression during sessions (see Figures 11 through 13). Those who were minimally expressive at baseline increased their emotional expression and those who were slightly over-expressive decreased their emotional expression as the sessions progressed. Either minimal or maximal emotional expression is likely a reflection of anxiety in the family system (Bowen, 1991; Nichols & Schwartz, 1998). Minimal expression often occurs when a person feels anxious about the effect of such expression on other family members or how other members will react to such expression, and maximal expression often involves emotional reactivity to a tense situation. Healthy functioning, therefore, would involve a moderate level of emotional expressiveness, rather than a very high or very low level. Therefore, the changes observed in family members’ emotional expressiveness during sessions appear to have improved during the treatment phase.

Summary. Apparently, FNMT did not have a consistent effect on parental nurturance in these two families. Whereas Family 2 reported some evidence of improvement in the self-rating scale scores and clinically significant improvement in the responses to the open-ended questions, Family 1 showed no such improvement. The only improvement in this family occurred during baseline (i.e., younger-daughter-report). From the therapist’s perspective, both families were already functioning at a high level of parental responsiveness and family balance of closeness and distance prior to participating in the intervention, but observations did show improvement in emotional expressiveness during the treatment phase for all participants.

Study Limitations

There were a number of limitations in this study that call for caution in viewing the results. These limitations include research design, differential data collection, small number of participants, combined researcher-therapist role, use of self-rating scales, possibility of autocorrelation, and chosen formula for effect size. It is important to keep these limitations in mind while studying the results to maintain perspective on the lack of generalizability of these results.

Research Design

The first limitation for this study was its nonconcurrent multiple-baseline design, for which there are a number of threats to validity. Although this design is one of the more powerful
single-system designs and was useful in fulfilling the purpose of this research, results from this type of design still have limits to their generalizability (Bloom et al., 2003). Possibly the most damaging threat to internal validity was the repeated completion of assessment instruments. Participants completed the self-rating scales three and six times and the FAD and CAFF two times before starting treatment. Both families then completed the self-rating scales six times during the intervention. These repeated administrations of the instruments most probably sensitized the participants to the purpose of the study and may have promoted boredom in some participants. Testing was also a threat to an external validity in that clients in similar situations do not normally complete as many assessment instruments as participants in this study did. A related threat to internal validity was instrumentation variability. Even though the researcher was familiar with the instruments prior to the study, there was likely a learning effect in the actual administration of the instruments because of the number of times this was done. Finally, although multiple-baseline designs traditionally control for history (i.e., external events that may influence participants’ progress), the nonconcurrent nature of this study does not allow for completely ruling out this threat. Even so, the effect of history was probably minimal because of the sequential nature of the families’ participation – Family 2 was completing pretest measures the same day that Family 1 participated in its final treatment session.

**Differential Data Collection**

The second limitation was that data were collected in a different manner for the baseline and intervention phases. Baseline data were collected via the telephone, and intervention data were collected in person. As a function of these collection conditions, adults and adolescents gave verbal answers for the baseline responses, with the exception of the first baseline data point for the six-day baseline participant family. These verbal responses appeared to be less sensitive to minor variations than the written ones, as evidenced by the participants’ tendency to use whole numbers when responding verbally and their willingness to mark between the integer points when responding in written form. Another confounding element for the different phases was the differential time periods between responses. Baseline data points were taken daily, and intervention data points were taken weekly (after each session). Although these tactics were necessary to fit the situation and avoid overtaxing the participants, they reduce confidence that the results reflect a true image of change as it occurred prior to and during treatment.
Small Number of Participants

The third limitation was that very few families participated in this research. Barlow and Hersen (1973) suggested that a minimum number (N = 3) be set for the sample size of participants in a single-system-design study in order to have some confidence that the results of the study are robust. Unfortunately, there were not three eligible participant families who were willing to participate in this study. Referral sources identified at least 13 families that were told about the study, but only two of these came forward to participate.

There are many possible reasons why so few families that were aware of the study might choose to participate. Two probable factors are the tight criteria for eligibility and the need for the family to have a telephone. Several referral sources mentioned that they had families grieving the loss of a loved one, but they did not fit one or more of the requirements for this study (i.e., children were young adults, not school-aged children or adolescents; death had occurred five years prior to the study; some other family member or significant person in their lives had died, not a parent). Another referral source knew of an eligible family, but the family did not own a telephone – a necessary component for the baseline measurements. Sandler et al. (1992) also found these factors to be impediments for participation in their study. Of the 866 families originally identified as having experienced a loss within two years of the study, only 272 could be contacted by telephone and only 88 of these fit the study’s criteria.

Another factor likely to have decreased participation is the perception that research is somehow more intrusive and less desirable than receiving treatment that is not part of a study. One of the potential referral sources for this study was unwilling to share information about the study with its clients because the treatment was part of a research project. Apparently, Sandler et al. (1992) experienced a similar phenomenon when they found resistance to participation, as can be seen by their final count of 26 eligible families who came forward to participate in the study. Another pair of researchers (Black & Urbanowicz, 1987) also found only a small number of families willing to participate in their bereavement study (i.e., 33 of the 46 eligible families contacted).

Even without the project being of a research nature, though, bereaved families with children are not likely to seek help for other reasons. One reason is that the family may be functioning well without outside intervention. Worden (1996) found that 65% of the bereaved
children participating in his study did not need professional counseling to adequately process their grief by the end of two years. Interviewers in the Black and Urbanowicz (1987) study identified strong social support systems in some of the people who would not participate in their bereavement study. On the other hand, the same interviewers found that other people who refused to participate were more highly distressed than those who accepted treatment. Christ et al. (1991) discussed this phenomenon and proposed that highly vulnerable families (i.e., those that functioned poorly prior to the death of the loved one) were more likely to work on maintaining the status quo and were less likely to seek outside help than were more resilient families. In the current study, several of the referral sources identified families in great need of help due to the chaotic nature of their family dynamics, and none of these families contacted the researcher.

Yet another possible reason for nonparticipation is that bereaved families might not seek help because they may not be aware that their children’s behaviors are related to grief (Rosenthal, 1980; Seager & Spencer, 1996). Children often respond to the feelings of grief by misbehaving in ways that parents typically would see as requiring disciplinary action, not therapy. Without more direct indicators of grief, the family system can remain in denial regarding their state of bereavement. This denial may be amplified if adolescents are present in the family because young people tend to avoid expressions of grief lest they be seen as different from their peers (Lenhardt & McCourt, 2000; Worden, 1996). In addition, adolescents, in their ongoing attempt to show their independence, are unlikely to express a desire for help from anyone (Kandt, 1994). Therefore, parents are even less likely to connect adolescent misbehavior with a grief reaction.

Another aspect of denial that may have been at play with some of the potential participants who chose not to take part in this study was the surviving parents’ belief that the only ones seriously affected by the death were the children. There were two phone conversations with potential participants in which the parents clearly stated that their children were the ones who needed therapy and that they were not interested in having family sessions. Although this goes against family therapists’ understanding that children’s problematic behaviors are often a function of family interactions and, therefore, that solutions for these behaviors are not just a matter of inducing change in the children (Matorin & Greenberg, 1992; Nichols & Schwartz, 1998), this perspective is difficult for many parents to acquire. One possible reason that this type
of denial takes place is to protect the parent from having to take on yet another task. Single parenthood thrust upon a surviving parent requires a tremendous amount of energy and time for restructuring and stabilizing the family (Worden, 2002). Any additional work, such as attending family therapy and dealing with painful emotions that are directly or indirectly related to the death, is likely to overtax an already stretched parental subsystem. In such a situation, parents are more likely to seek relief by obtaining professional help for their children than by participating in family therapy, themselves.

It would appear that there were a number of possible reasons that eligible families chose to not participate in this study. As a result of the difficulty in procuring the minimum of three participant families, the results of this study can only be seen as exploratory and not definitive in any sense of the word.

**Combined Researcher-Therapist Role**

A fourth limitation was that the researcher and therapist for this study were the same person. Although this was a necessary condition due to lack of funding or availability of eligible volunteers, it is important to consider this factor when looking at the results. In an optimal condition, the researcher is an objective observer who has no other relationship to the observed. The therapist’s role, although also considered relatively objective, is more involved with the process and expectation of client improvement than is the researcher’s role. According to the common factors research, the therapist-client relationship, which often includes such factors as respect, understanding, and warmth, accounts for approximately 30% of client improvement (Sprenkle, Blow, & Dickey, 1999). Therefore, such a relationship could not be totally objective in the same way as the researcher-participant relationship if the therapy were to be effective. Combining these roles in one person increased the difficulty level for performing each of these roles at their optimal levels, which likely confounded the results of the study. In addition, the use of one therapist for all participants and the unique combination of the researcher and therapist in one person prevents generalization to other practitioners or situations.

**Use of Self-Rating Scales**

The fifth limitation was the extensive use of self-rating scales. By their nature, self-rating scales are not standardized or tested for validity or reliability. Pedhazur and Schmelkin (1991)
stated that this type of scale is limited in that it relies on the raters’ perceptions of their worlds. As a result, the scales used in this study not only did not have any established psychometric properties, they also depended largely on participants ability and willingness to objectively rate their own internal states and other family members’ behaviors. Since this study was seeking the participants’ perceptions, however, this choice of instrument seemed a worthwhile risk. Other advantages for the scales were that they specifically addressed the issues being tested and they were quick and easy to complete – all necessary conditions when doing a single-system study.

**Possibility of Autocorrelation**

A sixth limitation was that the data were likely to be autocorrelated. Bloom et al. (2003) discussed the issue of autocorrelation, or serial dependency, of data in single-system designs. Although they suggested that all data sets with less than seven observations would benefit from transformation of the data to correct for the probability of autocorrelation, they also stated that there currently are no methods of calculating autocorrelation when the data reflect a trend and that the act of transforming data is likely to affect the very character of the data. Because of these issues, such transformations were not appropriate for the data in this study, which also means that the results need to be viewed with caution.

Another reason for using caution when analyzing these data is the use of X-mR-charts to calculate statistical significance. Even though Bloom et al. (2003) suggested that this method is useful when analyzing autocorrelated data, they also suggested caution in interpreting the results if there is a possibility that the data are autocorrelated. They further stated that such calculations with data reflecting a trend must be viewed in the context of other types of analysis. Since there appear to be no known ways to identify whether autocorrelation exists with trend data and since there are obvious trends in these data, statements regarding statistical significance must be weighed against visual analysis of the graphs.

**Effect Size Formula**

Finally, the way that effect size was calculated was a limitation for this study. The $g$-index was the formula of choice to calculate effect size. This index lacks the precision of the $d$-index as a measure of effect size; however, one of the key requirements for the use of the $d$-index is that the data not reflect a trend. Each graph of this study’s data showed a trend in one or both
of the phases (i.e., baseline, treatment), making it inappropriate to use the $d$-index formula (Bloom et al., 2003). As a result of the choice of formula for effect size, the effect sizes reported might not be as accurate as would otherwise be possible.

**Recommendations for Future Research**

This was an exploratory study. Therefore, there are many avenues that future research could take in studying this phenomenon. There is some evidence that the FNMT intervention may be instrumental in helping bereaved families dealing with the death of a parent achieve better family functioning (i.e., less parent-child conflict, more parental nurturance). The next step would be to see if, in fact, there is a causal link between participation in FNMT and family functioning improvement with this population. The best way to do this would be to conduct a randomized comparison-group experiment. For ethical reasons, it would not be appropriate to include a control group in this study. Families dealing with this situation are too likely to be in crisis and in need of some kind of intervention. A comparison group that would receive some other treatment (e.g., family therapy without narrative or music elements, family support group), however, would allow for testing of this hypothesis without putting families at further risk.

Another direction that future research could take would be to do a full-fledged qualitative study of the process of FNMT. This kind of study would provide in-depth answers to questions about how participants experience and respond to the different elements of FNMT or how therapists operationalize the FNMT activities. The resulting process information could provide guidelines for refining and tailoring FNMT activities according to different client or therapist characteristics or situations.

Whichever type of research is conducted, there are several tactics that may improve the participation level that was so problematic in this study. One of these tactics is to expand the criteria to include different types of death (e.g., sibling, grandparent, close friend, pet) or losses (e.g., divorce). To do this would require a more flexible version of the intervention, which would allow for greater generalizability to different practice situations. Another suggestion is that the research study encompass a larger geographical area. This would require participation by more therapists, but this addition would also add generalizability to the professional community. A third tactic would be to include more extensive advertising (e.g., newspaper) to recruit
participants more directly. This study required that referral sources not only know about eligible families, but also that they make the extra effort of encouraging these families to participate. It is possible that a more direct outreach might have resulted in a larger number of participants. Finally, third-party funding would be a major asset that could be used to pay participants for their travel expenses or therapists for their services. This would help in procuring additional participants with few resources and the services of qualified therapists. These modifications, then, would likely allow for a more rigorous and generalizable study of the phenomenon.

**Implications for Practice**

Since this was an exploratory study in which the results were mixed, practitioners need to use caution if they wish to use this intervention with clients in their practices. There were enough positive findings, however, to suggest that there is potential for its usefulness in loss situations. Because there is such variability in family characteristics and situations, however, the practitioner would need to use their professional judgment in determining whether clients need a more crisis-oriented intervention or long-term intervention or whether they might benefit from this short-term intervention. Another factor that practitioners need to keep in mind when using this intervention is the developmental level of the children involved, both at the time of the loss and the time of participation in therapy. For instance, a particular difficulty when working with young children (i.e., those employing preoperational or concrete operational thought) is their tendency to idealize their family situation even as they are having problems dealing with their loss. Adolescents in the formal operational stage also have unique blocks to processing their loss experience, such as their need to appear independent and self-sustaining while struggling with painful thoughts and emotions. Information about where the children are developmentally is crucial, therefore, to the effective implementation of this intervention. Finally, whenever considering the use of an intervention that has minimal research support, such as this one, it is important to incorporate frequent assessments in the work with clients to be sure, first, that no harm is being done and, second, that the clients are gaining some benefit from participating in the chosen intervention. In this way, practitioners can either adjust the activities or choose an alternate intervention to better fit the clients’ needs.
Conclusions

The death of a parent has the potential for inflicting major damage on surviving school-aged or adolescent children, especially when the surviving parent has difficulty communicating about the death with the children or allowing the children to express whatever emotions they are feeling, as opposed to a narrow range of socially sanctioned emotions. Although some parents are fully capable of making the necessary adjustments to promote their children’s healthy development, many parents could benefit from participating in at least a short-term intervention that provides tools for dealing with this type of loss.

FNMT is just such an intervention, and this exploratory study provides data on how families from this population changed while participating in this intervention. Although there was no clear consensus among the different reporters’ perspectives (i.e., each family member, therapist) or the different measures taken (i.e., standardized instruments, self-rating scales, responses to open ended questions, therapist observations), the overall picture of the results still points toward FNMT as having potential to change some problematic family interactions (i.e., parent-child conflict, parental nurturance). Further study is needed to gain greater understanding of the effect this intervention has on families from this or similar populations. However, practitioners may already find this approach useful in addressing a variety of loss issues as long as they incorporate continued evaluation of its effects on the different client families.
BASELINE/POSTSESSION SELF-RATING QUESTIONNAIRE FOR ADULTS

Instructions: Please answer each question by placing a mark anywhere on the line following the question.

1. How easy was it for you to express your sadness over your husband’s/wife’s death in front of your child today/this week?
   Not at all ___________________________ Extremely

2. How easy was it for you to discuss death with your child today/this week?
   Not at all ___________________________ Extremely

3. How intense have your arguments been with your child today/this week?
   Not at all ___________________________ Extremely

4. How easy was it for you to express happiness in front of your child today/this week?
   Not at all ___________________________ Extremely

5. How easy was it for you to talk with your child about your husband/wife today/this week?
   Not at all ___________________________ Extremely

6. How easy it was it for you to show your fear in front of your child today/this week?
   Not at all ___________________________ Extremely

7. How easy was it for you to show your anger about your husband’s/wife’s death to your child today/this week?
   Not at all ___________________________ Extremely

8. How easy was it to listen to your child talk about your husband/wife or death today/this week?
   Not at all ___________________________ Extremely

9. How easy was it for you to show affection for example, hugging to your child today/this week?
   Not at all ___________________________ Extremely
Open-Ended Postsession Questions

1. What was it like for you doing the activity during the session?

2. What, if any, changes have you noticed in the way your family interacts at home since the last session?

3. What, if any, changes have you noticed in the way your child behaves since the last session?
APPENDIX B

ADOLESCENT QUESTIONNAIRE
BASELINE/POSTSESSION SELF-RATING QUESTIONNAIRE FOR ADOLESCENTS

Instructions: Please answer each question by placing a mark anywhere on the line following the question.

1. How OK was it for you to cry over your father’s/mother’s death in front of your mother/father today/this week?
   Not at all | | | | | | | | | | | | | | | | Extremely

2. How easy was it for you and your mother/father to talk about death today/this week?
   Not at all | | | | | | | | | | | | | | | | Extremely

3. How intense have your arguments been with your mother/father today/this week?
   Not at all | | | | | | | | | | | | | | | | Extremely

4. How easy was it for you to show happiness in front of your mother/father today/this week?
   Not at all | | | | | | | | | | | | | | | | Extremely

5. How easy was it for you to talk with your mother/father about your father/mother today/this week?
   Not at all | | | | | | | | | | | | | | | | Extremely

6. How easy it was it for you to show your fear in front of your mother/father today/this week?
   Not at all | | | | | | | | | | | | | | | | Extremely

7. How easy was it for you to show your anger about your father’s/mother’s death to your mother/father today/this week?
   Not at all | | | | | | | | | | | | | | | | Extremely

8. How easy was it to talk to your mother/father about your father’s/mother’s death today/this week?
   Not at all | | | | | | | | | | | | | | | | Extremely

9. How easy was it for you to hug your mother/father today/this week?
   Not at all | | | | | | | | | | | | | | | | Extremely
Open-Ended Post–Session Questions

1. What was it like for you doing the activity during the session?

2. What, if any, changes have you noticed in the way your family interacts at home since the last session?

3. What, if any, changes have you noticed in how other members in your family have been acting since the last session?
APPENDIX C

CHILD QUESTIONNAIRE/ANSWER SHEET
BASELINE/POSTSESSION SELF-RATING QUESTIONNAIRE FOR CHILDREN (5-11)

Instructions to Child:

I am going to ask you some questions about your family, and you get to mark your answers on the sheet of paper I gave you with the smiley faces on it. Do you see the smiley faces? In each row, the faces start with a straight face and end with a face with a great big grin. Do you see that? When I ask you the question, I want you to think about this statement and mark on the line under the one smiley face that shows how much you agree with that statement. Do you see the line under the smiley faces? If you don’t agree at all, you will mark under the straight face. If you agree lots, you will mark under the face with the big grin. If you agree somewhere in between not at all and lots, you will mark on the line close to the face that shows how much you agree. Do you understand? Which color marker would you like to use? Let’s try some examples. The first example is, “I like chocolate ice cream.” Where would you mark on the line? (Give child a chance to mark the line.) The second example is, “I like going to school.” Where would you mark on the line now? (Give child a chance to mark the line.) OK, here we go with the real questions.

1. It’s okay to cry in front of my mommy/daddy.

2. I can ask my mommy/daddy questions about death all I want.

3. My mommy/daddy yells at me.

4. I can laugh and play when my mommy/daddy is at home.

5. I can talk about my daddy/mommy with my mommy/daddy all I want.

6. My mommy/daddy helps me when I am afraid.

7. It’s okay to be angry in front of my mommy/daddy.

8. My mommy/daddy listens to me when I talk.

9. I can hug my mommy/daddy whenever I want.

(Open-ended questions)
That was good! Now I want you to just tell me what it was like for you doing the activity during the session?

Great! Now I would like you to tell me if anything is different at home since the last session.

Okay! You did a good job. Now we can join your mother/father again.
ANSWER SHEET FOR CHILDREN’S POSTSESSION QUESTIONNAIRE

a.

Not at all | Lots

b.

Not at all | Lots

1.

Not at all | Lots

2.

Not at all | Lots

3.

Not at all | Lots

4.

Not at all | Lots

5.

Not at all | Lots
APPENDIX D

THERAPIST BEHAVIORAL OBSERVATION FORM
POST–SESSION BEHAVIORAL OBSERVATION OF THERAPIST

<table>
<thead>
<tr>
<th>Type of emotional responsiveness to child:</th>
<th>Denigrating</th>
<th>Neutral</th>
<th>Empathetic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting behaviors:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>❑ Angry tone of voice</td>
<td>❑ Calm tone of voice</td>
<td>❑ Warm tone of voice</td>
<td></td>
</tr>
<tr>
<td>❑ Angry affect</td>
<td>❑ Relaxed affect</td>
<td>❑ Positive affect</td>
<td></td>
</tr>
<tr>
<td>❑ Negative remarks about child</td>
<td>❑ Affirming remarks about child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>❑ Dismissive remarks</td>
<td>❑ Nodding of head</td>
<td></td>
<td></td>
</tr>
<tr>
<td>❑ Closed body language</td>
<td>❑ Open body language</td>
<td></td>
<td></td>
</tr>
<tr>
<td>❑ Lack of eye contact</td>
<td>❑ Eye contact</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How conflict expressed by parent:</th>
<th>Other-blaming</th>
<th>Collaborative</th>
<th>Self-blaming</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting behaviors:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>❑ Angry tone of voice</td>
<td>❑ Calm tone of voice</td>
<td>❑ Sad tone of voice</td>
<td></td>
</tr>
<tr>
<td>❑ Angry affect</td>
<td>❑ Calm affect</td>
<td>❑ Sad affect</td>
<td></td>
</tr>
<tr>
<td>❑ Finger-pointing</td>
<td>❑ Conciliatory statements</td>
<td>❑ Self-blaming statements</td>
<td></td>
</tr>
<tr>
<td>❑ Statements blaming other</td>
<td>❑ Use of “I” statements</td>
<td>❑ Hitting self</td>
<td></td>
</tr>
<tr>
<td>❑ Closed body language</td>
<td>❑ Open body language</td>
<td></td>
<td></td>
</tr>
<tr>
<td>❑ Clenched fists</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>❑ Hitting object</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dismissive</th>
<th>Restrained</th>
<th>Openness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting behaviors:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>❑ Turning away from other</td>
<td>❑ Taut affect</td>
<td>❑ Open affect</td>
</tr>
<tr>
<td>❑ Loss of eye contact</td>
<td>❑ Strained tone of voice</td>
<td>❑ Calm tone of voice</td>
</tr>
<tr>
<td>❑ Verbal refusal to discuss</td>
<td>❑ Verbal protest</td>
<td>❑ Open body language</td>
</tr>
<tr>
<td>❑ Closed body language</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How close to or distant from each other for most of session (90%):</th>
<th>Fused</th>
<th>Differentiated</th>
<th>Cutoff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting behaviors:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>❑ Physical contact</td>
<td>❑ 2-4 feet apart</td>
<td>❑ &gt; 4 feet apart</td>
<td></td>
</tr>
<tr>
<td>❑ &lt; 1 foot apart</td>
<td>❑ Willing to separate</td>
<td>❑ Eager to separate</td>
<td></td>
</tr>
<tr>
<td>❑ Refusal to separate</td>
<td>❑ Balanced turning</td>
<td>❑ Turning away from other</td>
<td></td>
</tr>
<tr>
<td>❑ Turning toward other</td>
<td>toward/away</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall emotional expressiveness:</td>
<td>Minimal</td>
<td>Moderate</td>
<td>Effusive</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>Parent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotions expressed:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Anger</td>
<td>☐ Love</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Anxiety/fear</td>
<td>☐ Calm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Sadness</td>
<td>☐ Happiness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Guilt/bad about self</td>
<td>☐ Contentment / good about self</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Child B                          |         |          |          |
| Emotions expressed:             |         |          |          |
| ☐ Anger                          | ☐ Love  |
| ☐ Anxiety/fear                   | ☐ Calm  |
| ☐ Sadness                        | ☐ Happiness |
| ☐ Guilt/bad about self           | ☐ Contentment / good about self |

| Child C                          |         |          |          |
| Emotions expressed:             |         |          |          |
| ☐ Anger                          | ☐ Love  |
| ☐ Anxiety/fear                   | ☐ Calm  |
| ☐ Sadness                        | ☐ Happiness |
| ☐ Guilt/bad about self           | ☐ Contentment / good about self |

| Child D                          |         |          |          |
| Emotions expressed:             |         |          |          |
| ☐ Anger                          | ☐ Love  |
| ☐ Anxiety/fear                   | ☐ Calm  |
| ☐ Sadness                        | ☐ Happiness |
| ☐ Guilt/bad about self           | ☐ Contentment / good about self |
APPENDIX E

LIST OF RHYTHM INSTRUMENTS
1. Suzuki 4-note slit drum, Model SD-4, with two yarn-covered mallets
2. 6" x 10" Taos drum with leather-covered mallet
3. Remo 8" x 10" floor tom with two felt-covered mallets
4. 10" Lollipop (paddle) drum with felt-covered mallet
5. Crow sounder with mallet
6. Two-toned woodblock with mallet
7. Combination rhythm sticks (1 pair)
8. 20" Rain stick
9. Egg shakers (8)
10. LP Hand Percussion Collection
    a. 8" hand drum with plastic mallet
    b. 10" hand drum with plastic mallet
    c. 8" headless plastic tambourine
    d. 14" fish style guiro with striker
    e. plastic maracas (1 pair)
    f. mini cabasa
    g. wood claves (1 pair)
    h. wood castanets on a handle (1 pair)
    i. 6" triangle with metal clapper
    j. 5½" cowbell
    k. metal Shake-It
APPENDIX F

INSTITUTIONAL REVIEW BOARD APPROVAL LETTERS
APPROVAL MEMORANDUM
Human Subjects Committee

Date: 1/29/2004

Susan Strickland
P. O. Box 20162
Tallahassee FL 32316

Dept.: Social Work

From: John Tomkowiak, Chair

Re: Use of Human Subjects in Research
Family Narrative/ Music Therapy: Children Dealing with Death of a Parent

The forms that you submitted to this office in regard to the use of human subjects in the proposal referenced above have been reviewed by the Human Subjects Committee at its meeting on 1/14/2004. Your project was approved by the Committee.

The Human Subjects Committee has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval does not replace any departmental or other approvals which may be required.

If the project has not been completed by 1/13/2005 you must request renewed approval for continuation of the project.

You are advised that any change in protocol in this project must be approved by resubmission of the project to the Committee for approval. Also, the principal investigator must promptly report, in writing, any unexpected problems causing risks to research subjects or others.

By copy of this memorandum, the chairman of your department and/or your major professor is reminded that he/she is responsible for being informed concerning research projects involving human subjects in the department, and should review protocols of such investigations as often as needed to insure that the project is being conducted in compliance with our institution and with DHHS regulations.

This institution has an Assurance on file with the Office for Protection from Research Risks. The Assurance Number is IRB00000446.

cc: Dr. Nicholas Mazza
HSC No. 2003.760
APPROVAL MEMORANDUM (for change in research protocol)

Date: 3/8/2004

To:
Susan Strickland
P O Box 20162
Tallahassee FL 32316

Dept: Social Work

From: John Tomkowiak Chair

Re: Use of Human subjects in Research
Project entitled: Family Narrative/ Music Therapy: Children Dealing with Death of a Parent

The memorandum that you submitted to this office in regard to the requested change in your research protocol for the above-referenced project have been reviewed and approved. Thank you for informing the Committee of this change.

A reminder that if the project has not been completed by 1/13/2005, you must request renewed approval for continuation of the project.

By copy of this memorandum, the chairman of your department and/or your major professor is reminded that he/she is responsible for being informed concerning research projects involving human subjects in the department, and should review protocols of such investigations as often as needed to insure that the project is being conducted in compliance with our institution and with DHHS regulations.

This institution has an Assurance on file with the Office for Protection from Research Risks. The Assurance Number is 1RB00000446..

cc: Dr. Nicholas Mazza
APPLICATION NO. 2003.760
APPENDIX G

INFORMED CONSENT – ADULT
ADULT/PARENTAL INFORMED CONSENT FORM

I freely and voluntarily and without any element of force or coercion consent to participate and give my consent for my child, ____________________, to participate in the research project entitled “Family Narrative/Music Therapy: Children Dealing with the Death of a Parent.”

This research is being conducted by Susan J. Strickland, who is a doctoral candidate in the Interdivisional Marriage and Family Therapy program at Florida State University. I understand the purpose of her research project is to determine the effectiveness of a family therapy intervention in improving family relations. I understand that if we participate in the project, we will be asked to discuss our family’s relations and my feelings about the death of my spouse. We will also be asked to participate in session activities (i.e., listening to music, playing percussion instruments, drawing, and storytelling).

I understand that my child and I will be asked to fill out paper and pencil questionnaires during the study. The total time commitment for each participant will be approximately nine hours (six 50-minute sessions and 10-minute postsession interviews to be held once a week, no more than eight 10-minute phone interviews prior to therapy sessions, and one 50-minute and two 30-minute sessions to answer questionnaires). I also understand that I am responsible for transportation to the project clinic; however, parking is available behind the clinic for my use while participating in project sessions. Any questions my child or I have will be answered by the researcher, or she will refer us to a knowledgeable source.

I understand that our participation is totally voluntary and we may stop participation at any time. All our answers to the questions will be identified by a subject code number and kept confidential to the extent allowed by law. No names will appear on any of the results. I also understand that our sessions will be videotaped, as is customary for training and research purposes at the agency where sessions will be held, and that parts of our sessions will be audiotaped. The videotapes will be used for supervision, and the audiotapes will be used for research efforts. Both will be carefully secured at all times and will be destroyed after completion of project supervision and data analysis. I understand that the findings obtained may be reported in professional journals and that all efforts to maintain the anonymity of my family will be taken. However, I further understand that the information obtained on my family may be reported in a single-case study format, which carries a slight, but potential, risk of identification.

I understand there is the possibility of a minimal level of risk if I agree that we will participate in the study. We may experience various uncomfortable emotions, such as anxiety or anger, when talking about our family relations. The researcher will be available to talk with us about any emotional discomfort we may experience while participating. We may also stop our participation at any time.

I understand there are benefits for participating in this research project. We may experience an improved ability to handle the loss our family has experienced and a closer relationship among family members. In addition, the results of this study will help other family therapists know if these interventions might be useful in helping other families with children.
who have experienced the death of a parent. This knowledge can then help them provide services to other families in distress.

Overall results will be sent to me upon my request. I understand that this consent may be withdrawn at any time without prejudice, penalty or loss of benefits to which I am otherwise entitled. I have been given the right to ask and have answered any inquiry concerning the study. Questions, if any, have been answered to my satisfaction. In the future, I understand I may contact Ms. Strickland (850-212-0702), Dr. Nicholas Mazza (850-644-9702), or Heidi Hodges (850-644-8633) for answers to questions about this research or our rights. I have read and understand this consent form.

(Subject)                      (Date)  

(Witness)
APPENDIX H

DEMOGRAPHICS SHEET
Demographics Sheet

Date of Birth (mm/dd/yyyy): ______/_____/______

Age: ______

Gender: _____ Male
        _____ Female

Ethnicity:
       _____ Caucasian/White
       _____ African-American/Black
       _____ Hispanic/Latino
       _____ Native American
       _____ Asian-American/Asian/Pacific Islander
       _____ Other (Please specify: _____________________________ )
       _____ Biracial (Please specify: _____________________________ )

Education:
       _____ Less than high school
       _____ High school diploma/GED
       _____ Some undergraduate college
       _____ Bachelors degree
       _____ Some graduate or professional school
       _____ Graduate or professional degree
       _____ Other (Please specify: _____________________________ )

Annual income: _______________

Sibling Subsystem (Please list the ages and genders of all children currently living in the house.):

<table>
<thead>
<tr>
<th>Age</th>
<th>M</th>
<th>F</th>
<th>Age</th>
<th>M</th>
<th>F</th>
<th>Age</th>
<th>M</th>
<th>F</th>
</tr>
</thead>
</table>

Date of spousal death (mm/dd/yyyy): _____/_____/______
Length of marriage/relationship: _____ years _____ months
Age of spouse at time of death: _____
Manner of death:
       _____ Heart disease/attack
       _____ Cancer
       _____ HIV/AIDS infection
       _____ Other long-term illness
       _____ Motor vehicle accident
       _____ Other accident
       _____ Suicide
       _____ Homicide
       _____ Other (Please specify: _____________________________ )
APPENDIX I

INFORMED ASSENT – ADOLESCENT
INFORMED ASSENT FORM (AGES 13-18)

I agree to take part in the family sessions. These sessions will be led by Susan Strickland, who is in the Interdivisional Marriage and Family Therapy doctoral program at Florida State University. I understand the purpose of the sessions is to see if family therapy will help our family get along better. I understand that if I come to these sessions, I will be asked to describe feelings, behaviors, and/or reactions having to do with the death of my parent and how members in my family get along. I will also be asked to participate in activities during our sessions, such as playing percussion instruments, drawing, and storytelling.

I understand that I will be asked to fill out questionnaires during the study, to come to six family sessions, and to answer some questions before beginning therapy and after each session. My name will not be placed on any of these questionnaires. Sessions will be videotaped and audiotaped to help the researcher, Ms. Strickland, with her research and supervision. The only name on these tapes will be Ms. Strickland's, and the tapes will be kept secure at all times.

I understand I may feel uncomfortable emotions when I think about my family’s problems or my parent's death. Ms. Strickland will be there for me if I have any bad feelings while I am in the session. It’s okay for me to leave or quit at any time, but I understand that good things can happen while I am taking part in these sessions. I may have fun, and I may feel better about myself and my family.

I understand that I can leave or quit this study at any time without anything bad happening to me. I can ask questions about the study, and Ms. Strickland will answer them or find the answers for me. Ms. Strickland has answered all the questions I have right now. I understand I can contact her through my parent/guardian or directly (at 850-212-0702) if I have any other questions. I have read and understand this assent form.

____________________________________
Youth’s Signature

____________________________________
Date
APPENDIX J

INFORMED ASSENT – CHILD
CHILD ASSENT SCRIPT (AGES 6-12)

Hello, __________________________, my name is Ms. Susan. How are you doing today? I would like your help in a study that I am conducting. I will be asking you to answer some questions, and later you will get to come with your family six times to listen to some music, play some percussion instruments, draw some pictures, and tell some stories.

Now, some of these questions I will be asking are for older kids, and you may not know the answer. That’s okay. You just try your best. And, if you feel funny and don’t want to answer any other questions, you just let me know and we can stop at anytime. You won’t get in any trouble, and no one will be mad at you. By coming with your family to these sessions, though, you may start to feel better about yourself and your family. So will you help me by answering some questions?

If Yes - Great, let’s get started. I’m going to be writing down what you say because it is very important. And do you see that little black box on the shelf? That is a videotape camera. It will record us while we are talking, and that will help me remember what you say. I’m going to leave it right over there so we don’t touch it and keep it safe. Now, we have to use our big voices so the recorder can hear us. Can I hear your big voice? Good job. Okay, we are all set. Are you ready to begin?

If No - Child will be free to leave, thanked by the researcher, and dismissed from the study.
REFERENCES


Daley, J. G., Ridenour, T., & Reich, W. (n.d.). *The child assessment of family functioning (CAFF) scale*. (Available from James G. Daley, Ph.D., jgdaley@iupui.edu)


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BIOGRAPHICAL SKETCH

Susan J. Strickland was born in Flushing, New York, on January 30, 1956. Her meandering path to reach this point in her education included earning an A.A.S. in Accounting (1976) at the State University of New York in Delhi, New York; a B.S. in Systems Science (1985) and a B.A. in Music (1994) at University of West Florida in Pensacola, Florida; and an M.M. in Music Therapy (1996) and M.S.W. (2000) at Florida State University in Tallahassee, Florida.

In the course of this study, she has held a number of professional positions in various capacities. She has served as individual and class Guitar Instructor at Pensacola Junior College and private individual Piano Instructor for children with and without disabilities. She has also served as Music Group Leader at a children’s stress center and at a day treatment and assisted-living facility. As a Music Therapy Intern, she facilitated music therapy groups at an inpatient psychiatric center, an adolescent substance abuse treatment center, and Florida State Hospital. Concurrent with these activities, she volunteered as a telephone counselor at the Telephone Counseling and Referral Service, now known as 211 Big Bend. She went on to serve as Children’s Bereavement Coordinator in a hospice and Group Facilitator in a community mental health facility day treatment and partial hospitalization program. Her work as a Social Worker Intern involved family counseling with families of at-risk adolescents at an outpatient facility connected with a runaway shelter and individual and family counseling at a boy’s ranch for at-risk adolescents. Service as a doctoral student has included positions as Marriage and Family Therapy Practicum Therapist at the University Center for Marriage and Family Therapy, Teaching Assistant (4 semesters) and classroom instructor (3 semesters) at the College of Social Work, and Doctoral Marriage and Family Therapy Intern in a private practice setting.

Other professional accomplishments include three articles published in peer-reviewed journals: (a) “Parenting practices and adolescent peer relations” in *Adolescence*, currently in
press; (b) “Music and the Brain in Childhood Development” in *Childhood Education*, published Winter 2001/02; and (c) “Effect of Song Writing Versus Recreational Music on Posttraumatic Stress Disorder (PTSD) Symptoms and Abuse Attribution in Abused Children” in *Journal of Poetry Therapy*, published 2000. She has also given two presentations: (a) a workshop on child physical and sexual abuse to the Sisters in Sobriety in 2002 and (b) “Cultivating Respect for Differences in Supervision” in the *Clinical Supervision Workshops* series at Florida State University, October 2002.