The Value of Music Therapy in Addressing Childhood Traumatic Grief

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Author Note

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Abstract

Childhood traumatic grief (CTG) is a condition that causes a combination of prolonged trauma and grief symptoms which significantly interrupt a child's development and daily functioning. The available research regarding the condition is limited and suggests shortcomings of traditional treatment models designed for childhood trauma and grief. This study surveyed board-certified music therapists in the United States who currently work or have worked in the past with children with CTG to examine the use of music therapy for this population. The participating music therapists described the methods, settings, and perceived effectiveness of the practice within CTG treatment processes.

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Introduction

The death of a loved one can cause several interferences in everyday life. When the already complex process of grieving is significantly interrupted or hindered by the simultaneous presence of trauma surrounding the circumstances of the death, a more specific challenge emerges. This affliction is known as traumatic grief.

It is unfortunately inevitable that many children will someday be faced with the death of a significant person in their lives. Children who are grieving the loss of a parent, sibling, friend, or other influential figure in their life may face an array of resulting limitations and challenges. When the circumstances surrounding the person's death were traumatic for the child, the child may experience symptoms of trauma in addition to the typical symptoms of bereavement. Specifically, several researchers have found that children who have suffered a traumatic loss will often display symptoms of Posttraumatic Stress Disorder (PTSD). According to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM–5; American Psychiatric Association, 2013), these symptoms typically include emotional and physical responses to trauma reminders, a feeling of isolation, inconsistent memories of the traumatic event, decreased interest in once preferred activities, aggression, and difficulty concentrating. In combination with the child's grief, these symptoms can impact the child's perception of the lost loved one and the child's ability to appropriately grieve the loved one (Mannarino & Cohen, 2011).

There is a noticeable lack of research and literature surrounding the unique condition of childhood traumatic grief (CTG). No widely-used screening process or measurement tool currently exists to diagnose a child with CTG. Therefore, many children experiencing traumatic

grief will not receive effective treatment. This lack of research leads to a distinct lack of availability of services aimed to assist this unique population of children.

Statement of the Problem

Trauma's impact on a child. Several studies have proven the challenges a developing child may face after exposure to trauma. The means by which traumatic memories interfere with daily life have been explored as early as 1887 by Jean-Martin Charcot (as cited in Loewy, 2007), who described the phenomenon as a "parasite of the mind" (p. 23). In essence, Charcot's understanding was that memories of a traumatic event can be intrusive, interrupting the flow of speech and thought and causing great distress to the trauma survivor. These intrusive memories which cause the survivor to mentally relive the event are observable in modern cases of PTSD. While not every individual who endures a traumatic event will develop PTSD, they may display symptoms similar to those of the condition. These symptoms may cause a child to become avoidant or anxious, appear detached, or experience derealization or depersonalization (Sutton, 2002). Such limitations can negatively impact a child's relationships with others and prevent them from completing tasks of everyday life, often leading to poor academic performance. For instance, trauma may cause a child to lack foundational skills such as prioritization, problem-solving, and sequencing, which may prevent the student from successfully completing a spontaneous writing assignment in the classroom (Gailer, Addis, & Dunlap 2018).

The trauma that may be experienced specifically after the loss of a loved one has similar and occasionally more detrimental impacts on daily functioning. A study funded by the National Institute of Mental Health found that a group of young, female college students who had experienced a traumatic loss had similar symptoms to a group of students who had trauma

backgrounds unrelated to loss. However, the group that had experienced a traumatic loss showed higher rates of acute stress, intrusive memories, and decreased academic performance (Green, Krupnick, Stockton, Goodman, Corcoran, & Petty, 2001). The results of this study show that traumatic loss can pose an equal or larger threat to an individual's functioning as other types of trauma. Furthermore, the traumatic loss of a child's attachment figure can cause the child to experience typical trauma symptoms in addition to separation distress, as the child yearns for the deceased person and experiences intense feelings of loneliness (Neria & Litz, 2010).

Traditional treatment of trauma and grief. Several studies have sought to find a treatment method suitable for addressing trauma and grief in children. A commonly used model in the treatment of trauma is Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), designed in 2006. The model uses foundational principles of cognitive-behavioral therapy to reduce a child's symptoms of PTSD and to provide them with education on coping skills, reacting to traumatic exposure, and behavior through joint sessions with their primary caregivers (de Arellano, Lyman, Jobe-Shields, George, Dougherty, Daniels, Shoma Ghose, Huang, & Delphin-Rittmon, 2014).

Treatment has also commonly been administered to traumatized children through pharmacological means. Children who experience PTSD symptoms as a result of grief or trauma may be prescribed medications such as Selective Serotonin Reuptake Inhibitors (SSRIs) to alleviate the depressive and anxiety-based symptoms associated with PTSD. These children may also take medications aimed to decrease PTSD symptoms impacting the child's attentive or sleeping behaviors, increasing the child's ability to engage in therapy such as TF-CBT. This kind

of pharmacological treatment of childhood trauma is meant to improve a child's functioning and quality of life (Donnelly, 2003).

Music therapy for children with traumatic grief. Music therapy is defined by the American Music Therapy Association (AMTA) as "the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program" (AMTA, 2019). Music therapists are extensively trained to use music as a clinical tool, serving a variety of populations to address cognitive, behavioral, emotional, social, physical, and spiritual goals. In this therapeutic and musical relationship, the music therapist aims to introduce and enforce skills that the client can apply to their lives outside of music in support of the client's overall mental and physical health. Existing literature regarding the influence of music therapy on the reduction of both trauma and grief symptoms in clients of all ages and from several areas of the world will be reviewed as a means to defend the clinical use of music as part of treatment for general trauma, general grief, and traumatic grief experiences. The specific goals set and the methods used by music therapists when working with individuals experiencing these conditions will be investigated and reviewed. In addition, the effectiveness of those goals and methods used will be analyzed based on the reported outcome of treatment in order to establish music therapy as a treatment option for traumatic grief and similar conditions.

Background and Need

The impact of trauma and grief on child development. After years of research, psychologists and clinicians have come to a general understanding of the developing child's brain after exposure to a traumatic event. It has been found that trauma causes dysregulation in

the typical stress response, particularly noticeable in brain structures responsible for the regulation of emotions. This includes the amygdala, described by neuroscientist Joseph E. LeDeux as the "hub of the wheel of fear" (1998, as cited in Swallow, 2002 p. 48). When the amygdala is suddenly and unexpectedly assaulted from the high stress of a traumatic event, the structure's cells will become damaged (Swallow, 2002). This neurological damage implies that a child who survives a traumatic experience will be faced with an impaired system of emotional regulation, interrupting their development and negatively influencing their daily functioning and relationships. Further explanations on the physiological responses to trauma will be analyzed in the Literature Review.

In the specific case of childhood traumatic grief, the child endures a prolonged period of grief that impacts their functioning and wellbeing in a manner that is beyond the typical human experience of grief. A child may face traumatic grief after experiencing more than one loss or if the death of the individual's loved one was unexpected, painful, violent, or the result of conditions that are stigmatized in their societies, such as suicide or AIDS (The National Child Traumatic Stress Network, 2019). Other definitions of the condition specify that CTG can emerge when the death is perceived by the child to be traumatic or particularly scary. For instance, while an adult may view the natural passing of an elderly relative as upsetting yet expected, a child who did not know that relative was going to die, who was in the room when that relative died, or who witnessed that relative suffer in any way before their death may be left with symptoms of trauma (Cohen & Mannarino, 2011). A child who is coping with traumatic grief experiences trauma symptoms resulting from the death of a loved one at a level of intensity that hinders the progression of the typical grieving process.

Shortcomings of traditional treatment. When attempting to implement trauma-informed interventions into a school environment in an effort to serve traumatized children, limitations may arise and prevent treatment from being fully effective. The integration of trauma-informed interventions into school systems can only be successful if it is supported unanimously by all school officials (i.e. principals). Children who are traumatized may struggle to respond to the established structure of a school environment, and some school personnel may feel threatened by any changes to this structure. They may fear that changes made in order to accommodate traumatized students makes the school's leaders appear "soft," straying from the more discipline-focused structure they are accustomed to (Walkley & Cox, 2013 p. 124).

Additionally, the nature of trauma often hinders a child's ability to verbally process their experience. This can make treatment methods such as the aforementioned TF-CBT model difficult for a traumatized child to engage in. With this in mind, one can infer that the participation in an alternative form of therapy in conjunction with TF-CBT and similar treatment models may allow the child with traumatic grief to be more open and capable of participating in more traditional treatment processes.

Furthermore, much of the literature regarding childhood trauma and grief treatment excludes children who are non-verbal or pre-verbal. A very young child who has not reached the developmental milestone of verbal expression can face difficulty understanding all elements of talk-based therapies such as TF-CBT (Scheeringa, Weems, Cohen, Amaya-Jackson, & Guthrie, 2010). They may, however, benefit from an alternative form of therapy that allows for means of self expression beyond verbal communication.

Trauma, grief, and music therapy. While trauma and grief have long been individually connected to music therapy treatment in published texts, there is little existing literature regarding the relationship between the specific condition of traumatic grief and music therapy. Since the benefits of music therapy in the treatment of children experiencing traumatic grief are so underexplored in the available literature, there is also a noticeable lack of music therapy services in the United States for these children.

Considering the lack of published research on the benefits of music therapy for the specific experience of childhood traumatic grief, the effectiveness of music therapy for this population remains understated. Parents and guardians of the children impacted by traumatic grief may not be aware that music therapy is an option for their child. Moreover, government officials and managers of schools and mental health facilities also seem to be unaware of the practice of music therapy and how it can be a vital tool in serving the children within their communities who are coping with a traumatic loss. Because of this, the children affected by traumatic grief are not offered sufficient opportunities to engage in treatment processes with board-certified music therapists and are potentially missing out on an incredibly unique and effective resource. A study to identify and prove this need can serve to advocate for increased funding and prioritization of music therapy as a potential part of the treatment process for children experiencing traumatic grief.

Purpose of the Study

The purpose of this study is to examine evidence of the effectiveness of music therapy as a part of the treatment process for children under the age of 18 coping with traumatic grief in the United States, as well as the accessibility and quality of these music therapy services. The

researcher sought to uncover the goals music therapists consider when working with their young clients experiencing traumatic grief as well as the specific music therapy methods and interventions used to address those goals. Additionally, the study serves to explore the availability of music therapy services within communities across the United States from the perspective of music therapists who work with children with CTG. The inherent qualities of music make music therapy an invaluable tool in reaching trauma survivors when other methods of treatment may be insufficient. Further, the specific population of children experiencing traumatic grief deserves access to thorough, quality music therapy services within their communities.

For this study, the researcher used a social media platform to obtain a sample group composed of board-certified music therapists who currently work or have worked in the past with children coping with traumatic grief and whose primary location of practice is within the continental United States. The music therapists who fit that criteria and consented to participating in the study were sent a brief online survey composed using the online service "Surveymonkey." Participants were asked to identify specific aspects of their music therapy sessions with children experiencing traumatic grief, including the schedule, setting, goals, and interventions of their average music therapy session with this population. The survey also asked for the participants' perspectives on the effectiveness of music therapy treatment for their young clients coping with traumatic grief. Finally, participants were asked to rate and comment on their level of satisfaction with the accessibility and quantity of the music therapy services offered to children in their communities who are coping with traumatic grief. The survey was created to illustrate both the effectiveness and necessity of music therapy as a part of treatment for

childhood traumatic grief from the perspective of music therapists who have experience working with said children.

Research Questions

What are the needs of children experiencing traumatic grief?

What goals do music therapists address when working with children coping with traumatic grief?

What methods are used by music therapists to work towards those goals?

What makes the use of clinical music so uniquely effective when addressing traumatic grief?

In what ways does music therapy sufficiently meet the needs of children with traumatic grief?

Significance to the Field

This study is important to the field of music therapy because it calls upon board-certified music therapists who work or have worked in the past with a specific population of clientele to share their insight on the impact of music therapy for that population to a general audience. The survey involved in this study offers the participating music therapists an opportunity to advocate for increased space in their communities for music therapy with survivors of childhood traumatic grief. The study is also beneficial to the advancement of the field of music therapy as it verifies the effectiveness and the validity of the practice within the treatment of a population that is currently understudied in the context of music therapy. Finally, this thesis further solidifies the power of the general practice of music therapy as a means of treatment of a wide variety of individuals.

Definitions

The following terms will be referenced throughout this study:

Childhood traumatic grief: The occurrence of traumatic grief in children in which the child's symptoms of trauma related to the death hinders the typical course of child bereavement as well as overall child development.

Cognitive behavioral therapy: A short-term treatment process involving the use of goal-oriented psychotherapy to change the client's thinking patterns and promote problem-solving.

Traumatic grief: The condition that results from the combined experiences of trauma and grief; characterized by a prolonged period of grief that impacts an individual's functioning and wellbeing and interferes with the progression of the typical grieving process.

Trauma-Focused Cognitive Behavioral Therapy: A treatment model in which the traditional elements of cognitive behavioral therapy are adapted and used to address trauma in children, adolescents, and adults.

Music therapist: A credentialed professional who provides music therapy treatment.

Music therapy: An established, evidence-based medical practice involving the clinical use of musical interventions to address an individual's physical, emotional, cognitive, social, or spiritual goals.

Ethical Considerations

While this study is related to children under the age of 18 who are coping with the vulnerable experience of traumatic grief, no children were directly involved in the survey process. The sole participants of this study were individuals confirmed to be board-certified music therapists who work or have previously worked with such children. The open-ended questions of the survey were included with the explicit expectation that participants would

maintain the guidelines client confidentiality as outlined in the American Music Therapy Association's code of ethics when discussing their work and experience.

Literature Review

Introduction

Trauma is not a topic that can be easily simplified. The diagnostic criteria for trauma has evolved considerably, as seen in volumes III-V of the Diagnostic and Statistical Manual of Mental Disorders. Despite the confusion that may arise from the ever-changing definition of trauma, the experience of trauma which results from loss has clear neurological and psychological ramifications. This literature review will analyze current research on the impact of trauma on a child's development, music therapy in the treatment of traumatized children, and current understanding of childhood traumatic grief (CTG). The first section will look deeper into both the biological and emotional effects of trauma and the impact a traumatized child will continue to experience in adulthood. In order to address childhood traumatic grief by any means of treatment, it is imperative to explore the exact psychological and physiological workings of childhood trauma in general. The second section of the literature review will explore the ways in which traditional treatment models are able to meet the needs of children coping with trauma, grief, and traumatic grief. Finally, the current use of music therapy in the treatment of general childhood trauma will be reviewed as a means to explain the potential of music as a clinical tool in healing the effects of different types of trauma, such as traumatic grief. The information presented in these three areas of research demonstrates the need for additional literature covering the methods of assessment of CTG as well as the use of music therapy in the specific population of children coping with traumatic grief.

Understanding the Impact of Trauma on Child Development

Children who survive early life trauma may be missing out on crucial steps of their development processes. This is illustrated in Frank W. Putnam's "The Impact of Trauma on Child Development," published in the Juvenile and Family Court Journal in 2006, a general overview of the neurology of trauma as well as the psychosocial impact of trauma on a child. From a neurodevelopmental standpoint, one can see that trauma through neglect or abuse can interfere with the sensitive periods of early brain development, therefore impairing functioning for the rest of the child's life. Trauma has also been shown to lower IQ and decrease the size of certain regions of the brain, including the frontal lobe, in charge of functions such as decision-making and planning (Putnam, 2006). Additionally, studies have demonstrated that children who have suffered maltreatment tend to have lower levels of N-acetyl-asparate, a chemical which promotes neuron health, in the region of their brain responsible for rapid decision making. This is a trend that has also been noted in the brains of adults with Posttraumatic Stress Disorder (Putnam, 2006). Putnam also covers the impact of trauma on a child's psychosocial development, including disturbance of a child's attachment bonds. In infancy or early childhood, attachment is defined as having a figure who has a strong, emotional relationship with the child, who provides a sense of security and pleasure to the child, and whose loss or threat of loss would be extremely distressing to the child (Putnam, 2006). Disturbances in or a lack of this kind of bond can lead to drastic issues later in life, including cognitive immaturity, low self-esteem, patterns of dissociation, and difficulty in social interactions (Putnam, 2006). Putnam continues by summarizing the implications of these studies of neuro and psychosocial development in children with histories of maltreatment, analyzing the effectiveness and availability of current child abuse prevention programs in the United States. Putnam states

that the most effective aspects of treatment for childhood abuse survivors include programs with long durations and programs involving Trauma-Focused Cognitive Behavioral Therapy.

This article is a sufficient summary of trauma's impact on a child. It provides a useful, general outline of the damage done to a child's brain and the hindrance of child development when the child is placed under extreme stress, such as in cases of traumatic grief. The similarities between the brains of abused children and the brains of adults with PTSD imply that any traumatic experience can damage the brain and interfere in its development. A child's traumatic loss of a loved one can also be connected to this article's discussions of attachment dynamics of neglected or abused children. The definition of attachment implies a child who suddenly lost their attachment figure would endure great distress and damage to their psychosocial development on a similar level to a child who is abused or neglected. Finally, this article advocates for increased accessibility and duration of treatment for traumatized children, similar to the purpose of this thesis.

Exposure to trauma at an early age can negatively alter one's biological stress-regulating systems throughout the rest of their life. Published in Psychoneuroendocrinology in March 2008, "The link between childhood trauma and depression: Insights from HPA axis studies in humans" by Christine Heim, D. Jeffrey Newport, Tanja Mletzko, Andrew H. Miller, and Charles B. Nemeroff is a summary of several clinical studies of the adult human stress response under the influence of childhood trauma. Heim et. al. provide an overview of several studies conducted regarding the hypothalamic-pituitary-adrenal (HPA) axis (the system that allows a mammal to maintain homeostasis in the face of psychological or biological stress) and how its functioning is impacted throughout the lifespan of a traumatized child. Specifically, the authors identify

childhood trauma as a risk factor for depression in adulthood based on several observable biological factors. Trauma in early life can raise the activity of one's Corticotropin-releasing factor (a neuropeptide necessary in the typical neurological response to stress or trauma), or CRF. This permanently changes the functioning of one's HPA axis, or the interaction between the hypothalamus, pituitary gland, and adrenal glands during the stress response. To help prove this, Heim et. al. conducted a study on the HPA axes of adults with histories of childhood physical and/or sexual abuse. Through interviews, psychometric rating scales, controlled CRF stimulation tests, and more, the means by which trauma impacted the functioning of adults with trauma backgrounds were uncovered by the researchers over the course of several years. The administration of synthetic CRF in adults with backgrounds in childhood trauma as well as psychosocial stress tests revealed that the adults had an increased sensitivity to stress, which is a key characteristic of Posttraumatic Stress Disorder (Heim, Newport, Mletzko, Miller, & Nemeroff, 2008). The team involved in these studies also made notable discoveries of the impact of childhood trauma on the size of the survivor's hippocampus. The researchers found that the left hippocampus in depressed women with a history of childhood abuse was 15% smaller than in the control groups of healthy women (Heim et. al., 2008).

Limitations of the studies summarized in this document are noted by the authors, including the lack of dependability of self-reported incidences of childhood trauma. The unfortunate nature of trauma is that it can interfere with the survivor's memories and perception in many ways. This means the conclusions drawn by the authors that were based solely on responses given by the study's participants in interviews may not be wholly accurate, nor can they be used in a general conclusion of the HPA axis dynamics of all childhood trauma

survivors. Despite this, the studies using controlled CRF stimulation and observations of activity and volume of the hippocampus of trauma survivors provide valuable insight into the neurobiological impact of childhood trauma and the importance of early treatment of a traumatized child.

According to the literature, trauma in any form can disturb and damage the neurological and emotional development of the traumatized child throughout their entire lifespan by several means. This is evident by both observable neurological patterns as well as the external behavioral symptoms demonstrated by survivors of childhood physical and sexual abuse, which often stretches into adulthood and leaves adults with trauma backgrounds susceptible to depression. Such evidence implies a great need for intervention in cases of childhood trauma.

Traditional Treatment Practices in Traumatic Grief

To examine the potential alternative treatment options for traumatic grief, one can first analyze traditional means of treatment of childhood trauma and grief. One article which describes treatment methods meant to meet the needs of traumatized children is "Complex Trauma in Children and Adolescents," published in the Psychiatric Annals in 2005. The authors of this document outline the traumatized child's need for treatment, describing how exposure to childhood trauma can result in lifelong deficits such as insecure attachment patterns, dissociative behaviors, and unstable behavioral regulation (Cook, Spinazzola, Ford, Lanktree, Blaustein, Cloitre, DeRosa, Hubbard, Kagan, Liautaud, Mallah, Olafson, & van der Kolk, 2005). The several domains of child development impacted by exposure to trauma warrant immediate and effective treatment. Before treatment begins, a clinician must first assess the nature of the child's trauma through the child's self-disclosure, disclosure of the child's caregivers and healthcare

providers, the clinician's observations of the child, and standardized assessment of the child, their caregiver, and (if possible) their teacher (Cook et. al., 2005). Assessments should be culturally sensitive while also considering the child's family and medical history. The clinician working with the child should use information collected in the assessment period to determine the interventions appropriate for the child's treatment. The authors provide a general description of the treatment programs designed in an attempt to target the specific components of trauma impacting the child's functioning. Several treatment plans have been developed within this area of study. These programs are varied in method and scope. For instance, some are relationship-based, focusing on both parent and caregiver. Some treatment models may feature group therapy sessions for child trauma survivors, while some are individualized. Treatment programs such as the Skills Training in Affect and Interpersonal Regulation (STAIR), Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), and Trauma Adaptive Recovery Group Education and Training (TARGET), all provide group therapy, a method proven useful for children who require assistance in the promotion of interpersonal connection and self-regulation (Cook et. al., 2005). The goals of these treatment programs are to teach and enforce the development of "concrete skills," with the benefit of group processing to "decrease stigmatization and increase normalization" (Cook et. al., 2005 p. 397). Additionally, treatment can vary in duration based on the child's individual needs. The authors further specify that psychopharmacologic interventions are given in order to manage any attentive or cognitive symptoms may interfere with the child's ability to participate in psychosocial treatments (Cook et. al., 2005).

This article provides a sufficient base-line understanding of the traumatized child's needs and how they are met through thorough assessment and treatment. Though discussion of the specific treatment methods is short, the document emphasizes a need for continued research on the development of trauma-focused treatment programs for children and adolescents. In addition, there seems to be a lack of data regarding the effectiveness of these more traditional techniques of psychosocial and psychopharmacologic treatments for traumatized children.

The sudden death of a loved one is difficult for anyone to process, let alone a child. Treatment and intervention for a child experiencing a traumatic loss is imperative. In "Traumatic Loss in Children and Adolescents," an article published in the Journal of Child and Adolescent Trauma in 2011, Anthony P. Mannarino and Judith A. Cohen describe the interesting nature of childhood traumatic grief (CTG), specifically regarding the ways in which the condition differs from general childhood bereavement based on the intensity of its symptoms. Research shows that childhood traumatic grief is not a typical response to the loss of a loved one, and therefore should be treated differently. The authors explain that a key component of CTG, as opposed to other experiences of grief, is that it significantly interferes with the child's functioning. This is because the child with CTG essentially becomes "stuck" on the traumatic elements of their loved one's death, afflicted by intrusive, frightening mental images of the traumatic events leading up to the death even upon thinking of positive memories they have with the deceased (Mannarino & Cohen, 2011, p. 25). In essence, the traumatic circumstances surrounding the death of the child's loved one prevent the child from maneuvering their grief in a way that is typical. As of the publication of this article, the only published and validated assessment system of CTG is the UCLA/BYU Expanded Grief Inventory (EGI). This EGI asks children to respond to 28 items on

a five-point scale. This document also covers the current treatment models that have been proven to be useful in treating CTG based on traditional therapeutic interventions focusing on PTSD and grief. In Traumatic Grief Cognitive Behavioral Therapy (TG-CBT), elements from the traditional model of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) are implemented into parallel sessions with both the child and their parent(s) or caretaker(s). Once the child suffering with traumatic grief has resolved the circumstances of their trauma using traditional methods of cognitive behavioral therapy, the next step of TG-CBT addresses the child's grief. The therapist's goals at this point of TG-CBT treatment include providing grief education and assisting the child in grieving the loss and addressing lingering, complicated feelings they may have surrounding the person who died. TG-CBT also aims to help the child in "preserving positive memories" to further solidify the child's ability to comfortably face the memories of the deceased person (Mannarino & Cohen, 2011 p. 30).

Mannarino & Cohen also explore the UCLA Trauma/Grief Program for Adolescents, another treatment method for CTG based upon traditional means of trauma therapy with incorporated grief work. This treatment model focuses on adolescents who have suffered a traumatic loss. The goals of the UCLA model aims to assist children ages 11 and older in processing their trauma "through exposure and cognitive restructuring," addressing trauma and loss reminders, "focusing on the interrelationship between trauma and grief," and promoting the teenager's development (Mannarino & Cohen, 2011 p. 30). This treatment model has been found to reduce both trauma and grief symptoms in adolescents and teenagers as well as improve their functioning, such as improving their academic performance (Mannarino & Cohen, 2011).

Finally, this document addresses Child-Parent Psychotherapy (CPP) as a traditional method of therapy for children with traumatic grief. Originally designed for infants and preschool-aged witnesses of domestic violence, CPP was adapted in 2005 for young children who suffered a traumatic loss of their parents (Mannarino & Cohen, 2011). CPP is a relationship-based model of treatment involving joint sessions with both parents and their young children with the goal of assisting the parent and their child in "creating a joint narrative of the traumatic events," allowing both parties to appropriately process their shared trauma (Mannarino & Cohen, 2011 p. 31). The authors note that further research is needed into the specifics of utilizing the CPP model to address traumatic grief in children.

The authors of this report utilize several resources to summarize the strange nature of CTG and the current treatment models available for the condition. Mannarino and Cohen's work also illustrates the need for a clinical tool to assess CTG in very young children, as the UCLA/BYU EGI is designed only for children who are at least seven years old. This is because the current methods of CTG assessment require the child to self-report, which can be difficult for a young, pre-verbal or pre-literate child. Acknowledging this kind of limitation is an important step toward improving the quality of treatment for children experiencing traumatic grief. After analyzing all the available information regarding CTG, Mannarino and Cohen conclude that research on alternative methods of CTG treatment must continue as we learn more about the complex needs of children who experience the condition..

Children who suffer a traumatic loss experience unique symptoms, and therefore require unique treatment. One article titled "Seasons of Grief: Helping Children Grow Through Loss" explores the concepts of trauma and traumatic loss and how children experience them. The

article was written by Donna Gaffney, a clinician who found herself profoundly impacted by the events of September 11th, 2001 and the children in New York City who were left traumatized and coping with traumatic loss as a result. She begins by defining the differences between a traumatic event and a typical stressor, highlighting the fact that trauma instills feelings of fear and depression that often persist long after the original traumatic event(s) occurred. Gaffney then covers the unique effect that trauma can have on a child when it works in tandem with symptoms of grief. When trauma and loss intersect, the child may experience intrusive flooding of painful memories upon yearning for a deceased loved one. An important aspect of the grieving process is allowing the child to reflect and talk about their loved one. However, in cases of traumatic grief, doing so can bring forth "agonizing images and thoughts, further complicating the grief process" (Gaffney 2007, p. 57). This means the symptoms of trauma must be addressed before the child can properly process their grief. Gaffney details how traditional methods of childhood trauma treatment have successfully approached these symptoms in ways that most thoroughly support the child experiencing traumatic grief. Gaffney also suggests that it is helpful to reframe the idea of "closure" for children with traumatic grief. She instead believes CTG treatment is more effective when the clinician aims for "integration." This establishes that memories of the event leading to the death of a loved one should not be erased, but rather unified with every other aspect of the child's history (Gaffney 2007, p. 58). Finally, Gaffney states that another effective manner of addressing childhood traumatic grief is to seek non-traditional methods of treatment when the child faces difficulty simply talking about their emotions, such as "play therapy, art therapy, bibliotherapy, photography, journaling, bodywork, drama, guided imagery, music

therapy, meditation, and yoga" (Gaffney 2007, p. 58). Specifically, Gaffney sees value in the use of music, play, and metaphor.

This article is well-written and insightful, but it is limited by its short length and lack of specific evidence or case studies to support the author's points. A clinician who reads this article may need to complete additional research to feel fully comfortable with applying any of Gaffney's ideas and strategies to their own clients coping with childhood traumatic grief. Despite this, Gaffney's article remains an excellent overview of the idea that the sole use of traditional methods of Cognitive Behavioral Therapy may be insufficient in addressing the complicated issue of childhood traumatic grief. In this light, Gaffney's work also highlights the need for more research on these nontraditional means of treatment of childhood traumatic grief.

Childhood traumatic grief is a complicated, incredibly unique experience that has only very recently begun to be understood by clinicians. Research regarding the specifics of CTG is slim, but it points to a need for alternate means of treatment for the children who face the condition. When the elements of trauma and grief are combined, a child may find it difficult to express their emotions verbally. This makes the traditionally used methods of talk therapy and CBT challenging to apply to CTG.

Music Therapy in the Treatment of Childhood Trauma and Grief

While little published literature is available regarding music therapy for the specific matter of childhood traumatic grief, we can analyze the clinical use of music for both trauma and grief symptoms in children separately. One article that tackles the use of music therapy in addressing trauma is Rivka Felsenstein's "From Uprooting to Replanting: On Post-Trauma Group Music Therapy for Pre-School Children," included in the Nordic Journal of Music

Therapy in 2013. This document is a case study of a music therapy intervention used with three groups of pre-school children who had been forcibly removed from their homes following the Israeli disengagement from the Gaza Strip in 2005. The children had been displaying symptoms typical of PTSD as a result of this sudden life change. Felsenstein covers the many ways in which music therapy is useful in the treatment of PTSD, including its ability to stimulate traumatic memories in the process of processing trauma, provide nonverbal means of expression for trauma survivors who may be challenged by a loss of expressive ability, and serve as a "voice" for young children who are pre-verbal and/or verbally inhibited by their trauma (Felsenstein, 2013). This study used a model Felsenstein calls the *Uprooting to rePlanting* model, or UP. In this case, there were three different branches of UP applied to these groups of preschoolers via music therapy: *Adaptation* to the sudden change of environment, *coping* with trauma, and *working* through the loss of their community (Felsenstein, 2013). Adaptation was addressed through the opening song of every session, which repeated the phrase "Shalom (name of child) -- and how are you today?" (Felsenstein, 2013). This established trust between members of the group and their environment and allowed each child a chance to share their feelings by singing and strumming the therapist's guitar based on their mood. Several strategies were used to help the children cope with trauma, including group songwriting, drum circles, singing, improvisation, and lyric substitution of familiar songs. Felsenstein notes that drumming was especially successful in facilitating the children's expressions of anger. One four-year-old client used a 1-5 scale provided to her by Felsenstein to rate her feelings at the end of a session that involved drumming and reported decreasing from a 4 in anger to a 1 (Felsenstein, 2013). Drumming was also useful in turning painful, scary memories into lighthearted and humorous

activities, demonstrated when a client compared the sound of his drum to the sound of bombs and his fellow group members laughed and joined him. The instrument provided a medium for the children to take control of the upsetting sound and face a traumatic memory in a playful way (Felsenstein, 2013). The issue of dealing with the loss of a familiar environment was addressed with a ritualistic closing song at the end of every music therapy session. Upon the end of treatment, the children engaged in a final session to reflect on their experience over the course of their music therapy sessions with Felsenstein. This consistent closing song along with the final termination session provided the children with a symbolic sense of gradual closure that they did not receive on the day they were suddenly evicted from their homes (Felsenstein, 2013).

This article highlights the value of holistic care in treating traumatized children. In her music therapy sessions with these pre-school children, Felsenstein successfully addressed spiritual, emotional, social, cognitive, and physical goals. Felsenstein's work also demonstrates the benefits of group music therapy for traumatized children; though the children who were in this group were all there for the same reason (being evicted from their homes). Additional research is needed on the effectiveness of the UP model for groups of children who do not have a single type of traumatic experience in common.

There also exists evidence to support the use of music therapy for children grieving the loss of a loved one. In "Development of the Grief Process Scale through music therapy songwriting with bereaved adolescents," two board-certified music therapists, Thomas A. Dalton and Robert E. Krout, seek to create a new assessment tool to be used with bereaved adolescents engaging in music therapy songwriting interventions. The use of songwriting in weekly music therapy sessions helped a group of bereaved adolescents musically express their feelings,

concerns, and coping mechanisms regarding the death of a loved one. By analyzing 123 songs written by these adolescents, Dalton and Krout organized the common lyrical themes into five "grief process areas": understanding, feeling, remembering, integrating, and growing (Dalton & Krout, 2005, p. 132). The researchers then used these grief process areas to create a questionnaire composed of six statements for each grief process area. Below each statement was a 100-millimeter line that connected two opposite responses: "easy" and "hard." Participants are then asked to draw a mark on the line that aligns with how easy or hard it is for them to complete the task described in the statement. For example, the first statement requires the participant to rate the difficulty of looking at photos of their deceased loved one on a scale from 0 to 100 (Dalton & Krout, 2005, p. 139). After the assessment was created, Dalton and Krout engaged 14 participants in a seven-week music therapy treatment plan based mostly on songwriting. Six participants who had scheduling conflicts and could not attend these music therapy sessions were used as a control group, for a total of 20 participants. In each session, clients worked with a music therapist and a music therapy intern to write lyrics within 5 song structures prepared by the therapist. The five pre-prepared structures were titled based on the five grief process areas: "This is What Happened," "So Many Feelings," "I Remember," "Slowly Moving Away," and "My Life is Changing" (Dalton & Krout, 2005, p. 135). Within these structures, clients were given opportunities to add original lyrics based on their own experiences of grief, improvise on instruments to nonverbally express the content of their lyrics, and customize the musical elements of the song, such as rhythmic patterns, chord progressions, and genre (Dalton & Krout, 2005). The completed songs were recorded onto physical CDs, and treatment ended with each client sharing their songs with their fellow group members. All participants were given Dalton

and Krout's Grief Processing Scale (GPS) assessments before and after the seven-week treatment. The differences in responses before and after treatment were then analyzed. On average, clients who completed the seven-week songwriting intervention reported a 43% decrease in difficulty in the grief process areas of understanding and feeling, a 45% decrease in difficulty in remembering, a 41% decrease in difficulty in integrating, and a 31% decrease in difficulty in growing (Dalton & Krout, 2005). On the other hand, the control group reported a slight increase in difficulty in all areas after seven weeks of not receiving music therapy treatment (Dalton & Krout, 2005). Completion of songwriting-based music therapy treatment reportedly made processing the grief of a loved one less emotionally challenging for all clients who participated.

The purpose of this study was more focused on the application of a new measurement tool rather than on the effectiveness of music therapy for bereaved adolescents, however, evidence of the latter is still clearly present in the study's results. There are several limitations within the procedure of this study, including the small sample size and the short duration of treatment. One can infer that an even greater decrease in the difficulty of grief processing could have been reported after a more long-term treatment process. Additionally, there exists a need for more research on the accuracy of Dalton and Krout's newly created assessment tool within this population. Despite these drawbacks, this work provides promising data on the efficacy of the specific music therapy intervention of songwriting for bereaved adolescents.

In cases of childhood trauma and grief, music therapy is an invaluable tool. The inherent nonverbal and nonintrusive qualities of music can be harnessed by clinicians to address all areas of a child's neurological and emotional development that are impacted by experiences of trauma

and grief. The use of evidence-based musical interventions assists the traumatized or grieving child in achieving their spiritual, emotional, cognitive, creative, and physical goals.

Summary

For a child, navigating a traumatic experience such as the sudden death of a loved one is a complex, polarizing process. Several studies prove that the combination of trauma and loss can potentially impair a child's neurodevelopment and psychosocial development. These experiences can also cause the child to display PTSD-esque symptoms, separating the experience of childhood traumatic grief from that of typical bereavement. As researchers and clinicians' understanding of the specific experience of childhood traumatic grief continues to develop, treatment options for these children must continue to be refined and analyzed. The literature described in this review indicates a need for more creative and atypical treatment methods for children experiencing CTG. Based on research regarding the unique power of music for both childhood trauma survivors and children in mourning, it is reasonable to conclude that music therapy could fulfill this need.

Methods

Introduction

In this study, the execution of music therapy treatment with children coping with traumatic grief was assessed. In order to examine the goals addressed, techniques used, the effectiveness of those techniques, and the necessity of the service for this particular population, the researcher created a short survey for music therapists who work or have worked in the past with clients experiencing CTG. The survey asked for music therapists to self-assess the effectiveness of the interventions they have used to address CTG based on the responses of their clients on a 1-4 scale, with additional space for any open-ended comments they could offer. The therapists were also asked to rate and comment on their satisfaction with the current music therapy services available in their communities for children with CTG.

Setting. This study was conducted electronically. Participants were notified of the survey through a social media network for music therapists as well as through direct e-mail communication. The results of the survey were analyzed and reported in the completion of an online course at Anna Maria College in Paxton, MA. Results were gathered from March 22nd, 2020 through April 10th, 2020.

Participants. The specific participants of this survey were music therapists who are board-certified following the certification requirements of the American Music Therapy Association. This study was designed for board-certified music therapists who work or have worked in the past with children with CTG (not specifying if CTG had officially been diagnosed). Only music therapists who practice within the continental United States were eligible to participate. Participants were asked to identify their primary region and clinical setting

of practice. The presented options were the Great Lakes Region, the Mid-Atlantic Region, the Midwestern Region, the New England Region, the Southeastern Region, the Southwestern Region, and the Western Region. Data was collected from 13 voluntary participants in total.

Materials and Measurement Instruments. The materials necessary for this study include the electronic questionnaire created with the online service "Surveymonkey," accessible from computers, tablets, smartphones, etc. Marketing for the survey was done through a social media group for music therapists called "Music Therapists Unite!". The survey consists of 5 multiple-choice questions and 2 questions warranting a response on a 1-4 rating scale as a means to collect quantitative data. Qualitative data was collected through two optional open-ended questions for a total of 9 questions (See Appendix A). The purpose of this survey is to discover the effectiveness and accessibility of music therapy treatment (the independent variable) to assess the necessity of music therapy for children with CTG in the United States (the dependent variable).

Procedure and Analysis. Using multiple-choice questions, scaled responses, and open-ended responses, data regarding the effectiveness of and music therapists' satisfaction with the current services available for children with CTG was collected. To ensure further accuracy and specificity, multiple-choice questions included an "Other" option, with space for open-ended comments from participants if their experience did not fit the responses given. Due to the qualitative, opinion-based nature of this study, the validity and reliability of these results consistently were left open to participant bias or error.

Details of the survey were posted on the "Music Therapists Unite!" Facebook group. Any interested parties who fit the criteria for participants were provided a direct link to the

questionnaire. Further responses were gathered when the researcher sent an electronic message to music therapists directly with a link to the survey and a call to share the link with other MT-BCs. Data was analyzed using the built-in analytical features available to Surveymonkey users. The questions of the survey were designed to address the research questions and collect results that would open further conversation and research into the importance of music therapy treatment for children coping with traumatic grief.

Results

All data presented has been analyzed based on 13 responses from board-certified music therapists. Participating therapists each identified the methods they use or have used in music therapy when working with children coping with childhood traumatic grief. Additionally, respondents provided their perceptions on the effectiveness of these methods and their satisfaction with the care offered to this population within their communities. These gathered responses have been organized into qualitative and quantitative data.

Each respondent indicated their primary region of practice. The regions represented in this study included the Great Lakes Region, the Mid-Atlantic Region, the New England Region, the Southeastern Region, and the Western Region. There were no responses from music therapists in the Midwestern or Southwestern Regions. Around 54% of participants represented the New England Region. The Great Lakes and Mid-Atlantic Regions were each represented by two participants, while the Southeastern and Western Regions each saw one respondent (Figure 1).

Within this group of respondents, the combined use of both individual and group music therapy sessions for children with CTG was the most common format of treatment (Figure 2). Participants identified a wide array of settings in which they work or have worked with children with CTG (Table 1). The most commonly identified setting of practice was within community-based facilities, selected by roughly 46% of participants. Around 30% of respondents identified as working within residential facilities, 23% in school systems, 15% in hospitals, and 8% in psychiatric facilities. An additional 31% of participants chose to identify a

setting or settings of practice not listed. These settings included hospice and bereavement centers, "home and clinic-based" centers, home visits, and private practice.

The common goals addressed by music therapists working with children with CTG were also measured by this survey, inviting participants to select all answers that applied to their experience (Table 2). Several participants chose multiple responses. Notably, 100% of participants indicated that they address or have addressed emotional goals for their clients with CTG. Other common responses were psychosocial goals (92% of participants), behavioral goals (77%), and communication goals (62%). Roughly 31% of participants reported working towards cognitive goals. One participant chose to identify a goal not listed, reporting that music had been used in working to "decrease pain" and "nausea."

Concomitantly, the therapists identified the musical interventions used to address the clinical goals of their clients with CTG (Table 3). Once again, participants were provided a list of music therapy interventions to select based on their experience working in this population. These interventions were songwriting (selected by approximately 92% of participants), instrumental improvisation (85%), vocal improvisation (77%), musical play (77%), instrumental instruction (46%), music-assisted relaxation (46%), music and movement (38%), and guided imagery and music (38%). Six respondents chose to include methods not listed. These included "creative arts," "verbal processing," "creating [a] music video," and "music-based mindfulness." Three participants identified music listening and lyric discussion/analysis as an intervention used.

The closing questions of the survey asked participating music therapists to rate their perceived effectiveness of music therapy interventions for children with CTG based on the outcome of treatment (Figure 3). Participants were asked to rank this level of effectiveness on a

scale from 1-4 (1=not effective, 2=slightly effective, 3=effective, 4=very effective). 54% of respondents rated their perceived effectiveness at a 3, 31% at a 4, and 15% at a 2, for an average overall rating of roughly 3.15. Participants were then able to share any additional comments on their selected rating. One participant who rated music therapy treatment of CTG as a 4 ("very effective") wrote that music therapy treatment is "incredibly powerful" specifically for "children who have experienced trauma." Another participant expanded on this, stating that musical interventions "frequently consist of nonverbal, bottom-up processing, which is effective treatment for trauma, grief, and traumatic grief."

Finally, participants were asked to rate their level of satisfaction with the accessibility and quantity of music therapy services offered in their communities for children with CTG, using a similar 1-4 scale (1=not satisfied, 2=slightly satisfied, 3=satisfied, 4=very satisfied) (Figure 4). 54% of respondents rated their satisfaction at a 2, 23% at a 1, and 23% at a 3, for an average overall satisfaction rating of 2. Respondents were once again offered space to explain their answers, an opportunity seized by three participants. One participant wrote: "There are not a lot of providers for childhood mental health issues, which is a huge challenge, and leaves alternate therapists to be the sole provider for many of these children." Another reported working in a "rural area" in which their company of employment "is the only provider for music therapy in 3 counties," stating that they "wish there were more providers so clients have choice and agency." A third respondent commented on the lack of available music therapy services due to their community's recent introduction to music therapy, stating: "I am currently the first music therapist in my area and I am trying to educate providers on what I do."

Discussion

A sample of 13 music therapists were surveyed about music therapy as treatment for childhood traumatic grief. The respondents identified the formats, settings, goals, and methods involved in their music therapy practice, as well as their perceptions on the effect of music therapy and their satisfaction with the availability of music therapy services for this population. The data gathered can be used to assess the importance of accessible music therapy services for children with CTG.

Music therapy practice for childhood traumatic grief

Half of the participants reported delivering music therapy services to children with CTG in the format of both group and individual sessions. Further, a majority of the participating music therapists identified multiple settings of practice, with the most common being community-based facilities. Home visits were also a popular answer, specified by several therapists within the "Other" category. Including schools, bereavement centers, hospitals, residential facilities, and psychiatric facilities, the variety of settings identified by the respondents indicates a high amount of locations in which treatment for CTG is relevant and necessary.

The results also show a wide variety of categories of clinical goals applied by music therapists while addressing CTG. Every respondent identified at least two types of clinical goals they have addressed during their time working with children with CTG. All respondents reported working towards the emotional goals of their clients. Additionally, 12 out of 13 respondents identified working towards psychosocial goals. These results align with the unique ability of music to address the emotional and psychosocial challenges resulting from grief and trauma, as noted in the literature.

In addressing these many clinical goals, the data from this survey shows that there is a diverse array of options for musical interventions commonly used by music therapists in treatment of CTG. Once again, all participants selected at least two interventions they use or have used in the past during music therapy with children with CTG. The response shared by 12 out of 13 of the participants was the use of songwriting. Perhaps the popularity of this response aligns with the unanimous identification of emotional goals in music therapy for this population. Combined with literature regarding music therapy songwriting interventions for childhood grief, these results could further indicate a positive connection between the use of therapeutic songwriting and the emotional needs of traumatized, grieving children. While interventions such as songwriting, instrumental and vocal improvisation, and musical play seemed to be preferred by the surveyed therapists, the interventions of music and movement and guided imagery and music were each only selected by five of the participating therapists. This could be due to the small sample size of participants as well as the increased training necessary for the use of guided imagery and music. Despite these interventions having the lowest response rates, five out of 13 is still a significant number of participants. These results of this particular survey question offer insight into the assortment of options available to music therapists in addressing the needs of children facing childhood traumatic grief.

Music therapy's role in CTG treatment

In rating the overall effectiveness of these interventions, the participants seemed to agree that music therapy is an effective strategy in addressing childhood traumatic grief. Using a 4-point Likert scale, the participating therapists rated the effectiveness of music therapy within this population as an average of 3. Participants were offered an optional space to provide

additional details or justification for their selected rating. Due to the small sample size of the survey, only two respondents commented. These two respondents used the words “effective” and “powerful” to describe the practice in relation to childhood trauma and grief. It seems these music therapists agree with the literature in the idea that musical interventions possess unique abilities to clinically serve children coping with traumatic grief.

The surveyed music therapists used a similar 4-point Likert scale to rate their level of satisfaction with the availability of music therapy services in their area for children with traumatic grief. The average rating amounted to a 2, indicating only slight satisfaction amongst the participants overall. Three of the respondents provided additional comments on their ratings, commenting on the lack of accessibility of music therapy in their communities as well as a need for advocacy for the practice in general. The limitations these music therapists report facing reflect a lack of availability of music therapy for children who could reportedly benefit from the service. Each of these responses combined with the overall low satisfaction rating indicate a need for further research and implementation of music therapy as part of treatment of childhood traumatic grief.

Limitations and Future Considerations

The small sample size of this study greatly limited the accuracy of the results. Respondents were collected through electronic mail and the researcher’s social media outreach, which ended up restricting the level of participation. In particular, the use of e-mail to reach potential participants led to a majority of participants identifying New England as their primary region of practice, and little to no representation in other regions. Should this study be repeated,

a larger sample size should be attained in order to diversify the results and to more accurately reflect the practice of music therapy in childhood traumatic grief across the entire nation.

Conclusions

Though small in scale, this study and its results point to a necessity for increased awareness, research, and evidence for the effectiveness of music therapy in treatment of childhood traumatic grief. The participating music therapists provided data which reinforces the existing research regarding the use of music therapy in treating trauma, grief, and traumatic grief. One of the main points to take away from this study and its results is the incomparable value of music when it is harnessed clinically. Trauma, grief, and traumatic grief are unique afflictions which deserve unique attention and treatment, which are not always provided through traditional means of treatment such as Trauma-Focused Cognitive Behavioral Therapy or school-based interventions. The diverse set of clinical goals that are addressed through a vast array of effective, evidence-based musical interventions could provide such treatment, fulfilling gaps left open by the limitations of traditional treatment methods. Research exists to prove the powerful effect of therapeutic music for children experiencing trauma or grief, while awareness and knowledge of music therapy's role in the particular condition of childhood traumatic grief seems to be lacking. As a result, there is a noticeable need for available and accessible music therapy services as an option for CTG treatment processes, as reported in both the literature and in comments from participants of this study. Continued studies into the practice and its role within the treatment of childhood traumatic grief are necessary to further advocate for increased space within our communities for music therapy services.

Appendix A: Informed Consent and Questionnaire

Informed Consent Form

Before beginning the survey, the music therapists were made aware of all terms, benefits, and risks involved in participating in the study. The following informed consent form was displayed before participants were permitted to begin the survey:

If you have received this online survey, you have indicated that you are a board-certified music therapist in the continental United States who has worked or currently works with children under the age of 18 who have experienced a traumatic loss. You are therefore invited to participate in a research project being conducted by Camryn Gallagher, a student at Anna Maria College in Paxton, MA. The survey is estimated to take approximately ten minutes to complete.

Participation: Your participation in this study is completely voluntary. You may refuse to take part in the survey or exit the survey at any time. You are free to decline to answer any question you do not wish to answer for whatever reason. To have your responses included in the study, be sure to click "Submit" upon completion of the survey.

Benefits: You will receive no direct benefits from participating in this survey. However, your answers may help facilitate further learning about the importance and effectiveness of music therapy for children coping with traumatic grief.

Risks: There are no foreseeable risks involved in this study higher than those faced in everyday life.

Confidentiality: Your survey answers will be sent to a link at Surveymonkey.com where data will be stored in a password-protected electronic format which will only be accessed by Camryn Gallagher. Surveymonkey does not collect identifying information such as your name, email address, or IP address.

If you have any questions about your rights as a research participant, please contact the Anna Maria College Institutional Review Board Chair. The IRB Committee reviews research studies and protects the rights of research subjects.

By clicking "OK," you certify that you are a board-certified music therapist in the continental United States who works or has worked with children under the age of 18 experiencing traumatic grief, and that you have read this information and have had the study purposes, procedures, risks, and benefits explained to your satisfaction.

Questionnaire

The Value of Music Therapy in Addressing Childhood Traumatic Grief: A Survey for MT-BCs.

1. Please identify your primary region of practice.
    a. Great Lakes Region
    b. Mid-Atlantic Region
    c. Midwestern Region
    d. New England Region
    e. Southeastern Region
    f. Southwestern Region
    g. Western Region
2. What is/was the format of your music therapy treatment for children coping with traumatic grief?
    a. Individual sessions
    b. Group Sessions
    c. Both individual and group sessions
3. In what setting(s) do you currently work or have worked with children coping with traumatic grief? Select all that apply.
    a. School system
    b. Community-based facility
    c. Psychiatric facility
    d. Residential facility
    e. Hospital
    f. Other (Please specify):_____
4. What types of goals do/did you address in music therapy sessions for children coping with traumatic grief? Select all that apply.
    a. Behavioral
    b. Cognitive
    c. Psychosocial
    d. Emotional

   e. Communication
   f. Other (Please Specify): _____

5. What methods do/did you use in music therapy with children coping with traumatic grief? Select all that apply.
   a. Music and movement
   b. Instrumental improvisation
   c. Vocal improvisation
   d. Musical play
   e. Instrumental instruction
   f. Music assisted relaxation
   g. Guided Imagery and Music
   h. Songwriting
   i. Other (Please Specify): _____
6. From your clinical experience, please rate the effectiveness of music therapy treatment for your young clients coping with traumatic grief based on the outcome of treatment on a scale from 1-4.
   a. 1 (Not effective)
   b. 2 (Slightly effective)
   c. 3 (Effective)
   d. 4 (Very effective)
7. (Optional) Please share any additional comments you may have about your answer to question #6.
8. From your clinical experience, please rate your satisfaction with the accessibility/quantity of music therapy services offered in your area for children who have experienced a traumatic loss and/or are coping with traumatic grief.
   a. 1 (Not satisfied)
   b. 2 (Slightly satisfied)
   c. 3 (Satisfied)
   d. 4 (Very satisfied)

9. (Optional) Please share any additional comments you may have about your answer to question #8.

*Questions on this survey were written based on Nancy A. Jackson's *A Survey of Music Therapy Methods and Their Role in the Treatment of Early Elementary School Children with ADHD*, published in 2003 by the American Music Therapy Association.

Appendix B: Tables and Figures

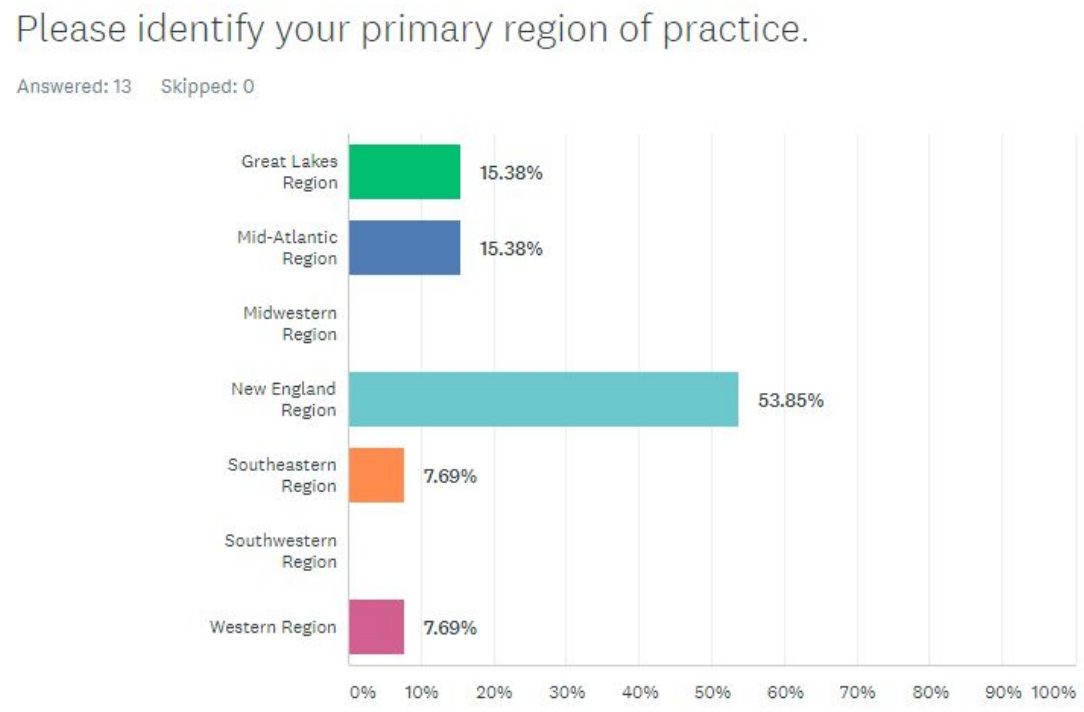

Figure 1: Respondents' Primary Regions of Practice

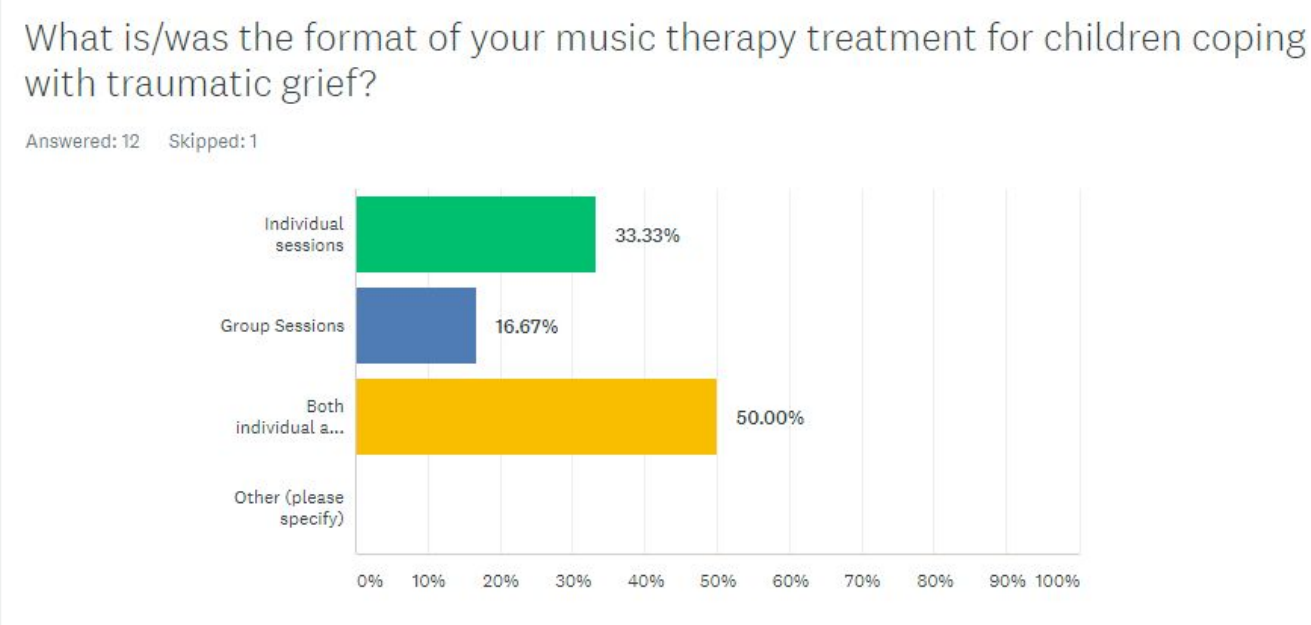

Figure 2: Reported Formats of Music Therapy Treatment

Table 1: Settings of Music Therapy Treatment

Setting	**Number of Respondents**	**Percentage of All Respondents**
School system	3	23.08%
Community-based facility	6	46.15%
Psychiatric facility	1	7.69%
Residential facility	4	30.77%
Hospital	2	15.38%
Other	4	30.77%

Note: Respondents were asked to indicate all answers that applied to their experience. Settings categorized as "Other" by respondents included hospice and bereavement centers, private practice, home and clinic-based facilities, and home visits.

Table 2: Clinical Goals Addressed in CTG Music Therapy

Type of Goal	**Number of Respondents**	**Percentage of All Respondents**
Behavioral	10	76.92%
Cognitive	4	30.77%
Psychosocial	12	92.31%
Emotional	13	100%
Communication	8	61.54%
Other	1	7.69%

Note: Respondents were asked to indicate all answers that applied to their experience. The goals specified as "Other" by one respondent were "decreasing pain, nausea."

Table 3: Methods Used in CTG Music Therapy

Method	**Number of Respondents**	**Percentage of All Respondents**
Music and movement	5	38.46%
Instrumental improvisation	11	84.62%
Vocal improvisation	10	76.92%
Musical play	10	76.92%
Instrumental instruction	6	46.15%
Music assisted relaxation	6	46.15%
Guided imagery and music	5	38.46%
Songwriting	12	92.31%
Other	6	46.15%

Note: Respondents were asked to indicate all answers that applied to their experience. Methods categorized as "Other" by respondents included creative arts/arts making, music listening and lyric discussion/lyrical analysis of preferred music, verbal processing, music video creation, and music-based mindfulness.

Perceived Effectiveness of CTG Music Therapy Treatment

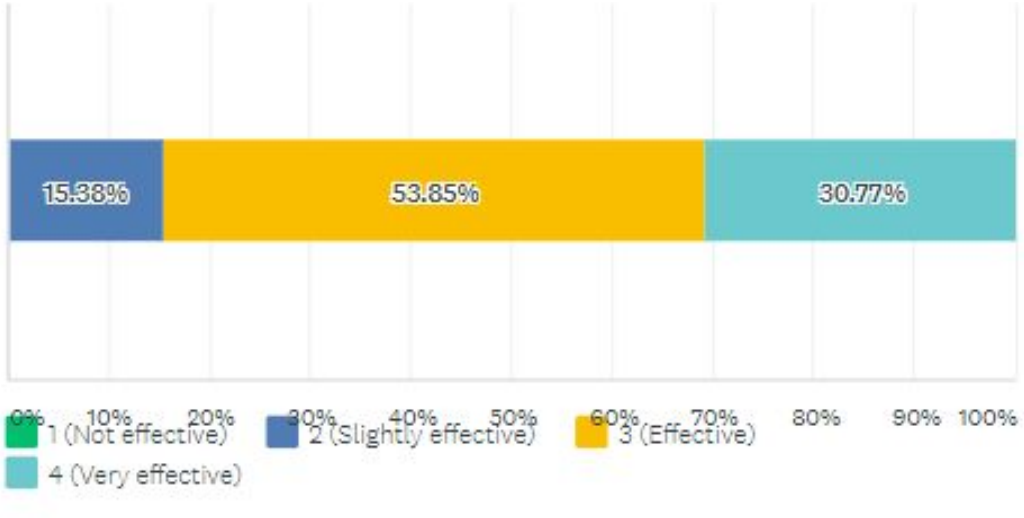

Figure 3: Respondents' perceived effectiveness of music therapy treatment

Music Therapists' Satisfaction with Music Therapy Services

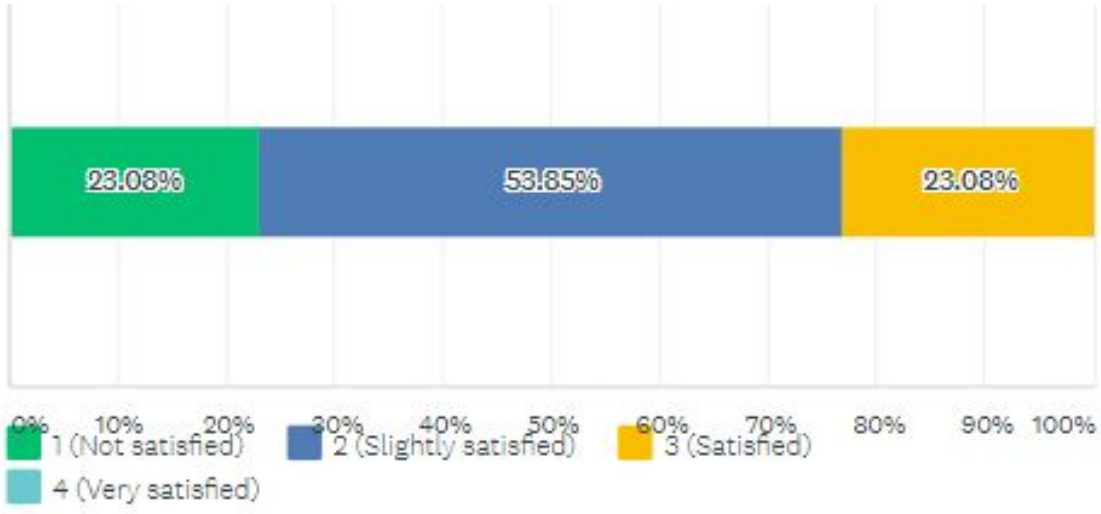

Figure 4: Respondents' reported satisfaction with the accessibility of music therapy services for children with CTG in their area of practice.

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