Shadow Grief: Exploring Bereaved Mothers' Receptivity to Music Therapy Following Miscarriage or Stillbirth

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Abstract

Bereavement following miscarriage or stillbirth can be a traumatic experience. Each day in the United Kingdom seventeen babies die as a result of stillbirth or neonatal death while approximately one in four pregnancies ends in miscarriage. This particular type of loss differs from other forms of bereavement in that grief is for a life unlived. There are no shared experiences or memories. Shadow grief may linger for many years, yet despite recent improvements in health policy, bereaved parents are not always adequately supported in their grief. A literature review has revealed a dearth of music therapy in this area.

As a precursor to the implementation of clinical work, the main objectives of this qualitative feasibility study was to investigate the bereavement experiences of mothers who have suffered loss through stillbirth or miscarriage, and to consider their receptivity towards music therapy as a potential bereavement intervention. Semi-structured interviews were conducted with befrienders from an organisation supporting bereaved parents. Findings suggest there is scope for music therapy to support newly bereaved parents, those undergoing a subsequent pregnancy, for shadow grief with the long-ago bereaved, to interact with current support services and to facilitate the support and supervision needs of befrienders.

Keywords: music therapy; miscarriage; stillbirth; bereavement; grief; parent; remembrance; support; qualitative

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Introduction

This article is based on a clinical research project dissertation submitted in 2010 towards completion of the MSc Music Therapy at Queen Margaret University in Edinburgh, supported by the Music Therapy Charity. The dissertation was also presented at the World Congress of Music Therapy in South Korea (Broad 2011). As a precursor to the implementation of future clinical work with bereaved parents, the main objectives of this qualitative study were to investigate the bereavement experiences of mothers who have suffered loss through stillbirth or miscarriage and to consider their receptivity towards music therapy as a potential bereavement intervention.

Figures published in *The Lancet* indicate that on a global scale there are 3.2 million stillbirths per annum or 8700 stillbirths per day (Flenady et al. 2011). In the UK one in four pregnancies results in miscarriage (NHS 2009) and 17 babies die each day as the result of stillbirth or neonatal death (Why17 2010). Over 70% of stillbirths occur in women with no significant medical condition. Stillbirth is ten times more common than cot death. According to Gordon Smith, professor of obstetrics and gynaecology at Cambridge University, stillbirth is a

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forgotten problem which gets little attention and is ignored in funding for research (Smith 2011).

As Aslam (2004) points out, although we have words to describe all kinds of bereaved people such as widow, widower and orphan, even language cannot bear to contemplate the fate of a parent who has lost a child. While the manifestations of grief following miscarriage or stillbirth may follow common grief reactions (Bowlby 2005; Kűbler-Ross 2009; Parkes 1996; Worden 1991), it is important to acknowledge other issues specific to this type of bereavement. Pregnancy is normally expected to result in the birth of a healthy baby. Bereavement following miscarriage or stillbirth can be a very traumatic experience. According to the Miscarriage Association (2009) this type of bereavement creates a particular kind of loss involving grief for an unlived life and the loss of the future as the parent of the baby who has died. As Hockey (1990: 40-41) says "[a] stillborn is someone who did not exist, a nonperson with no name. It is an empty tragedy and a painful emptiness difficult to talk about [...]".

One of the key difficulties may relate to grieving without memories. According to Peppers and Knapp (1980) bereaved mothers carry the burden of grief for the rest of their lives experiencing an ongoing 'shadow grief' that stems from their desire never to forget the loss or from lack of support and understanding from others:

> "Unable to find legitimate avenues of expression, the need to remember becomes paramount. The mothers believe that if they do not remember, no one else will; the memory of their child must be kept alive at all costs" (Peppers & Knapp 1980: 49).

As a result of such experiences or unmet needs, parents may need to call on support from beyond their family and friends.

Support organisations

Support for bereaved parents has increased significantly in the last three decades with the advent and development of self-help organisations such as the Miscarriage Association (2009). As a result of successful campaigning by SANDS (2009) the legal age of foetal viability was reduced in 1992 from 28 weeks to 24 weeks gestation[1].

A stillborn baby is now legally recognised as an individual whose death must be registered and the baby buried or cremated.

Policy change has also led to the adoption of guidelines for professionals in supporting bereaved parents. Indeed the role of health professionals and others can be vital in confirming the reality of parenthood (Riches & Dawson 2000). Training and support are essential for staff to be able to effectively carry out their work in this very demanding area (Schott, Henley & Kohner 2007).

A search of the music therapy literature revealed there are papers relating to music therapy and maternity care (Allison 1991; Browning 2000; Chang & Chen 2004; Kaiming, Shuping & Xiaofen 1997) and many examples of music therapy as a means of bereavement support in general (Aldridge 2003; Bright 2007; Krout 2005; Lindenfelser, Grocke & McFerran 2008; O'Callaghan 2004; Smeijsters 1999). There appears however to be a gap in the literature relating to examples of music therapy work following miscarriage and stillbirth. After reading an article in the *APMT/BSMT News* (Bruce 2009) concerning the personal experiences of three music therapists on losing a baby and their struggles to cope with their grief, I realised that despite improvements in healthcare support in recent years, the loss of a baby is today still a personal tragedy for bereaved parents.

And so the focal point of and motivation for this study were conceived from personal interest in this area, having myself experienced the loss of a baby through miscarriage over twenty years ago, coupled with the discovery that there appears to be a lack of music therapy literature relating to stillbirth or miscarriage.

Research aims and methods

Aims

The main objective of this research was to investigate the bereavement experiences of mothers who have suffered loss through stillbirth or miscarriage, to examine the role music played in their grief process and from their narratives to consider their receptivity towards music therapy as a potential bereavement intervention. The findings from the study may serve as a foundation for planning and implementing clinical work with bereaved parents who have experienced this type of loss.

[1] In the UK miscarriage is defined as the loss of a pregnancy before 24 weeks gestation (NHS 2009). Stillbirth is pregnancy loss after 24 weeks gestation. Neonatal death occurs in the period from birth to 28 days (SANDS 2009).

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Methodology

Qualitative rather than quantitative exploration was chosen for this research as the emphasis was on exploring the lived experience of support workers who are bereaved parents. It may be difficult to measure the feelings and meanings associated with the birth or death of a child therefore a quantitative approach seemed less appropriate given the sensitive nature of this subject area. Qualitative studies in the area of bereavement have been carried out by Magill (2009a, 2009b), Klingler (2000), McFerran-Skewes and Erdonmez-Grocke (2000). Lauterbach (1992) investigated mothers' experience of perinatal death of a wished-for baby.

A phenomenological-orientated approach was adopted. Phenomenology is concerned with examining life experience as it is lived in order to provide deeper understanding of the experience. The theoretical perspective of phenomenology was developed by philosophers Hegel, Husserl and Heidegger (Sim & Wright 2000). Forinash (1995: 368) states "[phenomenology] is not a search for truth, but rather for meaning and relevance". It is a relational form of research concerned with unique and multifaceted human experience (Sim & Wright 2000). This makes it very suitable for investigating different grief responses. The research and the researcher are not separated (Forinash 1995). Finlay (2008: 5) notes "[the] researcher's aim is to empathise with the participant's situation and offer further prompts geared to exploring existential dimensions of that situation". Methodological approaches based on phenomenology have been employed a range of music therapists (e.g. Trondalen 2003) and in a bereavement study by Skewes (2001).

Sampling

Purposive sampling (Miles & Huberman 1994; Robson 2002) was necessary as it was essential that participants met the criterion of having experienced miscarriage or stillbirth. In order to identify the feasibility of recruiting potential participants, preliminary e-mail enquiries were made via organisations supporting bereaved parents. Two organisations were approached. One declined to participate as it mainly provides telephone support and deemed it unlikely that music therapy could be incorporated within its current support network.

The second organisation indicated its interest in the study. A face to face meeting was then arranged with three representatives from the organisation. A broad outline of the study was given and opportunity provided for the representatives to ask any questions about the study and to express any concerns. This was particularly important, given the sensitive nature of this study. Detailed information about the study was then sent by email to one representative of the support organisation, who acted as contact liaison between the researcher and potential participants. Four participants were recruited who were themselves bereaved mothers and who had acted as a support worker for a miscarriage and stillbirth support group within the last five years. Participants A, B and C experienced loss as a result of stillbirth over fifteen years ago. Participant D suffered loss through stillbirth within the last five years. All participants were of white British origin.

Ethical considerations

Ethical approval was granted in accordance with the Queen Margaret University ethics procedures.

This study addresses a sensitive topic area. Although the participants were themselves bereaved parents, to become befrienders they had undergone training in dealing with bereavement. For this reason re-traumatisation resulting from the research was likely to be minimal however they were provided with a resource sheet of information about organisations offering counselling and support services.

Since it was possible that difficult or sensitive issues might potentially arise for me as a result of the study, I also had access to support.

Interviews

Data was generated from semi-structured interviews (see below) which were audio recorded. Individual interviews were carried out in the participant's home or in an office belonging to the support organisation. The same interview schedule was followed with each participant to increase the validity and reliability of data. As researcher I tried to be impartial to the views of participants differing from my own experience. Sim and Wright (2000) suggest rapport between researcher and participant is essential to gain insight into the participant's lived experience. In order to maximise the integrity of the study and minimise researcher bias, I kept a reflexive journal (Bruscia 1995) recording my own perspectives and acknowledging possible blind spots and biases (Aigen 1995).

Participants were asked to view two brief clips of video footage available in the public domain. The purpose of this was to identify and/or raise their awareness of music therapy and to stimulate response about the use of music as an intervention in bereavement. The first clip, specific to music therapy, was a publicity video available on the

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Nordoff Robbins website[2] showing extracts of case study material. It proved difficult however to find a suitable music therapy clip relating specifically to bereavement within the public domain. The second clip[3] showed a discussion with a hospital chaplain describing the sensitive use of music to match the feeling state of a bereaved mother in an approach resembling that of music therapy.

As the main focus of the study centred on Nordoff-Robbins music therapy, an outline of the Nordoff-Robbins approach was given. Using improvised music the therapist seeks to engage creatively with the client, adapting the musical experience to meet individual need, in the belief that everyone can respond to music despite illness, disability or trauma (Nordoff & Robbins 1983; Nordoff-Robbins Music Therapy in Scotland 2013; Robbins 2005). Participants were also given a book to read *Every Note Counts* (Simpson 2007) containing a range of photographic material and further background information about this approach.

Below, the interview schedule is provided. The purpose of each question is provided in italics, whereas probes and prompts are indicated in brackets.

1) When and how did you become a befriender for a miscarriage and stillbirth support group?

Simple opening question to put participant at ease and gain insight into background and motivation for becoming a befriender.

2) Who attends a support group? (couples, bereaved mothers/fathers, others?)

Identify population attending support groups.

3) How soon after their bereavement do they come for support? (weeks, months, years?)

Identify stage of grief process.

4) How long do they attend? (weeks, months, years, intermittently, continuously?)

Gain insight into the duration and frequency of attendance at groups by bereaved parents.

5) Would you tell me what types of support you offer in your role as a befriender? (verbal, listening, creating memories, other)

Gain insight into the experience of being a befriender. Identify types of support offered.

6) In what ways do you think these types of support help bereaved parents?

Identify how support may facilitate mourning process.

7) In a support group have you ever used music in any way to help bereaved parents? (If yes – how? If no – are there any reasons why not?)

Identify role of music within support groups up to the present time.

8) What is your personal interest in music? (playing an instrument, singing, listening or does it not interest you?)

Gain insight into participant's personal experience of music as this might influence his/her receptivity to music therapy as an intervention.

9) In your own personal experience of bereavement have you found music helpful in expressing difficult feelings?

If yes – how? (listening, playing, singing; sadness, anger, frustration, loneliness?)

If no – are there any reasons why not?

Gain insight into the participant's personal experience of music for bereavement to provide a rich source of data. Hopefully participant would feel relaxed by this point in the interview to talk about personal experience.

10) What do you know about music therapy? (Have you heard of it? Do you know anyone who has had any involvement with music therapy?) [Before viewing DVD footage]

Identify participant's current level of awareness about music therapy.

11) Are there any ways in which you think music therapy might help parents who have lost a baby through miscarriage or stillbirth?

If yes – how? (expression of grief, sharing with others in a group, one-to-one support, song, instrumental playing?)

Identify possible areas in which music therapy might act as an intervention.

If no – for what reasons?

Identify potential barriers to the use of music therapy as an intervention.

12) When do you think music therapy might be the most helpful for bereaved parents? At which stage of their grief? (early, later, does it not matter?)

Identify stage(s) of grief when music therapy might act as an intervention.

[2] Video file '*An Introduction'*. Retrieved from: www.nordoff-robbins.org.uk

[3] Video file *'Reverie harp story 1'*. Retrieved from: www.youtube.com/watch?v=ejQLvtz0u_U

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Content analysis

Interviews were transcribed verbatim. Content analysis was used to organise data from interview transcripts into categories and subcategories to discern emerging themes (Aigen 1995; Miles & Huberman 1994; Simpson 2000). The categories and subcategories were coded manually. A copy of transcripts was sent to participants for verification of accuracy. Peer debriefing took place with a fellow student who acted as co-researcher to check the organisation of categories of data and emerging themes for triangulating the dependability of data.

Findings

The content analysis coding split into five data categories: 1) organisational context, 2) feeling states, 3) support, 4) music, and 5) potential for music therapy.

1) Organisational context

The support network holds an inclusive open door policy. Support network information is made available to bereaved parents in the hospitals by health professionals or via its website. The organisation does not approach bereaved parents directly neither does it involve itself in legal issues between parents and health services.

The policy for befriender recruitment is intended to safeguard the wellbeing of the befriender, as well as the client, in what can be a very demanding role. It is essential that prospective befrienders have worked through their own grief sufficiently to enable them to support bereaved parents. A minimum period of one year after bereavement must elapse before a bereaved parent can be eligible to train as a befriender. The role of the befriender involves collaborative working with health professionals, liaising between parents and health professionals and providing peer support to other befrienders. Each befriender expressed her motivation for taking up this role as a desire to use her own experience of loss to support other bereaved parents thereby turning a negative experience into something positive.

Regional variations in support exist within the network. Three participants are involved in meetings which take place in hospitals. The fourth works within a community centre. Meetings have an open, informal format. Specific meetings are held to support parents in subsequent pregnancy and for 'long-ago' bereaved parents experiencing shadow grief and most recently for grandparents.

Historically, support meetings have been attended mainly by bereaved mothers. In recent years more couples have begun to attend. Family members, friends or health professionals may accompany parents who feel unable to come alone.

Patterns of attendance at meetings vary considerably. Factors which influence attendance include time of year and location of meeting; parental expectation of support; initial apprehension about support meetings; parental need for support particularly around significant milestones such as the first anniversary of the baby's death. Parents who attend regularly may eventually go on to become befrienders themselves. Others attend sporadically. Some newly bereaved parents attend immediately after their loss while others do not come until the birth of a grandchild, when unresolved feeling states associated with shadow grief are triggered (Schott, Henley & Kohner 2007). Others may stop coming after the birth of a subsequent baby. With such variable patterns of attendance it is therefore not surprising that group size also varies widely, ranging from one to twenty.

2) Feeling states

Within this second category the feeling states of bereaved parents were identified both generally and at particular stages of grief, including manifestations of complicated or shadow grief. Further reference will be made to this category during the discussion of the potential for music therapy.

Feeling states	
Codes with sub-codes	***Transcript extract***
Bereaved parent feeling states: - Sadness - Isolation - Anger - Jealousy - Disbelief - Anxiety - Fear - Helplessness - Yearning	Well, there's obviously a lot of tears, a lot of sadness, a lot of anger. Em… very mixed… It's quite amazing the full spectrum of emotions that can be around at a meeting. But, but, yes, a lot of tears and a lot of emotional depth and they're difficult. They're very draining (Participant C 5: 19-29).
Newly bereaved parent feeling state: - Numbness - Shock - Self absorption with grief	In that initial three month period your emotions are so raw and real and at the front of your every waking thought (Participant D 27: 41-44).
Bereaved parent feeling states in later stages of grief: - Laughter - Comedy - Joy	Sometimes actually there's laughter. Especially if we've not got anybody who's newly bereaved. And if we've maybe got a group of people that are maybe trying again for another baby (Participant D 26: 60-65).

Table 1: Feeling states

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3) Support

3.1) Parental need for support

Four main areas of need for support were identified:

3.1.1) The need for expression of feeling states was stressed by all the befrienders.

> *Sometimes you can have people that come in are very aggressive and sometimes you can have people that just want to be quiet and only want to speak when they feel ready (Participant D 26: 77-81).*

3.1.2) Need for social inclusion was particularly important with regard to acknowledgment of loss and the need to identify with others with a similar experience.

> *I think they feel supported because a lot of people, up until they come along, feel that it's just them. They are on their own. Nobody else knows how, how it feels (Participant B 4: 4-7).*

> *Eh, when they come in to meet other bereaved parents they realise that there's other people going on the journey as well, be it a different journey from the one they are on. That just to know that there are other people know how they feel or can imagine how they feel, makes it a bit less lonely for them (Participant B 4: 7-11).*

3.1.3) The need for strategies to cope with the intensity of grief and for holding on to a sense of self were reported.

> *I lived for that meeting every month. It was like a pressure cooker building up and then you had your meeting and you got a chance to talk and you know, you sort of simmered down again for another month (Participant C 7: 14-19)*

A strong need for narrative emerged when the most recently bereaved participant told me the 'story' of her loss in fine detail during the interview process, which took place the day before the anniversary of her loss. As Peppers and Knapp (1980) point out, the interview process itself can cause shadow grief to re-emerge.

3.1.4) The intrinsic need for remembrance was identified as the fourth main need for support.

> *And even if it has been well spoken about and grief has been worked through, as it is more so nowadays, it still doesn't go away but hopefully you do, you are able to integrate it and move on. But you wouldn't ever want to forget (Participant C 4: 49-55).*

> *I don't think I could have kept them out of my mind, the memories any way, whether I wanted to or not. It's just part of you. I think at the beginning I was worried I would forget. That was a fear. I think a lot of people have the fear of forgetting. But I know now, that you don't forget (Participant B 6: 82-91).*

Each befriender referred to ways in which it can be helpful to create memories for the future. (References in brackets show where findings concur with the literature review). Parents are offered memory boxes where they may store mementoes such as scan photographs, photos of the dead baby, scrapbooks, certificates of birth and hospital appointment cards (Schott, Henley & Kohner 2007). The baby's identity can be affirmed in a naming ceremony (Jenkins & Merry 2005). A funeral may help to express loss, confirm the baby's existence and give opportunity for family and others to offer sympathy. Books of remembrance, memorial services, tree planting, stories and poems published by SANDS and other organisations are ways in which parents try to come to terms with their loss (Schott, Henley & Kohner 2007). Collaboration between support organisations has resulted in October 15th being marked as International Pregnancy and Infant Loss Awareness Day when bereaved parents world-wide acknowledge their loss with events such as 'Wave of Light' services and balloon releases (Babyloss 2010). Web-pages such as the 'Forget-me-not Meadow' and 'Lights of Love Tree' (Miscarriage Association 2010) provide opportunity for bereaved parents to post on-line messages expressing their loss.

Body art, in the form of tattoos of the baby's name or footprint, was stated to be the most recent trend amongst bereaved parents in creating memories.

3.2) Facilitation of support

Current facilitation of support by befrienders is mainly through talking, listening and offering practical advice. The befrienders stated that parents find benefit from relationships formed within the support groups and from the acceptability of being able to acknowledge their feeling states openly and honestly with others. Support groups can be a bereavement lifeline particularly for parents lacking adequate support from family and friends.

The befrienders all spoke of their anxiety about gauging the level of support to meet the needs of bereaved parents, particularly with regard to individual needs within the group framework (Hindmarch 1993).

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Sometimes you can get the anger and we've got to be careful cos people are allowed to feel angry but we've got to be then careful that it doesn't spill over to everybody else in the group cos people are at different stages of grieving (Participant D 26: 52-57).

One befriender is able to refer parents to a bereavement counsellor who works in tandem with that particular support group. The counsellor also acts in a supervisory capacity supporting the befrienders within that group. This facility appeared to vary regionally within the organisation.

Findings relating to perspectives on befriending were not covered in the earlier literature review. This may warrant more detailed examination with particular regard to the potential for music therapy to facilitate befriender support and supervision needs.

3.3) Support inhibitors

Many of the support inhibitors identified tie in with previous findings. In terms of cultural differences, it was interesting to note that of those bereaved parents who attend meetings, there are very few from different ethnic backgrounds. It was suggested that they perhaps find support from within their own families and communities.

Support inhibitors	
Code	***Transcript extract***
Gender differences in grieving	In a way he never, my husband wouldn't bring the subject up. But whether it's a man thing, he never felt the need to talk about it. Or whether he couldn't. I don't know. Maybe he couldn't talk about it and that was mainly the reason why I went to the (organisation) group, was because there was no one else that I could speak to (Participant B 8: 33-41).
Cultural differences in grieving	We don't often get a lot of ethnic communities coming. We've got quite large pockets of ethnic communities in (city). And we often wonder why that is and should we be doing more about it? So really I don't know whether it's a cultural thing that they want to keep it private or what (Participant D 15: 88-95).
Social restriction on timescale for grieving	But I think the biggest thing for them is that they know that it's the one place that they can come, talk about their baby and nobody is going to think "Well why are you still talking about that?" ...after a certain time span (Participant A 5: 8-12).
Family restraints on expression of grief	It's also a place that they can offload anything that has upset them or made them angry, that people have said – and it's usually close family – and you know. They are maybe not able to express that within their family (Participant A 5: 12-17).
Lack of social awareness and acknowledgement of bereavement	People still perceive it, especially if the baby is a stillborn baby, it hasn't lived in this world and that it's really not worth remembering. And it's easy for other people to forget that that was a person and part of that family unit. Em, so I think that's probably a really big issue for a lot of families and a lot of parents (Participant A 6: 60-66). I think it's quite isolating the death of a baby that no one else knows (Participant B 16: 191-2).
Dilemma for parents in acknowledging bereavement	And there's also the dilemma for where it's their first baby for parents when they're asked by Joe Public "Oh do you have any children?" They're in a dilemma as to whether they say "Well yes I have but my baby died" or "Well, no" and then they are denying it themselves that this happened (Participant A 6: 67-73).
Unresolved grief in subsequent pregnancy	And often people do get pregnant again within three months. I mean it can happen very quickly because there's just a huge urge to be pregnant again. Then the subsequent baby is due round about the first anniversary of the baby's death so that obviously is very difficult. And we have had people actually let out of the maternity hospital to go to the grave on a first anniversary (Participant C 7: 41-52).

Table 2: Support inhibitors

4) Music

Music was regarded by all the befrienders as being of utmost value in their remembrance services, which take place annually or bi-annually. The measure of need for this type of support is indicated by the large volume of parents and family and friends attending these collective opportunities for remembrance (over 1000 people). All four befrienders described the care with which music is consciously chosen to relate to alternating themes and to underpin symbolic gestures within the service. Reference was made to active song-writing by a bereaved parent. Musical contributions provided by external groups and choirs are highly

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valued by bereaved parents and befrienders alike. It is interesting to note the passive appreciation of music in this context. Although none of the befrienders described themselves as being particularly musical, they nevertheless seemed to find a sense of musical identity via family members. No one spoke of active music making to assist their own mourning other than listening.

A recurring theme was the need for musical flexibility in services to meet parental need:

> *I think our music changes throughout the service as well because we always go out on something that's kind of powerful and uplifting for them leaving the service. Whereas when they come in it's very quiet and subdued (Participant A 13: 27-32).*

> *We sometimes ask parents for music that really means a lot to them. You know, a favourite song or a favourite track and we've played that at these services and it can be really, really moving (Participant C 3: 11-15).*

Music was seen as a key to unlocking suppressed grief, as a unique avenue for expression of feelings and a means of bringing hope for the future with song lyrics being important for remembrance and expression of feelings.

Music listening was important and beneficial during the befrienders' own bereavement. Contrasting opinions emerged about the conscious and unconscious choice of music listening. One person consciously listened to particular songs to evoke tears. Another was uncertain in hindsight whether this was an un/conscious decision. This area of un/conscious song recall may warrant further research.

Music does not currently play a part in support meetings but participation in the study stimulated reflection of the potential to introduce background music to enhance their ethos of creating a comforting meeting environment.

5) Potential for music therapy

5.1 Receptivity of befrienders

The befrienders expressed their lack of awareness about music therapy and its availability. This may reflect the gap in music therapy literature relating to this population. With regard to her own bereavement, one participant said:

> *If there was another channel in which they could have said – 'Look, there's some music therapy open to you here' - I absolutely would have taken it but there wasn't (Participant D 23: 20-24).*

All four were receptive to the concept of music therapy as a support intervention to assist bereaved parents. Due to their lack of knowledge, none were sure how to implement music therapy with bereaved parents. One in particular was apprehensive of the new concept:

> *I don't know what I would have done if I was confronted with maybe someone wanting me to take part in music therapy. But never having experienced music therapy I don't know if whether maybe that would have been a good thing. I don't know. It's probably something I that I don't really know enough about it to say (Participant B 12: 19-27).*

Anxiety about music therapy was possibly congruent with her perception of her own musicality and with befriender anxiety in general about gauging the level of support.

5.2 Potential strategies for implementing music therapy

Befrienders suggested that music therapy might be potentially beneficial for bereaved parents as a non-verbal intervention for grief, to open up channels of communication, to match the intensity of grief and for empathic attunement.

Suggestions were made for music therapy to potentially collaborate with counselling, to interact with current support services and for referral by midwives in the hospitals.

CDs of remembrance services are made available for bereaved parents. In line with this, one person thought a DVD/CD might be a useful tool to introduce newly bereaved parents to the concept of music therapy. It was suggested that group music therapy sessions might be initiated with bereaved parents who have attended support meetings for some time. All the befrienders felt that this should be offered as an optional addition to their regular support meetings. Individual rather than group sessions would be essential for newly bereaved parents. Drumming was suggested by participants as a potential outlet for anger in music therapy sessions with bereaved parents.

5.3 Music therapy and stage of grief

Befrienders envisaged potential benefits from music therapy at all stages of grief but the recurring theme was the necessity for music to attune sensitively to the differing needs of parents during those various stages:

> *I think it just depends on the individual. I think, you know, it's like grief is different for every individual and how they react it's different. …and I think it would mean different things at different times as well (Participant A 13: 7-11).*

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In response to the video clips, one befriender reflected most carefully about the potential for music therapy as an intervention with the newly bereaved. Again this would tie in with their need to gauge the level of support. From the examples in the video clips the participants envisaged that music therapy may be potentially beneficial for reduction of anxiety and relaxation in subsequent pregnancy. In the later stages of grief it was considered to be appropriate to support parents trying to conceive another baby and for shadow grief.

Music therapy and stage of grief		
Stage of grief	***Feeling state***	***Potential for music therapy***
Newly bereaved	Numbness Shock Self absorption with grief	For comfort To trigger emotion To offer sensitive support without words
Subsequent pregnancy	Anxious preoccupation Stress Guilt	For relaxation To induce calmness
Later stages of grief	Laughter Comedy Joy	To support parents trying to conceive another baby
Shadow grief	Re-emergence of unresolved feeling states	To open a channel for grieving

Table 3: Music therapy and stage of grief

Reflections and conclusions

This was a small scale study. In future research a larger sample might be selected from a wider geographical area and from several support organisations. Participants were made aware of the study but it was left to them to make direct contact with me. Because of this, it was not possible to select participants as purposefully as intended therefore this sample is representative of parents who have experienced loss through stillbirth but not through miscarriage. Nevertheless despite these limitations, this preliminary study offers insights which may serve as a foundation for planning and implementing a pilot study of music therapy clinical work with this population. It may also serve as a means of providing evidence to assist in attracting funding for such a pilot study.

A possible way forward to introduce music therapy would be to offer taster sessions for befrienders with the rationale that experiencing music therapy themselves might inform them about music therapy and allay any anxiety about gauging the level of support to meet the needs of bereaved parents. Parents might subsequently be offered taster workshops with follow-up sessions on a time-limited basis.

Given the variable patterns of attendance at support meetings, consideration needs to be given to the format of music therapy sessions, whether these would be open/closed sessions; individual/group work; for couples or for specific stages of grief. The findings suggest there is potential to implement music therapy particularly with newly bereaved parents, those undergoing a subsequent pregnancy or for shadow grief with the long-ago bereaved. The recurring theme is the need for sensitive facilitation of support at each stage of grief. Patterns of attendance in support groups might also indicate that bereaved parents, who feel apprehensive about attending on their own, may wish to be accompanied in music therapy by family, friends or health professionals.

Future studies might examine the effects of specific music therapeutic strategies such as drumming, song-writing, listening and improvisation on the conscious and unconscious mourning processes of this population. Further research might also consider the relationship between music therapy and gender differences in grieving, grandparents' grief and bereavement within multicultural groups.

One participant experienced post-traumatic stress disorder as a result of stillbirth. In subsequent pregnancy approximately 20% of mothers experience PTSD related to the stillbirth experience (Hughes & Cockburn 2007). As music therapy has assisted PTSD in other areas (Bensimon, Amir & Wolf 2008), further investigation may be warranted with bereaved parents. Fostering collaborative working with health professionals may assist the mourning of this population. Changes in professional practice might allow the distribution of information leaflets about music therapy to bereaved parents by health professionals, particularly by midwives in hospitals.

As the music therapy profession seeks to embrace new areas of clinical work, the challenge to the profession is there to take up this highly sensitive area of bereavement. Is it not time for music therapy to acknowledge and support this forgotten area?

References

Aigen, K. (1995). Principles of Qualitative Research. In B. Wheeler (Ed.), *Music Therapy Research: Quantitative and Qualitative Perspectives* (pp. 283-311). Phoenixville, PA: Barcelona.

Aldridge, D. (2003). Music therapy references

ISSN: 1791-9622

relating to cancer and palliative care. *British Journal of Music Therapy*, *17*(1), 17-25.

Allison, D. (1991). Music Therapy at Childbirth. In K. E. Bruscia (Ed.), *Case Studies in Music Therapy* (pp. 529-546). Gilsum, NH: Barcelona.

Aslam, N. (2004). *Maps for Lost Lovers*. London: Faber and Faber Ltd.

Babyloss (2010). *Baby loss awareness campaign*. Retrieved from www.babyloss-awareness.org/events.htm

Bensimon, M., Amir, D., & Wolf, Y. (2008). Drumming through trauma: Music therapy with post-traumatic soldiers. *The Arts in Psychotherapy*, *35*(1), 34-48.

Bowlby, J. (2005). *The Making and Breaking of Affectional Bonds*. Abingdon: Routledge Classics.

Bright, R. (2007). Music therapy, death and grief. *Nordic Journal of Music Therapy*, *16*(2), 179-80.

Broad, M. (2011). Shadow grief: How might music therapy assist bereavement following miscarriage or still birth? *Music Therapy Today* *9*(1), 78-79. Retrieved from www.musictherapytoday.wfmt.info

Browning, C. A. (2000). Using music during childbirth. *Birth: Issues in Perinatal Care*, *27*(4), 272-276.

Bruce, A. (Ed.). (2009). The tonic: Members questions answered. *BSMT News*, *1*, 10.

Bruscia, K. (1995). The Process of Doing Qualitative Research: Part III: The Human Side. In B. Wheeler (Ed.), *Music Therapy Research: Quantitative and Qualitative Perspectives* (pp. 429-443). Phoenixville, PA: Barcelona.

Chang, S., & Chen, C. (2004). The application of music therapy in maternity nursing. *Journal of Nursing*, *51*(5), 61-66.

Finlay, L. (2008). *Introducing pheno-menological research*. Retrieved from www.lindafinlay.co.uk/publications.htm.

Flenady, V., Koopmans, L., Middleton, P., Frøen, J. F., Smith, G.C., Gibbons, K., Coory, M., Gordon, A., Ellwood, D., McIntyre, H. D., Fretts, R., & Ezzati, M. (2011). Major risk factors for stillbirth in high-income countries: A systematic review and meta-analysis. *The Lancet, 377,* 1331-1340.

Forinash, M. (1995). Phenomenological Research. In B. Wheeler (Ed.), *Music Therapy Research: Quantitative and Qualitative Perspectives* (pp. 367-387). Phoenixville, PA: Barcelona.

Hindmarch, C. (1993). *On the Death of a Child*. Oxford: Radcliffe Medical Press Ltd.

Hockey, J. L. (1990). *Experiences of Death: An Anthropological Account*. Edinburgh: Edinburgh University Press.

Hughes, P., & Cockburn, J. (2007). The Next Pregnancy after Stillbirth. In J. Cockburn & M. E. Pawson (Eds.), *Psychological Challenges in Obstetrics and Gynaecology: The Clinical Management* (pp. 193-208). New York: Springer Science and Business Media.

Jenkins, C., & Merry, J. (2005). *Relative grief*. London: Jessica Kingsley.

Kaiming, Z., Shuping, D., & Xiaofen, Y. (1997). Use of music in nursing care of induced abortion. *Shanxi Nursing Journal*, *11*(4), 159-60.

Klingler, J. C. (2000). Relation of adaptation, life meaning and belief in god in central and southern appalachian culture in response to the unexpected and violent death of a child. *Dissertation Abstracts International*, *60*(8B), 4230.

Krout, R. E. (2005). Applications of music therapist-composed songs in creating participant connections and facilitating goals and rituals during one-time bereavement support groups and programs. *Music Therapy Perspectives*, *23*(2), 118-128.

Kübler-Ross, E. (2009). *On Death and Dying (4th Edition)*. Abingdon: Routledge.

Lauterbach, S. S. (1992). In another world: A phenomenological perspective and discovery of meaning in mothers' experience of death of a wished-for baby. *Dissertation Abstracts International*, *53*(6B), 2786-2787.

Lindenfelser, K. J., Grocke, D., & McFerran, K. (2008). Bereaved parents' experiences of music therapy with their terminally ill child. *Journal of Music Therapy*, *45*(3), 330-348.

Magill, L. (2009a). The meaning of the music: The role of music in palliative care music therapy as perceived by bereaved caregivers of advanced cancer patients. *American Journal of Hospice & Palliative Medicine*, *26*(1), 33-39.

Magill, L. (2009b). Caregiver empowerment and music therapy: Through the eyes of bereaved caregivers of advanced cancer patients. *Journal of Palliative Care*, *25*(1), 68-75.

McFerran-Skewes, K., & Erdonmez-Grocke, D. (2000). Group music therapy for young bereaved teenagers. *European Journal of Palliative Care*, *7*(6), 227-229.

ISSN: 1791-9622

Miles, M. B., & Huberman, A.M. (1994). *Qualitative Data Analysis (2nd Edition)*. Thousand Oaks: California: Sage.

Miscarriage Association (2009). *Acknowledging pregnancy loss: How you might feel.* Retrieved from www.miscarriageassociation.org.uk/ma2006/information/leaflets.htm

Miscarriage Association (2010). *Support: Remembering/marking the loss*. Retrieved from www.miscarriageassociation.org.uk/ma2006/support/remembering.htm

NHS (2009). *Choices: Your health your choices*. Retrieved from www.nhs.uk/conditions/miscarriage/Pages/Introduction

Nordoff, P., & Robbins, C. (1983). *Music Therapy in Special Education (2nd Edition)*. Saint Louis: MMB Music Inc.

Nordoff-Robbins Music Therapy in Scotland. (2013). *The Nordoff-Robbins Approach.* Retrieved from www.nordoffrobbinsscotland.org.uk/music_therapy/approach.php

O'Callaghan, C. (2004). Music therapy's relevance in a cancer hospital researched through a constructivist lens. *Journal of Music Therapy, 41*(2), 151-185.

Parkes, C. M. (1996). *Bereavement: Studies of Grief in Adult Life (3rd Edition)*. London: Routledge.

Peppers, L. G., & Knapp, R. J. (1980). *Motherhood and Mourning: Perinatal Death*. New York: Praeger Publishers.

Riches, G., & Dawson, P. (2000). *An Intimate Loneliness: Supporting Bereaved Parents and Siblings.* Buckingham: Open University Press.

Robbins, C. (2005). *A Journey into Creative Music Therapy.* Gilsum, NH: Barcelona.

Robson, C. (2002). *Real World Research (2nd Edition)*. Oxford: Blackwell Publishing.

SANDS (2009). *Promoting research*. Retrieved from http://www.uk-sands.org/Research.html.

Schott, J., Henley, A., & Kohner, N. (2007). *Pregnancy, Loss and the Death of a Baby: Guidelines for Professionals (3rd Edition)*. Shepperton on Thames: Bosun Press.

Sim, J., & Wright, C. (2000). *Research in Health Care: Concepts, Designs and Methods.* Cheltenham: Stanley Thornes Publishers Ltd.

Simpson, F. (2000). Speaking with clients: Perspectives from Creative Music Therapy. *British Journal of Music Therapy, 14*(2), 83-92.

Simpson, F. (2007). *Every Note Counts: The Story of Nordoff-Robbins Music Therapy*. London: James & James Publishers Ltd.

Skewes, K. (2001). *The experience of group music therapy for six bereaved adolescents.* Doctoral dissertation, University of Melbourne. Retrieved from www.musictherapyworld.net

Smeijsters, H. (1999). Music therapy helping to work through grief and finding a personal identity. *Journal of Music Therapy, 36*(3), 222-252.

Smith, G. C. (2011). Stillbirth – a forgotten problem. *The Independent (14 April 2011),* 18.

Trondalen, G. (2003). 'Self listening' in music therapy with a young woman suffering from anorexia nervosa. *Nordic Journal of Music Therapy, 12*(1), 3-17.

Why17. (2010). *What is Why17?* Retrieved from www.why17.org/About-the-Campaign.html

Worden, J. W. (1991). *Grief Counselling and Grief Therapy: A Handbook for the Mental Health Practitioner (2nd Edition)*. London: Routledge.

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