Volume One, Number Two
Winter/Spring 1983

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Music Therapy Perspectives

A periodical publication of the National Association for Music Therapy, Inc.

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Another Perspective

A Story—And a Question

I want to tell you a story, and then I want to ask you some questions. No, this isn't a test. I just want to know why you music therapists don't take full advantage of the power of music. There are many, many people out there who need your help. Why don't you help them?

Let me tell you the story. It's a true one. And it still hurts me to try to put it into words.

I've been a faculty member in the School of Education, University of Kansas, since the early 1950's. I worked with Thayer Gaston, a pioneer in your field, and with many of the music therapists he trained. I was tuned in (pardon the pun) to the idea that music could be more than an art form—more than a pleasure to the ear. I learned that music also had work to do.

Early in 1981 my wife, Evelyn, entered our University Medical Center with acute leukemia. She was started on a regimen of chemotherapy, which brought on a number of devastatingly painful side effects. She was hospitalized from February through June as she and our excellent medical and nursing staffs brought the disease into remission.

Evelyn fought hard. The two of us read everything we could find about the ways cancer patients can participate in their own recovery. We learned to use biofeedback to help with nausea and to combat the disease process itself. We found how family and friends can be parts of a vital and effective support system. We discovered the importance of faith in enabling us to face the challenge of each day (believe me, there were challenges).

The biofeedback process we used included a period of relaxation and meditation. Following that was a time in which Evelyn visualized the things she wanted to happen within her body. She saw bodily processes occurring to ease pain and discomfort, to repair damaged tissue, to increase the growth of healthy blood cells.

One day she was suffering more pain than could be managed by the biofeedback process. Medication helped, but it was not entirely effective. I was suddenly struck with the notion that we had a resource available that we had not yet tapped.

We had spent two memorable weeks in Tahiti the previous year and had made a cassette tape of our favorite music from several records we brought back with us. I went out to our car in the hospital parking lot, brought in this tape, and put it in the radio-cassette player in Evelyn's hospital room.

We worked through the initial stages of the biofeedback process. When Evelyn was relaxed, I said, "Honey, your body is just no fun to be in right now. Listen to this music I'm going to play. Visualize the two of us in Bora Bora or Moorea. Watch the dancers we saw there. Look at the musicians as they play those ukeleles and rhythm instruments. In your mind do all the pleasant things we did in the places we heard this music. See the surf coming in. Feel those cool sea breezes. Watch the moon come up and be reflected in the water. Enjoy! As the music gets softer, begin to feel sleepy—and then just drift off."

It worked. Within about five minutes she was sleeping. The music had helped her to become more comfortable and permitted her to overcome the intense pain. At other times we used music of American Indian and Mexican American origins as she visualized trips to the Gallup Indian Ceremonial and to the homes of friends in New Mexico and Arizona. Music helped her in controlling pain.

In June, Evelyn was released from the hospital. By this time we were looking for other ways we could use music as an aid for coping with the problems the two of us faced. We had grown up in the "big band" era of the late thirties and had begun our married life during World War II. We were accustomed to finding expression of our thoughts and feelings in music.

Perhaps we were two of the last of the great romantics. Perhaps we were overly sensitive to the effects of words and melodies (the french horn passage in *Pavanne* could make either of us sad for awhile). We could relate to the messages composers and lyricists had in mind for their music.

At any rate, we found that some music had special meaning for us, and helped us by expressing feelings that were very important to us at that particular time in our lives. It seemed that some songs were written especially for our situation. Thank goodness Waylon Jennings and Jessie Coulter cut the record titled *Storms Never Last* (RCA, 1981). These words helped:

> Storms never last, do they, Baby.
> Bad times all pass with the sun.
> Your hand in mine stills the thunder,
> You make the sun want to shine.

And Don Williams had to be thinking of us when he sang

> Lay down beside me, and hold me and hide me
> And kiss all the hurt of this world away.
> Hold me so close that I feel your heart beat
> And don't ever wander away. (*Lay Down Beside Me*, ABC Records, 1978)

When time is short, priorities change. It is difficult to spend time and energy on the kinds of activities which typically bring success to university professors. When time with a loved one is limited to months, or perhaps weeks, it seems vital to make certain that what is left be of high quality. Rex Allen, Jr. and Margo Smith were speaking for us when they sang

> I don't want to be the fiery sun,
> I just want to be your candle, Honey.

and

> I don't want to be the deep blue sea,
> I just want to be your cup of tea. (*Cup of Tea*, Warner Bros. Records, 1981)

You get no apologies from me that this music was performed by country and western artists.

When the most important person in your life is undergoing the trauma of a bout with a life-threatening disease, you don't ask about the social status of your source of assistance. When both of you know that you have only a short time left to be with each other, you accept help wherever you find it.

Just a year after Evelyn first started treatment, the leukemia recurred. Within a month she was gone.

It was then I found yet another use for music. The grief process seems less traumatic when I let music help me with it. I don't mean music just to have some sound in a house suddenly empty and silent. I mean music which affirms the triumphant aspects of the end of life on earth and the promise of the hereafter. Such music brings comfort in the same way other sorts brought comfort at other times.

Thank goodness I knew enough about Thayer Gaston's ideas to find ways to put music to work.

That is the story. And now for the questions. Why haven't more music therapists looked at ways to help people in pain? Why not investigate ways to do some things for families in the stressful situations which accompany life-threatening disease? How about finding ways to help those who are grieving? There are a lot of people like me who need help to cope—and who never knew Thayer.

Will you help?

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Songwriting as a Therapeutic Procedure

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ABSTRACT: A brief discussion of the healing role of creative acts and a survey of the documented use of songwriting in therapy provide a rationale for the therapeutic value of songwriting experiences. The major portion of the article is devoted to examples of exercises to aid clients in songwriting, progressing from highly structured to less structured procedures.

Muskatevc (1967) states that there are inherent in music "certain qualities and behavioral manifestations which can only be expressed and experienced in its involvement. What happens to a person involved in a musical act is unique and cannot be substituted for, with verbalization" (p. 138). Through the act of writing songs, clients participate in the actual creation of their own music, thus becoming involved in a musical act in a very intimate way.

Since songwriting is a creative act, it can be used as a way of promoting many of the healing qualities inherent in creative acts. Torrance (Reference Note) contended that creativity is necessary to maintain mental health. Participants in the Rockefeller Foundation's conference on *The Healing Role of the Arts* (1978) made the following statements:

> The arts are one way of transcending one's being; they lead us to create forms which communicate intimate feeling and compensate for internal and external chaos. (Spencer, p. 2)
>
> The arts ... direct a person inward, and in encouraging expression, help one to order and deal with feeling. (Spencer, p. 5)
>
> Through art, we organize our experience and share it with others. It is a harmonizing experience, based on self-expression, which enhances self-esteem. (Mitchell, p. 39)
>
> Creativity can give joy, relieve the shoddiness of life, and promote clear thinking. (Edelman, p. 44)
>
> Creativity is a form of revelation—a way of reaching the unconscious mind. Developing skills in painting, music, and drama can also alleviate the guilt too often attached to enjoying oneself. (Kolb, p. 52)
>
> Creativity can help people adapt to their environment. Art can relieve failure and disappointment; it can make patients accessible to other people and treatment. (Kolb, p. 52)

From the above statements, it would seem that involvement in creative acts such as songwriting can be a very beneficial and therapeutic part of treatment programs.

Documented Use of Songwriting in Therapy

Some writers have begun to explore and document the use of songwriting and composition in therapy. Batcheller and Monsour (1972) found that group music making and composition are useful in encouraging group involvement and also provide a sense of security while still allowing for freedom and novel experiences. According to Apprey and Apprey (1975), songwriting can facilitate the recovery of repressed material. They also suggest that songwriting will be more effective as therapy if done in a group where discussion of different aspects of the lyrics and choices of musical settings can be encouraged. Priestley (1975) used group improvisation (which could be termed a form of spontaneous composition) to facilitate group cohesiveness and found that an individual client became aware of patterns of interaction and was able to express and share feelings through the use of composition. Ficken (1976) noted that songwriting provides an open-ended experience which can be readily adapted to fit the abilities and interest levels of different clients. He found songwriting to be particularly useful in therapy because the experience could be internalized by the client and lead to more socially acceptable behaviors. Citing examples of both group and individual sessions, Ficken (1976) concluded that songwriting is useful in promoting group cohesiveness, in serving as an appropriate expression of feelings, in building self-esteem and a feeling of accomplishment, and in helping to modify behavior.

Since songwriting is a creative act, it can be used as a way of promoting many of the healing qualities inherent in creative acts.

Two Basic Questions

Once music therapists have decided to use songwriting as a technique in sessions, they are faced with two basic questions:

1. Which should come first, the words or the music?
2. Who should provide the melodic structure, the therapist or the group members?

The first question has been debated many times. Some state adamantly that the words should always come first and music be set to them to reflect the natural speech rhythms. Others contend that it is also valuable to proceed from a known musical structure and struggle to make the lyrics fit that structure. Both procedures can be useful and effective in different situations. The question becomes not so much words first or music first, but how much structure one must provide for the group members, taking into account such aspects as their expressive language skills, level of musical sophistication, and the emotional content of the subject of the song.

The second question—"Who should provide the melodic structure?"—is also related to the question of how much

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structure the therapist must provide for the group members. At first, it would probably be wise to work from pre-existent melodies or to have the therapist suggest melodic material, simply because most of the people with whom music therapists work are probably unfamiliar with the manipulation of musical and melodic components. Even at this stage, the group members can determine such elements as tempo and dynamics. As the members of the group gain facility and confidence in working with musical materials and composing melodies, they can provide more and more of the melodic content of the song.

Techniques to Facilitate Successful Songwriting Experiences

The following general procedures are suggested as a basis for facilitating songwriting experiences. The procedures include exercises ranging from very structured to very unstructured situations and call upon the individual to provide either the musical setting or the lyrics or both. If the group members are given improvisational experiences involving the manipulation of melodic components concurrently with beginning experiences in lyric writing, they can begin to create their own musical settings as soon as possible.

Lyric Writing

Lyric wiritng by those in the group can be approached through successive steps of approximation. One highly structured, non-threatening way to begin lyric writing is to have the members substitute their own word or phrase for a single word in a popular song. The therapist might introduce this procedure by having the group sing the first three verses of *If I Had a Hammer* (Simon, 1975), noting how the composer made new verses simply by changing one or two words. Volunteers from the group could then add their own verses to the song using the same procedure. Similarly, group members might be asked to substitute their own words and ideas for "love" in *What the World Needs Now* (Simon, 1975) or for "kindness" in *Try a Little Kindness* (Bock, 1972). Depending on the functioning level of the group, the new lyrics may be sung and individual choices discussed.

When the people in the group have grown comfortable with substituting one word, longer phrases can be omitted and individuals can fill in the blanks with their own phrases to complete the lyrics. The main idea is to use parts of the original lyrics to give the group members some direction to start forming their own ideas. *My Favorite Things* (Snider) could provide an easy transition from one-word substitutions. After hearing or singing the song, members of the group could be asked to list their own favorite things to make a new verse.

When asking the group to provide more than one word, it may be helpful to have the phrases from the song and the blanks for each person to fill in on handouts. This way everyone can take some time to process the material and can complete the handout for themselves even if sharing their new creations with the group is initially too threatening. This consideration can become more important as the group members are asked to deal with more emotional subjects, as in the following procedure based on Carole King's *It's Gonna Take Some Time* (Bradley):

It's gonna take some time to get myself ______________.
I really fell ______________ this time;
I really missed ______________
The birds on the telephone line are cryin' out to me.
And I won't be so ______________ next time.
And I'll find ______________.
But it's gonna take some time this time
And I can't ______________.
But like the young trees in the winter time
I'll learn how to ______________.
After all the ______________
How could we ______________?
So it's one more round for ______________
And I'm ______________,
And it's gonna take some time this time.

When using "fill-in-the-blank" songs which call for deeper emotional involvement and expression, it may be more beneficial to have the people in the group fill in their own phrases *before* hearing the original lyrics.

Many lyrics come from strong feelings or opinions—the lyricist feels something needs to be talked about or wishes to express certain feelings or share knowledge or a new outlook.

Group members can also gain experience in formulating lyrics by making a song collage. Each person picks a phrase from a favorite song or from a group of songs dealing with a central theme. The group then works on combining these fragments to form a new lyric. (A hint: If each person's phrase is written on a separate strip of paper, it will be easier to manipulate the order of the phrases as the group works on the new lyric.) Melodic material for the new lyric may come from the original songs or be newly composed.

Another way to promote lyric writing skills is to have the group members add their own verses to existing songs. Folk songs lend themselves particularly well to this procedure. As a variation of this idea, members of the group could be encouraged to write parodies of existing songs. Singing examples of parodies (such as those found in *Mad* magazine) might facilitate this procedure.

Groups can also be encouraged to supply original lyrics through improvised songs using a conversational or question and answer format. A basic melodic and/or harmonic structure is repeated, with lines or verses contributed alternately by the therapist and group members. *Where Is Thumbkin* (Berg, 1966), *Billy Boy* (Goodwin, 1961), and *Skip to My Lou* (Goodwin, 1961) are common examples of songs using a question and answer format. Initial experiences might use these familiar melodies with the words varied slightly to fit the therapeutic situation, encouraging individuals to state feelings, suggest answers to problems, and the like.

Many lyrics come from strong feelings or opinions—the lyricist feels something needs to be talked about or wishes to express certain feelings or share knowledge or a new outlook. One way to help the group members write original lyrics is to have each individual focus on a particular person or event that meant a lot to him or her, quickly write down all the phrases that come to mind, pick out the more interesting phrases and expand on them, and gradually refine these phrases into a shape. Specific topic suggestions by the therapist may initially help in this original lyric writing process.

Since lyrics are basically poetry, the music therapist might consider either working with a poetry therapist if one is available or using some of the techniques employed in teaching poetry writing. Kenneth Koch, in *I Never Told Anybody: Teaching Poetry Writing in a Nursing Home* (1977), gives several suggestions to facilitate poetry writing. For example, people can dictate poems to overcome writing difficulties and promote free and spontaneous expression. Koch also suggests methods for writing group poems (e.g., each member writing one or two lines about a certain topic and combining these to form one poem) and recommends techniques to encourage and refine individual offerings. Some sessions might be spent exploring and discussing different styles and types of poetry or lyrics (e.g., free verse, different rhyme schemes), promoting the idea that there are no "have tos" in lyric writing and that any creative utterance is accepted as that and not judged. This does not preclude discussing or refining the original lyric as long as no value judgements are placed on the work. Scoggins (1975) warns that "self-concept is extremely vulnerable in the creative process . . . Be careful to accept creative effort for what it is and realize that to criticize the creation is to criticize the creator" (p. 109).

Musical Settings and Melodic Construction

As with lyric writing, creating musical settings or melodies can also be approached gradually through successive steps of approximation. Procedures which explore natural speech inflections and rhythms can help the group members discover the relationship between words and music. Orff activities which use simple ostinati or pentatonic scales may promote creative melodic responses. Melodic construction can be explored in listening and improvisation experiences, noting elements such as rhythmic organization, melodic contours, and phrasing. Improvisation and listening experiences could also be used to explore ways in which the expressive content of music can be varied by changes in dynamics, articulation, tempo, or timbre. For example, group members might be asked to choose instruments to improvise sound compositions which portray certain feelings or to create a musical setting for a picture or poem. Graphic scoring (using pictures to represent instruments, dynamics, and other musical elements) could be used to aid in discussing and patterning the composition. If several sets of resonator bells are available, an individual could compose a melody by lining up the bells on a table so the tune is played simply by beginning with the bell on the left and moving to the right, striking each bell once.

Vocal improvisation or scat singing can also be useful to encourage melodic creation. Group members are encouraged to vocalize freely over a harmonic structure provided by the therapist. Initially, it may be beneficial to have the therapist offer ideas for "licks" which could be echoed by those in the group, gradually encouraging all individuals to develop their own improvisations.

Melodic construction can be explored in listening and improvisation experiences, noting elements such as rhythmic organization, melodic contours, and phrasing.

Combining Words and Music

For lyrics to make the transition from poetry to song, they must be set to music. The musical setting serves to underscore, clarify, and intensify the thoughts and feelings embodied in the lyrics. Wunderlich (1966) stated that "by means of music . . . we can put more meaning and more feeling into the words," resulting in "intensified speech, natural and necessary in human life" (p. 94).

One way group members can begin to add their own musical settings to their lyrics is to speak the lyrics rhythmically and then "orchestrate" them with percussion and/or melody instruments, much as they did in the improvisation experience of creating sound compositions to describe feelings, pictures, or poems. Songs with choral speaking parts could be introduced to show how similar techniques have been used by other composers.

Another highly structured way to "compose" melodies to fit original lyrics is to use a multiple choice method. After the lyrics have been read rhythmically to determine a meter, the therapist offers several alternate suggestions of melodies for each phrase; in this way, the preferred melody can be chosen. Discussion of each person's choices could be encouraged, depending on the functioning level of the group.

Predetermined musical forms, such as 12-bar blues, can facilitate creative songwriting efforts by providing a focus and direction for self-expression. These procedures can be structured or unstructured, depending on the skills of the group members. Listening experiences can familiarize the group with the form and provide examples of different ways the form can be used. For initial songwriting attempts, certain phrases may be provided to aid the members of the group in writing lyrics (see sample procedure below). As the people in the group gain confidence, they can be encouraged to write lyrics without specific guidance.

Sample Procedure

Writing Songs in 12-Bar Blues Form

Structure. 12-bar blues is a musical form, or pattern for songwriting. There are usually 3 lines or phrases with a "break"

or instrumental interlude between each phrase. The words of the first phrase are usually repeated for the second phrase, while the third phrase has different words.

Content. Although blues songs often express melancholy or sad feelings, 12-bar blues is merely a form or pattern for songwriting and can be used to express *any* feeling, including a happy one. How fast or slow the music is played and sung helps show what kind of feeling is being sung about.

WRITE YOUR OWN SONG TO TELL HOW YOU FEEL. USE THE MODEL BELOW AS A GUIDE OR WRITE A SONG USING ALL YOUR OWN WORDS.

Hey, ev'rybody, I'm feeling ______________ today.
Hey, ev'rybody, I'm feeling ______________ today.
It seems like ________________________.

In setting the lyrics to music, the therapist plays a 12-bar blues chord progression (e.g., E-E-E-E7/A7-A7-E-E7/B7-A7-E-E7) to provide the harmonic background while the person with whom one is working sets the tempo and provides the melodic and rhythmic setting for the lyrics. Initially, group members may be given the option of just speaking the words in order to reduce self-consciousness about solo singing. Later they are encouraged to improvise a melody over the harmonic background. Depending on the level of the group, the content of the lyrics and the choices of tempo, rhythm, and dynamics might be discussed.

If the members of the group are comfortable with all the procedures discussed, they are probably ready to write their own songs without much structure from the music therapist. At this point, the therapist can be less directive and serve mainly as a facilitator, helping notate words or music, offering different options for musical arrangements, and encouraging group members to discuss their songs.

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A Psychotherapeutic Classification of Music Therapy Practices:

A Continuum of Procedures

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ABSTRACT: This article categorizes music therapy practice into three levels: music therapy as an activity therapy, insight music therapy with reeducative goals, and insight music therapy with reconstructive goals. Music therapy as an activity therapy includes much of music therapy as traditionally practiced, with the goals achieved primarily through the use of therapeutic activities. In insight music therapy with reeducative goals, the music experience is generally used as a stimulus for verbalization, with verbal processing which leads to insight, which can then help the client to change his behavior. In insight music therapy with reconstructive goals, music therapy techniques are utilized to elicit unconscious material which is then worked through in an effort to achieve reorganization of the personality. Examples of the use of music therapy in these three ways are provided, as well as related classifications from the music therapy and psychotherapy literature. It is suggested that these, or related categories, can help make communication about the work of the music therapist more clear, which will aid both treatment and education.

Music therapy as it is usually defined covers a variety of techniques and procedures. One common definition is, "The use of music in the accomplishment of therapeutic aims; the restoration, maintenance, and improvement of mental and physical health" (National Association for Music Therapy, Inc., 1980). It is understood from this definition that the people who receive music therapy services may be of any age and that the therapy may be directed toward virtually any aspects of their health. As one considers all the options for treatment which might be included under this definition, one realizes that the possibilities are infinite. As a sample one may see: handicapped children trained in specific, minute behaviors; children taught educational concepts; more adaptive physical movements worked toward; better social skills promoted; communication begun; inner conflicts worked through; or those who express their own images and fantasies.

With such a wide range of procedures included under music therapy, as well as the variety of populations worked with, it is difficult to know exactly what one means when one refers to music therapy treatment. This paper provides an outline of a conceptual framework which has proven useful in beginning to delineate various "types" of music therapy. For the most part, this framework has been applied to work which has been done with adult persons with emotional difficulties. Therefore, while the framework is potentially applicable to other populations, the focus will be on work with adult psychiatric clients.

Existent Classifications of Music Therapy

When one reviews music therapy and related literature, one discovers that several classifications of types of music therapy and related therapies have been made. Music therapists have traditionally been classified as activity therapists, or as those therapists whose techniques employ qualities intrinsic in activities structured to have therapeutic value. Recreation therapy and occupational therapy are also included as activity therapies. All of the above are valid because they involve clients in *doing* something which provides experiences needed to help make them healthier. The *therapy* in music activities comes largely from the involvement of the person in a therapeutically oriented activity rather than from talking about this involvement. This model seems to have been the basis for much of the music therapy traditionally practiced in this country. In his classic *Processes in Music Therapy*, Sears (1968) seems to have referred to music therapy as an activity therapy when he discusses that it provides experience within structure, experience in self-organization, and experience in relating to others.

The use of music therapy in educational situations seems to be another way to utilize music as therapy. It is closely related to music as an activity therapy; however, the projected goals involve the learning of skills needed for educational pursuits rather than for other aspects of living. At some of the more elementary levels of behavior, this category merges with music as an activity therapy. For instance, when children learn better coordination, they develop a pre-educational skill which can also be applied to aspects of life outside the educational setting. Clearly included under this category would be music therapy which involves the teaching of reading and mathematics concepts, as well as various speech techniques.

In the past ten or so years, music therapists have increasingly identified themselves as *creative arts therapists* or as *expressive therapists* (American Psychiatric Association, 1980; Robbins, 1980), and have made alliances with art and dance therapists and at times with psychodramatists. In addition to the obvious commonality of using arts media as therapeutic devices, music, art, and dance therapists who identify themselves in this way seem to have several characteristics in common. One is that they frequently use their media to assist

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clients in becoming aware of their feelings, and the verbal processing of this experience is often seen as an essential aspect of the therapeutic process. The clients' internal experiences are generally the focus of the work. In his discussion of the creative arts therapies, Zwerling (1979) suggests that an important point in the application of these therapies is that the nonverbal media which they employ are able to tap emotional (rather than cognitive) processes more directly than can the verbal therapies. This capability is important to the success of the creative arts therapies as clinical modalities.

A classification of music therapy by levels was done by a panel which presented their work several years ago (Canter et al., Reference Note). This group discussed three levels of music therapy, with the first level similar to music therapy as traditionally practiced, the second level similar to what music therapists do as creative arts therapists, and the third level as the use of music therapy in in-depth work with unconscious aspects of the personality. It will be seen that the classification presented in this paper owes much to the levels of music therapy concept presented at that time, as well as to the levels of psychotherapy proposed by Wolberg, summarized below.

Levels of Therapy in Psychotherapy

Certainly the area of psychotherapy is at ieast as broad as music therapy in terms of the possible types of therapies offered. Wolberg (1977) has developed a useful fomulation of types of psychotherapies which include: supportive therapy, reeducative therapy, and reconstructive therapy. For each category he outlines goals, appropriate clientele, and techniques utilized.

Supportive therapy has as its goal to restore individuals to an emotional equilibrium so that they can function as closely as possible to their normal levels. Efforts are made to ameliorate symptoms; to strengthen existing defenses; and to develop better mechanisms of control, which may include the suppression of feelings. Attempts may also be made to reduce external sources of stress. Supportive therapy may be utilized appropriately with those who have a basically sound ego structure and need only a brief period of therapy in order to restore them to normal functioning. On the other end of the spectrum, it can help people who have been so severely damaged that the best for which one can hope is symptom alleviation which will enable them to live more comfortably with their handicaps. It is also appropriate when someone has not responded to other more intensive therapy, and may be the treatment of necessity when the therapist does not have time to work with all clients more intensively.

In reeducative therapy, efforts are made to help the individual function at a higher level. The objective is

> the modification of behavior directly through positive and negative reinforcers, and/or interpersonal relationships, with deliberate efforts at environmental readjustment, goal modification, liberation of existing creative potentialities, and, hopefully, promotion of greater self-growth. (Wolberg, p. 101)

Individuals undergoing reeducative therapy may achieve sufficient command of their difficulties to enable them to keep acting-out impulses in check and to deal with or adjust to environmental distortions, to organize and to execute life goals better, and to consolidate some adaptive defenses and alter others that are less adaptive.

Reconstructive therapy has as its objective an alteration of the basic structure of the personality, which includes the rediscovery of potentialities which were thwarted in the course of the individuals' development. It is utilized with people whose egos are strong enough to change and who are interested enough and who are able to devote extensive time to the process.

A Continuum of Music Therapy Procedures

In this section, the categorizations of psychotherapy and of music therapy which have been presented will be adapted and integrated into a framework which can be used by music therapists for the conceptualization of their work. Deliberate attempts will be made to separate the three types of therapies in order that they may be clearly delineated, although it is recognized that it is never as clear in a real therapy situation. The three levels of music therapy will be labelled: music therapy as an activity therapy, insight music therapy with reeducative goals, and insight music therapy with reconstructive goals.

The activity therapy approach may be viewed as one which suppresses . . . impulses in favor of more adaptive behaviors.

Music Therapy as an Activity Therapy

In using music therapy as an activity therapy in its traditional form, goals are generally achieved through the use of therapeutic activities rather than through insight. These therapies are concerned with using activities (including, when appropriate, verbalization about the activity) to bring about changes of behavior. The achievement of better understanding as to *why* a behavior occurs is not considered important. Lord (1971, p. 69) has listed 12 goals for music therapy or other activity therapies. They are:

1. to increase tolerance of instruction
2. to decrease avoidance behavior in possible failure situations
3. to teach *how* to achieve success in long-term projects
4. to increase attention span and concentration skills
5. to develop a realistic view of self
6. to increase self-esteem
7. to decrease "irresponsible" behavior in work situations
8. to increase tolerance of authority figures
9. to decrease avoidance behavior in social situations
10. increase awareness, acceptance, and responsibility to others' feelings
11. to develop skills in dealing with intense emotions
12. to develop knowledge of ways to avoid seclusive, passive living in the community

In order to achieve most of these goals, the musical activity is structured so that the person has an opportunity to practice the behavior being worked toward. Following the activity therapy model closely, the verbal processing which ensues is aimed fairly directly at what was experienced during the activity, with minimal discussion of other related feelings elicited either by the musical activity or by the verbal interaction.

Sessions which use music as an activity therapy normally utilize a positive relationship with the therapist, who takes a somewhat authoritarian role in directing the session and helping those involved behave more adaptively. Sessions may at times include advice and information giving. Reassurance is frequently used. The approach may be viewed as one which suppresses the clients' impulses in favor of more adaptive behaviors which are structured by the therapist, rather than the exploration of instincts and impulses. One focus is to strengthen the clients' defenses. Frequently, their areas of competence are utilized in musical activities, thus building self-confidence.

To the extent that the therapy remains part of the activity therapy model, the need for therapist insight is minimal. Since the emphasis in the sessions is primarily on overt behaviors, the major need of the therapists is to be able to observe such behaviors. As the people with whom they work begin to deal with their feelings, the need arises for therapists to be aware of their own feelings.

To illustrate the principles of music therapy's use as an activity therapy, several examples from the music therapy literature will be cited. Cassity (1976) describes the use of guitar lessons with adult psychiatric clients to achieve improved peer acceptance and group cohesiveness. This approach is placed in the category of music therapy as an activity therapy because the guitar experience itself, and the set of circumstances produced by it, accomplished the therapeutic goals, which were changes of behavior and perceptions of others, not the achievement of insight in order to be able to change behavior and perceptions.

Ficken (1976) used songwriting in a psychiatric setting, where the activity itself provided the work towards his goals. Any increased awareness of feelings appears, as he describes it, to be secondary to the experience of the creation of the song. If songwriting were used as a way to increase awareness of an expression of the clients' feelings (as it might well be in a different situation) this activity could be classified as insight music therapy with reeducative goals.

Wasserman (1972) describes several aspects of a traditional music therapy program in which the goals were: to encourage the development of the client's ego strength; to attempt to replace pathological defenses with healthier methods of coping; to resocialize the client; and to serve as an opening through which the client could begin to communicate again, find an outlet for tensions, develop a sense of pride, and to learn to enjoy music as a listener or performer. She describes several activities, which include vocal dynamics (i.e., speech and body exercises which assist the client in verbal and nonverbal communication through the use of voice, rhythm, and body movement), singing groups, and instrumental group activities. As in the activities mentioned previously, the therapy took place through participation in activities, not through insight achieved through them. These activities also follow what was stated earlier about the therapist taking a leadership (authoritarian) role with the focus on changed behavior rather than on the understanding of behavior.

In insight music therapy the music itself often elicits certain emotional and/or cognitive reactions necessary for the therapy.

Insight Music Therapy with Reeducative Goals

As one begins to utilize insight music therapy with reeducative goals, more verbalization begins to occur, while the verbalization which ensues plays an increasingly important role in the therapeutic process. Music may also be used in a different manner. While in music therapy as activity therapy, an activity taken from another discipline could usually be substituted for the musical activity and the same results achieved, in insight music therapy (either reeducative or reconstructive) the music itself often elicits certain emotional and/or cognitive reactions necessary for the therapy. The major focus of this music therapy is on feelings, the exposition and discussion of which lead to insight, which in turn results in improved functioning. This type of music therapy relies on what Zwerling (1979) considers to be one of the unique features of the creative arts therapies: their ability to tap deeper emotional levels than are normally accessible. The feelings which are discussed in insight music therapy with reeducative goals are those which are relatively close to consciousness and can therefore be elicited through attention to the here-and-now, including personal feelings and interpersonal reactions. The reliance on here-and-now feelings and behavior, and therefore the focus on relatively conscious material, is what distinguishes this level of therapy from the next level, insight music therapy with reconstructive goals.

Both positive and negative transferences are utilized in insight music therapy with reeducative goals. Negative transference is analyzed as it develops in terms of the reality situation. Existing defenses may be challenged. The goal of both the musical and the verbal aspects of the session is to help individuals examine the ways in which they relate to other people and to their individual selves. In the process, the sources of tension are explored and those who receive treatment are helped to see ways in which they participate in fostering their emotional disturbances and perpetuating maladaptive patterns of behavior. Music therapy used in this way shares much with the other creative arts therapies.

In the instances where music therapy is used as insight therapy with reeducative goals, the music is frequently used as a stimulus for verbalization and the thrust of the therapy

is toward the insight achieved through discussion. The feelings that are brought into awareness through the music are often important for the therapy. The distinction between insight music therapy with reeducative goals and insight music therapy with reconstructive goals is not definite, particularly where the music has been utilized to elicit emotions. When the emotions are fairly accessible and the work with them revolves around conscious material, the music therapy would be classified as insight music therapy with reeducative goals. As the emotions become less accessible, and the material worked with previously unconscious, the music therapy becomes music therapy with reconstructive goals.

The majority of the procedures contained in the books by Plach (1980) and Wolfe et al. (1975) are examples of insight music therapy with reeducative goals. In both books numerous suggestions are given for musical experiences to be used as a stimulus and guide for later discussion which is centered around either material presented in the musical experience or feelings elicited by it.

While the use of handbells in music therapy might normally be thought of as the use of music therapy as an activity therapy, Rubin (1976) has expanded her use of the handbells to include many elements of insight music therapy with reeducative goals. She includes, in addition to the performance on the handbells (the activity therapy aspect), discussion of feelings and attitudes which occur both in the group and away from it. She suggests that, in this way, individuals can begin to see the similarity of their feelings and attitudes in and away from the group. One can explore one's self-defeating attitudes, and can begin to develop healthier ways of relating to others. This exploration is the essence of insight music therapy with reeducative goals.

Some of the work of Priestley (1975), Tyson (1966), and Bonny (1975) which is presented as insight music therapy with reconstructive goals would properly be called insight music therapy with reeducative goals. This would be the appropriate classification when clients deal with fairly conscious material.

Insight Music Therapy with Reconstructive Goals

Insight music therapy with reconstructive goals occurs when music therapy techniques are utilized to elicit unconscious material, which is then worked with in an effort to promote reorganization of the personality. The ability of music to tap deeper levels of emotion, as mentioned earlier, is utilized to reach this unconscious material. The goal is to work through situations that were inadequately lived/resolved as the person grew up. Music used in this way frequently elicits images and feelings which may be associated with either the present or the past. One goal is to achieve insight into how individuals became the way they are.

Music therapists who utilize insight music therapy with reconstructive goals *must have advanced clinical training and be thoroughly aware of individual dynamics and psychopathology.* They must have an integrated theoretical framework and extensive clinical supervision. Since indepth and potentially powerful material is dealt with at this level, advanced clinical training is essential.

One example of this type of music therapy is Priestley's (1975) work. She presents a number of techniques for working with clients through improvisation. The splitting technique is described as "especially useful where the client has projected part of herself onto another character and, in doing so, lost the emotion invested in this person" (p. 123). Priestly describes a client who, unaware of her own anger, projected it onto another person, and was then terrified of that person. Briefly, in the sessions, the client initially improvised herself (i.e., her feelings) while the therapist improvised the angry other person; they then changed roles and the client improvised the angry person while the therapist improvised the victimized client. This experience, plus the discussion of it, provided the client with an awareness of her own anger so that she no longer needed to project it onto the other person. She could then deal with the other person's real anger, which allowed her view not to be distorted by her own projections.

Music therapists who utilize insight music therapy with reconstructive goals must have advanced clinical training and be thoroughly aware of individual dynamics and psychopathology

Tyson (1968) describes a drummer who was referred to music therapy for corrective breathing and voice placement. The client had many somatic complaints and experienced great anxiety about the fragility of his head, apparently stemming from several accidents in which he had been involved. Stimulated by the aural and breathing experiences of the music therapy session, this client reexperienced a related childhood accident which he had repressed and which included, along with the later accidents and the music therapy session, strong aural elements. He was able, through this experience, to relive the anxiety-producing accidents, deal with them in depth (in his psychotherapy sessions), and begin to feel some relief of his anxiety. Throughout the following months of sessions, this client's work with breathing and singing produced an awareness of several other previously unconscious feelings which, when worked through, no longer restricted the way in which he functioned.

Bonny (1975) uses specially selected recorded music to assist clients in becoming aware of feelings and experiences which have previously been out of ordinary consciousness. She suggests that "the multidimensional qualities of musical sound allow it to touch many levels of consciousness both simultaneously and/or in sequence" (p. 130). The use of this method allows many important events and influences in the person's life to be experienced as the music carries the person from one state of consciousness to another. Bonny gives brief descriptions of some people's experiences in guided imagery sessions. To the extent that people become aware of

previously unconscious feelings, which may then be used for growth, this approach to music therapy may be reconstructive. It is frequently used, also, as a means to increase awareness of more conscious feelings and images, in which case it is insight music therapy with reeducative goals.

Conclusion

From this overview of some of the uses of music therapy, it can be seen that music therapy procedures can be placed in certain categories in accordance to how the music is used and how awareness of feelings and discussions about feelings contribute to the therapy. It is hoped that the categorization of music therapy as activity therapy, insight music therapy with reeducative goals, and insight music therapy with reconstructive goals will stimulate other music therapists to think of exactly how they use music therapy and to use their experiences to revise and refine these categories. This process could lead to clearer communication as music therapists discuss their work, to better education which could be designed specifically for the type of music therapy which the person intends to do, and to better treatment for those who might benefit from one approach over the others.

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National Association for Music Therapy, Inc.

STANDARDS OF CLINICAL PRACTICE

Preamble

Music therapy is the specialized use of music in the service of persons with needs in mental health, physical health, habilitation, rehabilitation, or special education. Services are rendered to people of every chronological age, mental age, and adaptive level of functioning in a variety of health care, habilitative, rehabilitative, educational, community, and private practice settings. In each instance, the purpose is to help individuals attain and maintain their maximum levels of functioning.

Music therapy services are rendered by Registered Music Therapists (RMTs), clinicians certified and registered by the National Association for Music Therapy, Inc. (NAMT). Although music therapy services exist in diversified settings, there is a core of common procedures and considerations stated formally as standards of general practice for all RMTs. Additional standards that are germane for particular clientele are delineated herein for eight areas of music therapy service: adult psychiatry, consultant, developmental disabilities, general hospital, geriatrics, physical disabilities, private practice, and school setting. These eight areas reflect current music therapy services, but should not be interpreted as strict limits that would prevent development of new areas for music therapy.

Concomitant with the NAMT *Code of Ethics*, these *Standards of Clinical Practice* are designed to be of assistance to practicing RMTs and their employers in their endeavor to provide quality services. The RMT shall utilize best professional judgement in the execution of these standards. The NAMT Standards of Practice and Special Target Populations Committee is charged with periodic revision to keep these standards current with advances in the field.

Introduction

The reader should be aware that the standards for the eight areas of music therapy service are further delineations of the general standards, and are linked closely to them. The close relationship is reflected in the numbering system. For example, section **2.0 Assessment** in the General Standards ends with standard 2.7. The standards on assessment in Adult Psychiatry, which clarify the general standards, begin with 2.8. Thus, the reader should read the *General Standards* first, and have them in hand when reading the specific standards.

GENERAL STANDARDS

In delivery of music therapy services, RMTs follow a general procedure that includes: 1. referral and acceptance, 2. assessment*, 3. program planning, 4. implementation, 5. documentation, and 6. termination of services. Standards for each of these procedural steps are outlined herein and shall be adhered to as closely as is feasible by all RMTs in their delivery of services.

1.0 Standard I – Referral and Acceptance

A client shall be accepted for music therapy in accordance with specific criteria.

1.1 A client may be a candidate for music therapy when a psychological, educational, social, or physiological need might be ameliorated or prevented by such services.

1.2 A client may be referred for an initial music therapy assessment by:
- 1.2.1 an RMT
- 1.2.2 members of other disciplines
- 1.2.3 self
- 1.2.4 parents, guardians, or advocates

1.3 The final decision to accept a client for music therapy services, either direct or consultative, shall be made by an RMT and, when applicable, shall be in conjunction with the interdisciplinary team.

2.0 Standard II – Assessment

A client shall be assessed by an RMT prior to the delivery of music therapy services.

2.1 The music therapy assessment shall reflect the psychological, educational, social, or physiological functioning as related to the client's needs; and shall focus on the client's responses to music and music skills and preferences. The assessment shall attempt to determine the client's strengths as well as weaknesses.

*indicates definition in glossary

2.2 All music therapy assessment methods shall be appropriate for the client's chronological age, functioning level, and cultural* background. The methods may include, but need not be limited to, observation during music or other situations, interview, verbal and nonverbal interaction, and testing. Information may also be obtained from other disciplines or sources such as the medical and social history.

2.3 The assessment shall recognize variability of performance resulting from medications, adaptive devices, positioning, involvement in other therapies, psychosocial conditions, and current health status.

2.4 *All interpretation of test results shall be based on appropriate** norms or criterion-referenced data.

2.5 The music therapy assessment procedures and results shall become a part of the client's file.

2.6 The results, conclusions, and implications of the music therapy assessment shall become the basis for the client's music therapy program and shall be communicated to others concerned with provision of services to the client. When appropriate, the results shall be communicated to the client.

2.7 When assessment indicates the client's need for other services, the RMT shall make an appropriate referral.

3.0 Standard III – Program Planning

The RMT shall prepare a written individualized program plan based upon the music therapy assessment, the client's prognosis, and information from other disciplines and sources when applicable. The client shall participate in the program plan development when appropriate. The music therapy program plan shall:

3.1 Be designed to help the client attain and maintain the maximum level of functioning

3.2 Be in compliance with federal, state, and facility regulations

3.3 Delineate the type, frequency, and duration of music therapy involvement

3.4 Contain goals* that focus on assessed needs and strengths of the client

3.5 Contain objectives* which are operationally defined for achieving the stated goals with estimated time frames

3.6 Specify procedures, involving music and music materials, for attaining the objectives

3.7 Provide for periodic evaluation* and appropriate modifications

3.8 Be consistent with the following according to the best* professional judgement of the RMT:
- 3.8.1 the program plans of other disciplines
- 3.8.2 established principles of normal growth and development

3.9 Be changed to meet the priority needs of the client during crisis intervention

4.0 Standard IV – Implementation

The RMT shall deliver services according to the written program plan and shall:

4.1 Strive for the highest level and quality of music involvement consistent with the functioning level of the client
- 4.1.1 The RMT's provision of music shall reflect his or her best abilities as a musician.
- 4.1.2 Appropriate musical instruments and materials, and the best possible sound reproduction equipment should be used in music therapy services.
- 4.1.3 The RMT shall make every effort to insure that the client is not exposed to music or other sounds that exceed ninety* decibels, sound pressure level.

4.2 Use methodology that is consistent with standard health and safety practices

4.3 Maintain close communication with others involved with the client

4.4 Record the schedule and procedures used in music therapy programming

4.5 Periodically evaluate the client's responses to determine progress towards the goals and objectives

4.6 Incorporate the results of such evaluations in subsequent programming

4.7 Consider the psychological therapeutic separation as termination of services approaches

5.0 Standard V – Documentation

The RMT shall document the client's referral to music therapy, assessment, placement, program plan, and ongoing progress in music therapy in accordance with federal, state, and facility regulations.

5.1 The RMT shall periodically document the client's level of functioning according to the goals and objectives.

5.2 Documentation of progress shall describe significant intervention techniques and client responses.

5.3 All documentation relating to music therapy services shall:

5.3.1 Be written in an objective, professional style based on observable client responses

5.3.2 Include the date and signature of therapist indicating the professional status, *Registered Music Therapist* or *RMT*

5.3.3 Become part of the client's file and shall remain confidential unless proper authorization for release is obtained

5.4 The RMT shall document referrals made to other sources, and include plans for initiation of music therapy services if such services cannot be instituted immediately.

5.5 Significant client contacts and contacts with persons involved with the client outside the structure of music therapy sessions shall be documented.

6.0 Standard VI – Termination of Services

The RMT shall terminate music therapy when the client has attained stated goals and objectives, fails to benefit from services, can no longer be scheduled, or is discharged. At the time of termination, consideration shall be given for periodic reassessment to determine the need for follow-up services. The RMT shall prepare the music therapy termination plan in accordance with federal, state, and facility regulations. The termination plan shall:

6.1 Be consistent with the goals of the individualized music therapy program plan

6.2 Be consistent with the individualized program plans of other services

6.3 Be developed in sufficient time to allow for approval, coordination, and effective implementation when possible

6.4 Summarize the client's progress and functioning level at the time of termination

7.0 Standard VII – Continuing Education

7.1 It is the responsibility of the RMT to maintain knowledge of current developments in research, theory, and techniques in music therapy and related areas.

7.2 The RMT shall contribute to the education of others regarding the use and benefits of music therapy.

ADULT PSYCHIATRIC

These Standards of Clinical Practice are designed specifically for the RMT working with adult psychiatric clientele. The RMT shall adhere to the General Standards of Clinical Practice and the specific standards for adult psychiatric described herein. The RMT shall also adhere to the standards of other areas of music therapy services when applicable.

Music therapy with adult psychiatric clientele is the therapeutic use of music to restore, maintain and improve mental health. It addresses the following areas of function: cognitive, psychological, psychosocial, affective, communicative, and physiological. Music therapy services for the adult psychiatric client may be delivered in, but need not be limited to, the following: in-patient, out-patient, partial* hospitalization facilities, client's home, halfway houses, community clinics, and private practice.

1.0 Standard I – Referral and Acceptance

1.2.5 Other agencies

1 2.6 Members of an interdisciplinary team

2.0 Standard II – Assessment

2 8 The music therapy assessment shall address affective, communicative, and psychosocial needs when applicable.

2.9 Music therapy assessment methods shall be congruent with client's level of functioning and shall address the following areas:

2.9.1 Motor development (fine, gross, perceptual-motor)

2.9.2 Learning abilities

2.9.3 Developmental level

2.9.4 Speech development

2.9.5 Physical abilities (including neuromuscular)

2.9.6 Sensory capacity

2.9.7 Sensory integrative functioning

2.9.8 Substance use or abuse

7.0 Standard VII – Continuing Education

7.1.1 Related areas may include, but need not be limited to: psychiatric disorders, specific areas of dysfunction, diagnostic knowledge, psychotherapy, treatment approaches, administrative skills, and psychopharmacology.

7.1.2 Some form of personal* psychotherapy shall be recommended.

CONSULTANT

These Standards of Clinical Practice are designed specifically for the RMT working as a consultant in various situations such as educational, psychiatric, and rehabilitation facilities and with professionals of other disciplines The RMT shall adhere to the General Standards of Clinical Practice and the specific standards for consultation services described herein. The RMT shall also adhere to the standards of other areas of music therapy service when applicable.

The music therapy consultant may provide services to other RMTs, professionals in other areas, and others directly involved with the client. The consultant may provide resource information regarding music therapy techniques and materials or design programs for various settings.

1.0 Standard I – Referral and Acceptance

1.4 The consultant shall establish details of the contract, which may include: type and administration of assessment, resource information, and direct services.

1.5 The written contract shall detail the service and function of both the consultee and the consultant.

1.6 The consultant shall adopt a fee schedule which is in accordance with fees of other professionals in the community.

DEVELOPMENTAL DISABILITIES

These Standards of Clinical Practice are designed specifically for the RMT working with clients who are developmentally* disabled. The RMT shall adhere to the General Standards of Clinical Practice and the specific standards for developmental disabilities described herein. The RMT shall also adhere to the standards of other areas of music therapy service when applicable.

Music therapy services are rendered to clients who are considered developmentally disabled when the client appears to have or manifest a dysfunction, impairment, or developmental lag in one or more of the following areas: psychomotor, affective, sensory, communicative, psychosocial, or cognitive functioning.

1.0 Standard I – Referral and Acceptance

1.2.5 Professionals from other facilities, i.e., group homes, intermediate care facilities, day treatment facilities, residential facilities, and schools

2.0 Standard II – Assessment

2.8 The music therapy assessment shall reflect functioning or developmental levels in the following areas when applicable: psychomotor, affective, sensory, communicative, psychosocial, or cognitive.

6.0 Standard VI – Termination of Services

6.5 The RMT shall document the client's functional ability in the following areas at the time of termination of services: psychomotor, affective, sensory, communicative, psychosocial, and cognitive.

7.0 Standard VII – Continuing Education

7.1.1 Related areas may include, but need not be limited to, psychopharmacology, neurology, psychology, psychiatry, and special education.

GENERAL HOSPITAL

These Standards of Clinical Practice are designed specifically for the RMT working in the general hospital. The RMT shall adhere to the General Standards of Clinical Practice and the specific standards for general hospital described herein. The RMT shall also adhere to the standards of other areas of music therapy service when applicable.

Music therapy in the general hospital may be defined as the specialized use of music in the service of persons in various hospital units which may include but need not be limited to: medical-surgical, pediatric, psychiatric, palliative care, obstetrics, and orthopedic.

1.0 Standard I – Referral and Acceptance

1.3 Note: Some hospital regulations may require the physician to make the final decision regarding acceptance of a patient for music therapy services.

1.4 All referrals for music therapy must be received from or approved by the attending physician through a written order. The written order shall precede the initial music therapy assessment.

2.0 Standard II – Assessment

2.2.1 Specific considerations should include, but need not be limited to, the following:

- 2.2.1.1 Activity status, pre-operative and post-operative
- 2.2.1.2 Attitude toward surgery and/or medical procedures
- 2.2.1.3 Cardiac precautions
- 2.2.1.4 Communicative limitations
- 2.2.1.5 Impact of surgery and/or loss of body function on self-image
- 2.2.1.6 Infection control precautions
- 2.2.1.7 Medical equipment precautions
- 2.2.1.8 Medical regime and possible side effects
- 2.2.1.9 Mental status
- 2.2.1.10 Pain tollerance and threshold level
- 2.2.1.11 Postural restrictions
- 2.2.1.12 Scheduling requirements, coordination with other medical treatments
- 2.2.1.13 Seizure precautions

2.8 Consideration may be given to a patient's spiritual* interest and needs.

2.9 The music therapy assessment shall reflect communicative functioning related to the client's needs.

2.10 The RMT shall assess the ability of the patient's family or involved others to implement any proposed treatments at home.

4.0 Standard IV – Implementation

4.8 Include family member participation in the treatment plan

4.9 Disclose information to patient and family consistent with the physician's judgement and discretion and in accordance with hospital regulations

5.0 Standard V – Documentation

5.3.4 Documentation of the referral shall include date of referral, confirmation of physician orders, source of referral, services requested, and plans for initiation of services if such services cannot be instituted immediately.

5.3 5 Discharge summary outlining patient's response to treatment

5.6 The frequency of documentation shall be established so that the most recent music therapy progress notes reflect accurately the:

- 5.6.1 Current functioning level of the patient
- 5.6.2 Current goals, objectives, and intervention treatment plan

5.7 In no instance shall the frequency of documentation of music therapy services for inpatients be less than once per week.

6.0 Standard VI – Termination of Services

6.5 The RMT shall consult with the attending physician regarding termination of music therapy services.

7.0 Standard VII – Continuing Education

7.1.1 Related areas may include but need not be limited to: basic medical terminology, pharmacology, and death and dying.

GERIATRICS

These Standards of Clinical Practice are designed specifically for the RMT working with geriatric clients. The RMT shall adhere to the General Standards of Clinical Practice and the specific standards for geriatrics described herein. The RMT shall also adhere to the standards of other areas of music therapy service when applicable.

Music therapy in the geriatric setting may be defined as the specialized use of music with emphasis on the development, restoration, or maintenance of each individual to the highest possible level of functioning.

2.0 Standard II – Assessment

2.8 For the purpose of program planning the initial assessment may include, but need not be limited to, assessment of:

- 2.8.1 Motor skills which would include ambulation, eye-hand coordination, range of motion, and grasping skills
- 2.8.2 Mental functioning which would include reality orientation (time, place, person), spatial and body concepts, and cognitive functions including memory and attention span
- 2.8.3 Communicative skills
- 2.8.4 Socialization skills
- 2.8.5 Auditory perception
- 2.8.6 Visual acuity
- 2.8.7 Affective/emotional responses

7.0 Standard VII – Continuing Education

7.1.1 Related areas may include but need not be limited to sensory integration, sensitivity training, and death and dying.

PHYSICAL DISABILITIES

These Standards of Clinical Practice are designed specifically for the RMT working with clients who have physical disabilities. The RMT shall adhere to the General Standards of Clinical Practice and the specific standards for physical disabilities described herein. The RMT shall also adhere to the standards of other areas of music therapy service when applicable.

Music therapy with physically disabled clients is the use of music to help individuals attain and maintain their maximum levels of functioning in the areas of physical, as well as cognitive, communicative, and social/emotional health.

1.0 Standard I – Referral and Acceptance

1.4 A client may be a candidate for music therapy when health (mental or physical) is threatened by trauma, sudden injury, chronic illness, or other incapacitating conditions.

1.5 A client may be a candidate for music therapy when a communicative need is demonstrated

2.0 Standard II – Assessment

2.8 The music therapy assessment shall reflect communicative functioning as related to the client's needs.

3.0 Standard III – Program Planning

3.10 Be consistent with established principles in areas such as facilitation, positioning, sensory stimulation, and sensorimotor integration.

5.0 Standard V – Documentation

5.6 Documentation of referral shall include date of referral, source of referral, and services requested.

6.0 Standard VI – Termination of Services

6.5 Include a description of methods, procedures, and materials used such as adaptive devices and behavioral techniques

PRIVATE PRACTICE

These Standards of Clinical Practice are designed specifically for the RMT working in private practice. The RMT shall adhere to the General Standards of Clinical Practice and the specific standards for private practice described herein. The RMT shall also adhere to the standards of other areas of music therapy service when applicable.

1.0 **Standard I – Referral and Acceptance**
The RMT responds to a referral or request for services and accepts or declines a case at his or her own professional discretion.
- 1.4 The RMT shall send a written acknowledgement to the referral source.
- 1.5 Upon accepting a client for music therapy services, the RMT shall prepare a written contract for services agreed upon with the client prior to or at the onset of delivery of services. The contract shall include:
  - 1 5.1 Frequency of sessions
  - 1.5.2 Length of each session
  - 1.5.3 Projected length of music therapy services
  - 1.5.4 Terms of payment for services
- 1.6 The RMT shall adopt a fee schedule which is in accordance with fees of other professionals in the community.

5.0 **Standard V – Documentation**
- 5.6 A periodic evaluation shall be sent to the referral source when appropriate.
- 5.7 The RMT shall document·
  - 5.7.1 Each session with the client
  - 5.7.2 The client's payment for services

7.0 **Standard VII – Continuing Education**

- 7.1.1 The RMT shall maintain knowledge of current developments in research, theory, and techniques concerning the specific populations receiving music therapy services.

SCHOOL SETTING

These Standards of Clinical Practice are designed specifically for the RMT working in the school setting. The RMT shall adhere to the General Standards of Clinical Practice and the specific standards for school settings described herein. The RMT shall also adhere to the standards of other areas of music therapy service when applicable.

Music therapy in educational settings for handicapped students may be defined as the use of music as a medium for assisting the students in meeting defined educational goals and objectives. In providing this service, the music therapist works closely with the classroom teacher and other supportive services.

2.0 **Standard II – Assessment**
- 2.8 The music therapy assessment should be individualized according to the student's behavior or handicap.
- 2.9 The RMT should be a member of the team which writes the student's individual* plan, e.g., IEP, IHP, IPP.

4.0 **Standard IV – Implementation**
The RMT shall deliver services according to the individual plan.
- 4.8 Evaluation must be made in terms of goals and objectives stated in the student's individual plan.

GLOSSARY

appropriate norms or criterion-referenced data – Standardized tests, whose interpretations are based on data derived from "normal" populations, are generally not beneficial for program planning. Such tests should be used with caution. Criterion-referenced assessments, designed with the client's level of functioning in mind, are usually more helpful in determining both the strengths and weaknesses of the client.

assessment – The process of determining the client's level of functioning at a given point in time.

best professional judgement – The RMT is obligated to make decisions based on the current knowledge that exists in music therapy and related fields.

cultural background – Should include, but need not be limited to, the client's geographical origin, language, religion, and family experiences.

developmentally disabled – Refers to children (0-18 years) with one or more handicapping conditions which include, but may not be limited to: auditory impairment, autism, emotional disturbance, learning disability, mental retardation, motor impairment, multihandicapped, and visual impairment. The term also includes persons whose handicap has continued into adulthood, with the exception of those clients who, upon reaching age 18, would be better classified as adult psychiatric.

evaluation – The review of a client's status in reference to the program plan goals, with consideration given to the appropriateness and/or necessary modification of the plan.

goal – A general expected behavior towards which a client is encouraged to reach. Goals are often stated in broad terms, as opposed to specific objectives.

individual plan – A program of therapeutic or educational intervention focused on the specific needs and strengths of the individual client. Various names are used for such programs, such as Individualized Education Program (IEP), Individualized Habilitation Plan (IHP), and Individualized Program Plan (IPP).

ninety decibels, sound pressure level – Continued exposure to sounds above 90-100 decibels may result in auditory fatigue that is permanent and pathological in nature. See Moore, B.C.J. *Introduction to the Psychology of Hearing*. Baltimore, Maryland: University Park Press, 1977, p. 80.

objective – A specific expected behavior that a client is to reach under stated conditions. The objective should state the conditions under which the expected behavior is to occur and be considered successful. The accomplishment of several objectives usually leads to completion of a goal.

partial hospitalization facilities – Refers to day clinics or facilities where clients return for evaluation or boarding while working in the community.

personal psychotherapy – This includes a variety of therapy procedures; e.g., client-centered, humanistic, and ecletic, that may be group or individually oriented. The importance for a therapist to strive for his or her personal awareness and development is essential, particularly in working with adult psychiatric populations. Skills learned in such experiences can be utilized as they relate directly to the verbal and nonverbal components of music therapy sessions.

spiritual interest and needs – A strong interrelationship among music, religion, and personal belief systems has long been recognized. This interrelationship may be of particular value in selecting music for certain patients in the general hospital setting. The RMT may be advised to work closely with the chaplaincy department in meeting the needs of these clients.

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Adopted November 11, 1982

Functional Value as Criterion for Selection and Prioritization of Nonmusic and Music Educational Objectives in Music Therapy

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ABSTRACT: The fundamental premise presented in this paper is that curriculum development should become an integral part of music therapy planning and that within this process, a criterion of functional value should be considered as the standard for the selection and prioritization of objectives. Functional value is discussed as a criterion for nonmusic as well as music objectives. The author suggests that functional tasks are those valued skills in a situation that, when learned, will have the consequence of the student becoming (a) more independent in that situation, and (b) ultimately more independent in the student's current environment as well as in the natural environments of the home, school and community. The acquisition of each functional skill in the curriculum is viewed both as a step to reduce the so called "handicapping" condition of the student and as a step to successively approximate the behavioral repertoire of nonhandicapped peers and adults. The development of objectives and goals that are consistent with the aim of maximal independence for handicapped students in the heterogeneous natural environments in our society is considered of great importance.

The area of curriculum development has historically been the domain of educators in various disciplines. The question *What should the student learn?* has resulted in the development of a plethora of curricula to be found in numerous documents and texts. Music education is no exception. The development of music education curricula is evident at all levels of education and the topic is inherent to numerous methods texts as well as song series.

Curriculum development has not appeared to be a primary concern for music therapists. Although some publications suggest what could be taught by specifying objectives and activities to reach those objectives, these suggestions are not necessarily presented as a curriculum in the traditional sense. These collections of activities are often valuable resources for music therapists, but they are generally episodic and do not provide an overall, sequentially organized, longitudinal plan of what the student *should* learn. A few exceptions exist. Purvis and Samet (1976) developed a curriculum guide for use in music therapy with emotionally disturbed children. This guide, based on a developmental therapy model (Wood, 1975), presents objectives and appropriate music activities arranged in a hierarchy over five sequential stages of therapy within four curriculum areas. In a text written specifically for the National Association for Music Therapy, Madsen (1980) emphasizes the necessity for individualization and specification of *pinpoint behaviors* to be established or eliminated. Determining what should be taught, or the *pinpoint*, would happen at "many different levels relating to many differentiated academic and social behaviors" and the author suggests that this should lead to a hierarchial arrangement of skills and behaviors based upon specific behavioral objectives. Madsen provides examples of pinpoints as well as teaching and evaluation procedures within a general developmental paradigm under broad curriculum areas. Both of the examples discussed (Madsen, 1980; Purvis and Samet, 1976) emphasize the importance of goals and objectives and the hierarchial sequencing of objectives—components of curriculum.

The mandate of PL 94–142 (the Education for All Handicapped Children Act) and the Individualized Education Program (IEP) has resulted in increased attention to such concepts as goals and objectives and their prioritization. Professionals in the field of music therapy will have increasing involvement in the IEP process and ultimately the selection and prioritization of goals and objectives as well as curriculum development in varying degrees. Jellison (1979) suggests that music therapists develop curriculum and identify goals and objectives that will increase the probability of the handicapped student's successful integration into home, school, and community, music and nonmusic environments. "Steps" are provided by the author for this curriculum development and implementation. The author emphasizes the importance of the music therapist's involvement in curriculum development and writes, "music therapists must assume the responsibility of working with parents and colleagues to develop and implement a curriculum that is consistent with the student's education plan and that is based on well established and recognized knowledge and techniques."

The purpose of this paper is to further discuss various aspects of curriculum which must be considered by music therapists and to emphasize the need for music therapists to identify and prioritize *functional* nonmusic and music skills as objectives in the development of curricula for handicapped students. It is the premise of this paper that a criterion of ultimate functioning (Brown, Nietupski, and Nietupski, 1976) should be the standard by which the music therapy program is evaluated as having met the needs of the handicapped student.

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Goals and Objectives

While it is assumed that music therapists are very familiar with the concepts of goals and objectives, a brief overview, in reference to curriculum, would be beneficial to the intent of this paper. In general, the primary difference between goals and objectives is one of specificity. Goals are known to be very general statements about what the student should learn. They are usually distinguishable by the lack of overt behavioral responses that are directly measurable and therefore they are usually subject to a variety of interpretations. An example of a goal might be: "The student will develop an understanding for physical safety." Examples of key words that could be found in goal statements are: understands, appreciates, knows, comprehends, thinks, feels, etc. Objectives, on the other hand, are very specific statements about what the student should be able to do. They are distinguishable by the inclusion of overt behavioral responses that are measurable and are therefore subject to limited interpretations. An example of an objective might be: "When walking and approaching an intersection, the student will walk or stop with the appropriate traffic signal but will also look for traffic before crossing and continue to observe for traffic while crossing." Examples of key words that could be found in objective statements are: walks, describes verbally, imitates, points to, sings, etc.

An instructional objective has been described as consisting of three components: (a) A description of the terminal behavior (BEHAVIOR), (b) A statement of the conditions under which the behavior is to be observed (CONDITIONS) and (c) A statement of the criteria for acceptable performance (CRITERIA), (Wheeler & Fox, 1972). Often, however, the term *objective* simply denotes the skill or pinpoint behavior that is to be learned. When particular situations (conditions) are identified under which the skill (behavior) is to occur, this may be referred to as a task. To shake a person's hand is a skill, but to shake the person's hand (skill) when a person offers his/her hand for shaking (condition) would be considered a task. Whether described as objectives, pinpoints, skills, or tasks, most importantly, they consist of observable behaviors. Questions that may be used to assist the music therapist in determining if an objective is stated clearly and specifically are: (a) *What* should the student do when engaged in a particular activity or as a result of a particular situation? (Observability) and (b) *How* will an individual know that the student has achieved the objective? (Measurability).

Curriculum

The IEP requires statements of annual goals as well as short-term instructional objectives. Goals are defined more specifically only by the identification of several related objectives and, in turn, goals are reached through the acquisition of their respective objectives. The identification of goals and the identification and organization of intended objectives to meet those goals are basic components of curriculum development.

Curriculum, in its broadest sense, is an organized set of educational goals and their specific learner outcomes (objectives). Objectives traditionally comprise a set of consistent learner outcomes which reflect the intended educational goal and general subject matter of the curriculum (i.e., language, social, music, affective, motor, etc.). A curriculum serves as a value statement of what is important for a specific body of individuals (or individual) to learn. A curriculum could be considered generic if the objectives of that curriculum are intended for all individuals to eventually learn. Curriculum then should be viewed as a longitudinal plan for learning across time and should not be subject to constraints of annual IEP's or monthly planning forms. However, statements of objectives for the IEP or even daily sessions must in reality be considered the core of any curriculum and will have the effect of facilitating or impeding the student's progress. Appropriate objectives should be organized in a hierarchy to be taught across time (days, weeks, months). It is through the student's acquisition of each objective (a process of successive approximations) that the educational goal is achieved. Evaluation serves as the correction procedure to determine the appropriateness of the objectives identified as well as their hierarchical sequencing.

A curriculum serves as a value statement of what is important for a specific group of individuals to learn.

Values and Educational Goals

Curriculum indicates *what* is to be learned, and instruction indicates *how* to facilitate learning. A critical question which precedes and is also integral to curriculum as well as instructional planning is *why* particular plans should be made. All members of the IEP team (parent, teacher/therapist, administrator, and student) have values regarding the handicapped as a result of their own learning histories. These values will be expressed in decisions as to what the student's life should be outside and inside the school environment. Educational goals and objectives are directly influenced by the values held by the members of the IEP team. Although team members bring individual values to the decision making process, the why or rationale for those educational goals must be consistent with legislative mandate.

Central to legislation such as Public Law 94-142, Section 504, and all other Civil Rights Acts is an integration imperative. The Congress in PL 94-142 has required the States to establish policies and procedures to insure:

> That to the maximum extent appropriate, handicapped children, including children in public or private institutions or other care facilities, are educated with children who are not handicapped. (Federal Register, 1977, p. 42497)

Section 504 of the amended Rehabilitation Act of 1973 (PL 93-112) provides that:

> No otherwise qualified handicapped individual in the United States, shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. (Federal Register, 1977, p. 22676)

Section 504 was originally introduced by Senator Hubert Humphrey as a bill to include the handicapped in the Civil Rights Act of 1964. When introducing the bill, the Senator stated:

> The time has come when we can no longer tolerate the invisibility of the handicapped in America, . . . I am calling for public attention to three-fourths of the Nation's institutionalized mentally retarded, who live in public and private residential facilities which are more than 50 years old, functionally inadequate, and designed simply to isolate these persons from society. (Congressional Record, 1972, p. 525)

Since the beginning of the civil rights movement, the mandate to end discrimination has been clear. Therapists and educators should assist in ending discrimination by designing educational programs for handicapped students so as to insure that the student will have access to and be maximally independent in the least restrictive environments of the school, home, and community. The aim for all handicapped students of *ultimate functioning* should be the rationale for the identification of any educational goal. Considering that objectives comprise educational goals and identify what the student *will do,* it then becomes imperative that behaviors identified within those objectives have *functional value*. It will be the student's acquisition of functional behaviors that will ultimately lead to acquisition of educational goals that affect the student's ability to be maximally independent in the least restrictive environments of our society.

Defining Functional Behaviors and Skills

Behaviors may be labeled as functional by an individual or society if the behavior results in an intended outcome. They are often purposeful actions, or may even become habits in a given activity or situation, and are maintained by the individual as long as the action results in the intended outcome and that outcome remains acceptable to the individual and society. Whether through formal or informal instruction, functional behaviors are learned and maintained as a result of rewarding or positive consequences or in order to avoid or escape punishing or negative consequences. Numerous examples occur throughout daily life which are acceptable or even expected in our society. For example: paying for objects at the grocery store, stopping at red lights, tying one's shoes, putting antifreeze in a car during winter, pursuing a career, meeting deadlines, brushing teeth, bringing books to school, possessing a positive self-concept, and taking appropriate care of records and phonograph equipment. Particular functional behaviors in society are even considered as a necessary part of daily living (i.e., preparing and eating meals, dressing and grooming, demonstrating skills for employment, communicating, and socializing). These functional behaviors which are generic (performed by many individuals) are often so important to society that they are identified as objectives, tasks or skills for all individuals, including the handicapped, to learn. Some skills are so valued that if a handicapped student cannot perform the skill, it is done for the student (i.e., daily living skills). Functional skills for the handicapped are traditionally identified by broad curriculum areas such as: Perceptual Motor, Academic, Leisure, Language, Social, Daily Living, and Vocational.

Careful examination of any given set of plans may reveal that skills are being taught that are rarely, if ever, performed by individuals of the same chronological age group in society and that impede rather than facilitate independence and integration.

The *intent* of most curricula for handicapped students is to identify for teaching generic functional skills that are performed in society and that will increase the student's independence and integration into society. However, careful examination of any given curriculum may reveal that skills are being taught that are rarely, if ever, performed by individuals of the same chronological age group in society and that impede rather than facilitate independence and integration. For example, the skill of sorting various colored beads into like piles (which the teacher will mix up for sorting again) is not a generic functional skill that is performed by a nonhandicapped thirteen year old. Similarly, this same adolescent would not be found singing *If you're happy and you know it, clap your hands.* These tasks are neither valued by society for the thirteen-year-old nor will acquisition of the skills to complete these tasks facilitate integration with peers or society in general. Therefore, it follows that the skills *are not functional* and that the selection and teaching of these skills is entirely inappropriate for the thirteen-year-old retarded adolescent. While a rationale might be given that the student is learning discrimination skills (color sorting) as well as perceptual motor skills (meeting hands in clapping at midline), these same behaviors may be taught and learned in situations more natural to the everyday environments of nonhandicapped adolescents (i.e., color matching socks when dressing, or after laundry; clapping hands at concerts and sporting events; or playing cymbals in a music group).

If it is intended that a handicapped student will remain forever in a restricted environment, segregated from his/her nonhandicapped peers and nonhandicapped adults in the school and community, chronological age-appropriate functional behaviors may not be valued in the curriculum. Under these conditions, the curriculum is not only restrictive and dehumanizing but it is in contradiction to all civil rights acts. Even if integration is intended, if a handicapped adolescent were to bead sort and sing and clap hands to early childhood songs outside of the segregated setting, it is highly unlikely

that the consequences would be rewarding. In fact, the student may suffer emotionally as a result of social disapproval or the lack of social acceptance when those behaviors are performed. It is unlikely that the retarded thirteen-year-old who sorts beads on the floor of the doctor's office while waiting with parents for an appointment, or who sings and claps hands when happy while riding on a bus, will experience positive social consequences. The curriculum for this student and therefore objectives must be selected that will enhance and not impede positive experiences for the student in various community and school environments.

A functional task for a handicapped student may then be defined simply as valued behavior (skill) in a situation(s) that, when learned, *will* have the consequences of the student becoming (a) more independent in that situation, and (b) ultimately more independent in his/her current environment as well as in the natural environments of the home, school, and community. The acquisition of each functional skill is a step to reduce the so called handicapping condition of the *individual and a step to successively approximate the behav*ioral repertoire of nonhandicapped peers and adults. The following questions are suggested in order to assist the music therapist in defining skills as functional:

1. Will this skill result in rewarding or positive emotional, social, physical, or educational consequences and/or result in avoiding negative consequences for the student in his/her current setting *and ultimately in heterogeneous integrated settings* (home, school, or community)?
2. Is the task, as well as the materials and criteria for performance, chronologically age appropriate?
3. If the functional skill cannot be performed exactly as it can be by nonhandicapped individuals due to various sensory or motor impairments, have minimal adaptations been made to allow the student to be maximally independent and still partially perform the functional skill?
4. Will this skill ultimately prepare the student to be maximally independent in environments outside of the school setting or predetermined 'school day'?
5. Could this student function as an adult without this skill?
6. Will acquisition of this skill improve the quality of this student's current life style and ultimately his/her life style as an adult?

Functional Nonmusic and Music Skills

Music therapy has been defined as "the systematic application of music . . .to bring about desirable changes in behavior" (National Association for Music Therapy [NAMT], 1980). In the NAMT *Career Brochure* (1980), the music therapist has been described "as a member of the therapeutic team" who "participates in the analysis of individual problems and in the projection of general treatment aims before planning and carrying out specific musical activities." Traditionally, the term *nonmusic* has been used as a general term to describe these "desirable changes in behavior" for the clients in music therapy. The term has been convenient to distinguish *nonmusic objectives,* which are generally predominant in music therapy practice from *music objectives,* which are generally predominant in music education. It appears that *nonmusic behaviors* have become synonymous with music therapy and *music behaviors* have become synonymous with music education. Forsythe and Jellison (1977) emphasized this distinction in an attempt to define primary professional roles and goals which would ultimately affect *aesthetic education* and music therapy services provided for the handicapped.

While the use of the terms *nonmusic* and *music* assists in clarifying the primary roles and goals of music therapists and music educators, respectively, it is important to be aware of the direct implications that these terms may have on curriculum development. A criterion of functional value for objectives suggests that these terms be re-examined for several reasons. First, the music therapist, as a member of the therapeutic team, will need to consider the *functional value of nonmusic objectives* prior to including them for instruction in music therapy. Secondly, while music objectives for aesthetic *education are generally within the music education curricu*lum, functional music objectives for *independence* and *integration* become important as curriculum in music therapy.

Music therapy has primarily provided a successful alternative method to traditional instructional methods and the music therapist has had an important role in teaching objectives identified as important for the individual.

Functional Nonmusic Skills

The value of music therapy as a procedure to teach nonmusic skills is well documented in the literature. Alley (1979) states that the field of music therapy maximizes the enjoyment and teaching potential of music within the paradigm of sound special education techniques to enhance the learning process and facilitate the growth of each child. Music therapy has primarily provided a successful alternative method to traditional instructional methods and the music therapist has had an important role in teaching objectives identified as important for the individual student. Although emphasis on specific objectives may vary, it is very likely that specific instructional objectives for a student in such areas as gross motor coordination, self-esteem, spontaneous speech, social, etc., would be identified for instruction across various program areas, including music therapy. This team approach, of course, is educationally sound and should be continued. Generally, the music therapist, unless working on independent objectives confined to the music therapy setting, has cooperated with team efforts to *teach the same objectives* as other professionals working with the student but has used techniques specific to music therapy practice.

As a member of the therapeutic team, it is important that the music therapist consider the functional value of the nonmusic objectives being discussed for the student and also

become actively involved in curriculum decisions. Objectives to be taught across program areas should be examined in light of questions presented earlier. The music therapist should not passively accept predetermined objectives. The question, "*Why* does this 15 year old student *need to* point to a triangle, a circle, and a square?" should be answered relevant to functional value *before* the music therapist writes the song and plans and carries out specific music singing activities to teach the objective.

Functional Music Skills

It is probably safe to assume that music objectives for aesthetic education have been valued less than nonmusic objectives in curricula for both the handicapped and nonhandicapped student. Emphasis (i.e., time and money) within curricula for both populations has been on traditional domains rather than on music, arts related, or recreation/leisure domains. The problem is even greater for handicapped student with numerous skill deficiencies requiring even more instructional time and a larger variety of professional services than is required for the student in the regular classroom. As a result, even less attention is being given to nontraditional curriculum, i.e., music. Music has become a related but not a required service.

Public Law 94-142 states that related services may be identified as are required for the student to benefit from their required special education (Federal Register, 1977). While music therapy and music as an artistic or cultural program are included as related services, *music,* unlike physical education, *does not appear as part of the special education or required* curriculum. Considering the emphasis on nonmusic instruction in PL 94-142 as well as the traditional and successful use of music in therapy to teach functional nonmusic objectives, it is assumed that nonmusic objectives dominate the curriculum and that music objectives are not frequently identified for the handicapped student. It is understandable that emphasis must be placed on nonmusic functional programs; however, the pleasure that can be provided in one's lifetime through music education provides a strong rationale for its inclusion, in some part, into the curriculum. Music therapists working with handicapped students not yet integrated into the classroom, or those who receive no music education per se, have generally provided these students with pleasurable music experiences within the music therapy session while teaching nonmusic objectives. This indirect music education is of course only a stopgap attempt to provide some aesthetic education for the students. Music education in the regular classroom is still the least restrictive environment and the environment in which students will best be provided with a sound music education curriculum by a well-trained professional.

Since the music therapist has traditionally focused attention on nonmusic skills with a general understanding that the teaching of music skills is more within the realm of the music educator, he/she may not be considering the value of *functional music skills* for the handicapped student. In the previous discussion of objectives and goals, it was stated that goals are defined by objectives that are consistent with that goal and in turn goals are reached through the acquisition of their respective objectives. The ultimate aim or goal for students in music education is aesthetic education. The ultimate aim or goal for students in music therapy is maximal independence in least restrictive environments. The question as to whether an objective is a music education or music therapy objective is only answerable in relation to the long-term goals which emphasize either *aesthetic education* or *functional independence* for the student. *Music objectives are therefore appropriate within both music education and music therapy curricula.* While the role of the *music educator* is primarily to identify appropriate objectives to reach *aesthetic goals,* the role of the *music therapist* is primarily to identify appropriate objectives to reach *functional goals* relating to independence in various environments—many which may involve music. When the music therapist identifies music environments and teaches a student skills for functioning within those music environments, the music therapist is teaching functional music skills.

The role of the music therapist is primarily to identify appropriate objectives to reach functional goals relating to independence in various environments.

Jellison (1979) suggested that the music therapist investigate the music environments of the student's home, school, and community in order to develop music instructional programs that would facilitate integration and independence for the handicapped within those environments. Students should be taught functional music skills for home and community leisure and recreation (e.g., operating a phonograph/cassette, playing a chord organ, finding and purchasing desired records, applauding at the appropriate time in concerts, and locating the desired radio station and operating radio controls). In addition, students should be taught functional music skills to facilitate integration into the school music program (e.g., discriminating high/low and loud/soft, starting and stopping, taking turns, and basic rhythm skills). Communication between the music educator and music therapist is vital in order to identify functional music skills appropriate to a given music classroom. In order to develop appropriate functional music curricula the music therapist should be knowledgeable of the music personnel and music resources in the student's home, school, and community for these are the environments where the student will work, learn, and play. Additionally the music therapist should be knowledgeable of music activities and preferences of the handicapped student's chronological age peers as well as those activities and preferences of the student himself/herself. Finally, the identification and prioritization of music objectives should be examined as to a criterion of functional value.

Six questions were presented earlier to assist the music therapist in defining skills as functional. To demonstrate how a music objective may be a functional music objective, an example objective will be discussed. A goal such as "learning to play an instrument" may initially be considered as a music goal consistent with the aim of aesthetic education for the student. However, suppose that upon discussion with parents or from teachers' reports and files, the music therapist became aware that the parents value this activity for their handicapped child. Instead of dismissing this objective as being a music education objective, with music aesthetic consequences, the music therapist may investigate further as to possible nonmusic consequences—consequences that facilitate independence and integration for this student into natural environments. While the aesthetic education of the studnet is valued, the music therapist may teach the objective of "learning to play the guitar during leisure time" to increase the probabilities of positive home interactions and to therefore assist in increasing the probability of the student spending more time or even residing in his/her natural home rather than in a residential setting. If this probability is increased with the quality of the music performance, the music therapist may decide that the musical development of the student is an important step toward the nonmusic aim of independence and integration in the home. With acquisition of the skill, consequences for the student may indeed be positive from peers, parents, and other adults. The student's independence is increased outside of the school day and his/her quality of life improved. The specific question, *Could this student function as an adult without this skill?* may initially seem difficult to answer when focusing only on the skill of guitar playing. However, when considering it as a leisure skill in the natural home environment with subsequent positive consequences, the functional value of this skill becomes more apparent.

While there may be a tendency for music therapists to teach only nonmusic objectives, functional music objectives should receive equal consideration in the music therapy setting. When music objectives are learned, significant positive consequences follow that affect the student's aesthetic life. When functional music objectives are learned, significant consequences follow that affect the student's *independent life in natural settings*.

Summary

Although all members of the student's education team will have concern for the student's individual needs, the fundamental premise presented here is that the music therapist must assume responsibility for developing functional curriculum in cooperation with other instructional personnel, for it is through this active involvement that the music therapist will be able to assist in identifying and prioritizing *functional* objectives for the student. Also, as music therapists identify objectives that meet a criteria of functional value, both music as well as nonmusic objectives should be included within the curriculum. While in the former, the functional music skill becomes the objective (curriculum), in the latter, the music skill becomes the technique (instruction) to reach the nonmusic objective. However, whether (a) a functional music skill or (b) a functional nonmusic skill to be reached through music is identified, ultimately the music therapist should be involved in developing and implementing *longitudinal* and individualized functional curricula that will assist the student to be maximally independent in heterogeneous nonmusic, as well as music, environments.

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The Ward Music Therapy Group and the Integral Involvement of Nursing Aides

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ABSTRACT: Thirty-two long-term psychiatric adult patients and sixteen staff members from Eastern State Hospital in Lexington, Kentucky participated in a sixteen month ward music therapy group. The progress of the group from a weekly thirty minute sing-a-long to a weekly sixty minute therapy group with the goal of interpersonal awareness training among group participants and staff was due, in part, to the personal commitment and involvement of the psychiatric nursing aides. The aides encouraged individuals to actively participate in music therapy. In addition, the aides served willingly as partners to the more regressed group members. Throughout the program monthly meetings were held to discuss progress and to plan future goals, objectives, and methods for achieving these. In all facets of the program the nursing aides were part of the decision making and plan implementation.

The success or failure of the therapeutic treatment for long-term psychiatric adults is, in part, contingent on personal commitment of the individual patient. Some indicators of a person's attitude toward treatment are attendance in groups or individual sessions, willingness to attempt new or different activities, and acceptance of therapy and the therapist. The nursing aide, as the single most influential staff member in the patient's daily life (Talbott, 1973), is in a position to encourage those under his/her care to participate or not participate in therapy groups or individual sessions.

Nursing aides are in continuous contact with hospitalized individuals and are generally responsible for custodial care as well as shuttling individuals to and from therapy meetings. In the move toward accountability in mental health care, additional duties such as record keeping and behavioral programming are being placed on the nursing aide. Reinforcement for contributions in this area of patients' care is generally disregarded.

Hollander (1973) noted that nursing aides were more willing to follow through in extra "data" duties when they were reinforced with bonuses. In addition, aides who received bonuses were found to work more directly with patients on tasks for which data was being collected. The indication is that aides can be expected to complete tasks other than custodial care if they are reinforced.

Talbott (1973) recognized the importance of the aide in professional staff training and patient care decision making. Aides were able to make more practical recommendations for therapy because of their view of the individual receiving treatment in terms of functional change. It was on this premise that aides were included in the decision making as well as implementation of a ward music therapy group at Eastern State Hospital in Lexington, Kentucky from February, 1978 to June, 1979.

The purpose of this writing is to discuss the ward music therapy group and the involvement of the nursing aides in the planning and implementation of the program. Their commitment to patient care through music therapy had a significant influence on the evolution of the ward music therapy group from a weekly sing-a-long to a structured program in the management of personal awareness among patients and staff.

Members of the group were thirty-two long-term psychiatric adults who were in residence at the state hospital in Lexington, Kentucky. Length of hospitalization ranged from two to fifty years (two year residents were measured on current hospitalization). Ages ranged from twenty-five to seventy-two years. The staff who worked with the group were nursing aides (employment ranging from two to twenty-five years), recreation therapists, workshop training staff, psychologists, psychiatrists, psychiatric nurses, and a music therapist. Employment for these additional groups ranged from six months to three years.

Prior to the inception of the ward music therapy group, all ward residents and nursing staff, under the leadership of the social worker, met once weekly to listen to announcements about home passes and to sing songs played on the piano by a minister of music. Following the sing-a-long all ward residents were given coffee and rolls. All of these activities were conducted in the dayroom on the ward. For approximately one year the group had not met. When the music therapist was hired, a request was made to re-establish the group.

Initially the music therapist met once weekly with approximately five patients and three aides, on the ward, where song leading and singing was conducted. (It should be noted that thirty other ward residents were in the area at the same time these meetings were held.) During these meetings it was observed that the aides enjoyed being a part of the group as was indicated by the fact that they would bring more ward residents to each meeting and encouraged them to participate. Within a few months more mobile experiences which involved physical activity were introduced. Following each meeting the aides were verbally thanked for their assistance and were asked for recommendations on future procedures. After each gathering all ward residents were given coffee and rolls.

Within four months the music therapist, aides and now

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other staff met to determine goals, objectives, criteria levels, and reinforcement schedules for participation. The aides suggested that coffee be used as a reinforcer for participation. It was decided that ward residents who remained in the area of the group for five minutes within a thirty minute session, with or without direct involvement, would receive the coffee and roll.

The general goal of the group was to provide a structured non-threatening environment for group participants to interact with each other and staff. The overall objectives were that group members be able to select or accept selection of a partner and maintain contact with that partner throughout group meetings. More specific monthly goals and objectives, and methods for achieving these, were written during planning meetings and often included individual treatment goals and behaviors to be monitored.

Each month the staff met to discuss maintenance of monthly objectives and criteria levels. The ward clerk collected data on all participants at all meetings. Individual goals were monitored by the staff charged with the responsibility of that individual. Within a year group criteria included participation in the group for the duration of the meeting, now one hour, maintenance of the same partner, and completion of 80% of the tasks presented.

Experiences presented began with sing-a-longs of old favorites of the group members and aides. By the fourth month songs written about individuals and patient/patient, patient/staff interaction were introduced. When staff increased to sixteen, more regressed individuals could be given more individualized attention and folk dancing was begun. For one year this was the main procedure with the initial dances being simple—only the steps walking forward and back with a hand shake while in a large circle. Eventually the group was able to perform the *Virginia Reel* and other more complex dances.

It was suggested by the aides that the program move in the direction of more verbal contact and information sharing. For several months these opportunities were provided through song, movement, and instrument playing. Eventually an eight week experimental project designed to determine the effectiveness of music therapy and group therapy in the training of partner interpersonal awareness was conducted. Results of the study showed that in a controlled setting music therapy and group therapy, when compared to no therapy, can effect change in interpersonal awareness (Tunks, Reference Note).

Throughout the sixteen month program the aides became most willing to encourage those who attended to participate throughout all sessions. It is assumed that this was, in part, a result of their personal commitment in the decision making and plan implementation of the program. In addition, positive reinforcement provided by other staff may also have influenced this behavior. It was noted that the attendance by group members in the smaller music therapy groups improved during the period of the program from 40% to 90% attendance over six consecutive months and continued for three months at the 90% level.

Unless the music therapy program on the longterm ward is well established and supported, the music therapist who comes into this setting will find it beneficial to spend a considerable amount of time meeting with the aides. In addition to the volumes of information they can provide on each patient, the aide can be a valuable asset in the development of a music therapy program. Aides who have been employed for some time can be very good contacts for equipment acquisition, locating patients, and other kinds of assistance which may be needed.

In a survey conducted by Handler (1973), patients were asked to rate psychiatric aides and to define their role in the hospital with regard to patient care as custodial or human. Patients rated the job more humanly than did some aides and gave higher ratings to aides who treated them more humanly. These same aides rated the job more humanly and, in general, were the younger aides. The aides who rated the job in a more custodial manner received lower ratings from patients.

The aides' approach to patients, to their job, and their attitude toward patient care can be influenced by other staff. If the aide is included in the operations of the therapeutic treatment process, their willingness to encourage patient involvement in therapy will be heightened. The benefit of support by the aides in the music therapy program will be passed on to the participants in the music therapy sessions. In a job as demanding as music therapy with long-term psychiatric adults, it is to the advantage of the music therapist to find time and energy to include the knowledge and skills of the nursing aide in the development and implementation of the music therapy program.

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Facilitation of Communication between Service Delivery Team Members

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ABSTRACT: Public Law 94-142 mandates an interdisciplinary team approach to delivery of educational and therapeutic services to special children and youth. Music therapists often serve with special educators on the team which develops Individualized Education Programs [IEP's]. This article offers suggestions in the facilitation of professional communication: learning basic terminology of another discipline; translating terminology into specific, observable behaviors; and sharing teaching techniques and philosophies. Included is a list of special education terms and their definitions in relation to a music setting. The special education technique of clinical teaching is explained. Professionals who share this type of information will be able to participate more fully in team development of IEP's. Communication barriers may be overcome, and professionals may realize how extensively the knowledge and philosophies of their respective fields overlap. Service to special children and youth will be enriched greatly.

Public Law (PL) 94-142, the Education for All Handicapped Children Act, passed in 1975, mandates a free appropriate education for all handicapped children and youth of ages 3 through 21. The concept of least restrictive environment is included in the criteria for an education to be considered appropriate. *Least restrictive environment* has been interpreted to mean an educational setting which allows handicapped children, to the maximum extent appropriate, to receive instruction with their nonhandicapped peers (Kaufman & Morra, 1978). Mildly handicapped children often have been mainstreamed, which means they spend 50% or more of their school day with regular students, particularly in the areas of music, art, and physical education.

Mainstreaming has been judged inappropriate for some children with more severe handicaps because their instructional and social/emotional needs could not be met in a regular classroom. For these children the regular classroom has not been considered the least restrictive environment at all but has been viewed as restrictive. PL 94-142 states that no handicapped children can be excluded from receiving a full program merely on the basis of their handicaps. Therefore, since regular students receive music instruction, handicapped children cannot be deprived of this service.

Educators have become aware of the unique contribution which music can make in the education of special children. Some school districts have hired music therapists to provide music experiences for their special students, particularly for those in self-contained classrooms who require a more intensive, therapeutic approach. Few professionals now view music simply as a recreational activity which requires a minimum of instructional preparation. PL 94-142 mandates that for each student an Individualized Education Program (IEP) be developed by the professional service delivery team. Music therapists and music educators increasingly are being asked to serve as integral members of the interdisciplinary IEP team. Efficient planning depends largely on the communication skill of team members.

Interdisciplinary Communication

Team members can facilitate communication when they know the basic terminology used by other team professionals. The rise of a common language can lead to in-depth exchanges of information and values. Through such an exchange professionals may discover that the philosophies and treatment techniques of their own field are not radically different from those of fellow team members.

Because the service delivery team always includes a special education professional, music therapists and music educators will find it practical to be conversant in special education terminology. To learn the definitions of the terms is an initial step. However, musicians can progress beyond this stage if they think through what the terms mean in a music therapy/education setting. For the terminology to be usable and practical it must be translated into specific, observable music behaviors. Special education professionals who receive this information from musicians will increase their knowledge of music therapy/education and will realize that music therapy and special education have common treatment goals.

To aid interdisciplinary communication a list of special education terms and their definitions in relation to a music setting appears at the end of this article. [The list is arranged in common perceptual areas.]

The IEP and Instructional Planning

With communication established, the music therapist/educator and special educator can participate more fully in the team development of the students' IEP's. The IEP is a written statement which specifies which services the students are to receive, the extent to which they will receive instruction with nonhandicapped peers, annual program goals, and short-term objectives. Annual goals describe the educational performance which reasonably can be expected by the end of a school year. Short-term instructional objectives are steps be-

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tween the students' present levels of skill performance and the desired levels as stated in the annual goals.

The terms below provide a collection of operationally defined behaviors from which short-term IEP objectives and specific instructional objectives may be developed. Once short-term objectives have been determined, the professionals are responsible for providing their own unique services. However, before delivering those services, team members could share information which concerns techniques to determine if one field has something of value to offer another field. The special education technique of clinical or prescriptive teaching, for example, can be applied readily in music therapy/education.

Clinical or prescriptive teaching is scientific. Strengths and weaknesses are evaluated by standardized psychoeducational tests, but a special education teacher may also devise informal, curriculum-based tests. The teacher/therapist carefully observes students' academic and/or social/emotional behaviors and formulates a hypothesis about the current problems. Instruction/therapy is then planned to meet the students' unique needs. In music, ideally, this would involve the establishment of musical and nonmusical objectives. Stated differently, this approach would involve teaching musical concepts and providing musical experiences which simultaneously aid musical and emotional growth and develop specific skills needed for academic learning. The teacher/therapist observes the students' learning styles and their areas of strengths and weaknesses, and then plans initial experiences which capitalize on strengths, which insures success and positive reactions.

To plan instruction, special educators and therapists employ the process of task analysis, which identifies specific skills required to accomplish a task. They also examine which perceptual channels are used in the task (auditory, visual, kinesthetic, tactile, or all) and determine if a shift from one process to another is required. They also determine how each individual student processes information.

Special educators, as well as therapists, also examine which levels of learning are involved (perception, memory, symbolization, conceptualization, abstract reasoning). They determine at which specific level each particular student functions and plan instruction to begin at that level. Instruction then usually proceeds in small steps while the educator/therapist constantly observes the student's responses and evaluates specific techniques used. Positive reinforcement should be provided for appropriate responses.

Conclusion

Because PL 94-142 mandates a team approach to service delivery it may be viewed positively as an impetus toward interdisciplinary communication. Professionals of the various disciplines involved have much valuable information to share with each other. If each professional begins with a positive attitude and openness toward just one professional of a different discipline the effect will snowball. Communication barriers may be overcome, and perhaps professional jealousy and "turf guarding" will be decreased as professionals realize how extensively the knowledge and philosophies of their respective fields overlap. A mutual support system could evolve. The experience would be personally and professionally rewarding and would enrich greatly the services provided for special children and youth.

Special Education Terms

auditory awareness: awareness of the presence or absence of sound

auditory reception: ability to understand what is heard; to follow directions

auditory discrimination: ability to differentiate among sounds or words that contain similar sounds like *pin, tin*—In music: the ability to note differences between higher and lower sounds; louder from softer; differences in timbre, etc.

auditory association: ability to relate spoken words in a meaningful way

auditory closure: ability to integrate nonmeaningful elements of the environment into meaningful wholes and sequences, such as blending of letters into a word

auditory figure-ground: ability to pay attention to the stimulus while background, competing noises are present

auditory memory: ability to remember what has been heard

auditory sequential memory: ability to remember spoken or sung material in the exact order in which it was originally presented, or the ability to remember the exact sequence of rhythms presented

sound localization: ability to identify the direction from which a sound comes

visual reception: ability to perceive and understand what is seen—In music: ability to understand symbols representing melody and/or rhythm

visual discrimination: ability to perceive similarities and differences between movements seen, or symbols that are seen

visual memory: ability to remember movements or symbols which have been seen

visual sequential memory: ability to remember the exact order in which the original material was seen

verbal expression: ability to express ideas in spoken language or songs sung

kinesthetic sense: sensation of movement in muscles, tendons, and joints; used in creative body movement and to play an instrument

tactile sense: the sense of touch used to play a musical instrument

temporal concepts: concepts which relate to time—In music: relating to duration of sound; sensing the beat; adjusting one's playing or singing to fit with others

body image: awareness of the body in space and its possibilities for movement; used in creative movement

laterality: ability to differentiate left and right halves of the

body and control each side or both sides together; used in creative movement and to play instruments

directionality: the sense of all directions from the body out into space: right, left, up, down, back, front, to each diagonal

midline, crossing of: an imaginary line from head to feet down the center of the body; crossing the midline occurs when eyes move across a musical score or when a musical instrument is played from left to right (such as a mallet instrument).

unilateral movement: to involve one side of the body, such as a foot stamp to a musical pulse

bilateral movement: to involve both sides of the body, such as hand clapping or playing two tone bars simultaneously

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Information Sharing

Formation of a Music Therapy Association in a Clinical Setting to Promote Professional Growth

ROBERT KROUT, R.M.T. AND JAMES DZIWAK, R.M.T.*

"There are those who know who they are, are able to expand, grow, change and have the self-confidence to share, recognize success many times through others, and demonstrate consistent high energy directed in a productive manner" (Bitcon, Reference Note).

The sharing and recognizing of what Bitcon speaks can be thought of as contributing to "professional growth." Unfortunately, this growth is not always facilitated for or by music therapists in clinical settings. Reasons for this include: geographic distances between music therapists, lack of communication between music therapists in particular settings, difficulty in scheduling time designated for professional growth, and lack of interest among some music therapists in the professional growth process.

Music therapists at Camarillo State Hospital have addressed the above concerns by creating the Camarillo State Hospital Music Therapy Association (CSHMTA). This organization, formed in 1980, is comprised of registered music therapists and music therapy interns. (It should be noted that both music therapists and an internship program have been in operation at the hospital prior to 1980.)

The association provides for its members a framework for exploring and sharing issues, experiences, and concerns common to the group and the profession. A weekly meeting brings members together to combine four elements of the association: the internship program, a business meeting, inservice training, and group process/counseling.

The clinical training program (approved by the National Association for Music Therapy, Inc.) provides training for music therapy interns in various clinical environments. During the first half-hour of each weekly association meeting time, interns join their counselors and the Clinical Training Director to discuss matters relevant to the internship program. Additional therapists join the group for the following thirty minutes to review observations made of interns at their work locations during the previous week. This time is valuable, as interns have the opportunity to receive feedback from, and share experiences with, the group. The additional therapists also have the opportunity at this time to bring up concerns they might have regarding the internship program.

As the internship portion of the morning concludes, the entire organization gathers for a thirty-minute business meeting. Here, items such as upcoming events, member announcements, and committee reports are presented and discussed. Association committees include: Public Relations, Fundraising, Internship, Correspondence, Music Library, Inservice, and Executive (comprised of CSHMTA Chairperson, Vice-Chairperson/Treasurer, Secretary, and committee heads).

Inservice training provides the organization with another vehicle to elicit professional growth. Hour-long inservices, presented by both members and invited guests, follow the business meeting. Inservice topics have included: data-collection, instrument repair and maintenance, aspects of the task analysis, folk dancing, interview skills, psychodrama, sensory integration, assertiveness training, and pharmacology.

Finally, the morning closes with an hour of group process/counseling. At present a licensed clinical social worker leads the members in exploring various personal and professional issues. The group leader utilizes an eclectic approach, allowing the participants to gain further insight into the professional growth process.

Response to the CSHMTA has been favorable from both within and outside the organization. Verbal reports from registered music therapists and intern members indicate that the meeting time is used in a productive manner. Although participation in the organization is optional for members, the group looks forward to continued change, success, sharing, and growth.

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Information For Contributors

Objectives of *Music Therapy Perspectives*

1. To speak to the immediate client service needs of the practicing music therapist clinician.
2. To appeal to a wide readership, both inside and outside the profession of music therapy.
3. To include information which would be useful to music therapists, and other professionals, nationwide and internationally.
4. To include articles which deal primarily with implications for music therapy practice (clinical, academic, and administrative).
5. To be self-supporting.

This publication of the National Association for Music Therapy, Inc. will attempt (a) to speak to the needs of music therapists in all their various roles, and (b) to appeal to the wide base of other professionals outside of the field of music therapy who are interested in it. Articles in which the implications to the field of music therapy are clearly articulated will be considered for publication. These may include, but are not limited to, such topics as (a) various therapeutic approaches, perspectives, and modalities, (b) information useful to clinical training directors, academicians, and administrators, (c) theory, (d) philosophy, (e) case studies, and (f) critiques. Manuscripts must be clearly written and be supported by any available data.

Ethical Considerations: Implicit in the preparation and submission process are the ethical considerations governing the assignment of credit for publication; these standards are articulated in the *Code of Ethics* of the National Association for Music Therapy, Inc. To summarize the code's guidelines: major professional contributions by two or more persons to a common project are recognized by joint authorship, whereas minor professional contributions are acknowledged through appropriate references. Within the textual and reference citations, authors should acknowledge unpublished as well as published material that directly influenced their writing.

Criteria for Acceptance: Articles are to present general approaches, techniques, or perspectives which would be useful to music therapists and other interested professionals.

Cover Sheet: On a separate sheet of paper include (a) the title, (b) author(s), with pertinent information, (c) affiliation, and (d) running head.

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