LET US PRAY

O God, Creator of our Universe, by whose infinite wisdom all things reveal the ultimate lawfulness and order of a perfect design, we are permitted to share in so many ways in the realization of this divine plan. Bless, O Lord, the food we are about to eat; bless the hands that prepared it; and grant that we may evermore use all these blessings to glorify Thy Holy Name. Amen.

Grace offered at the banquet,
Fifth Annual Conference,
National Association for Music Therapy,
by The Reverend Arthur Flagler Fultz.
ACKNOWLEDGMENTS

The National Association for Music Therapy presents to all who are interested in the advancement of the use of music in medicine this volume, Music Therapy 1954; The Book of Proceedings of the Fifth Annual Conference, held at the Henry Hudson Hotel, New York City, October 15-18, 1954.

Such a publication as this would have been impossible without the time and labor of those music therapists and their colleagues in allied fields who presented papers or otherwise participated in the program. The Association is indebted to these eminent participants and in particular to Arthur F. Fultz, Program Chairman.

Gratitude is due the following people who helped in the preparation of the manuscript: Kay Rankin Kiser, Ann Rumsey and Doris York Chronister. Special recognition and gratitude is due Harold Allen, Publisher, for his patience and many services.

E. THAYER GASTON
Editor
There are two kinds of persons for whom a Book of Proceedings is useful: first, the kind of person who needs the stimulation of inspiring speeches, good fellowship with people in his own professional class, and the enlarging influence of a broadening social outlook in his field of specialization; and second, the kind of person who for one reason or another could not attend the sessions of the conference.

The Book of Proceedings will serve both kinds. The former will find it an invaluable frame of reference on which to expand his own professional understanding, and the latter will possess at least a minimum report of what happened on which to base his comprehension of the matters of importance in contemporary music therapy. Further, of course, it will stand as a record of proceedings which will add another section to the historical account of the development of the field.

Each conference has brought out some one or two signal values pertinent to our work and to our workmanship in music therapy. The Fifth Annual Conference in New York attempted the difficult task of delimiting the field, and of identifying the more fruitful avenues of general emphasis by which music therapists may be guided. By classifying these avenues into four core constructs, we may gain access to a class, or order, of events in which to hunt for answers to many of the puzzling problems of our work.

The first of these is developmental education. Fundamental to the operations of music therapists are the changes demanded of patients in their total response pattern. Such a large part of a therapist’s time is spent trying to engender and guide these changes that the contribution of a field chiefly concerned with growth and change is most welcome. Here, indeed, is a field of scientific study which identifies changes, on the one hand, in terms of spurious, superficial, temporary, unchallenging results, and on the other hand, in terms of authentic, vital, permanent results which pervade every department of the individual’s life picture. A core construct, or generalization dimension, which promises valid light on problems of developmental change deserves a place in our thinking. This does not mean that therapy is to be regarded as but another form of education, but it does suggest that all true therapy implies growing, deepening, vitalizing life-experiences for each patient at whatsoever level he is met by the therapist. Developmental education offers help to
people who seek tested methods and materials in musical growth with which to perform their operations as therapists more effectually.

The second core construct to be included in this conference is communication. It hardly seems necessary to justify its inclusion here, since it has already been extensively used as a music therapy basic in previous conferences. In this conference, only one aspect of communication was selected for consideration, but it is one with which every music therapist must be cognizant if he is really to treat a patient's basic needs. Musical behavior is unquestionably a way of conveying certain kinds of information. It is always an attempt to influence someone, including the performer himself, his neighbor, his community, or society in general. Granted the truth of this statement, the music therapist must give heed to the vast accumulation of knowledge that has been developed by scientists who have studied communication problems. Communication theory, and its applications in the special field of musical action abound in usable values for the therapeutic situation. They truly afford a glass with which to view more expertly the experiences, not only of patients, but of therapists as well.

Group Dynamics constitutes the third core construct selected in this connection. This is a relatively new concern of social science. Many schools of public relations in universities and colleges in the United States are busy building a respectable body of research findings pertaining to the findings of group dynamics. More recently, in mental hospitals, there has been a marked rise in the use of these concepts, especially in connection with the ever-widening group-therapy focalization. In politics, in education, in industry also, there is an increasing "group-dynamic-consciousness" at this time. The fact that there is a growing conviction among hospital authorities that small-group operations with patients provide the most economical and effective use of a music therapist's time suggests that the clarifications coming about through the findings and conclusions being reached in this field should receive the careful attention of our people.

The fourth of these basic common denominators which music therapists eventually will come to recognize as core constructs is perception. Although, since it is a process upon which communication depends, and therefore, might be thought of as a corollary of communication, there is such an extensive body of knowledge in the psychology of perception that it seems to de-
serve a separate category of its own. Further, and what is more
important from the viewpoint of a music therapist, is the notion
that perception may be regarded as an approach to personality.
Is it not possible that herein lies a rational approach to the very
baffling problem of personality, one which every music therapist
wrestles every time he deals with another human being? It is
very appealing to a practical worker because it is possible in this
field to find some straight-forward explanations for behavior
without resorting to unwieldy concepts or wordy explanations.
Further, here is something than can be experimentally demon-
strated. Can it be that at long last, a theoretical, or conceptual
structure has been found by which some tangible data may be
sought in events that occur when a listener is moved by what he
perceives in musical situations by appealing to the findings of
the psychology of perception?

It is hoped that the big contribution of the 1954 Conference
may be formulated in terms of these constructs. However, every
effort has been made to include as wide and instructive a scope
of the whole field of music therapy as possible. Demonstrations
of some of the most helpful operations were arranged. It will be
noted, however, that these were placed in a position of secondary
importance, because it is our firm conviction that these demon-
strations should always do what their name implies, demonstrate.
Care was taken to delineate as clearly as possible what was to be
demonstrated in connection with each presentation. At no point
were demonstrations intended to prove anything about the
events, but rather only to illustrate them. Especial care was ex-
ercised not to allow the exploiting of a patient's condition merely
to arouse the sympathy of observers, or to provoke sentimental or
romantic associations in their minds.

ARTHUR FLAGLER FULTZ
President, 1954-55
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PRESIDENTIAL ADDRESS
"ON OUR WAY"

MYRTLE FISH THOMPSON

A year ago Dr. E. Thayer Gaston, when he was president, brought to you a serious challenge: "What next?" He reviewed how much this association had accomplished in sound foundations laid and in more than satisfying growth. This year I come to you as president at a memorable time, the fifth birthday of N.A.M.T.—or if you prefer, the fifth anniversary of the joining together of two professions, music and therapy in a country-wide professional association.

Five years is a milestone in any life and in the life of any organization. Five years' worth of application and constant effort mark the way, drawing on the ideas and dreams of many years gone before and on the present skill and imagination of many devoted workers from all parts of the United States whose tool is music, and whose dedication is to its maximum effective usefulness.

We took stock last year in order to clarify our aims and purposes. The goals were set: high standards of training for music therapists in order to insure high standards of workmanship and service; improved understanding by medical and nursing personnel and by educators and the public at large of the functions of a music therapist. Their confidence we are gaining by jobs well done and by a wide distribution of worthwhile literature and information, as well as by continued search to learn more of the answers as to how our media can best be utilized for good.

Another year is gone and we are well on our way toward seeing results. Some of these are tangible, such as the many new college and conservatory courses offered in Music Therapy, and in such practical contributions to the future as Mu Phi Epsilon's allocation of $2500 to five colleges for scholarships for Music Therapy students. For these we can well thank the Education Committee for establishing standards which earned acceptance by the National Association of Schools of Music. Equally high standards for clinical training programs are fast being set by examples such as that of Topeka State Hospital's program in Kansas, and by New England Conservatory's requirement of 1000 hours of supervised clinical training. Our membership is ap-
proaching 500 with seven Regional Chapters now formed. In order of application for acceptance these were the Mid-Atlantic, the Mid-Western, (formerly the Topeka Group of Music Therapists), the New England, the Southern California, the South-Eastern centering in Murfreesboro, Tennessee, the North-Western centering in Stockton, California, and more recently the Great Lakes. Orderly routines have been set for membership classification, treasury, the business management of publications. A thoughtful study of adequate budget has been made and incorporation* is under way. That interest is growing everywhere in Music Therapy is shown by the quantities of inquiries here and from abroad, and from many comments of administrators in answer to our recent Questionnaire on "Music in Institutions." These express interest in expanding music activities or initiating programs. The sales are constantly increasing on our Books of Proceedings and Bulletin subscriptions with steady interest shown by libraries, hospitals and universities. Salaries still cover a wide range but a slow pull upwards is indicated as professional status is realized.

In all this advance we can feel honest pride, but we should also feel some awareness of the dangers of fat growth and thin service. And it is of this I would speak to all of you today in the NAMT family who feel loyalty to its standards and pride in its advances.

We have made great strides and we have many assets. We have the strength which lies in organization of skilled workers. This is ours to command if we lead it well. We have the power of a good and honorable reputation which will stand us in good stead if we harness it to serve us properly. But as eternal vigilance is the price of liberty, so constant care, untiring service and continued wise management are the costs of healthy growth. These take: time and effort.

There is much work still to do, not in building higher or growing larger for uncontrolled growth becomes gargantuan and loses its meaning; but we must fortify and perfect what we have already built, for nothing living can remain static. The gains we have made cannot be held without continuing hard work, not only hard work in our own individual jobs, but hard work in addition, for the ideal. Associations do not grow on words and promises alone. This truth must be faced. The kind of growth and health we must maintain demands service and some sacri-

* Editor's note: Incorporation completed January 14, 1955.
fice from all. In these formative years of establishing a profession, each of you is a missionary, who, by the quality of his daily work both proves himself and justifies his professional status. If this is only for your own prestige in your own jobs you are each in the task alone. Each is vulnerable and transient unless his work is fortified by the good works of many others toward the common goal. Progress is made through united effort. In organizations such as ours the extra work we give toward the group goal must often be a labor of love. Granted it is sacrifice in time and in thought and in energy and that most of us are busy people. Yet no one person has a monopoly on pressures and no one stands alone in having personal problems.

The need being real for help from the many, and the pride we each feel in our association being well merited, it then becomes a matter of evaluation. NAMT requires our united efforts. Is it worth it? Are we dealing with something big enough and deserving enough of devotion, even to the point of personal sacrifice? I think the answer is "Yes" and that it lies in the joining of the two words music and therapy.

In our present culture, with the world so filled with stresses, the individual has deep need for inner peace. The values of creative expression and emotional release found in the arts are admitted. In fact, we seem to be standing on the threshold of a great development of all the arts as agents of therapy. Of them all, each with particular special values, music seems perhaps the most personal form of expression, communicating meaning and feeling without need of speech or explanation. We who work with it and live with it intimately know its comfort, its solace and its joy.

But not only are we dealing with music. We are dealing with patients, the ill, the maimed, the handicapped, the lost ones—lost to normalcy, lost to assurance and self-confidence and to security, and cut off from any place of importance in their families, jobs and communities, except as added burdens. Even the well have times of loneliness, of discouragement and defeat. How much more need have the long term physically ill, and the mentally and emotionally sick for something warm and comforting and relaxing, something vital and invigorating, something that can be grasped by anyone as a thing of good when the opportunity is given. Music means these things and much more in therapy. A sense of fulfillment is made up of more than family ties, job satisfaction, and play. Knowing himself, finding him-
self, expressing himself—these are innate needs of each person. If some of this exploring can be in the area of beauty where the arts are found can we question that this welding of music and therapy is a worthy enough cause to merit our service?

Identification with the National Association for Music Therapy helps the individual member through its prestige and growing power because it is the lodestar right now for the country as a whole in this new field. The medical profession is according it respect and the educational world has turned to it for leadership for setting standards. Can we afford to perhaps slip backwards by resting on our laurels now? Are we soundly enough established to substitute past achievements for moving forward?

We are on our way, a good way. Let us move on with dedication.
Mr. Fultz, Ladies and Gentlemen: You see before you, embodied in my person, the consummate wisdom of your program committee. After listening to my whimsical attempts at erudition on the scientific programs of two of our previous annual meetings, this year they decided with infinite compassion and tact to relegate me to the post of toastmaster at your annual banquet. I shall presume they did this on the assumption that a toastmaster should function much like a eunuch at a well-run seraglio: he should arrange and expedite affairs, but should take no further personal part in the proceedings. I shall therefore accept my limitations and stay well within this role—but please, let's drop the analogy just long enough to permit me to introduce to you the charming ladies and gallant gentlemen round about me:

Edwina Eustis, Chairwoman of Arrangements; Mrs. William Van de Wall; Mr. Donald E. Michel, Treasurer; Mrs. Dorothy Brin Crocker, Recording Secretary; Mrs. Myrtle Fish Thompson, Past President; Mrs. Wilhelmina K. Harbert, Executive Committee; Mrs. Hartwig Dierks, 2nd Vice-President; Mrs. Ernest Fifield, Corresponding Secretary; Dr. and Mrs. Robert S. Johnson, Boston State Hospital; Dr. J. G. Sutton, Superintendent of Essex County Overbrook Hospital; Mrs. Hermina Browne, 2nd Vice-President of the Mid-Atlantic Region; Mrs. Irene Whitney, Executive Secretary of Musical Guidance; Dr. Ira Altshuler, Director, Division of Music Therapy, Eloise, Michigan; Dr. Roy Underwood, Head, Department of Fine Arts, Michigan State College; Esther Gilliland of Roosevelt University; Lenard Quinto, Chief of Music, Special Services of the Veterans Administration; and Edwin Hughes, Executive Secretary of the National Music Council. Miss Alice Phelps, organist, and the Messrs. Thomas Thompson, Ernest Fifield and Alexander Dick who have made such notable marital contributions to our Society. And by the way, the musical obligato to all this talk came from a Baldwin Electronic Organ furnished through the courtesy of Mr. Leonard Van Olden.

And now, if I can for once make a piece of toast pop out at
the right time, it is proper (which we are not always) and fitting
(which we invariably try to be) to honor especially the man who
contributed so much effort and wisdom to arranging this annual
meeting: Mr. Arthur Flagler Fultz.

Ladies and gentlemen, if you are becoming a little tired of
hearing my seemingly interminable recitative, please let me (a)
remind you that, in divine retribution, I have to stand much
closer to my voice than you do and (b) hasten to apprise you of
immediate and welcome relief. We have with us tonight a young
piano virtuoso who has already won eminently deserved acclaim
on three continents, and who, in perfect musical collaboration
with Bach, Ravel, and Liszt, will now commune with us in the
transcendent language we love best. Mr. Seymour Bernstein,
may our anticipatory applause usher you to the piano?

[Recital by Mr. Bernstein]

Classical Concert—

Fantasia in C minor ________________ Bach
The Fountain ______________________ Ravel
Tarantella _________________________ Liszt

Ladies and gentlemen, Mr. Bernstein will now join with an-
other artist from Overbrook in a duo-piano performance of the
original arrangement of Gershwin's Rhapsody in Blue:

[Duo Recital]

Rhapsody in Blue _______________ Gershwin

Finally, ladies and gentlemen, I am faced with my most
redundant task of the evening, pretending that an introduction
of our famous speaker is necessary to an audience as musically
sophisticated as this. What can I say about him that you do not
already know? Honorary degrees? After honoring my own uni-
versity by graduating from it in 1916, he has distributed his fa-
vors widely by accepting degrees honoris causa from no less than
fifteen other of our highest institutions of learning. Musical
awards? Beginning with the Prix de Rome in 1921, he proceeded
to win nearly every major award in music, and to be elected or
appointed to many positions of leadership in the field. Recogni-
tions of his genius? His symphonies and other compositions are
now a precious part of our musical heritage. Tributes to his
artistry as a conductor? He has led nearly every philharmonic
orchestra from San Francisco eastward to Berlin, and would by
now have done so in the other direction had that not been a void
of barbarism. Academic status? Since 1924 he has been Director
of the Eastman School of Music at the University of Rochester.
Pre-eminence in our field? He was the only musician in history ever asked to lecture the American Psychiatric Association on the psychologic effects of music—and lectured with such profound effect that he was promptly asked to give a second address the next year. And by Apollo, God of Music and Medicine, and by every effort I can make he shall be asked to give a third! Exquisite taste in the choice of a life partner? There is only one adequate answer to that: Mrs. Hanson, will you please rise and let everyone see you? Ladies and gentlemen, Dr. Howard Hanson will now address you on the topic of "The Challenge of Music Therapy."
The Challenge of Music Therapy

Howard Hanson, MUS. D.

Director, Eastman School of Music
Rochester, New York

Thank you very much for that beautiful introduction. I am happy to be here for a variety of reasons. But first, I should tell you that you are a fortunate group of people. You are fortunate for two reasons, the first of which you know, and the second of which you do not know. First, you are fortunate because you are pioneering in a movement which I believe will bring untold benefit over the years to hundreds of thousands of people, and which will take its place in history as one of the great movements of an art form for the sake of people. The second reason why you are fortunate tonight is that I have lost my speech. Last night, I was speaking in Philadelphia at a banquet honoring Eugene Ormandy. I had a very erudite speech prepared for you tonight. This noon when my wife and I were having luncheon in the Bellevue Stratford, I placed my speech on the chair, and it is still there, to my knowledge. This I account a very fortunate incident. It spares you a long speech, and allows me to ramble on as I would much prefer to do.

I am particularly happy to be here, because I feel as though I am an unworthy god-father of this organization. As some of you will recall, the National Association for Music Therapy sprang from early meetings which were under the auspices of the National Music Council. I recall the days of the first committee and the hospital letter which was published in the National Music Council's Bulletin. I should say that the real godfather is not I, but my very dear friend, Dr. Edwin Hughes, who helped much in the early organization of this wonderful group, and my other good friend, Ray Green, who was, I believe, the first President of this association. I salute them with you tonight.

My own incipient interest in this type of work which I admire so much was a rather strange one. About eight years ago Dr. William Menninger, who was President of the American Psychiatric Association at that time, asked me if I would speak to the convention which was then meeting in Boston. I had no desire or intention of speaking because I knew nothing about the subject. I still know nothing about it, but he knew a good friend of mine, a psychiatrist in Rochester, Dr. Kirby Collier, and he
asked Dr. Collier if he would get in touch with me and ask me if I would speak in Boston. From that time on, whenever I saw Dr. Collier coming down one side of the street, I went on the other side of the street. After a few weeks of “ducking” Dr. Collier, we finally met face to face, and with his wonderful persuasiveness, he urged me to accept.

He told me something that we all know—those of us who speak in public from time to time—namely that the fact that one knows nothing about a subject need not be any deterrent to speaking on it. So, I spoke before the association in Boston, and two years later I was invited to speak again at the Centennial, which I believe was held in Philadelphia. On the first occasion I spoke about some emotional aspects of musical expression. On the second occasion I spoke about some studies in rhythm, and again I had a wonderful time and enjoyed meeting men for whom I had the very highest regard and respect.

To my great surprise, two years later, I was again invited to speak, this time in Montreal. By now I was beginning to feel that I should have an honorary M.D. degree, and, I must confess, had become just a little conceited about the whole business. I said to my wife one day, “This is really quite an honor to be invited to speak in Boston and then two years later at the Centennial in Philadelphia, and now to be asked for the third time to speak in Montreal. This must mean that I’m really quite good.”

She looked at me and said, “Nonsense—they just consider you a most interesting case-study.” That, I’m sure, is one of the purposes for which good wives are created.

My second experience with music in therapy was when I met a distinguished Russian psychiatrist who was very much interested in music and who was himself a good amateur musician. He was telling me about his use of music, and about its effectiveness. After we talked awhile he said, “By the way, I have found some of your own music very useful.” And then, in his wonderful Russian accent he said, “I find that your suite from Merrymount is especially valuable in the violent cases.”

From that introduction to the whole problem of music therapy, I began gradually to take an interest, a very casual one, I am afraid, but a very real one. I began to realize a little more fully the great problems which you face and at the same time the great work which you are doing. What I am to say tonight I am sure you will regard as purely coincidental, and nonprofessional.
I am a composer, a musician, a conductor, and quite a good music theorist, and if I speak of anything with authority, it is on the latter subject.

However, I am reminded of my favorite conductor's story which my wife has heard me tell so many times that, as I look at her now, I can see her writhe. It is about the amateur choral conductor who had a chorus in his community, and every year a professional symphony orchestra visited it. He conceived the very bright idea of giving a performance of the Messiah with his own community chorus and this wonderful professional symphony orchestra. But when he came to put them together for the first time, he realized that he didn't know anything about conducting an orchestra. He counselled with himself as to just what he should do—whether he should apologize to them beforehand. He decided that this would probably be a bad approach, and so he decided that he would bluff it through. So he started out, and, of course, the rehearsal went very badly. He stopped the orchestra, and he began upbraiding them. He told them that they had no conception of bowing; they bowed down bow when they should bow up bow. They had no conception of phrasing. They had no conception of tempo. They had no conception of the interpretation of the work. The woodwinds had not the proper "embouchure." He went on at some length. Finally the little German concert master, who couldn't stand it any longer got up, took his violin and placed it on the chair, placed the bow on top of the violin, went up to the conductor's stand, shook his fist in the conductor's face and said, "Von more vord from you and tonight at the concert we follow you." I warn you that whatever you do after this speech, don't follow me, because I don't know where I am going.

I feel that we owe you two great debts of gratitude. The first one is a curious debt because I believe that with this use of music as an aid to therapy, you have brought to the attention of us, as musicians, a very disconcerting fact. That is the fact that we know very little about music. Oh yes, we have read our Helmholtz. We know something about the theory of figured bass. We know something about the sixteenth century theorists and the later theorists, but none of these men were particularly interested in the affective powers of music. None of them, if they were interested, made any particular research in what makes music do things to people, what music is for, and how it is put together from the affective standpoint.
We know, of course, that music consists of several things—of curious, subtle combinations of various devices and forms. We know that it can be separated into elements which can be quite clear. There is the relationship of sound as organized tone, the relationship acoustically and mathematically of sound, of tones performed together, performed consecutively, performed in terms of counterpoint, melody or harmony. We know that there are relations in terms of time and pitch, in terms of meter in time, in terms of rhythm in time, but we don't know, particularly, the importance of consonance or dissonance at the more subtle levels.

We know very little about the objective results of differences in rhythmical patterns upon people. We know perhaps a little more about such elemental things as the dynamics, intensity, extensity, but when it comes to the subject of quality in its affective sense, we know nothing about it whatsoever, or at least, very little. And when it comes to that overall organizing force which we call—and it's a very bad term, I think—architectonics or musical form, we know even less. We know that it is a kind of moving panorama of sound. It is as though we were travelling from New York City to, shall we say, Albany, and between New York City and Albany there is stretched a great mural. As we pass by on the train, we look at this mural, and we see certain relationships here which we remember back there; certain relationships at the end of the trip which confirm some of the things which came to our eyes at the beginning. But this, after all, is a very elementary explanation of the subtleties which go together to make up organized sound.

Therefore, I think, ladies and gentlemen, that before we will make the ultimate experience in music as an aid to human living, we shall probably have to understand much more about music than we do at the moment, and much more about the affective power of music. We may begin probably with normal people, or more or less normal people, such as ourselves, and when we find out how music affects us as normal people, then we will, I believe, begin to have increasingly powerful tools with which to work sociologically and, perhaps, psychiatrically.

However, I believe that in order to do this we must break down barriers which exist in our universities today. The greatest barrier, I believe, is the tremendous objection to what we might call interdisciplinary projects. We have become so stratified, so oriented in terms of small pieces of knowledge that it is extremely difficult for us to find patterns which will allow us to combine
the knowledge of many people. In the study of the affective power of music, I believe that this breakdown of barriers is essential.

I've seen many cases in our graduate schools in which excellent theses in physics which had to do with sound, proved valueless because the physicist knew nothing about music. I have seen theses in music which touched on the fields of acoustics, psychology, and physics which proved to be ineffective because, though the writer was an excellent musician and an excellent theorist, he was neither a physicist, a psychologist nor an acoustician. Until we can bring these various fields or areas of knowledge together; until we can break down those barriers, separating one from another, I believe we shall never attain to that which I believe to be possible.

Therefore, my second congratulations to you is that I believe you have—perhaps more than anyone else—begun to break down that barrier. To associate men and women of high degrees of technical competence in different fields, to bring this knowledge together, focused on one single problem, is to make solutions valid, because those solutions are the results of the working of many minds—minds which are expert in different fields.

I'm going to take a moment of your time, if I may, to explain one thing which I think must be done. It is a subject in which I have been enormously interested for many years, for at least twenty-five years. But, I don't believe it was until I had the benefit of meeting some of you and of knowing of your work that I realized how important such a study might be.

I'm thinking of the study of one small element in this wonderful art-science which we call music. That is the element of the relation of tone. About twenty-five years ago I started making a detailed analysis of every possible combination of sound in music as we know it, in occidental civilization, in terms of the type of temperament which we use, for example, in our modern piano when it is more or less in tune. And I found a very interesting thing. I found that it was possible by a certain amount of analysis to separate music into what you might call its chemical elements. You can find forms of analysis which are quite effective and quite accurate, and which tell you something about music—not because you believe it, but because it is actually so—in the same way in which you can analyze chemical compounds, and find out the elements of which they are made.

In pursuing this analysis I found several other interesting
things: that there are six basic elements in tone which go together to make particular types of sounds whether these sounds are melodic or harmonic. Out of these six basic elements you can make six different types of music. You can then find those elements which are mutually attractive and you can put them together in still other series of combinations. Then if you wish, you can neutralize them by putting together elements which are not mutually attractive so that the end result is not positive but neutral in character. I assure you it is a very fascinating experiment. You see quite clearly why the music of Ravel does not sound like the music of Palestrina; why the music of Tchaikovsky does not sound like the music of Mozart.

And so finally in my home I arranged in my studio a large chart. It fills one side of the wall. And on that chart is every possible combination of musical tone as we know it, and every interrelation of those combinations. As you look at the chart, down on the extreme right lower hand, you see all of the music, all of the combinations that go together to make, for example, the music of Palestrina. Then as you go up a little further to the left, you find those chemical combinations that go together to make up the work of Beethoven. Then a little to the right, the combinations which go together to make up most or a great deal of the music of Debussy. A little higher up, the music of Shostakovich and here in the middle section, up and down both sides, the music of a Schoenberg.

Now, why is this important? It is important only because it begins to give us for one element of music, something quite definite, an analytical approach which tells you the kind of music to which you are listening. It tells it to you quite positively so that you are not like the young mother who fed the baby arsenic because it was in powdered form.

Now, as you pursue this path of analysis, you find out something else, which you know as well as I, and that is that as you study these analyses, you realize that we still know nothing about the affective power of combinations of musical tones. We do not yet know why the descending Lydian fourth gives us such a curious feeling of nostalgia and sadness. The Greeks felt it, but no one knows quite why. You all know that when you hear the music of Rachmaninoff, there is something very strange about it. It is nostalgic. It is "sad" in the sense of yearning. Why this is, we still do not know, but we can know what makes it. And when you come to the music of a Schoenberg, a music which is
protesting, you can see the combinations of consonance and dissonance, one on top of the other, until out of this whole combination comes perhaps the most complex form of musical expression.

So it is my hope that as our universities become more and more interested in music, as they recognize the arts and the effect the arts can have in the lives of men, we will get two things—a much greater amount of research in music as an affective art, and eventually a much greater interdisciplinary relationship. There will be a relationship between those fields upon which musicians must rely, as well as the theory of music and of sound, if such findings are going to have validity.

Finally, there is one other thing for which I think we all owe you a great debt of gratitude. There is no doubt that for a long time, for many decades past, perhaps for a period of over a century, music has been becoming more and more highly individualistic. It has become more and more the expression of the personal ego and perhaps farther and farther removed from the needs of men and women. There has been much more to do with music for music's sake, or with music for musicians, or musicians for music, and less of music for people and people in relation to music. I think that the summing up of that whole philosophy in the old slogan, "art for art's sake," had great validity in its time. Eventually that philosophy was perverted until it became art for my sake, art for the sake of the individual, art for the sake of the conductor who expressed his personality through the orchestra, art for the sake of the individual performer. A philosophy which was at first noble became perverted until it was selfish, unrealistic, and disassociated from the needs of men and women. I believe that this great movement for music in therapy has gotten us back on the right track at last. We realize now that music is not for music, art is not for art, but that music and art are for the glory of God and the better fulfillment of the needs of the individual here below. Certainly in these times we need that inspiration, we need that comfort—if you will—as we perhaps have never needed it before in the history of mankind. And so, I hope for you and this association every continuation of the work that you are doing and every fulfillment that music—the greatest, subtlest, the most divine, the most soul curing of all the arts, the most expressive—will once more serve men and women. Thank you very much.
PART I

CORE CONSTRUCTS OF MUSIC THERAPY
You will note by your program that this is the first of a series of related sessions, which, by the very nature of their themes, will be educative, challenging, and developmental. The core constructs of music therapy are the basic syntheses which make up our methodology. You will have the privilege of exploring communication, group dynamics, and the structural and experiential determinants of perception, but first you are asked to spend a few brief moments with me on a developmental education as an integral part of the methodology of music therapy.

What is Developmental Education? To put it simply, it means education through growth from within: an evolutionary process, which in music therapy implies a functional, purposeful, and continuous progression to human adjustments through music.

We, who have learned through trial and error about music in therapy, who have made extensive searches through all available literature for better ways to use music therapeutically, who face the problems of the present-day parent of a rapidly growing child in the team of therapies, and who have the courage and understanding to explore the deeper meanings of music therapy through research, come together today to re-evaluate our concepts, to readjust our sights, and to set new targets for the future.

Near my old homestead in New Hampshire stand four giant pine trees which over the years have weathered many violent storms, losing a few branches from time to time, but still standing today as watchful sentinels over all beneath them. When I asked a friend recently how it was possible for them to weather the recent visit of "Hurricane Carol", he said, "Did you ever consider how long and far reaching are their roots?" In looking at Developmental Education in music therapy we must consider the length and depth of its roots; also, we must see how well we have done our spade work, examine some of the practical manifestations of the nurturing process, and determine the quality of
the fruits of our labors—developmental changes in musical behavior and better personal and social adjustments through music in therapy.

Our tree of Developmental Education in music therapy has five main parts.

1. The tap root is the *musical experience* for the student, educator, client, patient, therapist.
2. The trunk is the *growth from within*, based on responsiveness to music.
3. The branches are *the techniques* acquired by the music trainee in a clinical setting.
4. The foliage is the *scientific method of procedure* which provides a suitable climate for structuring experiments and validating findings.
5. The fruits are the *developmental changes* in patterns of behavior, both musical and social, and the *positive results* in readjustments, competencies, and creative capacities.

Let us examine these parts and see how they fit into our scheme of methodology for music therapy.

The basic core of developmental education in music therapy is the musical experience of the student, the educator, the client, the patient, and the therapist. The initial musical experience is, by its very nature, an aural one. It is only by feeling the effects of tone, by becoming aware of the inner substance of music, and by testing and re-testing our sensitivity to the musical experience that we can evaluate the impact on ourselves and others in terms of feelings, response, dynamics, and changes in behavior. Thus, the functional music experience, with all its psychological implications is first in importance as a basic construct in education in music therapy.

This does not mean to discount the place of music therapy in the stream of history. It does not mean to neglect the study of the social climate in which musical therapy is thriving today. It does not mean to ignore the place of music therapy as one of the many therapies working together as the ideal rehabilitation team of tomorrow. Rather, it means that in our methodology, if we would achieve the best development in music therapy, we must allow the growth of the student through a functional music experience; we must offer the student every opportunity to study the nature of music, its content, its effects, and its power of expressiveness; we must direct ourselves and our clients
into a series of experiences which shall build positive feelings for music, adequate responses to music, and deeper understandings of new ways in which to use it to promote the growth of more satisfactory interpersonal relationships.

The second basic construct is the developmental approach in methodology which fosters an active response to music, which in turn stimulates growth from within. Too often, we as therapists are inclined to think of music as modifying our moods and those of our patients with no conscious effort. We do not encourage our students to let music penetrate beneath the skin. We often feel that to respond to music freely without inhibitions may expose some emotional weakness of ours. If we would be effective in this developmental approach, we must stimulate in our students and our clients those responses to music which will relieve somatic tensions, promote emotional release, and develop creative perceptivity. To respond to music we are answering a message which has reached us aurally, we are replying to this message by some type of behavior. We want to move. We start to sing. We find pleasure in playing an instrument. We feel like joining in a dance. We are responding, and consequently are growing from within and developing or re-developing some new or forgotten patterns of musical or social behavior.

The third basic construct implies that adequate techniques of the music trainee can best develop in a functional setting where he learns (1) to project himself, (2) to become empathic toward his clients or patients, and (3) to allow the music experience to become the root of his understanding. This, of course, suggests a clinical situation, where interpersonal relationships gain significance, and where the music worker must put every learned technique to work in all possible ways and under every conceivable condition. Thus the student in training realizes the importance of the patient's social growth. How much the music worker contributes to this will determine his eventual standing on the psychiatric team.

The fourth basic construct in music therapy is the scientific method of procedure. Too often we have used trial and error methods or have neglected to explore possibilities in uncharted areas. We have failed to assemble data recording the positive results of the use of various techniques, and to share the findings with those capable of evaluating these techniques and findings scientifically. Too much speculation has been made on the healing power of music and not enough valid proof of its therapeutic
value has been made available to all members of the rehabilitation team of today. In many cases they have not asked for it nor attempted to cooperate with the trained music therapist along this line, but we believe that the time is at hand when valuable research material can be made available by those who are capable of drawing valid scientific conclusions. This implies controlled situations, more accurate methods of observation, careful tabulation of data, and objective interpretation of results. With this type of procedure, the tree of Developmental Education is bound to bear rich fruits in the days which lie ahead.

In Soibelman's recent book, *Therapeutic and Industrial Uses of Music*¹ we have an extremely comprehensive review of pertinent literature on the subject then available to the author.

In the summary Soibelman says, among other things:

Obviously, the more widespread the use of music in hospitals and similar institutions, the greater is the opportunity to study its possibilities as a therapeutic agent . . . With improved techniques available from the fields of physics and biology, and the newer methods employed in the study of physiology and psychotherapy, it should be possible to set up a program of co-ordinated research that would define the field of usefulness for music in medicine.

The student of functional music has to consider three phases of the problem. First is the knowledge available on the techniques of music and the elements that make up the total stimulus—tempo, rhythm, melody, pitch, and so forth—and how they may be manipulated or controlled for a given purpose.

The second is the knowledge available for the understanding of the patient as a person. That requires the study not only of his present condition and attitudes but also his background and the goal envisioned by clinical treatment. For this purpose it is necessary to go farther afield than the work with music therapy has proceeded heretofore.

Only a few of the complex factors that have a bearing on the subject have been mentioned.

The third phase is the knowledge available for combining the principles from these two broad fields into a program of application for specific ends. The trend now is in the direction of coordinating the work of interested groups in local communities, as well as on a national scale, and efforts are being made to organize and extend the available knowledge.

We can heartily agree with Soibelman that the student of functional music must gain all knowledge possible of the elements and techniques of music and how to use them; he must learn much about the factors involved in the make-up of his patient as a person; and he must know how to apply this knowledge

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in a practical program of scientifically sound procedure. However, it is the experiential approach to education in Music Therapy which will produce the most functional growth on the part of our students; it is through the interpersonal relationships developed in a clinical setting that a music trainee begins to understand his patients as persons; and it is through a more consistent, cooperative, and controlled program that our students will be able to chart the developmental changes in behavior patterns resulting from the therapeutic uses of music.

In Fultz' MOT Handbook, which is just off the press we have a "Method of Verifying Estimates of Musical Behavior." In the "Organization of the Area System" Mr. Fultz uses the following eight-point program to chart developmental changes in behavior patterns.

1. the effectiveness of musical skills
2. adjustiveness of social skills
3. sensibility of aesthetic enjoyment
4. efficiency of problem solving techniques
5. desirability of physiologic reaction
6. desirability of psychologic reaction
7. adequateness of personal viewpoint
8. adaptiveness of general integration

Last evening as we listened to and watched the production of the abridged edition of "Oklahoma" presented by the Glee Club of the Goldwater Memorial Hospital we were given a poignant illustration of this eight-point schedule of observation. At first there was the confusion of setting the stage for the patients, the hurried efforts of the volunteers to get each participant in his proper place, and the inevitable moments of the patients with their different limitations to become adjusted to a strange but friendly audience. From the moment the musical introduction began until the end of the show the "melodic contour" of the music increased the effectiveness of musical skills; the enthusiasm of the group made it into a most effective social unit; the attractive narrator continually demonstrated her sensitivity to the aesthetic enjoyments involved; the soloists with clear understanding of their individual problems, "martialed their sensory-motor skill" in such a way that we could observe "progressive improvement in their performance." Duple rhythms released

bodily actions in up and down movements of the heads of the girls, while triple rhythms at the same time, hummed by the boys was producing a flexible movement from side to side; and "appreciation of relationships" between the patients, their volunteer aides and the music therapist brought about a most desirable psychologic reaction. The enthusiastic leader seemed to rise above limitations in a free, creative type of leadership, indicating the adequateness of his personal outlook throughout the performance. Finally, we could see defense mechanisms melting away, and continuous progression toward satisfactory human adjustments through music as the "common factor."

At the beginning of this paper, five basic constructs in developmental education in Music Therapy were presented for your consideration: (1) the musical experience, (2) growth from within through responsiveness to music, (3) techniques acquired in a clinical setting, (4) the scientific method of procedure in structuring experiments and validating findings, and (5) developmental changes in behavior patterns in real adjustments, competencies, and creative capacities. We have discussed briefly four of these basic constructs.

From a survey of the literature on the subject made some six years ago, Soibelman concluded with a suggested three-point educational program for the student of Music Therapy: (1) knowledge of the techniques and elements of music in the total stimulus and how to put these to purposeful and controlled use, (2) knowledge and understanding of the patient as a person, with full recognition of all the variables, and (3) knowledge of the most effective ways in which to combine musical skills and the understanding of the total personality into a practical program with specific goals.

From Fultz' current book we have just quoted the eight area structure so well demonstrated for us in the program last evening. Rearranging these eight points and grouping them as they were observed by this writer, we became forcibly aware of (1) physiologic and psychologic reactions, (2) problem solving techniques and personal viewpoints, (3) musical and social skills, and (4) aesthetic enjoyment and general integration.

In Developmental Education in music therapy the fact that we state that there are three, five, eight or any specific number of basic constructs in our programs is not of great significance. It is important that from time to time we examine the observable fruits of our labors, which as we stated at the beginning
of this paper, are the developmental changes in patterns of behavior and the positive readjustments, competencies, and creative capacities. Just as the first frost may be the signal to gather the crop and ship it to market, a functional music experience may be the deciding factor in opening the door which leads to self-realization and satisfactory adjustment of the total personality to society.

We do not have to wait until individuals become "cases" to offer developmental music experiences. Rather, as music educators and therapists, we are challenged to initiate, wherever the opportunities arise in our communities, well-balanced programs of functional music. Thus our methodology will, in the words of our program chairman, bring about "the improvement of interpersonal relationships to a more adequate degree of competence through a transfer of developmental changes in musical behavior."
The second of the core constructs under which basic concepts of music therapy may be organized is communication. It is hoped that this area of our conceptual scheme will attain more and more general recognition as a factor contributing insight into the operations and events that characterize music therapy, and that eventually, it will come to be integrated into a sound theory of music therapy along with the other core constructs around which this Fifth Annual Conference is built: developmental education, group dynamics, and perception.

Communication has been on our agenda before. We have considered many of its general aspects, and have tried to apply its theoretical structure to music therapy wherever we could. At this point, it seems more appropriate to consider communication in terms of one of its many aspects, namely signals. A glance at the customary schematic diagram of a communication system will show how the signal represents the central factor in the communication picture.

When I came into the room this morning, I asked the electrician who has served us through our sessions, what he thought of when he heard the word signal. He replied, that he visualized a small black box near the back of the auditorium with a little light on top of it which could be flashed by a speaker on the rostrum when he wanted a slide changed on the screen.
Then I asked an esteemed colleague who has good knowledge of electronics, Wayne Ruppenthal, what the word signal brought to his mind. He defined a signal as any stimulus that was capable of evoking a response. In communication theory a signal is regarded as a codified message.

Now, as I weigh these three sources of information, I seem to get the notion that a signal has the function of influencing its receiver whether it be by indicating that it is now time to flash the next slide on a screen, or that an organism must react to a signalling part of its situation, or that changes have been made in a message from an intention into a code signal calculated to reduce uncertainty in a receiver. It is this function of influencing the receiver that makes signals important to us as music therapists. I want to take into consideration at this time, first, the nature of musical signals, second, the analysis of signal distortion, and third, a recorded model by which I shall illustrate the auditory effects (with such equipment as is here available) of changing the character of the signal.

The Nature of Musical Signals

It must be kept well in mind that in dealing with a signal, one is always dealing with a codified message, that is, the adoption of one kind of event or sequence of events which have come to stand for another kind of event or event sequence. A flashing yellow light at an intersection is a signal which codifies the thought "proceed with caution." The thought which it codes is wholly different from the coded signal that is perceived by the driver of a car. One may say that the rhetorical structure expressed in the three words, "proceed with caution," is also a codification of a sequence of neural events that occurred in someone's body, chiefly in his brain. Even the typed letters that comprise this sentence are signals which codify visually the neural and mental events that, organized, become associated more closely with the message itself. Just how the message, or intention itself is formulated is not clear. One theory maintains that certain cell assemblies in the brain form constellations, or more or less permanent tendencies to patterned relationship. The electrical and chemical events by which these neural processes become activated are also coded signals.

When a person sings or plays, the message itself in the mind of the performer has to be transformed into a very complicated
sequence of events which ultimately arrive at a stage where they are changed into vibration frequencies and intensities which constitute appropriate signals for transmission over a transmission channel. The channel may be fairly simple, or it may be extremely complex as in the case of electronic amplifiers, filters, power tubes, and speaker diaphragms plus air pressures that will impinge upon the tympanum of the receiver's ear, there again to undergo an intricate and almost indescribable reduction process which brings the neural and chemical-electrical excitation of the receiver into play. The signals somewhere in these last stages of transmission, having already been subjected to innumerable changes, become converted back into messages or intentions by the receiver's mind. The rate of transmission may be thought of somehow as a function of the speed with which the receiver's uncertainty is reduced.

In addition to all this, there is more "information" carried along the transmission channel than originated with the sender of the message. A portion of the body of signals transmitted is always made up of noise or other types of interference. We are told that transmission channels may be characterized chiefly by their capacity. In any given transmission channel only a certain total traffic of signals can be handled at one time. If sixty per cent of this capacity is devoted to the transmission of interfering or unrelated information, it is apt to "drown out" the sender's signals.

It must be quite obvious by now that there is a lot more than meets the eye in dealing with communication signals. These factors are important to the music therapist, for the vital stuff with which he deals, basically, is no more nor less than the signals of his patient in the musical situation. The fact that the patient has organized his musical ideas sufficiently to produce the act of singing in no way guarantees that the therapist will receive much better than a very distorted signal pattern. Still further, when this multi-changed pattern arrives at the therapist's receiving station, the probability that it will be reconverted into the original intention of the patient is still more reduced by the therapist's organic condition to say nothing about his previous experience with this kind of signal pattern. The last named state may make him violently prejudiced and blind to the patient's intended message.

Another very troublesome characteristic of musical signals
is the confusion that exists as to what may be the source of distortion of the signal. All musical signals whether organically or mechanically produced are translations of tonal-rhythmic patterns which convey information from one point in a musical situation to another. The object of this transmission from a communication point of view is to reduce uncertainty, and from the point of view of the acting performer who sends the signals, to influence someone, be it himself, another, or a group of other persons.

In summary, we have noted that signals (musical or otherwise) always involve the translation or transformation of one kind of event into another, the signal, which appropriately may be transmitted through different media—channels—which limit the transmission potential mainly through their available capacity. It is clear that musical signals are not confined to audible tones alone, but in any given musical performance may include a multiplicity of signals, *ad infinitum*. These may be neural, electrical, chemical, or mechanical, depending upon the type of channel met in their transmission. It is also clear that signals are subject to the interference and “crowding” of added signals not originally part of the sender’s intention, and that these tend to reduce the probability of transmission which, beyond a certain ratio, may so damp the intended signals as to make them imperceptible or unintelligible to the receiver.

**Analysis of Signal Distortion**

If we recognize the significant role played by signals, in a patient’s improvement of his interpersonal relationships, we may achieve some insight into one of the major interests of therapy on any level, namely, the adjustment or correction needing to be introduced to correct the distortions of signals. This is not to say that there is any guarantee of rehabilitation merely by assuring the purity of the signal. But it may prove fruitful for the therapist to begin his plan of treatment by eliminating any possible signal distortion that may exist in the patient’s musical performance.

Generally speaking, distortions arise in any one or more of the communication system parts. In the diagram, on page 24, signal distortion originating in A has been found to possess a very rough correlation with psychoneurosis. That originating in C, with psychosis. This is to say that psychoneurotics tend to distort messages by sending out wrong signals. They find it
hard to see why the world (receiver of their signals) does not understand them. Psychotics often, on the other hand, show symptoms of signal distortion in the way they incorrectly perceive the signals received by them. Hallucinations, illusions, and introjections represent distortions of signals in the receiving area of the system.

We have a musical game we play in our Group Music Therapy Club called *musical message sending* in which one patient sings phrases of familiar songs to another while standing apart back to back. The other patients present are to judge whether the receiving object can accurately reproduce the phrase sent to him even to tone of voice and distribution of stress points. When badly hallucinating patients begin to show signs of greater precision in the accuracy of their perception of musical signals, one may point to the enlargement of a reality world in their experience. Often the entire group of patients leave the club meeting with greatly improved contact with reality.

It is the therapist's duty to structure the musical situation in such a way that there is as free a channel for transmission of signals as possible. This means that interfering noises, purposeless, diverting stimuli, and the appearance of too much failure experience in the goal-achievements of performers must be eliminated as much as possible.

This is not to say that the music therapist who can locate the sources of message and signal distortion in the communication systems he sets up will also be able to correct these causes, but at least, he will know where they lie, and where to look for added distortions when he goes "trouble-shooting" the next time. To me as a music therapist, the discovery that my whole treatment plan for a given patient should be formulated in the light of poor signal reception would change everything even down to my own attitude toward being able to do something for the patient. There are many more implications that suggest sound research programs in connection with the view that musical situations can be described in terms of signals. Here is something tangible to work on for the enlightenment of your colleagues in music therapy for which they will be grateful.

*A Communication Model of Signal Structure*

(At this point, the speaker introduced to the conference, an
experimental recording made by James Fassett of Columbia Broadcasting System during the intermission of the New York Philharmonic Symphony concert on January 17, 1953, which demonstrated some of the specific effects that can be obtained by distorting musical signals through modifying the intensity of fundamentals and overtones relatively. A Schubert String Quartet was heard first as properly played, and then with experimental distortions. These experimental recordings were obtained from Columbia Records, Inc., called Strange To Your Ears.)

References

MUSICAL GROUP DYNAMICS

DEMONSTRATION

CHAIRMAN: MYRTLE FISH THOMPSON
Director of Music Therapy, Essex County
Overbrook Hospital, Cedar Grove, New Jersey

Music Program by patients and music therapy interns from Overbrook Hospital:

Orchestra
Andante Cantabile from the 5th Symphony — Tschaikowsky
Ballet Music from “La Gioconda” — Ponchielli

Choir
Hallelujah Chorus from “The Messiah” — Handel
Indian Summer — Campbell-Roff
Dry Bones — Watson
I Love a Parade — Arlen-Wilson

Dance Combo
Popular medley
The following material which includes a statement of the purpose of the session and a list of questions to stimulate comment was prepared by Mr. Fultz and handed to each person in attendance:

It is the purpose of this session to consider some of the conditions, relationships, and problems that confront music therapists in planning and executing group operations such as the ones demonstrated in the preceding session by Mrs. Thompson and the patients from Overbrook Hospital. We have phrased these factors below, chiefly in terms of Group Dynamics, which is regarded as one of the four major core constructs of music therapy. The following questions are offered to stimulate thinking, and to clarify our concepts concerning Musical Group Dynamics:

I. GROUP COHESIVENESS. Efforts to understand why a group "hangs together" become useful when they are aimed at appreciating how the group action satisfies needs of members.

1. What needs or deficits of the performers does the group enterprise fulfill?

2. What factors or elements of group action might prove to be disagreeable to members?

3. Are certain types of patients served better by group action than by other operations?

4. Is there a relation between the success experiences of participants and the attractiveness of the group action?

5. Does group cohesiveness depend more upon the action of the members of the group, or more upon individual need fulfillment?

6. Should group operations (orchestra, choir, dance combo, community sings, etc.) in music therapy be prescribed for the good of the individual or for the achievement of a group objective?
II. **GROUP STRUCTURE.** Group structure depends upon the way the group's members are related to each other. It can best be described in terms of how the nature of the group's organization affects (1) its communication potential, (2) its friendship possibilities (sociometric choices), (3) its range of power relations (assignment of responsibilities to certain members), and (4) its locomotion structure (movement of the group as a whole).

1. How does the group organization vary with changes in its communication network?

   (Communication networks: intrapersonal, "within oneself" interpersonal, "one to one" group, "one to many," and "many to one" cultural, "many to many" removed in time and space)

2. How are therapeutic aims modified by group structure with respect to the structure's communication network? Does knowing the group's communication potentialities aid us in formulating the therapeutic purpose of the operation?

3. Are there any specific suggestions to be made as to how a group structure could be organized to facilitate the possibilities of friendship between members?

4. Are sociometric choices made more easily by members of a group under some conditions than under others?

5. What evidence was presented in the preceding demonstrations of group operations, which showed that some members were accorded greater prestige than others? What characterizes those members who are given the least responsibility in the group action?

6. Do physical location in a group and ability to come face to face with other members affect the power relations between members? What other factors contribute to better group organization?

7. What actions were observed in the foregoing musical situations by which individual participants altered the group goals? Was there any evidence of a willing-

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ness to submerge personal ends to make the social purpose of the group succeed?

III. GROUP PRESSURES AND STANDARDS. Well-structured groups show greater awareness of the group goals, and sometimes provide disciplinary pressures, code of ethics, or regulatory measures to maintain the group intact.

1. Are group pressures more effectively applied when they are made explicit in a direct, formal statement, or when they remain implicit like "unwritten laws," in music therapy situations?

2. What effects accrue when a system of punishments and rewards is used to maintain group standards, i.e., in group operations in music therapy? Should patients be "bawled out" in group rehearsal for non-participation or unadjustive initiative?

3. What is the therapist's role in recognized, implied rules that tend gradually to emerge, as the group structure becomes more and more developed?

4. Can setting a standard for a group achievement be therapeutically contraindicated?

DISCUSSION

Mr. Fultz:

This discussion is to clarify some of our ideas about music operations. I hope everyone will feel free to participate in this discussion. Please identify the panel member to whom you address your remarks. Discussion will be confined to the questions that are on the printed page. We will conduct this as a parliamentary session; if you have a question, the moderator will recognize you and you may say what you wish. Panel members may make a comment on it or not. In each paragraph a statement is printed at the beginning which is supposed to clarify what follows; in these three statements we have tried to suggest what the questions are about.

I want to introduce to you Dr. Joseph Sutton, Superintendent of Essex County Overbrook Hospital. His patients performed for you during the preceding demonstration.

Dr. Sutton:

It is customary to start by introducing the panel and your printed program has already done that very well. But, in intro-
ducing one member of the panel, I shall ask your indulgence. Mrs. Thompson joined Overbrook Hospital during the regime of my distinguished predecessor, the late Dr. Hamilton. My greatest contribution, I think, was achieved in a negative way. I have tried, as far as possible, not to throw any rocks in her way, not to be an obstructionist. That is, perhaps, a negative approach, but its end result was a positive achievement.

This particular session, I think, is well placed on your program. It succeeds not only the demonstration by the Overbrook people, but also the work of autoharpists.

Our subject is the matter of the dynamics of music therapy groups. The discussion will have the demonstration as a point of departure. When the panelist makes a statement he will have to document it, in relation to the demonstrations. Usually talk is in vague terms with nothing to illustrate what we are talking about, but that will not be true in this instance.

I have the pleasure, first, of calling on one of the panelists to give a simple statement of her viewpoint in the matter of dynamics, based upon the demonstration.

Mrs. Whitney:

First, I want to comment on the inter-reaction of this group. It, I understand, is made up of people who are in institutions, not of their own free will, plus some interns who are helping them. I was amazed and delighted to see that you could not avoid being impressed by the fact that the most prominent characteristic here was the group cohesiveness, each one working with the other, each one assuming his responsibilities. The group could be dangerous because, if it were promoting too much aggression, there would be the danger of over-protection. There is the danger, also, that in trying to help the group one might forget the individual. All we had to do was listen to "Dry Bones," to become aware of the cohesiveness. Did you notice the dependence of the parts? It shall be remembered that if one had forgotten, the whole thing would fall, but not one forgot. In the orchestra each one had a responsibility, and if he did not fulfill that responsibility, the whole group would lose face.

There is no great danger of a music group becoming overly aggressive. There is not the danger in a music group that we might have in some other group organizations, because of the individual responsibility which falls on every single pair of shoulders in the group.
Leadership brings results from the group; leadership aids the members to choose things which they can do well as a group; leadership gives opportunities for success; leadership shares all the winnings; leadership shows affection, warmth of feeling and complete dignity, a dignity that reaches every single person in the group. I do salute Mrs. Thompson, the leader; I think she is one of the finest in the field of group dynamics that I have seen.

Dr. Sutton:

Thank you, Mrs. Whitney. Suppose we now hear from Mr. Fultz.

Mr. Fultz:

Please look at the second group of questions which are related to group structure. Whenever we come across the word “structure”, we are talking about group organization, not about the physical relationship of people in it, but about their psychological relationship. First, I want to mention the possibilities the group has for interaction in a communication setup. The network of communication determines something about these possibilities. Having a group makes it possible for these people to communicate on the same level. Did you observe the group’s action on any level of communication?

Second, a group has some friendship potentials and/or some enemy potentials.

Third, it has a certain number of responsibility assignments in it and Mrs. Whitney has emphasized this aspect.

Finally, there is a locomotion structure. We define this as movement as a group, but it is not limited to that alone. Did you see any difference in the way the performers reacted because there was someone occupying a position higher in their imagination than they were? Each member occupies a location, psychologically, with respect to the leader, to each other, and to you. I think that we can observe the effects of the group structure in terms of these four aspects. This is a way to describe the psychological structure of the group.

So, the second question is, “how are therapeutic aims modified by group structure?” Modified might mean to make worse or to make better with respect to the group’s communication network. Thus, knowing the group potentials aids us in formulating a therapeutic purpose for the operation. It is quite obvious that this demonstration was not done just for fun. Let us address
ourselves to that first item: the communication potentials of the group structure.

Comment from a Member of the Audience:

I noticed particularly the awareness of the interns in watching each other and in watching the director. The music group could not perform if there were not that sensitiveness and response to both the director and the group. Some members of the group were much more in rapport with the director and much more aware of group responsibilities than others; they were the ones who provided discipline for the group.

Mrs. Thompson:

Speaking of interns, I think they should perform in the group on the same level as the patients. This does away with any idea of segregation, such as “we are the trainers and you are the patients who perform, you are the guinea pigs.”

Mr. Fultz:

Yes, Mrs. Thompson, but when you consciously try for this operational goal, do you achieve it? Is there ever a time when each person in the group does not allot a certain prestige, status, or role to the others in the group?

Mrs. Thompson:

Never is it to that extreme, Mr. Fultz. There always is respect toward interns. I don’t think patients would spit out quite so fast if they were angry at the interns as they would to another patient. There would be a little more caution in the behavior toward the intern, and perhaps even a little more to the boss.

Mr. Fultz:

Do you think that the group structure has strengthened the patients by the reciprocal position of patients and interns, that is a feeling of mutuality that’s encouraged?

Mrs. Thompson:

Yes, I do. Actually, you might do this for a selfish point of trying to get something of a more professional performance. There is a dignity which goes along with that, and it brings patients and staff together in comradeship. Also, I think because it does give a little more pull towards a goal, it is supportive.

Dr. Sutton:

What is the goal?
Mrs. Thompson:

Within limits, the goal is to match a professional level of performance. Did we do “Dry Bones” as well as you may have heard it sung on the radio? Trying to attain a performance level is very important in prestige value for patients.

Question from a Member of the Audience:

All of the members of the group looked normal. Do they carry that self-respect over into other activities, into the dining room, for example?

Mrs. Thompson:

Self-respect is not only related to musical attainment for any attainment in art is carried over to other activities. I think any amount of prestige you build within yourself is something you carry to the dining room.

Mr. Fultz:

Is there anyone who would like to evaluate the communication network that we were observing? Did you observe the demonstration group operating on any one of the four communication networks. Was there any member who was just singing to himself? Was there a tendency for anybody to solo, to part from the group, in an effort to get to the audience and make a one-to-group relationship? Was it a group-to-one, many-to-one or a one-to-many relation?

Comment from a Member of the Audience:

I noticed one patient particularly. She has very good voice and wanted to sing very well. I have no doubt she would like very much to sing solo, but in singing with this group and singing so well with the group, I think she attained a satisfaction that would be impossible individually. I thought it was wonderful to see and I’m sure she now has a gratifying feeling from performing exceeding well this afternoon. I think it was good for her, and I think it was also good for the group.

Mr. Fultz:

Did you notice if she was laboring under any restriction? Was there any evidence that she was under pressure not to solo?

Mrs. Thompson:

This is a very interesting patient. I am glad you picked her out. The best thing that she was getting out of that situation was that she was not doing a solo, but conforming to the group
standards. She is a girl who needs the discipline of the group; she needs to be one among others. Given one tiny chance, she would have taken over the show; the fact that you picked her out makes me feel, in sense, that she was getting away with a little of that. One of her big failures in life has been that she has not learned to discipline her great urge to be important. That is why she has gotten in trouble so many times. In the music group she gets her discipline in a gentle way and still feels that she has a part in the center as well as a part in the whole.

Question from a Member of the Audience:

One of the members of the demonstrating group told me that the gentleman who played the piano had been a professional pianist before he was hospitalized. I understand he has been ill for a long time. What about this man, obviously a schooled musician? We all heard him make a few errors at the keyboard. Does this tend to make him more self-critical, or does it help him? Did the young lady who was in reserve at the second piano serve as a strong supporting figure to this gentleman?

Mr. Fultz:

Mrs. Thompson, do you feel that the way the group was structured had anything to do with supporting or defeating his accomplishment?

Mrs. Thompson:

This is a very good question for us to discuss. The point about support takes us back to the idea of the interns working in the group in reciprocal positions. This patient has done professional work; about fifteen years ago he played accompaniments on radio programs. He is deteriorated, a paretic. In groups he simply cannot function and reverts to psychotic behavior. I gave him the support of the girl at the second piano to relieve the suffering he would go through if he had to take the responsibility for all of the mistakes made by the pianist. It was very important for him to succeed here in New York. If he had made a mistake by himself he would have continued to think about the mistake and then would have made more and more errors. With the support from the other pianist, however, he is relieved of full responsibility, i.e., perhaps the audience would not know which pianist made the error. If he were to do the accompanying in his phase of deterioration, he probably would not stand up under that strain at all.
Mr. Fultz:

The group structure must include you, the therapist, as well as the performers and their conductor. You see, the situation is always defined as comprising those objects that are significant to the one you are discussing. If none of you were significant to this patient, your reaction wouldn't make any difference. You might just as well not have been here as far as he was concerned in this case, but you were important in the picture, and so were his fellow patients, especially the one assisting at the piano. And so, part of the group situation that was created was a structured situation in which this man could function optimally. The success experience that attended his functioning then was important for his security and his further improvement.

Mrs. Thompson:

He did have the support of the other person. Also had there not been that kind of support, he could have become worse, rapidly. Mrs. Whitney said a while ago that nobody made a mistake, but many did, for a moment, in the excitement of being before you. Part of the group tried to bring others back in and each tried to catch the words from the next. The pianist was not the only member who needed support; many of the singers both gave and received support from the other members in the group.

Someone spoke to me of our programming “The Hallelujah Chorus” and the quality of exaltation that the patients seemed to receive when singing it. This music was given to us by a very little and a very old nurse about three years ago. She brought fifty copies of it from England as a present to us. I was so touched by her thinking of us that I worked hard to find some way for our people to use the music. We deleted very little, actually. In our community The Messiah is performed each year by a fine music group. Because of this the “Hallelujah Chorus” has tremendous prestige value for our patients.

Question from a Member of the Audience:

Is it wise to use an intern as the lead violinist in the orchestra?

Mrs. Thompson:

Perhaps not. Perhaps it would have been better to let the patients in that section feel that they were carrying the responsibility alone.
Question: What psychological preparation was given the performers before coming here?

Mrs. Thompson: The staff has known for some time that we were to perform at this meeting, but the patients did not know. In order to keep the idea from becoming stale I did not tell the patients until recently, and then I announced it in this way, “Isn’t it wonderful that we have this invitation and that we will be able to do it?” I emphasized the aspects of the trip which would be fun, and suggested the prestige value of being in the choir, orchestra, and dance combo.

I am surprised that none of you spoke of the dance combo. The regular drummer was not able to come today and was very disappointed. The members of this group were professional dance band musicians before they became ill. Three of these patients are custodial cases and in all probability will remain in the hospital for the remainder of their lives. It is very important that they have an opportunity in the hospital community to receive satisfaction in the form of applause. Prior to hospitalization they had succeeded professionally in music. In the hospital routine they necessarily have to accept threats to their dignity, such as waiting at each locked door, and always moving with a crowd to eat. In the dance combo they have a chance to build their self-esteem. They have become an important group in the hospital and have real prestige in the eyes of the total patient population at Overbrook.

Dr. Sutton: It is quite clear to the medical staff that these patients have cohesiveness and team spirit.

Question concerning part of the audience standing for the “Hallelujah Chorus.”

Dr. Sutton: In other words, what would be the patients’ reaction when certain members of the audience stood up and others didn’t. Would you like to talk about this, Mrs. Whitney. What would you speculate on their reaction?

Mrs. Whitney: I think I am not well qualified to speculate on that reaction. They might have been comforted to know that we have indecisions too.
Mrs. Thompson:
Related to this point is the question of applause after the “Hallelujah Chorus.” I talked with the patients about this prior to coming here. I said that people generally do not applaud the “Hallelujah Chorus.” I also added, “Maybe they will because they like it so much. Maybe they will not because it is traditional not to applaud.” In this way I tried to prepare the patients for whatever might happen. I think it was much better that you applauded. They needed it after the first number.

Question:
Mrs. Thompson, do your groups perform enough when you are at home so this performance will not be a single highlight? If you do not, how will you ease their “let-down” feelings after this trip?

Mrs. Thompson:
There is never any time for the “let-down.” Something else is always coming along. Actually we do perform a good deal. We do not perform in the community frequently but we are constantly working on something new. We just finished doing H.M.S. Pinafore last month. That was a marvelous achievement; the roles were memorized; it was a polished performance. When we return to the hospital we will start work on a lot of music for Christmas. We do recital work. The choir sings each Sunday. I do not think it would occur to the patients to feel terribly let down. I think they feel they have had quite an outing. This is part of our everyday music-making at Overbrook Hospital.

Question:
I am very interested in music group activities. Mrs. Thompson, will you talk about the difference in the group interactions when, for example, one of your interns takes over a piano group, as instructor? How do the roles change?

Mrs. Thompson:
When patients and interns are all singing in a chorus, the intern is part of the group, more or less on an equal footing. But, it is quite easy for interns to change roles without any discomfort. Today they are on the same level in a chorus, side by side before me. Maybe tomorrow one of those interns will give lessons. I would not think of that as a problem in relationship. It might be if the teaching had to be done in a dictatorial manner. I think that it is just a matter of a good pupil-teacher
relationship. I do not think of this as something to worry about or as anything the patients would worry about.

Mr. Fultz:

May I say a word on that? It seems to me that we are all eagerly trying to occupy a reciprocal role with a patient. We are trying so hard to make him feel that the music therapist is not the teacher; the patient is not the pupil; we are just two fellows working together on a problem. We are overlooking an important fact: Some people cannot support a reciprocal role. These people actually are so in need of the support and domination and nurture of the stronger figure of the teacher, the director, or the conductor, that they would be put under a pressure at being left to hold up their end of reciprocal relationships. On the other hand, if I were to talk down to you right now, if I thought that you didn't understand what I was talking about, I could give you such an impression just by my tone of voice. I could indicate it to you by the way I look at you. You would feel offended because you are capable of handling a reciprocal role. If I know that someone else is a stronger person and can teach me something, I prefer to take the student, or learner attitude, and I feel more comfortable that way.

There is another role that we should consider and that is the role that cracks the whip. If the teacher imputes or implies by the way he handles his student he is going to blame him for not doing well, there is something that makes him respond. I believe those three roles are played constantly and interchangeably with different people as we go along. We should realize that many of the failures that we have with patients are because we adopt reciprocity as our role instead of the appropriate role as a leader.

Mrs. Thompson:

I think there is a kind of respect which is a very intangible thing. When you sit right next to a person in a group, an intern or patient, there is a mutual respect there. You can respect people, even if you know more than they about a certain thing.

Mr. Fultz:

But don't you think there is also an individual difference in the relation between the leader and each member of the group?

Mrs. Thompson:

Yes, there is a learner-role and a teacher-role.
Mr. Fultz:
I'm just raising the question as to whether or not some people can occupy this role. It is a matter of smart strategy on the part of the therapist, who can recognize the need of the patient, to shift the leadership role to the therapist.

Dr. Sutton:
That sounds like good pedagogy to me. We hear so much about punishment and reward, and it is noted under Group Pressures in the list of questions. Should patients be bawled out in group rehearsals for nonparticipation or just lack of initiative? Mr. Fultz, would you care to speak on that?

Mr. Fultz:
It is not so much what we say; it is how we say it. We are the ones who crack the whip, hold promises, or reject. Question concerning patient's misbehaving.

Mr. Fultz:
You may reject his action but not his person. This strikes deeply at a basic therapeutic principle, namely, that we have to look at every patient, behind his disguise, behind his deformities and his disabilities to his soul and mind. Back of anxiety, which is a form of deformity, there is a person who deserves love, respect, admiration and esteem. The only thing which is not lovable about people is the front they put up to keep you from hurting them further or from mixing with them.

Mrs. Thompson:
There is also a point which I think is a very interesting one. Where there has been bad behavior, how spontaneous the rejection of the whole group is toward that bad behavior! You do not have to wait for the leader to say anything. The feeling of the whole group is changed as a result of bad behavior by one of its members.

Mr. Fultz:
When the leader senses that, if he would take advantage of it and act on the group's backing, he could be more effectual. For example, a group of people in a chorus or glee club were preparing for some important program and one person in the group was constantly out of line, trying to gain recognition. Finally, the leader became exhausted and so exasperated that he whirled on this person and blasted him verbally. Everybody in the group applauded the leader. I think at times that it might be possible to establish the rapport that you need with a patient
on a basis which threatens him with immediate excommunication from the group. It has been said that a patient will do what you expect him to do.

On the other hand, however, the disorder that you are getting from your group may be because you expect disorder. Your attitude is read like a non-verbal cue. A psychiatrist had been dealing with a schizophrenic patient for some three months. He had met her every day for an hour, and not once during that time had there been more than five sentences exchanged between them. She would not communicate. One day he came down to the session, with a kind of impatience. He wanted to get some letters dictated, he wanted to get some other things done. In his mind was, "Why do I have to go and sit with this patient and waste another hour." He got there, he sat down, and all of a sudden the patient came out with, "Why do you want to kick me out?" in clear, plain English. The doctor looked at her and assured her that nobody wanted to kick her out, that he was glad that she was here and would be glad to talk things over with her. That closed the round. Then, later in the day, in a meeting with his colleagues, he recalled that he had been sitting with his knees crossed, and that his foot was moving back and forth. His patient had read this non-verbal cue, and she had read it correctly. Emotionally disturbed patients are far more sensitive to non-verbal cues than normal people are, and they act on them. Normal people discount them and say, "Oh well, it's just that he's tired, he's nervous, or he's hungry."

Mrs. Thompson:
The important thing on rejection is that we may reject the bad behavior or the action, but we can not reject in any sense the poor abilities or the patient himself.

Mr. Fultz:
But I wonder if the action of the patient, the musical action of the patient, is not a very real announcement of how he feels about things. When you talk about musical ability you are talking about the person's musical expression. It is how he uses musical action. Musical action is a vehicle by which he can say a lot of things quite frankly that in Boston would be banned if they were written or printed.

Mrs. Whitney, would you say just a word here about the comparison between the dynamics of working with patients and those working with students? Mrs. Whitney is head of the Music
Education Department at the New England Conservatory and is an expert on working with student groups and group dynamics.

Mrs. Whitney:

I think essentially they are not very different. I think the best way you work with a group is to be honest, fair, square, and expect the best efforts and to let them know that you have recognized their efforts. Take it at its face value and together you will push on to better efforts, better realization, or a higher skill. I think the people who are ill will depend, perhaps, a little more upon the leader than those who are not ill. The quality of the leadership, that personal relationship, that understanding that exists between the one who guides and the one who follows, are very important. It is usually the cooperative person who gives confidence to the performer, the one who shows in the way that she leads that she wants to be with her group. She enjoys them, she likes them. I think all good groups reflect the attitude of their leader, the realization that the leader is there because she wants to be there. It is important for every person in the group to have a relationship with the leader.

Dr. Sutton:

To summarize, I want to tell that I have heard some very sound psychiatry during this discussion. First of all, we have to individualize. Generalizations are always rather dangerous. Another thing was brought out that I like very much: People do what you expect of them. You do not get out of anyone anymore than what you expect. If you set the goal too low you probably will get only meager results.

Another thing that was very sound, is the emphasis on the words security and ego. In other words, a lot of the discussion, when boiled down in simple terms, is the matter of preserving the other person's ego. It doesn't make any difference if you are dealing with the patient or you and I with each other, you must preserve his ego. Mrs. Whitney was just now talking about the personal relationship, people must understand that you are working with them. One thing that has been emphasized more and more in recent years in our work in psychiatry is that what so many patients want is love, somebody who cares, somebody to understand, somebody who builds up their ego.
PERCEPTION
THE EXPERIENTIAL DETERMINANTS OF
THE PERCEPTION OF MUSIC AS AN APPROACH
TOWARD RESEARCH IN THE PSYCHOLOGY OF MUSIC

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No one can theorize about or conduct research concerning the nature of the individual's response to music without becoming aware of the crucial role played by perception. The perception of musical stimuli, whether perception is conceived to be crude sensory awareness or whether it is, in Klein's words, complex perceptual attitudes or Anschauungen, is of course, a sine qua non to musical experience.

A survey of psychological writings within the past decade or two reveals that there has been a renewed interest in, and consideration of the nature of perception and its relevancy to personality. Of still more significance in the area of personality theory and research is a shift away from attempts to define individual differences according to psycho-diagnostic systems toward an understanding of the determinants of individual differences in perceiving.

Recent research on these determinants of perception has given considerable promise of significant and far-reaching results. Although interrelated and interdependent, these determinants have been divided into two major classifications—structural or physical determinants and experiential determinants. It seems reasonable to assume that researchers concerned with the effects of music on human behavior and the nature of musical perception might also profitably relate their studies to these determinants. When the entire field of research in the psychology of music is reviewed from the viewpoint of the perceptualist a fresh and valuable point of departure for structuring future experimental study seems to be indicated.


Autochthonous Bases for the Perception of Musical Stimuli

Research which has been concerned with such psychoacoustical phenomena as pitch, loudness, fusion, difference tones, or beat tones, to mention a few, has been dependent primarily for its results on the autochthonous properties of the nervous system. Structurally all human beings are much alike, and because psychoacoustical phenomena are influenced much less by experiential determinants than they are by structural or physical determinants, it is to be expected that such a phenomenon as "octaveness," for example, is perceived as a property of musical sound and is recognized as such by a European, Chinese, Australian bushman, or Patagonian savage. Research in this area comprises at present the bulk of that done in the field of the psychology of music. No doubt this is true largely because many psychoacoustical phenomena lend themselves quite readily to the classical, single variable, experimental method. Wunderlich has gone so far as to attempt to show that the diatonic scale is composed of "perceptual entities," the musical understanding of which is dependent upon a definitely organized process in the nervous system.

Although the autochthonous aspects of the perception of musical sound underlie the most complex and idiosyncratic responses to music, they can do little to explain even a relatively simple musical response since they are most applicable and apparent in psychoacoustical phenomena wherein complex experiential determinants are of minor importance. The gulf between the perception of the loudness of a single tone, for example, and the response to a musical composition is enormous. In the former case such a perception may be controlled and predicted with sufficient reliability that generalizations may be made for the entire human race, while in the latter case the experiential determinants of perception are so complex and idiosyncratically unique that an understanding of perception may be achieved only by means of a rather complete analysis of the individual.

It is assumed, however, that there exists a continuum between a perceptual response wherein the influence of experiential determinants is slight and one wherein the influence of experiential determinants produces something complex and high-

ly individualistic. Unique as the total pattern of these determinants may be, it is also empirically evident that the individual's responses to music are not unique in every respect and that certain gross aspects of his responses to particular kinds of music may be similar to or identical with those of groups of other individuals.

Such similarities no doubt are caused in part by certain structural determinants which are, as has been stated, more closely related to the autochthonous properties of the perception of musical sound. However, since it is to music, not discrete tones, that the individual responds, and since experiential determinants must certainly affect the response to musical compositions, the reasons for the similarities as well as the differences of the responses to music might well be accounted for by the similarities and differences of the experiential determinants.

Some Experiential Determinants of the Perception of Music

A brief examination of some of the experiential determinants of the perception of music may serve to indicate how complex responses to music are structured. It is understood, of course, that the various headings which follow are but facets of the total relationship between the individual and an environmental situation which, in this case, is primarily of a musical nature. It should also be understood that they are not mutually separable, but, on the contrary are dependent to some degree, one on the other.

Personality

There can exist little doubt that the perception of musical stimuli with its concomitant behavioral responses is bound up with the personality of the individual. The problem is to relate behavioral phenomena to personality variables. Bruner states in reference to workable research techniques that "if we wish to work on personality factors in perceiving, then we must concentrate upon the investigation of those environmental cues which are appropriate to the confirmation of hypotheses which reflect basic personality patterns." This approach was used by Dan-

iels\textsuperscript{1}, Deri\textsuperscript{2}, and Hahn\textsuperscript{3} in an attempt to relate musical preferences to personality traits. These studies show that musical preferences and personality apparently are related, but that it is difficult to discover, conceptualize, and manipulate patterns of musical dynamics in such a way that a consistent and significant relation to basic personality patterns can be demonstrated.

The psychoanalysts have been much more thorough and persuasive in relating musical responses to the Freudian psychodiagnostic system.\textsuperscript{4-9} It should be noted, however, that although this system is a very fruitful one, considering its effective use in psychotherapy, experimental verification of responses to music in accordance with Freudian terms is impossible. This is as it should be, since the psychotherapist has frequently stated that his therapy is as much, if not more, an art than it is a science. Sterba states flatly that “it is considered proven that music is based on anal and narcissistic instinctual foundations . . . .” but he quickly goes on to say, “analytical investigation has not gone further than this.”\textsuperscript{6}

**Cultural Determinants**

It is significant in discussions regarding the predictability of responses to music that the warning is often given that music in Western culture (or that of some other culture) must be considered to the exclusion of all others. Obviously the implication is that a certain musical response is likely to occur only in individuals of a particular culture. The classification of individuals

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according to their perception of musical stimuli on the basis of broad cultural determinants is a primary and major division of people. Although a Japanese may perceive an octave in the same way as will a man of Western culture, and, to ascend to a higher level of complexity, although both will perceive and respond in much the same way to those characteristics of music which are stimulative, yet great differences in perception and response to the unique musical patterns of the other’s culture probably would appear if they were to exchange places. If broad generalizations are to be made concerning the perception and effects of music, it seems that much more investigation is needed to assess the influence of cultural determinants. It is also necessary to delineate and verify those effects of music which will cut across all cultures if there is to be a foundation upon which to erect a diagnostic-predictive structure which will take into account individual differences. Rank,1 Farnsworth,2 and Engreval3 have pointedly stated that music is created in accordance with a cultural ideology and that the perception of it, particularly the judgmental aspects of perception, is influenced greatly by cultural determinants. That rather esoteric concept, “musical taste,” although subject to the effects of musical training, is largely shaped by cultural determinants.

Musical Sensitivity, Ability, and Training

Takano4 states that musical hearing is both sensory and “judgmental,” the latter being derived from training, and that musical sensitivity is extremely varied, but quantitatively, not qualitatively. It does not appear to be necessarily dependent upon the ability to create music or upon music training; although, to reverse the statement, the ability to create music, either as a performer or composer, is invariably dependent upon musical sensitivity. Naturally, the ability to create music is also dependent upon training. Insofar as it is known, there is no means for

the measurement of musical sensitivity except by highly subjective empirical judgments. Hahn concluded from a case study of the musical preferences of twelve university students that "preferences for classical music are more dependent upon a response to the beauty and aesthetic value of the music for themselves than they are dependent upon extraneous cultural factors." It is believed that musical sensitivity can profoundly affect the individual's perception of music.

**Associational Determinants**

The associational determinants of the perception of music are to the highest degree idiosyncratic. It would appear to be impossible to account for all of them, even for one individual, and even if he were to undergo a long period of psychoanalysis. Any laws or principles of the effects of music on behavior or the perception of music must, perforce, always be qualified in terms of these highly individual differences. There is in many instances, however, no cause for dismay, since associational determinants may on occasion be turned to advantage and on others may be of inconsequential significance.

There are times in a rehabilitation institution or in an educational institution when it is necessary or desirable to work with individuals, and when a knowledge of their peculiar associations with music may be utilized to achieve a therapeutic or educational goal more quickly and effectively.

On the other hand, associational determinants may be of little significance in situations where a desired group response is of the highest importance and where the benefit to the individual, because of his group participation, would outweigh benefits he might secure from without the group.

In any case, basic research in the psychology of music has not yet advanced to the point where it is generally necessary to account for or make allowances for the attenuating factors of associational determinants. This does not mean that they may be ignored in some studies, but rather that research in this area must still be primarily concerned with the evolvement of valid concepts and laws of behavior which are necessarily related to groups of individuals.

1. Marcus E. Hahn. *op. cit.*
IMPLICATIONS FOR RESEARCH

1. While it is apparent that research concerned with psychoacoustical phenomena are important and informative, research should push beyond the autochthonous bases for the perception of musical sound and concentrate its efforts more heavily in the area of the perception of music, i.e., musical composition, in an effort to discover basic laws and principles.

2. The area of research which should receive the most attention at the present time should be concerned with the discovery and delineation of these experiential determinants of the perception of music which are indigenous to all cultures.

3. The next step would appear, then, to be a study of those experiential determinants of the perception of music which separate major cultures. This would logically be followed by studies of sub-groups within a culture.

4. At the same time research should be carried out in which experiential determinants of musical perception are related to dynamic systems within, and dimensions of personality such as, to mention a few, musical ability, intelligence, musical sensitivity, psychopathologies, and the dynamics of the psychological concept of need.
EXPERIENTIAL DETERMINANTS OF PERCEPTION
SOME CONSIDERATIONS FOR MUSIC THERAPY

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Experimental studies in perception in recent years have tended to emphasize that how a person perceives many important aspects of his environment depends in a large measure on how he has experienced that environment. Many studies\(^1\), \(^2\), \(^3\), \(^4\), \(^6\), \(^7\), \(^8\), \(^9\), indicate that a person's own needs affect his perceptions. What a person abstracts from a perceptual experience, and what he then recalls of this abstraction, is related to cultural factors.\(^2\)

Following the work of Ames\(^5\) others have demonstrated that how one perceives environmental cues depends on what he knows about his environment from previous experience.

In essence, these studies would seem to show that different people translate the same physical situations so that what is perceived is in harmony with the individual strivings, experiences and personal organization of the perceiver.

Most of these studies have had to do with visual perception.

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Several \cite{1,2,3} have dealt with auditory stimuli. Two kinds of experimental approaches have been characteristic: (1) the use of perceptual stimuli or stimulus situations such as fear-inducing stories, anxiety-inducing words, and symbols which were presumed to be related to the subjects' personal values, calculated to arouse emotional reactions; (2) the manipulation of perceptual cues which serve as anchoring points of orientation for the subject by changing the height of walls, the slope of floors, cues to distance, to mention a few. The focus has been on cognitive and symbolic processes.

None of this work has touched on the perception of music, although music is perceived sound and is often described as a subjective experience. The person who adapts functional music to the therapeutic program of a psychiatric hospital nonetheless recognizes that there are both certain experiential and non-experiential determinants of the perception of music which make it useful as a therapeutic device.

The following hypotheses about these determinants are offered:

1. \textit{Music is a segment of reality which is refractory to perceptual distortion}. In contrast to words, pictures, non-musical sounds and varied intensities of light, the \textit{structure} of music is such that it is not readily distorted to meet personal needs. To change the rhythm, the melody or the harmonic structure is to change the music itself into something which is no longer recognized as the original nor even offered as a substitute for it. Furthermore, music has specific meaning of such strength that it retains its identity in even extremely varied cultures. The lullaby in India, though perhaps employing a different scale than that of the Western World, is probably still recognizable as a lullaby. It is soft, slowly rhythmic, soothing—in short, sedative. The driving beat of action stirs the hearer whether it underlies a war dance in Africa, a patriotic march in a football stadium, or a jazz orchestra in a dance hall.

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In addition to this basic structural quality there is specific cultural meaning, reinforced by conditioning, which adds to the strength of the music. Barbershop harmony signifies close, pleasant, personal associations. It has been observed many times that a patient who hallucinates most of his waking hours will remain in relatively good contact through an hour of group singing, requesting that the group sing a certain favorite of his, or performing a number he knows as a solo for the entertainment of the rest of the group.

The hymn is identified with religion. That this identification is a directive one is seen in the almost dramatic change in the total atmosphere of the hospital chapel at the first notes of the organ prelude. The sound of monotonous voices, punctuated with hostile mutterings and occasional bursts of inappropriate laughter suddenly hushes into a quiet, worshipful silence. And if one patient should fail to respond to this controlling influence, several others around him, who appear at other times to be just as ill as he is, will attempt to reassure and quiet him.

The waltz symbolizes light, pleasurable good cheer, and under its rhythmic impact many patients who seem to be capable of few other appropriate responses will conduct themselves with social decorum on the hospital dance floor.

Music, therefore, provides a rigid perceptual structure to which the person must respond, if he responds at all, in a traditional way. In the midst of confusion it can thus serve as an orienting point. It remains as a tie or link to previous reality. And as long as there is one link, there is always an opportunity for forging others for the person who has otherwise lost his contact with reality. Since a person, no matter how sick, will tend to respond to music in a characteristic, normal way, music can be one familiar and acceptable experience in the course of the day in a hospital setting where all else is not only strange and unfamiliar, but often also unacceptable.

With its rigidity of structure and its cultural reinforcement tending to evoke traditional responses, music can be a means of arousing or directing behavior in such a way that the patient is not conscious of being aroused or directed. A typical example is the use of rhythmic, stimulating music to arouse a quiet ward and soft, soothing music to quiet a disturbed ward, in accordance with the iso-moodic principle.

II. Music is a segment of reality which is experientially non-threatening. Much of the experimental work described
above deals with threat. Words relating to sexual or aggressive drives are often the critical stimuli, for in our culture they reflect pressures which are control problems for everyone. When such words appear in experiments, they evoke emotional responses, for they touch on areas of high emotional charge. Thus their perception will often be distorted so that their emotional connotations are minimized. The way in which they are distorted reflects certain personality organization. Music, however, is without inherent threat.

Except for the very rare case where one has been forced to be musical to the point of oppression, there is, ordinarily, little about music itself or about the experiences with which it is identified in life which evokes anxiety or negative emotional response. In fact, quite the opposite is generally true. People do not avoid music, they are attracted to it and by it, if they respond at all.

This positive aspect of music, experientially determined for the most part, makes it widely applicable as a therapeutic device. In a psychiatric hospital, music can thus reach almost everyone. The most deteriorated patient will often beat two sticks together in time with a rhythm band activity, and the most hostile can sometimes find relief from his own hate in song. Even the paranoid patient whose very illness is to distort all logic does not distort music into a threat.

III. *Music is a segment of reality which is a contact device.* It is commonplace that music is a means of identifying with or communicating with the composer, the artist, the musicians. The musical participant also communes with his fellows in band, orchestra or chorus. Unlike other social situations, in a musical situation there must be harmony and cooperation. There is no room for struggles for dominance, power or mastery. Music thus serves as a bridge among people. Often this is the only bridge which can be used in comfort and safety.

So identified in everyone's experience for this purpose is musical activity that it becomes a natural contact device in a therapeutic situation where contact is the first step toward recovery. The task of the therapist is to demonstrate to the patient that the world is not hostile toward him, that he does not have to give up on people though some of his life experiences have been extremely difficult. Only through contact—frequent, positive contact—can the patient get this point. Often music is the most readily available bridge between patient and therapist, between patient and other patients, and between patient and vol-
unteers. Sometimes it is the only bridge. Experience has taught us that here, in music, it is safe and often pleasant to meet with other people.

The development of such a bridge of contact to other people is shown in a note, written to her music therapist by a patient after several months of attending a daily music listening group. It read:

The first activity I had off the ward was the music Listening Hour. I didn't know then that this hour was often to be, in the weeks and months to come, the only place where I could know any peace at all, any rest from the relentless turmoil within me.

It seems strange now, but I realize that I listened during the first few weeks with practically no feeling. I dared not feel then and the thing that was so satisfying about the music was the order and logic of it. Where all was chaos and confusion within me, here was a tangible source of regularity, of systematic development, repetition and enlargement of themes, always controlled, always limited, and yet as expansive as I was able to participate in. This feeling, that I could control my emotional response to it, was important; this I could hate, or love, or ignore, or analyze as little or as much as I chose; mercifully, it was available with no human taint. Yet it had warmth, beauty, fear, joy, sadness, pain, and all of the gamut of human emotions that were so terribly entangled in me.

Another aspect of the music that meant a great deal to me in the earliest weeks was its characteristic of movement. Somehow, it assuaged my continual restlessness, much as looking at the Pacific Ocean had done two summers ago. It was actually sometimes painful to me when the music ceased.

Gradually, I began to feel a little with it. I would think while listening, "This music, that throbbs and swells, and then subsides—it was written by human beings—like myself; they must have known the feelings I feel since they have created these forms which reach so deeply into my own being." With these people I could relate myself; with these people I was safe. I came to trust the music and sometimes it was a trust synonymous with the individual who created it or produced it.

It is difficult to trace these complex patterns within ourselves, but I feel quite certain that this trust in the music preceded my trust in the people here at the hospital; that it had a very real and concrete part in gradually turning my confidence toward them. This statement, I know, is impossible to prove, but as I come to trust my own feelings more and more, I know that the music I heard functioned in this manner. It was as if it were gently thrusting fingers of hope, of kindness, of acceptance, down into the hitherto inaccessible parts of myself.

The music listening hour also gradually came to be a place where I could work out many entangling threads of the therapy that was being carried on elsewhere. Sometimes, while listening, I found myself able to face a very difficult or painful feeling; the relaxation was conducive to flashes of
insight which eluded me elsewhere because of so many distracting things around me. I definitely experienced my first real feeling of hope during one of the hours and recognized it as such. I doubt that I will ever forget that particular period.

This is more or less the way I have used the Music Listening Hour. It has not taken into account the warmth and friendliness of the staff members; that is almost another area entirely. It is my relationship to the music itself that I have tried to describe here.

In summary, while there are certain aspects of music which may be subjectively interpreted, music has structure which remains objective and unchanged under all conditions. To this, experience adds permanent adjunct conditions: the absence of threat, the acceptability of inter-personal contact, and specific relationships between given kinds of music and certain life experiences. Taken together, these conditions underlie the effective adaptation of music to therapeutic use.
PART II

THE DYNAMICS OF MUSIC THERAPY
THE DYNAMICS OF THE MUSIC THERAPY RELATION

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It is a pleasure to have the opportunity to come here, although a pleasure that must be qualified. Those of you who know your Vice-President know that he is a very persistent man. When he sets himself up to a task I don't know of anyone who can dissuade him from it. When he approached me to come here to speak, two thoughts crossed my mind. First, I welcomed the opportunity to ventilate some of my own ideas about music and music therapy. Second, if Mr. Fultz asked me to come, I might just as well give in and come because he does not give up easily. In Boston, we are very much aware of this persistent effort and the results these efforts have produced.

The nature of a relationship, I think, should be prefaced by raising two questions. First, what is any relationship? And, second, what can or what does music add to a relationship? I would like to add at this point that I am one of those people who is completely ignorant, technically, as far as music is concerned. I cannot read a note; I do not say this with pride, but it is a fact. I am a listener; I enjoy music and I think I appreciate it, but I cannot discuss music with you in the technical sense. This may be an advantage.

Considering the first question, "what is any relationship?" I may be on dangerous ground because what I will say may seem exceedingly elementary to you. Yet, I do feel, nevertheless, that that which is elementary is exceedingly important and worthy of repetition. Any relationship, I think, first indicates to us a very basic fact: through any relationship is expressed the need of one person for another. This is a basic human need, the need of one person for another, the need to be important to somebody else.

It brings to mind an example of a man, a member of a rather well-known Yankee family, endowed with the traditional Yankee conscience, a very rigid conscience with many good aspects, but with many punishing aspects as well, who found himself involved with a woman in an extra-marital affair. This was sheer blasphemy in every sense of the
term to this man. And yet, he not only found himself involved, but he went through with it quite completely, because, among other reasons, he felt important to the woman. That feeling of being important to somebody was sufficient to break down an extremely rigid and rockbound New England Yankee conscience.

The need for any one of us to feel that we are important to someone else is, I believe, one of the things which gives us nourishment in life, the kind of nourishment that is not available from any other source. We know well that efforts to seek that kind of nourishment from other sources could, characteristically, take the form of neurotic symptoms. We cannot live alone.

You may challenge that remark, and you may point out examples of people who find that it is possible to make their lives full, with a good deal of gratification, and not have very much to do with people. For example, you might say, what about the scientist who is so completely involved with scientific work that he has no time or room for relationships with people. Or, we may speak of the artist who also is so completely involved in his work that he, too, seems to have no need for people. Yet I think it striking that, usually, we will refer to these people as follows: “He is in love with his work,” or, “He is in love with his art,” or, “His art is his love.” We thereby indicate that in this art or in this sublimated expression he is finding sustenance and nourishment. Yet, somewhere there are people involved, although they might be entirely in the person’s unconscious.

From the premise that we need other people, that through other people we can fulfill our lives more satisfactorily, we then should consider the situations in life that alter or distort, not the other person but the concept of one’s self. In addition it is necessary to realize that the specific needs of life, alter or distort the needs for another person, or other people, and alter or distort the expectations that we have from other people. It is for this reason then, that we speak of the pre-determined attitude arising from earlier experiences. It is from this conception that we speak of conflict. The trials of life serve to render the need for someone, from something that could have been tendered, from something that could have been loving and gratifying, to something now that is discolored by disappointments, anger, fear, and a variety of other unhappy emotions. This is true, I think, in every one of us.

In each of us, trials and tribulations have altered and dis-
colored our attitudes toward life in general, and towards people, in particular. This is especially true in those people with whom we work, patients.

It is also from distortions due to earlier experiences with other people that the nature of the transference is determined. The heart of all therapy, lies in the transference of the patient to the therapist, whether it be positive or negative.

At this point I would like to divert a bit. The diversion is not as extreme as it may sound. I wish to talk briefly on the topic of "closeness." This should be a subject dear to your hearts because as music therapists, you cannot operate from a distance. I know that there are uses of music therapy which consist, for example, of playing music over the loud speaker. I do not think they would work very well. We are not here concerned with such uses.

I think the more important kind of music therapy is where the musicians or the music therapist, are close to the patient. Because the question of closeness is more than an academic one, closeness is a very strange thing. I'm sure that no one here would deny that it is his aim or her aim to be close to other people. I think there is no one in this room, and I include all of us, who is not afraid of closeness; I think, too, that this happens to be a quality in all people. It is much worse in sick people, our patients, but every one of us is afraid of closeness.

What kind of closeness do I mean? I do not mean only the physical closeness of being near to someone, but more importantly the sense of closeness wherein we feel spiritually close, emotionally close, or where we feel that we are sharing in common something with another person. Most often this sharing goes unspoken, exemplified most characteristically in the act or in the feeling of love of one person for another. We all want to love. We all want to be loved, but in the process of achieving closeness, certain fears are aroused.

Each of us, despite our conscious intent and wishes, experiences some fear of closeness. Why? There are a number of reasons. I will mention a few that I think are important and, perhaps, most apparent. First, if we permit ourselves to be really close to someone we expose ourselves to the danger of losing the other person in a real sense as through death, or by separation in an emotional sense, where we feel the loss of someone else by rejection. This latter may
or may not be realistically so. So we fear that if we should give of ourselves so completely to someone else to foster a genuine feeling of closeness, we may get hurt somewhere along the way.

Secondly, to permit ourselves to become very close to someone else means that we expose ourselves to the danger of losing our own identity, of becoming the victim of impulses, conflicts, wishes, fears. Our sense of self-identity has arisen out of relationships earlier in our lives to important people around us, most particularly, parents. Impulses become threatening in a close relationship. To permit ourselves closeness to another person places us in a vulnerable position, whereby we might be hurt. The nature of the hurt will vary from one to another but everyone fears being hurt.

From this point of view, it follows that the person who is emotionally sick is more afraid because his conceptions of himself and his conceptions of other people have been so distorted or discolored that he expects only pain from closeness. This is a serious state of affairs because where this conception is predominant in the mind of a person, he effectively shuts off from himself any possibility for a warm, affectionate or loving relationship with someone else. This happens to be one of the dilemmas that the schizophrenic patient, for example, is constantly confronted with. His expectations of receiving are so great as to be unreasonable. On the other hand, his expectations of what he thinks will happen in a destructive, painful way are also great as to be equally unreasonable. He is "caught on the horns of a dilemma," wherein a close relationship carries for him only the means of pain, and in some cases, destruction. This is the kind of patient, to which you come as a music therapist.

The chief problem in treatment is that of always achieving a positive transference, of helping a patient feel positively towards you. Should he persistently feel negatively toward you, you cannot succeed with him, and treatment cannot proceed.

You, as music therapists, come with much devotion, sincerity and interest in the patient. Your intentions are of the best. You have had training in music and in understanding human behavior so that you may offer your services to people who are in need. But, we must remember that in the act of offering your services to patients who are emotionally disturbed you are at the same moment asking that patient to subject himself to his conception of your efforts. In effect, you are asking him to get
hurt. This may sound strange but I think to understand this point may relieve some of you from a great deal of discouragement such as frequently arises when your best efforts meet with abuse by the patient. It is important to be able to understand that a patient does want to be close, but for him closeness carries a much greater meaning, destructively, than it does constructively. He, therefore, greets you and meets you with this determined set of attitudes. He is afraid to come close to you.

The question, then, is how can music help?

First, I would raise the question, what is music? And, again, at least for myself, I must exclude the technical aspects of music. This puts me more in a position of a patient perhaps than in the position of a music therapist, because I have to subject myself to music as an experience, an emotional experience. I cannot sit down with a score and see how many mistakes this particular musician is making. I can only listen to the music and experience it. Music to me is rather exclusively a perception, an experience which may be emotionally pleasant or unpleasant because of what I hear, what I see if I'm watching the musicians, and also, what I imagine.

What is it that makes music pleasurable or unpleasurable? Why is great music great? Certainly, it is not simply those people who know the technical aspects of music, who preserve great music. Many people believe that those who revere great music do so because of the emotional experience they have when they hear great music. This is probably true for all people.

Music, then, in a music therapist-patient relationship has an emotional meaning and becomes an emotional experience to the patient. Music that is experienced as pleasurable must be connected with unconscious, perhaps even conscious, but certainly with unconscious pleasurable fantasies. At a certain point, music may become extremely pleasurable. The past few summers I have been vacationing at Tanglewood and have had the opportunity to discuss this with some of the musicians up there. At some point music becomes very pleasurable as an emotional experience. That pleasurable sensation I would describe in its broadest and most all-inclusive sense as a feeling of closeness, perhaps even as a feeling of love—for someone, in unconscious fantasy, or, perhaps, to someone pleasantly representative of that loved person. The present representative, of course, becomes the musician or the music therapist.
In one of my discussions at Tanglewood a concert pianist told me that when he plays for an audience, at a certain point he gets a "feel." That is the only way he could describe it; he gets a "feel" for his audience. He knows, at that point, that his audience is with him, or that his audience is not with him. He could not define it more closely than that, except to say that it is a great experience when he feels the audience is with him, not only because he knows they will now applaud him, but because he is experiencing something with his audience. He could not define what it was that he experienced, whereupon I presented him with the idea that perhaps this experience could be defined as a certain point in his music when the pleasurable sensations and fantasies arising in both musician and audience created a mutual, agreeable act of sharing.

Sharing, mutual sharing, always involves and evokes tender feelings. The greatest kind of music is that in which the emotional experience is one of love. This sounds trite, yet I believe it. This must be the source of unconscious communication between the musician and the listener. For that reason then, when the music therapist plays a certain type of music to a certain patient absolutely nothing happens. Well, maybe something does happen but you do not like what happens. At other times something happens to bring music therapist and the patient closer together.

It would seem to me that the music therapist has two jobs. First, he must evoke tender feelings, that is, a positive transference in the patient, through his understanding of the patient as a person. Secondly, he must be able to achieve this sense of mutual sharing through this music.

This past spring a pianist in Boston told me that he was treating a young schizophrenic male patient. He said to me, "I don't do anything. I play music and he plays it along with me, but I know this patient likes me and I like him and something happens. We get along very well." He said that he really had very little understanding of the schizophrenic, and for that matter, psychology in general, but when he sat down with this patient they somehow manage to get along well. In addition to the obligation of the music therapist to evoke tender feelings through his understanding of his patient as a person it is necessary that the music therapist have the additional obligation of
achieving this sense of mutual sharing through the medium in which you are trained, music.

Therefore, as much as the music therapist must apply himself to the task of understanding the person with disordered emotions so it would seem to me that he would have to work out the kind of music that will enhance his relations as a person to the patient. Yet, I would certainly say that a piece of music will never bring you close to a patient or a patient close to you. There must be something more. The something more is you, a person. Music is an additional tool whereby you hope to bring the patient even closer in this act of mutual sharing.

To be able to share mutually is a highly mature process. Music alone will not bring a person close to you; music alone will not cure any patient. For that reason I don't believe in canned music over a loud speaker system. There has to be two people involved. One of them is the music therapist; so I repeat music alone will not do it. But music, plus the capacity of the music therapist to understand and to relate to the patient consciously or unconsciously, may provide a means of helping the patient. Music cannot substitute for the human relationship. It can only be a part of it, but I think that as music therapists you are especially fortunate insofar as music, probably more so than many other artistic forms, is an emotional experience to more people.

In that regard I think you have a greater opportunity for using the emotional experience that can come from music to enhance the kind of relationship that is encumbent upon you as a person, not as a musician, to establish with the patient who needs your help. The proper use of music will enhance the capacity of a patient to draw close and try to partake of the kind of tender feelings that make life worthwhile.
The fact that three panel members all centered their interest on one particular aspect of the large and rather vague topic assigned seems to me to be evidence, not so much for telepathic communication, but, for the increasing and crucial importance of the working out of the relationship between the psychiatrist and the music therapist, and the gaining of an understanding of the vicissitudes of that relationship.

I wish first to emphasize that in my experience at Boston State Hospital I have found music therapy of definite and unique value, and music therapists, as a rule, cooperative, flexible, and energetic, if at times somewhat confused. Music therapy’s ability to move otherwise unmoveable patients has been demonstrated again and again. Although I have, I feel, little new to contribute toward an analysis of music’s therapeutic effects, I would like to select briefly those qualities of music which render it unique as a medium of emotional stimulus and personal communication.

First, there is the obviously all-inclusive spectrum of levels of development, at any level of which music exerts powerful effects: from the earliest levels to the most advanced verbal and socially oriented behavior levels; from the baby too young to sit alone who is visibly affected by music and attempts to beat time, to the courting couple at a dance, to university professors and leaders of society at a symphony concert, and finally to the culturally rooted edifices of liturgical, national and folk music. It is thus impossible to conceive of a psychiatric patient to whom music will not be appropriately disturbing and meaningful.

Secondly, music has almost unlimited power to penetrate almost any defense except total deafness. You cannot shut your ears as you can your eyes, and it is nearly impossible to divert your attention from strongly rhythmical or very familiar music. A great number of patients objected to the introduction of a disc-jockey program which was piped into all the wards on the basis of, “You can’t get away from it.” A patient of Irish background who felt that others hated him for being Irish managed to obtain a radio and proceeded to turn his ward into a shambles by playing a local two-hour Irish program at the very top decibel
level he could squeeze out of the set. However, the fact that music has such intrinsic power, even when obtained from the recording, does not contradict the point that Dr. Mann made, that it ends up being merely an irritating stimulus or a vague, unfocused experience unless a person, the music therapist, is involved directly with the patient.

It seems to me that the music therapist is quite aware of the powerful instrument that he controls, is, in fact, intensely proud of it, and is therefore ambitious, optimistic, eager to work with all kinds of patients no matter how sick, and convinced that he has a great deal of help to offer the psychiatrist. Furthermore, at least on a conscious level, he seems equally aware of the significance of the interpersonal relationship that exists between patient and therapist. As a result he is quite eager to discuss his work with the patient with the psychiatrist from both these points of view.

However, in practice, things do not continue to work out so nicely. The music therapist runs into problems and disappointments with his patients that baffle him, and he attempts quite sincerely to bring these to the psychiatrist for discussion. In my experience, at this early phase of my relationship with the individual music therapist, he attempts to structure the discussion around the exchange of “music therapy pearls” for “clinical psychiatric pearls.” It soon becomes evident that any problem that the music therapist feels is in the area of the patient’s psychiatric condition or, more specifically, in the area of dynamic interpretation of the relationship of patient and music therapist, is being tossed to the psychiatrist to solve. My attempts at this point have always been to try to help the music therapist to develop awareness of the relationship between him and the patient, and understanding of what is going on between them. Such attempts bring out the fact that the music therapist is quite ambivalent about this aspect of his work, even to the extent of resisting any help from the psychiatrist, covertly or overtly. A single, simple example of such covert resistance occurred when a music therapist who previously was able to attend all scheduled conferences with the various psychiatrists with whom he worked, rather suddenly found his schedule so crowded that he had to skip three out of four conferences in order to fit everyone in. I might add that the more open this resistance to the psychiatrist’s “pearls” becomes, the less eager is
the music therapist to bring the psychiatrist "pearls" from his own experience.

There is an increasing consciousness of and concern for "role," i.e., this belongs properly to the role of music therapist, while that belongs properly to the role of nurse, or psychiatrist. There is a feeling that because of different background and training, the psychiatrist does not understand, is indifferent to, or even hostile to music therapy. At the same time there is a confusion about what exactly is the role of the music therapist and what, so to speak, are the boundaries of this role, accompanied by more ambivalence as to whether the psychiatrist or the music therapist has the responsibility of defining the music therapist's role. As long as ambivalence does not lead to open rebellion or defection, the music therapist usually attempts to resolve it by a subtle or gross retreat from the field of "therapy" to the field of music therapy, or music as such. A few illustrations will give a clearer picture of the various ways in which this retreat from "therapy" to "music" is carried out.

A catatonic, mute, withdrawn, untidy male patient, sick for over twenty years, was assigned to a music therapy group where he immediately began to make outstanding progress. He became very interested in the therapist, who was young and feminine, finally maneuvering her into a somewhat secluded corner and making an overt sexual pass at her. The therapist immediately rejected him in panic, and as she herself felt, quite clumsily. She felt that it was absolutely necessary for her to drop this patient from her group, and wanted the psychiatrist as administrator to arrange this. She seemed to interpret the psychiatrist's attempt to work out with her what had happened in the relationship as a refusal on his part to let her drop the patient, and, out of a conscious desire to cooperate and do good therapy, she retained him in the group. He has retreated to a level of minimal participation with no further progress. The therapist has not been able to continue any attempts to understand the patient's behavior and her reaction to it, and, on the contrary, views the present state of affairs as satisfactory and "as good as you can expect" from this type of patient.

A life-long schizophrenic patient, who was probably mentally deficient as well, was picked up in a casual manner by a succession of music therapists, apparently because of his belief that he was a singer and dancer of professional ability. After five
years of this the only noticeable effect is that now he feels qualified to act out his fantasies by entering amateur hours and children's shows (at the age of 34). At no time did the music therapists fail to recognize the lack of therapeutic effect, but nevertheless were very interested in following his lack of progress with complicated charts and test results.

A usually wild, hebephrenic male patient, ill sixteen years, in music therapy at first listened passively, and then, instead of putting on his usual floor shows, became the neat, thoughtful chief assistant to the therapist. All went well until other patients made minimal efforts to displace him, sending him into bizarre and self-destructive rages. The patient's fear of showing aggression in a rivalry situation and anger at expected rejection were quite obvious to the therapist and the supervising psychiatrist, as was her own anxiety. In this case the music therapist's retreat from the interpersonal situation occurred in easily observable steps. Awareness of her anxiety in regard to the patient as a person was replaced by a feeling of being frustrated by her "limitations" as a "therapist." Later she felt that the patient "wasn't right" for music therapy, and must be peculiarly unsettled by the music itself. At this point she displaced onto the shoulders of the ward personnel and the psychiatrist the responsibility of deciding whether he was in fit shape for music therapy on any particular day, quite openly acting out the feeling: "I provide the music; you provide the patient."

That an individual's concept of his role is used defensively is further demonstrated by an instance differing quite markedly from the above. A very skittish, paranoid patient had never allowed any close relationship with any personnel until he was able to work with a succession of music therapists, the last one of whom established an excellent and firm relationship with him. As a part of his progress the patient gained insight into the unreality of his fantasies of being a song-writer, which had afforded him his original rationalization for allowing music therapists to deal with him, and asked to continue to see the therapist without the musical nonsense. Despite her understanding of this, which included a full realization that such insight had been one of the therapeutic goals toward which she was working, and her intense desire to keep seeing the patient and to help him, she felt quite guilty and insecure, and fought hard to maintain the music aspects of the relationship. However, instead of re-
treatting further and further toward music and away from the patient, she suddenly seized the opportunity to switch from music therapy to occupational therapy on the chronic female service. Only then, after she had openly abandoned her role as music therapist in the hospital did she feel free to see the patient without music. Interestingly enough, both she and the patient cooperated in setting up a new rationalization in which she saw him only on visiting days, as a "visitor," not as a "therapist."

Why this ambivalence? Why this retreat? Why this hyper-consciousness and confusion about the definition of role? Why this hostility, friction, and failure to work together on the part of the psychiatrist and the music therapist? It would seem obvious that most deeply and most importantly to be considered are the fears and anxieties about closeness that Dr. Mann discussed at length and which seem unnecessary to go into at this point. Still, these difficulties arise wherever people relate to people, wherever a therapist of whatever ilk deals with a patient. What can be said that is more specific for the music therapist?

Dr. Dreikurs has already described how the psychiatrist’s feelings in regard to protecting his position and prestige adversely affect the relationship between psychiatrist and music therapist, and I agree that in many instances this is so. I wish, however, to call attention to the music therapist’s feelings in this same area, first, because Dr. Dreikurs has already covered the psychiatrist’s feelings adequately, and second, because I do not see what good another journey down the path of hostility to the psychiatrist is going to do a group of music therapists.

In this area of prestige, the principal fact is that the music therapist is a specialist and wishes to be considered as such. Therefore he wants to protect his specialty from being laughed at and ridiculed by others, particularly the psychiatrist who is well known to be always finding flaws and "analyzing." Furthermore, he wants to protect his specialty and therefore himself as a specialist from disappearing. He tends therefore to keep to himself special knowledge, trade secrets. It is as if he said: "If I tell you all I know, then you will be able to take over, take over my unique position in the world, take over my job, etc." It is quite true that doctors have their problems in this area too, but I feel that the music therapist in his complaining that the doctor will not tell him anything, will not cooperate, etc., is often projecting his own feelings of protecting his position onto the psy-
chiatrist. Also, it is only natural that a specialist who trains for a career wants that career to pay off within the framework of his specialty. In other words, the music therapist does not want to become a junior psychiatrist and sometimes seems to fear that this will be all he is given credit for if too much emphasis is successfully placed on the clinical aspects of his therapy.

The problem can also be looked at from the point of view of the music therapist as a member of the “psychiatric team,” a concept far easier to accept on paper than in the field. As such he is a so-called ancillary person; the psychiatrist is not only a fellow-specialist but the “captain,” in other words, the boss. Delineating the relationships within the psychiatric team could be the subject of a monograph. Suffice it to say that all the feelings people have toward bosses, such as resentment and passing the buck upward, and all the intranodal tensions, with hostility toward the psychiatrist as father figure and sibling rivalries, to mention a few, must exist in such a setup. If the music therapist retreats from the field of psychotherapy where the psychiatrist or the psychiatric team holds sway, toward music where he can build his own empire, it is not surprising.

Does this have to be so? I do not think so. It seems to me that the music therapist can be skilled in observing and understanding the patient clinically, have a deep understanding of interpersonal relationships, and still be a music therapist. Then, this therapeutic tool would not lose its effectiveness as the patient’s newly mobilized energies meet a wall of misunderstanding, anxiety, and hostility in the very person who has used this tool to goad him from his withdrawal and challenge him to progress.

How are we to accomplish this? Obviously the general problem of the feeling of people for their role and their place in the treatment of the patient, has to be worked out on all levels, the high and all-encompassing as well as the low. Focussing, however, on the individual music therapist and his training, two plans of action are possible, one of which I feel may perhaps be of some value, the other of which I am sure is essential.

I think it debatable whether prescribed courses in clinical psychiatry would be of value—it might perhaps depend on the individual. It might be very important to some to feel able to relate to the psychiatrist on a more equal level by being able to “talk his language,” while others might unconsciously resist such
courses, and having taken them, refuse to draw on the knowledge gained in them in dealing with the psychiatrist, feeling perhaps, that they are challenging the psychiatrist on his own ground.

Far more important, I feel, is clinical supervision by the psychiatrist on a regular and intensive basis. Let me reiterate that this does not mean simple emotional support nor the making of administrative decisions which take the music therapist "off the hook." The essential meaning of supervision is the careful and intensive taking up and working out of problems that arise in the music therapy situation with a view to understanding what is going on, so that the field may be clear for the further progress of the therapy.
THE MUSICIAN IN THE THERAPEUTIC TEAM

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The invitation to take part in this round table discussion has seemed both a pleasant personal honor and a potentially constructive opportunity for an exchange of ideas between physicians and musicians on the responsibilities involved in the care and treatment of patients. I have been actively engaged in clinical work with psychiatric patients for some years now, but my personal concern with musicians in medicine, in more than a general way, dates back only two years when the Peabody Conservatory of Music in Baltimore and the Henry Phipps Psychiatric Clinic of the Johns Hopkins Hospital established an affiliation for the clinical training of musicians who plan to specialize in Music Therapy. My reflections on musicians in clinical work, therefore, will have at least the virtue of freshness. My personal feeling toward the efforts of musicians to find a useful function in clinical work is one of welcoming interest. Creativity and productivity have been outstanding characteristics of the music profession. That musicians who turn their interests to clinical problems may bring these characteristics with them is an agreeable prospect.

The bringing to bear of talents in a new field in an effective way always involves considerable groping and confusion as to roles to be filled and responsibilities to be assumed. The entrance of musicians into the field of clinical medicine would not seem to be an exception. The musician untrained in clinical work has only a dim conception of a patient and an illness and of the variety of objective, complex, never static, chemical, physical and emotional processes in operation with which the physician is constantly concerned. To the physician, the musician is likely to seem merely a sympathetically inclined layman whose practical usefulness in the treatment of patients is problematic. Notwithstanding these handicaps to rapprochement between physician and musician, working contacts have been established and musicians are active in many hospitals throughout the country. Nevertheless confusions still remain and I do not believe that the range and limits of the musician's clinical usefulness is yet fully clear either to the musician or the physician. The physi-
cian may regard the musician primarily as an entertainer, a con-
ception of his role which may be too limited. And the musician
may regard himself as a central therapeutic figure, a conception
of his role which may be too expansive. Both misrepresentations
do the musician with a serious clinical interest an injustice and
hamper an exploration of his usefulness in the day to day op-
portunities of clinical work. A clear, shared perspective is needed
by both physicians and musicians as to their relationship to each
other and to the patient, if musicians are to make a solid place for
themselves in clinical work and solid scientific contributions in
music therapy as a career.

In an effort to contribute something toward such a perspec-
tive, in the discussion this morning I should like to characterize
the roles and responsibilities of the physician and of other per-
sons, including musicians, working with patients as members of
—what seems to me an apt designation—a "therapeutic team." The
physician's responsibilities may be considered first. The
basic hardshell fact in present day medical practice is that
wherever there is a patient there is also a physician who is the
sole bearer of responsibility for that patient's treatment. In the
strict meaning of the term, the physician is the patient's only
"therapist." He may consult other persons to help him gain a
sound picture of the medical problem and he may enlist the skills
of other persons in carrying out treatment procedures, but the
judgments and responsibilities, moral and legal, are his. He bases
his treatment plans on his specific diagnostic understanding of
the individual patient's medical problem and potentialities for
response in the direction of health. Diagnosis is not a once-and
for all act. It is a continuing process, requiring constant reap-
praisal and constant adjustment of treatment goals and proce-
dures.

To help him carry out the indicated therapeutic procedures
the physician uses the help of other trained workers with a varie-
ty of special skills. This is the case in all fields of clinical medi-
cine and particularly so in the care of psychiatric patients. These
trained workers, together with the physician and the patient,
constitute the "therapeutic team." You will note that I include
the patient in this group. In psychiatric treatment particularly,
the patient is rarely the passive recipient of treatment measures
but is an active participant in the day-to-day experiences that
represent joint therapeutic endeavor. Besides the physician and
the patient, the therapeutic team in a hospital setting includes
the nurse. In addition there may be a social worker, a psychologist, a director of physical activities, trained workers able to provide opportunities for the enriched use of time in occupational activities and crafts, and, a still relatively new recruit, a musician. It is apparent that each of these workers is a specialist in his own profession and that a variety of skills and perspectives are represented. Each is also, of course, more than the sum of his special skills. He is a person, a personality, with whom the patient will have opportunities for new experiences in human relationships. These experiences often are an important part of his treatment.

I shall now focus briefly on some of the capacities which musicians as non-medical members of the therapeutic team need to develop for effective work with patients. In working with psychiatric patients it is important for the musician to be able to understand the physician’s diagnostic formulation of the individual patient’s problem. This diagnostic formulation, in current psychiatric practice, is likely to be stated at two levels of understanding: in terms of the symptoms and clinical characteristics of the patient’s illness, and in terms of the personal human problems and attitudes which constitute the patient’s personality and contribute to the emotional and social maladjustments which underlie his illness.

It is also important for the musician to be able to comprehend the physician’s strategic goals in treatment: what he believes this particular patient needs to achieve for his improved well-being, and can reasonably be expected to achieve. For many patients modification of certain attitudes is aimed for, and the development of latent potentialities which may enable him to participate in experiences with other people with more effectiveness and satisfaction than previously. In certain cases, symptom decrease alone may be the practical goal. In others, simply taking good care of the patient as a sick person and providing as pleasant and enjoyable an environment as possible is the realistic goal.

Then too, the musician needs to be familiar with established tactical procedures for establishing personal relationships with patients that are constructive in a therapeutic sense. He needs to be acquainted not only with the principles of what to do with patients but also how to go about what he does and to what purpose. Where there is musical activity of whatever sort there is also a musician and personal transactions between the musician and the patient take place. I have the impression that up to the
present time musicians in clinical work have focussed their attention primarily on music as their therapeutic tool, to the neglect of observations on the effect of the musician on the kind and degree of the patient's participation.

The musician's personal professional roles in working with patients are an extension of his intelligent comprehension of the considerations just presented. It is at this point that his own independent creative functioning begins. On the basis of his understanding of the patient's problem and the treatment goals, he can formulate procedures which draw on his musical resources for engaging the patient in patterns of action and response appropriate to his special personal needs and capacity for participation. There cannot be a single formula called "Music Therapy." Music as entertainment, or as a socializing force, or to lower or raise tensions, or as a highly personal subjective experience, or as a learning experience, or as an exercise or exhibition of individual skill, or as a temporary escape from troublesome worries, or as a creative outlet—any or all of these purposes, and others, may be served at one time or another in one patient or another. In using his ingenuity and special skills the musician has opportunities to contribute, as a co-worker with other members of the therapeutic team, in both the service and scientific tasks offered by the problems of clinical medicine.
The title of this panel is rather ambiguous; it could imply a variety of meanings. Probably all of them were intended for consideration. Clinical interpretation of music therapy can imply first, a clinical evaluation of music therapy as a method; second, an evaluation of the team of which the music therapist is a part; and third, the interpretation which the psychiatrist may provide for the music therapist. It seems that the second area, the relationship between music therapist and psychiatrist, is of paramount concern.

Music therapy as a method is well established by now. Its value and efficacy for patients, many of whom could not be reached by other approaches, have been proven and have given music therapy a permanent place in the treatment of the emotionally and mentally disturbed, within and outside of institutions. The therapeutic results are not questioned; however, which factors are responsible for them is still subject to controversy. Theoretical assumptions depend on the psychological orientation of the music therapist and his supervising psychiatrist. This is not the place to give a survey or to restate our own ideas, which were presented at last year's conference. It seems that the group approach in music therapy provides a significant aspect since it is often the group setting in which music therapy takes place. In music therapy as well as in any other form of therapy, the relationship to the therapist and to other members of the group is of prime importance; but music as such, through rhythm, mood and harmony, exerts its own dynamic influence. These are some of the clinical evaluations of music therapy as a method.

The relationship between music therapist and psychiatrist has become a more complex problem. At first sight it is not clear why this should be so, since other professional workers are part of the psychiatric team, without posing problems. There is relatively little confusion and uncertainty as to the working relationship between the psychiatrist, the social worker, the clinical psychologist, the occupational and the recreational therapist. Whatever may disturb their cooperation is of rather personal nature, without much general significance. For example, the well-
known conflict between psychiatrists and clinical psychologists does not affect their cooperation in the team; it stems from the desire of the clinical psychologists to seek independent license as therapists and the opposition which they encounter in this endeavor from the psychiatrists. As far as we know, the term "therapist" was never questioned in respect to any one of the above mentioned professional groups within the psychiatric team. It is questioned in regard to the music therapist. Dr. Betz spoke for many when she suggested that the term "clinical musician" may perhaps be more adequate than the term "music therapist." In which way is the music therapist different from other auxiliary therapists of the team?

Dr. Johnson pointed out that the music therapists themselves are often not quite sure of their role. Although I have never encountered any resistance from music therapists in my own supervisory contact with them, I can well understand Dr. Johnson's description of the subtle or open conflict which may arise. In some cases it may be the music therapist who disturbs the relationship, either by his resistance against the explanations or demands of the psychiatrist, by his uncertainty about his area of responsibility, or his frustrations in his work with the patients. Dr. Johnson described these factors very well. But the relationship can also be disturbed through the psychiatrist and his own attitude toward the music therapist.

Actually, the advent of music therapy poses new problems which heretofore were not encountered within the confines of the psychiatric team. And these new problems arise at a time when certain psychiatric concepts emerge in regard to therapy which seem to warrant special precautions and safeguards. The impact of these two factors seems responsible for a great deal of the present confusion. It will probably take considerable time before the conflicts involved will be clarified as to their nature, and probably more time will elapse before they will be resolved. It can be expected that friction and misunderstanding will probably increase as the field of music therapy becomes wider, both in extent and intensity of its program. This should not sound alarming, nor indicate any pessimism. It seems to be a realistic appraisal of the situation, particularly in the light of rapid and far-reaching changes which occur in the psychiatric thinking of today, as part of what may be called The Third Revolution in Psychiatry.

Let us now analyze the various elements mentioned. What
is so essentially new in music therapy not covered by established procedures? So far, the professionals involved in therapeutic procedures were either trained in psychotherapy, like psychiatrists, psychiatric social workers and clinical psychologists, or were strictly technicians like occupational and recreational therapists. The music therapist does not fall in either category. One remark by Dr. Johnson clearly indicates this new role which the music therapist plays. Dr. Johnson mentions the possibility that the therapist may retreat from the field of therapy to the field of music as such. It would be difficult to assume that an occupational therapist would be accused of "retreating into occupational activities" or the recreational therapist of "retreating from therapy into recreational activity." It is obvious that in these two categories of "therapists" the therapy consists just of the activity of occupational or recreational nature. This seems not to be the case with the music therapist. Here we find another, much stronger therapeutic agent to be involved. And why? Because, unlike occupational and recreational therapy, music has a much stronger emotional involvement for the patient. There is more that goes on within the patient, and between the patient and his therapist. It is not psychotherapy in the accepted sense, since little occurs on the verbal level. To a certain extent, problems arise in music therapy which may be found in group psychotherapy. But the music therapist is not supposed to be either an expert in psychodynamics or in group dynamics. He is using a very potent therapeutic agent, but not yet prepared or trained—or recognized—as a real therapist, outside of the application of music to his patients.

This seems to be the area of confusion and contradiction. This is the reason why some psychiatrists are inclined to question the term "therapist" as far as the music therapist is concerned and others want him to be more of a "therapist" than a musician. And this is the reason why a certain amount of suspicion exists between the two groups, since the music therapist seems to assume a function for which he is not prepared, or feels compelled to take on more than he can handle.

The situation would not be as tense and involved, had it not occurred at the present time of certain prevalent concepts within the field of psychiatry. Under their impact an aura of caution and apprehension prevails in regard to therapy. Many psychiatrists have not much confidence in the ability of patients to take things in their stride. An overprotective attitude is evident in regard to
all emotional, and particularly to mental disturbances, lest "defense mechanisms" are weakened, "ego strength" undermined, anxiety evoked. This apprehensive concern is pronounced if strong emotional processes are involved, as is the case in music therapy. Since emotions are regarded as irrational, fed by the depth of the "unconscious," one can never be sure of what will happen if they are evoked. A psychiatrist who is not so oriented does not share such assumptions. He is not afraid of the patient, nor of his emotions, which he understands as an expression of relationship. Neither does he fear any harm to the patient from emotional experiences. Even if a music therapist would greatly transgress his duties and limitations he could hardly do any more harm than is done by the prevailing conditions in institutions, the shortage and lack of trained ward personnel, the general atmosphere and all the other established procedures in institutions.

The music therapist, in turn, feels the uneasy ground on which he operates, from the point of view of many a supervising psychiatrist. Not being psychodynamically indoctrinated, he may, even have sound objections against some of the interpretations presented by psychiatrists, or recommendations against which his common sense may rebel. The difference of opinions between a psychiatrist and a not indoctrinated auxiliary therapist will have little significance in the more matter-of-fact atmosphere of occupational or recreational therapy. The impact will be much greater in the highly charged emotional atmosphere of music therapy.

Another factor enters the picture. In our democratic era team work will always require a certain amount of mutual respect, reflecting a status of social equality between the various members of the team. This does not mean that any one member may not know more about certain areas, or that the psychiatrist should not be in charge of the total therapeutic program. But being charged with a definite responsibility does not automatically imply a status of superiority. In this regard the psychiatrist is considerably handicapped. In his daily work he experiences an almost God-like superiority. It is difficult for him to extricate himself from this position. This is the more so if he has been trained to regard transference as the basis for a therapeutic relationship. The music therapist is often exposed to some kind of condescending treatment since the psychiatrist really cannot "explain" to him what he means. It is assumed that true insight in the dynamics can only be obtained through personal analysis. And there is little
chance that music therapists will be accepted for didactic analysis. For this reason his therapeutic endeavors will remain not only auxiliary, but handicapped, since he really cannot understand what he is doing.

On the other hand, the music therapist will find himself in alliance with other professional groups involved in therapy who struggle for their recognition, like group psychotherapists. At the present time, the uneasy status of many therapeutic groups leads to a hierarchic structure, one group considering itself superior to the other, and assuming a superior attitude of exclusiveness. As long as this situation exists, smooth team work will be difficult to obtain. Many of the existing conflicts and frictions stem from the lack of democratic organization, from a feeling of imposition and lack of status, with its inevitable resentment. As the therapeutic family grows larger, new perspectives for inter-professional relationships will be needed. Great progress has been achieved in establishing inter-professional harmony in the theoretical area; it is more difficult, but imperative, that the same harmony be established in the daily practice.

A few words about clinical interpretation given to the music therapist. Since I am not working in an institution, my contact is through private patients whom I refer to individual music therapists. My experiences with them are highly satisfactory. I found them open to suggestion, willing and able to carry them out, despite their lack of specific training in psychodynamics. In several cases the progress made in music therapy exceeded that accomplished through psychotherapy. In some cases the fear of, and distance to, members of the opposite sex, which was inaccessible in psychiatric treatment, was resolved in the emotional atmosphere of music therapy. Children who had responded little to either verbal approaches or play therapy, responded to the medium of music therapy. In each case the music therapist, discussing her observations, contributed to an understanding of the patient, and could carry out specific approaches designed to meet the therapeutic needs. It seems, therefore, that the clinical supervision of the music therapist should not pose any serious problems provided that proper communication between the psychiatrist and the music therapist is maintained.

However, some more specific training of music therapists in psychodynamics and group dynamics seems to be advisable. A therapist who understands the goals of the patient’s behavior is in a better position to deal with the patient adequately, and to
interpret correctly many peculiarities which may otherwise seem baffling. Every music therapist should acquaint himself with the psychological orientation of the psychiatrist with whom he works. While music therapy does not take place on the verbal level—with certain exceptions—it still is necessary for the therapist to understand the "logic" on which the patient operates.
PART III

MUSIC THERAPY FOR SPECIFIC SYNDROMES
It is gratifying that music therapy is turning its attention to the study of the needs of people in this area in specific terms, but in doing so great care should be taken that arbitrary conclusions are not drawn. Since music is recognized as a social art form it, of necessary, must be an important means of non-verbal communication. As therapy it should be, therefore, in forms that can be useful and understandable to the participants in a particular group. While much study in the evaluation of music forms that are effective has already been done, these studies are often approached with rather vague structuring and with preconceived ideas on the part of those involved. It would seem essential, however, that some goals for the therapist in music be clarified, so that each person in the field does not have to work on a trial and error basis and evolve his own theories out of his particular background, setting and experience.

There are basic reasons for sharing music in whatever setting it may occur. This effect of music is as evident in a string ensemble in a concert hall as it is in an institutional setting. An individual, whether actively or passively participating in a music session, seems to respond from his own emotions. When he is in a group of people, each in his own way participating in the activity, an empathic bond seems to be established. In the world outside of the institution, people are free either to choose their own groups for sharing this form of communication or to respond to music alone. Within an institution of any sort there is often less free choice. People are usually participants in a music session as a captured audience. Despite this often artificial and arbitrary structuring of the group, a feeling of empathy seems to exist among individuals participating in a music session. Differences in personality structure which often cause friction or indifference between individuals seem to be less obvious in many music sessions. The sharing of the music seems to form a bridge between the individuals who are present.

One problem of the music therapist is to enable people to have as much of a free choice as possible within the institutional setting so that people may feel a response to the music. It is in-
evitable that the therapist, out of his own needs, will feel more at home with music of a particular kind. He will, therefore, have a tendency to influence the music program accordingly. In any group of individuals who share this music with him there will always be some, and often many, who will respond with him. It is equally true that in any group some or many people will not be affected emotionally by the particular music in a particular program. It is then the problem of the therapist to lead the session in such a way that the choice is as much as possible a group choice rather than his own, and so broaden the number of people involved. When there is sensitivity to the needs of a particular group at a particular time, a powerful tool for strengthening relationships within the group is available for use. The shared emotional experience helps the individuals to feel close to one another. When this feeling of being in the midst of people who “understand” occurs, the fear of isolation from others is broken for a moment. This is no different in itself from the same experience anywhere in the world. It is only a less usual experience in an institution than in many other places. It may happen with hillbilly music in the mountain regions, with the singing of hymns in a church community, or with an evening of opera or chamber music. When the music leader is sensitive to the needs of a group, this bond is even stronger within an institution than in the world outside.

The people in an institution are brought together through the particular needs of their illness or social difficulties. Within the various groups, are people with as many differences in individual tastes, desires, and backgrounds as in a group of a similar size outside of the institution where no selective choice, on a personal basis, was used. The majority of activities in this setting are geared to treating or caring for the patients’ difficulties directly. Music, however, with its ability to stimulate individual emotions, reaches through the barriers of illness. Response to the music is from the needs of the individual regardless of his particular handicap. One rarely finds a person whose music interests are different during his illness than they were prior to it, even though he may feel an even stronger need for it.

However, owing to difficulties in physical or emotional areas, people have problems in relating to others. The music leader or therapist must therefore attempt to create a climate in the music sessions in which individuals who are participating may relax and respond to the music because of their own needs and
not from the needs of the leader. Members of groups should be selected for participation on the basis of their interest in a particular form of music rather than on the basis of the diagnosis of an illness, either physical or emotional. Whether a person joins a hillbilly band, the institution string quartet, the church choir or the dance group depends on his needs as an individual, not on his needs in this area as a schizophrenic or a psychopathic criminal. Only in creating the climate for the session will the leader be concerned with the illness of the individuals. As a leader, one would not expect a regressed catatonic schizophrenic to relate immediately to a large group as an active participant. But with the help of the empathic bridge of the music to which he responds as a person, and to which the leader or some one other person may respond similarly, he may dare to share his experience with that other. Gradually this bridge may be widened to contain several people without too much fear and he may feel at least temporarily that he can accept and be accepted by the group. This has nothing to do with what specific form of music was used, but that whatever form it was, the patient felt a response to it. He will respond, as a rule, when ill, to the same or similar forms of music that he did when well. The therapeutic use of this response lies within the area of making use of it as means of communication when so many ways of communication are closed to him, rather than stressing technical ability as a performer.

Evaluation of music sessions in the institutional setting are badly needed. Certainly sessions that are valuable to people with one syndrome, are not necessarily even helpful for a group with other symptoms. However, in evaluating the needs of particular groups and in what ways they are being met, a great distinction should be made between understanding what is going on in the way of relationships within the group through free communication, and what may be evaluated in terms of a particular music form. It is the structure of the session and the encouragement of initiative, spontaneity and self-confidence through the use of response to music as a tool that is the key factor rather than the attempt to pin down a specific factor in the music form itself. Similar values can be found in a session of song and a session of eager listeners at a music appreciation hour with an understanding leader. Patients are people wherever they may be, and as people they respond to music. Whether in prison, in a mental hospital, or in a school for the physically handicapped, as people
they will reach out when they are truly involved in a music pro-
gram. This involvement will come about when an understand-
ing and support is given to the participants as people and not
as patients. The therapist is using music to strengthen the in-
dividual's self-respect through his use of a non-verbal form of
communication and so enable him to relate to others. To the de-
gree that he feels rapport with the music therapist or the group,
to that degree he will be able to lay aside, at least temporarily,
the behavior patterns which isolate him. Study can be most valu-
ably spent in observing what was going on in the group or even
in a two-way relationship when this was possible for at least some
patients. The common principles in the music therapy program
are not only common to the various groups making use of this
tool in an institutional setting, but are also common to the other
disciplines.

Music therapy has its place in the total picture of rehabili-
tation when the patient, in spite of his difficulties, can use it
through the help of the music leader, as a means of communica-
tion or emotional expression.
It has been said that the extent to which an individual is able to adjust himself to another is the index of the extent to which recovery can be expected. If this is true then piano ensemble work is an excellent gauge for there is constant adjustment to one other player at least, in duets or in four-hand duos at two pianos, to two others in six hands at one piano, or to three other persons in eight hands at two piano combinations.

The strong factors of adjusting, sharing, and communicating which are characteristic of the activity make this a particularly suitable music assignment for schizophrenic patients. Catching the interest of persons who are seclusive, shy, withdrawn, and preoccupied requires an activity that is dynamic but yet not too assaultive, that subtly draws a patient along in spite of himself in a reality experience that is pleasurable. The healthy socialization and the drive together toward a common goal are antidotes to anti-social feelings. Enough concentration and application are required to counteract the pull toward shiftlessness and daydreaming.

The participants begin to communicate through the swing of the rhythm which they are feeling together, even with little conversation. It is a discipline which they are led into casually and informally. It is rather hard to continue to be apathetic against the subtle pull of a beat of which you are physically a part.

Self-consciousness, insecurity, inadequacy are lessened in the support of the small close group carrying through a piece to successful conclusion. Against the tendency to avoid responsibility is the necessity in a simple way of keeping one's own part of the whole moving "in time." A feeling of warmth battles against the old pattern of indifference and gradually attention and the stirring of interest defeats boredom a little. Negativism and resistance can gradually be overcome through repeated experiences of achievement in a performance where cooperation is required and becomes a habit.

Also important, that old enemy, the-will-to-fail, loses a little more each time there is success. It is challenging to see the
schizophrenic patient, who in the beginning stages of ensemble work insists over and over, “Oh, you know I can’t,” yield in the end to the reality, “But you did.” With awareness, he is finally and actually playing along through the passage, or the piece, and coming out right at the end, probably even with a flourish, for however simple the music there is always that nice finality to the do-sol-do feeling of the finale.

Let us work down from enumerating the healthy qualities of any large group effort to the specificity of this particular, small, music group-work at one or two pianos which is known as piano ensemble. Many elements of larger, more general group activity, non-musical, are also present in the small piano group. These are the advantages of group accomplishment of any kind, the satisfaction of working all together on a job with each responsible for his part, the values of socialization and the feel or support from others which is always comforting.

Move from these values of the broader activity to the particular advantages of large participation activities in music-making. Here there are the advantages listed above plus the invigorating stimulus of swing and beat in synchronized movement, the creative satisfaction of bringing out artistic feeling by interpretation through various uses of music dynamics and shadings. The togetherness of concerted activity is heightened sensually and emotionally in this shared experience, and also intellectually as the meaning of a composition is grasped.

Narrowing this down further to the advantages of any music ensemble which is small, but not piano exclusively, there is the virtue that, while still sharing an experience, the group is now small enough so no one feels lost or overwhelmed. Each gets individual attention and is more conscious of closeness to the other few in the group as persons. Each now contributes a known quantity, an identifiable part of importance.

Finally we come to the completely specific small piano ensemble group. While we find it embraces these several other points of value in the larger activities, plus those of the small mixed instrumental ensembles, there seem to be still further identifiable elements of importance unique to this activity. There is the physical closeness of seating, two at one piano, using the same instrument and the same music, which one does not get with two instruments, two music stands, and different copies. Even two people at two pianos, as in a duo, have the feel of oneness in that the placement of the pianos is almost always either
by dovetailing so that the strings are all together, or by a side by side arrangement of uprights so that the keyboard seems to run on from one piano into the other. There is the shared identity of problem—not two different kinds of instruments with different problems, one isolated from the other—but each person having identical keyboards, the same pedal problems, the same fingering problems. There is still more intimacy when three play at one piano, and more solidity and feel of power when four players are at two pianos. Whatever the grouping, along with the togetherness in performance there is always the nice interplay of complementary harmonies and themes typical of piano ensemble arrangements, and the tossing of the melody or its accompaniment back and forth. And there is a strong feeling of needing each other to make a successful whole. The melody needs the bass. Each piano needs the other. But more important, each person in the group needs each of the others. And the total artistic whole of the production is made by the group as a whole creating together a pleasing and satisfying performance, possibly for other ears, but with the primary importance being their own pleasure and satisfaction in the experience.

For successful piano ensemble coaching certain techniques must be understood by the therapist. First, the group must be chosen purposefully. They should be of approximate skill so that no one feels too inferior or, on the other hand, no one too bored. Quite often, however, good attitudes can be encouraged by some one more skilled helping a slower one, or being a good enough sport to play along in a group to make it go better for the others even when the music is too easy to be a challenge to himself. Sometimes it may be well for the group to have to put up with one unpleasant person in order to help that person, and thereby increase their own tolerance. But except where there is particular reason and intention of this kind it is, on the whole, wise to choose the group so that there will be a healthy challenge to each, musically, and a comfortable balance of behavior traits which insures that the experience will be “fun” for all.

Second, choosing the music is important. There is ample pleasing music in piano ensemble literature at all levels and for all arrangements. There is virtue in sight-reading a lot of different material. There is equal virtue in stopping to polish the performance so that it is really musical and therefore satisfying and mature. It must not be too hard, for the joy is in the mastery. Better to do the simplest number with style, ease and
shading than to stumble along badly in something too hard to master at that moment. Here enters a good ideal in therapy, for there is always tomorrow, and next week in which to improve for the later, harder music, through the effort of today.

Third, the group must be given the security of understanding certain fundamentals so that in doing this thing at all, together, they know what the finished job should be like, and also how to achieve that goal. This requires guidance and exploration in at least four directions: a) in sensing the artistic interpretation of the piece—and that applies to the simplest number as well as to great compositions; b) in understanding the mechanical problems of the piece, the timing, key signature, rhythmic patterns, and in anticipating hard spots (the technique here is to take a few moments to look over the piece before you begin, to sense and hear how it will sound, and to be ready for what is going to happen musically when you get to the actual playing); c) in acquiring poise in the activity—ease at the piano, sitting correctly, which will in the end be the comfortable way, using fingers the way that will work, not crowding each other physically, sensing the others in the group in relation to your own part, keeping your eyes upon the music and reading phrase lines rather than single notes; and lastly, d) learning something of the special "tricks of the trade" in ensemble playing—how to get started together so that you are sure, and not worried about it, how to hear that opening measure before you play it, how counting helps in combing out the snarls, how to ignore a mistake or an omission and go on without worrying about it, returning after to work out the problem spot, how to mark measures so you can find easily the places which need extra drill. Finally you have the cream of the adventure, the polished performance, in which all experience success, and are aware of their poise and feelings of security.

This activity becomes absorbing for every participant. Once past timidity anyone who plays at all finds it exciting and good fun to do ensembles. For the schizophrenic patient who so often maintains memory powers intact and some mental function unimpaired this is an ideal activity, because at the same time that it helps to keep him mentally alert it offers good therapy for his emotional and personality problems.
MUSIC THERAPY FOR THE CRIMINALLY INSANE AND THE PSYCHOPATH

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In this paper, the patients referred to are those who are called Criminally Insane, or who are one of the various types of psychopathy sent to the hospital primarily for the purpose of maximum security.

Until the recent opening of the new Maximum Security Hospital at Atascadero, the Mendocino State Hospital differed from other California state hospitals in several respects. It has a maximum security unit which houses about three hundred patients. Criminals from all over the state are sent to our hospital for maximum custodial care and treatment. Because over five hundred patients have criminal charges, an overlapping of responsibility exists between the hospital and the courts. The hospital receives all the sexual psychopath commitments from the northern half of the state. Specialized therapy programs are utilized for this group.

In discussing the use of a particular type of treatment procedure for the sexual psychopath, we must carefully consider the type of individual which confronts us. Most patients committed to a state mental hospital under one of the several California code sections provided for criminally insane commitments are sent to the maximum security unit, as well as patients under mental or other commitments who are considered security risks or dangerous.

There are five so-called criminally insane commitments. Penal Code Section 1026 provides for confinement in a state hospital for those who commit a crime and are found not guilty by reason of insanity. California law provides that an act committed by an insane person cannot be a crime, because he is unable to distinguish between right and wrong. If, after a year's confinement, it is the belief of the hospital superintendent that a patient under this commitment has regained his sanity, the patient must be returned to the court to determine whether or not he should be released. Penal Code Sections 1201 and 1370 provide for the confinement of persons found to be insane prior to or during their trial. These are sent to the hospital before
judgment, and returned to court if they regain their sanity. The final group of criminally insane commitments are those under Penal Code Sections 2684 and 3701, transfer of insane prisoners from a state prison to a state mental hospital.

We turn now from the criminally insane to the psychopaths. The new Standard Psychiatric Nomenclature is Sociopaths, but we use the more familiar term, psychopaths. In the commitment of the psychopaths as such, we are provided with four different commitments ranging from ninety-day observations to transfers from Youth Authority facilities; the delinquent is from ninety-day observation to an indeterminate commitment.

From this brief résumé of types of commitments it is evident that these people do not come to the hospital because they feel that they need help, but rather they are placed there because they have violated one or more of the laws of our society. Their offenses vary from vagrancy to homicide. Although the various commitments may fluctuate in expression, from state to state, their essence, however, will remain somewhat constant.

One might say to all of this, "So what!" A mental patient is a mental patient, whether he has committed a crime against society or not. This is partly true. However, it must be remembered that a great amount of unconscious emotional motivation goes into the making of an offender. The main difference between the criminal and other types of mental illness is best stated by Abrahamsen: "A criminal turns his aggressions outward and often gets locked up, whereas in other forms of mental illness the person turns his hostilities inward, and thereby, in one way or another, locks himself up."1 In the criminal are found great emotional difficulties resulting from family tensions and emotional deprivations. Homes where there are tensions as a result of resentment, bickering, nagging and the like, seem to set the proper climate for the would-be offender. The offender against society must get rid of these hostilities he has built up, and giving vent to his feelings is a momentary release of pent-up hostility. Many other factors permeate criminal acts, such as the faulty development of the superego, strong guilt feelings, or obsessive-compulsive behavior. All these, incidentally, seem to originate in the home situation. The majority of criminal commitments are found to be psychotic, mainly of the paranoid

dementia group. A fair number of psychopathic personalities are also found in this criminal group.

The constitutional psychopath is undoubtedly one of the greater problems in a maximum security situation. As Branon states:

The psychopath is our greatest single cause of a disruption of the interpersonal relationship of the patient. . . . He will take great delight in teasing and taunting a psychotic patient until he blows up; he will be the leader in planning escapes from the hospital; he will be openly defiant about obeying orders; he will turn "informer" and tell lies about the behavior and the plans of other patients.¹

These are but a few of the vast number of antics this individual will attempt. The age span of this group is somewhere between seventeen and thirty.

There seems to be great controversy throughout the literature as to what really constitutes a psychopath. I do not believe that any one definition is generally accepted. The essential feature of a psychopath is that he has a behavior disorder which prevents him from making a satisfactory adjustment to the society in which he lives. Such terminology as emotional instability, undue conceit, lack of common sense, social feeling and self-control, would all apply to this individual. Actually, he is the type which projects his own insecurity by blaming others. Generally speaking he is a highly excitable individual. This may result in many antisocial manifestations, ranging from being truant from school to acts of violence, such as robbery or brutal sex attacks. However, one should not be led so far astray as to believe that because a patient has committed a series of various crimes or is terribly antisocial, that he is necessarily a psychopathic personality.

As therapists, whether we work with music or with some other tool, several factors should be kept in mind. While it may seem a bit trite to mention it, each of these patients we have been discussing must be regarded as a person, a sick person. As one authority relates in connection with a maximum security situation, "Although all of our patients have committed violent

and serious offenses against society, they are mentally ill people who respond to the same methods of care and treatment used for other mental hospital patients. Even though these patients are legal commitments in a maximum security situation, they are there for treatment, which should include a permissive attitude. This attitude is opposed to the old attitude which classified the patient as a once-human-being who has sinned. Objectivity must be accepted as a goal. This means recognition of the fact that we shall like certain patients better than others, but that we shall do our best for all, no matter whether the patient's offense was murder or a series of petty thefts or misdemeanors.

Often we may be fooled by the superficial feelings of the patient which he frequently projects. It is highly essential, in the case of the psychopath, to know the dynamics of his illness so that one may not feel threatened, shocked, or amazed, by anything the patient may reveal in the patient-therapist relationships. We must constantly be aware that this group, as a whole, are all striving for attention, and will lure the therapist into a situation in which he will find himself emotionally trapped. It is also highly essential to realize that this group is anxious to relate themselves to anyone they can trust or with whom they can feel secure, even though this may not appear outwardly. Our chief psychologist at the hospital states that conflicts of the psychopath with society are actually conflicts with his father, with whom he has never been able to identify.

In my estimation, one of the key factors to therapy as such for this group is that the therapist must truly love life. If the therapist does not enjoy life, how can he instill in the patient a desire to fit himself for his return to the society that has placed him in this situation? A smile is often more effective than any method of restraint.

The treatment procedure for the criminally insane is essentially no different from the treatment of the psychotic in any other hospital, with the exception that he is in a very limited environment which will set forth a certain group of emotional reaction patterns. These emotional reaction patterns will be discussed in relation to the whole group in the maximum-security situation. For the psychopath we must accept a short-term goal whereby the patient is allowed, supposedly, to guide his or her own course of treatment. Here the approach of the music thera-
pist is definitely an important thing. He should have the same attitude as that of Diethelm: "The psychopathic individual has inherent potentialities which permit him to function adequately, if not successfully, if the right situation in life can be found for him."

In carrying on an activity program with this group of patients we shall encounter certain emotional reaction patterns which must be alleviated, or at least re-channelized. These include: fear, anxiety, suspiciousness, guilt feelings.

_Fear_ is one of the stronger reactions commonly encountered. By an accepting, understanding attitude, the therapist avoids arousing fear whenever possible, or will control it to a degree with the influence of music. This helps the patient to understand that a world with such beautiful music cannot be so fearsome.

_Anxiety_ is often found in groups of these patients. Verbal reassurance and some praise, within realistic bounds, seem to be the most helpful here. The relaxing agent found in music is employed in these instances.

_Suspiciousness_ is a strong factor in the make-up of the psychopath. He is apprehensive of having demands placed on him to conform to rules or regulations. The therapist must convince him that the therapist's interest is real and completely sincere.

_Feelings of guilt_ are especially prevalent among the criminal group. Their guilt feelings have played a major role in the onset of their psychoses. The patient with guilt feelings seldom is consciously aware of the source of those feelings. A permissive attitude of the therapist is very strongly therapeutic, since it becomes obvious to the patient that no one would go to the trouble of singing or playing beautiful music to a person actually as bad as the patient feels himself to be. Of course, hostility is often encountered, but isn't hostility a natural part of mental illness?

**Types of Activities**

Types of activities with these patient groups tend to be very similar to those for other groups, with a few exceptions. The exceptions occur primarily where the psychopaths are concerned. They have a tendency to work in groups. Each group seems to have a leader, or one who makes all vital decisions. Such a group should be carefully controlled, especially where the

members are working under minimum supervision. The therapist should at all times be alert to the great variety of ways they will utilize to gain attention. This should be carefully handled so as not to disturb the therapeutic climate, where several types of patients are in attendance.

Activities of this group in our hospitals, which a fair percentage may sooner or later attend, include:

1. Dance, concert band, and orchestra.
2. Class instrumental and vocal lessons.
3. Vocal groups, choirs, community singing.
4. Dramatic and dance groups.

Band and orchestra are designed to utilize patients who play a musical instrument, no matter how well, in an ensemble group situation. The patient is taught to collaborate with the efforts of other patients and of the staff, in order to improve his or her own situation. In this activity, a certain amount of excessive egotism can be controlled, since demands are placed on the patient which he cannot realistically escape. The experience gained here will follow the patient to his community, when he returns, and will serve as a wedge to new social situations.

Class instrumental and vocal lessons are given with the primary objective of the patient’s gaining the technique to play or sing. As an interesting sidelight, it appears to me that psychopathy as such has an influencing force on the patient’s choice of an instrument. Pick the loudest instrument and you will find the instruments most in demand. The object of lessons is not to make professional musicians, but to give the patient the opportunity to gain the social recognition which he so greatly needs.

In the music and dramatic groups the patient is placed in a group situation, where all members work for a common cause. Here he has a chance to do something for other people, thus taking his mind off of self. The patient is cautioned that once he embarks upon a certain phase of this endeavor he must see it through to the finish. This, again, is a common necessity in dealing with the psychopath.

Vocal groups, choirs, community singing, are part of the program. These are particularly adaptable to larger groups and to all degrees of talent. The premise is held that the majority of people can sing in some fashion. Again the patient has the opportunity to carry something to other people—making him
conscious of his fellow men. Many smaller singing groups are formed right on the wards, with a little encouragement by the unfortunate professionals and semi-professionals who have found their way into this environment. Passive listening groups have to be controlled, with the psychopathic delinquents taking the leadership in selection of only the latest in "cool" music. Of course, this is a method of allaying their anxiety, but they can easily get out of hand. Unless this activity is closely supervised, the psychotic patient never gets a chance to hear the music he likes best. Another significant fact is the ability of the group of psychopathic patients to create. Creating means taking the most insignificant of materials and fashioning something of worth. As a whole, they are an industrious group of people.

"EXAMPLES"

After relating a few of the pertinent facts one finds in working with the criminally insane and the psychopaths, we ask ourselves: Do we really contribute to the rehabilitation of these patients? What are their chances of going back into society? What sort of prognosis do these people have? The criminally insane, in percentage of releases, are comparable to other psychotic patients. Of course, their actual release into society is a matter for the judgment of the court, and depends, too, on the type of commitment. In California close to eighty out of one hundred first admissions return to society.

After a ninety day period of observation in our hospital for sexual psychopathy, the patient is returned to court with the staff recommendations as to whether he may be considered a sexual psychopath, and whether or not he will benefit by care and treatment in a state hospital. Once this is determined, and the patient returned on an indeterminate commitment, every available form of treatment should be used. The most general length of stay in our hospital under the sexual psychopath commitment is around one year.

I want to give you two illustrations from the psychopathic or psychopathic delinquent group to show the wide range in realized potentials of rehabilitation.

Taking the first illustration, we start with a headline in a San Francisco newspaper: "Fifteen-Year-Old Girl Murders Elderly Man." Quoted from the news story are several statements made by the girl:

"I had a desire to kill. I wanted to kill my father."
The feeling I wanted to kill got stronger and stronger," the girl said with no show of emotion. "I took the pistol and hiked two miles up the trail to see Joe. We talked a while in his yard and when he went into his cabin I followed him... He was standing at the stove with his back to me and I shot him through the head. Then I threw down the pistol and hiked back down the trail."

Here is a part of the psychotherapist's report on that girl:

"Born into a disturbed household of all boys, the patient became the favorite object of the mother and father and of one of the older sons. Father and mother fought over her and projected much of their marital difficulty onto her. She suffered much open rejection and interpersonal uncertainty because she gave attention to one and the other rejected her. After years of disturbed relationships she apparently attempted to gain support and stable interpersonal relations by attempted suicide."

It was a year later that the killing took place. She was committed by the court to our hospital.

During the year and a half she was assigned to musical activities she spent approximately ten hours a week in such endeavors as social and folk dancing, private and group lessons, choral and dramatic groups. She was found to be most unreliable, and good rapport was established only when she dictated the action. In her private lessons, she wanted to change every few weeks to some new instrument, and her attendance, if left up to her choice, was very spasmodic. After eighteen months her psychopathic condition was only slightly changed, if any, due to musical activities.

The second of our two illustrations is more gratifying.

This patient, a boy, was diagnosed as psychopathic personality without psychosis, and he had a history of offenses from the ripe old age of seven years. At that age he was first brought to Juvenile Hall for being on the streets without proper supervision. Authorities reported the mother's hostility and rejection of the boy. School authorities described him as "shy, sensitive, and withdrawn." When he came to our hospital he had been in and out of state institutions of one type or the other for the
last fourteen years. His offenses, starting with burglary, built up to stealing cars and guns, and forgery. On initial contact the boy lacked responsiveness. But, he made a request to learn to play the saxophone, and this was granted. Many times he wanted to give up or to change to something else, but by perseverance, the therapist was able to keep him going. This patient, during the course of a year and a half, was able to learn the instrument well enough to become a leader, as well as to learn "doubling" instruments and orchestration.

The following is quoted from a report sent to the field worker when this patient left the Hospital: "Definite improvement has shown in patient, due to the interest of the music therapist and the feeling of adequacy he has received from learning he does have talents and has gained approval in the use of them." That patient now out of the hospital, is continuing to receive approval in using his talents because he was so fortunate as to be accepted into an organization that made it possible.

It seems to me that this may indicate a fifty-fifty chance of succeeding in the rehabilitation of psychopaths. If that percentage can be sustained it permits a very hopeful outlook and one to which we could well feel our efforts have been fruitfully devoted. We cannot select the objects of our efforts; we work with the material supplied us by human frailties in operation. Music is a tool of the widest acceptance in any group, both in and out of hospitals; it has more facets, more modes of application—through vocal work, through the wide variety of instruments, through group activity, through the allied arts of drama and the dance. The diversity of human needs is more adequately matched in the work of music therapists than in any other therapy, because of this variety and flexibility. Material of that most challenging sort is ours. We have every reason to believe that we shall effectively meet that challenge.
Many theories have been advanced as to how music began, but it seems that the most logical theory would be that music had its roots in the desire for self-expression and in the urge for emotional outlet. Primitive man derived much satisfaction from drumming out rhythms on the trunks of trees and on rocks, and much later the workers in the field sang songs of their own creation to lighten their chores and brighten their hours of toil.

Unfortunately, over a period of years, music has become so commercialized that the average layman thinks of it mostly as a commercial art. The phonograph, the radio, and television have made music so accessible that an overwhelming majority of people have become passive listeners who enjoy music, but never stop to think how this pleasure could be perpetuated if everyone were to take such a passive attitude.

So far as blind people are concerned, and their attitude toward music, it is interesting to note that despite the many recreational activities available to them, such as reading, dancing, bowling, swimming, roller skating and the like, they feel that their life and education would be incomplete without music. Many sighted people feel the same way.

The Lighthouse Music School of the New York Association for the Blind offers music lessons without charge to any blind person registered with the Lighthouse. No entrance examination is given; all that is necessary for the blind person is the desire to study. We provide all material, instruments for practice; and in many cases, carfare and transportation. Do you not think that many sighted people would avail themselves of such an opportunity if it were offered to them? It follows, therefore, that many blind people study music not because they are blind, but because it is a convenient experience to have, and because it takes the place of other recreational activities not available to them.

At present there are registered with the Lighthouse about 4,700 blind persons, of whom about two hundred study at the Lighthouse Music School. This approximates four and one-half per cent of the total registration. If four and one-half per cent
of the population of the United States were to take music lessons, about seven million people would study.

The Lighthouse Music School gives instruction in Organ, Piano (classical and popular), Violin, Viola, Cello, String Bass, Clarinet, Saxophone, Trumpet, Singing, Ear Training, Languages, all branches of Music Theory, Braille Notation, Staff Notation, Posture Training and Choral Singing. We have a staff of twenty professional teachers who give about one thousand lessons each month. Most of our students learn their notes from Braille or large print, but there are others who learn by rote or by ear, and in this latter group there are a number of therapy cases. They are taught individually and seem to get much pleasure from what they are able to learn.

Our large-print music is made at the Music School and is intended for those who still have enough vision to read it. We will now demonstrate the use of Braille music, how it is transcribed, and how it is memorized by the blind student.
PART IV

MUSIC THERAPY
FOR
EXCEPTIONAL CHILDREN
PANEL: MUSIC THERAPY FOR EXCEPTIONAL CHILDREN

CHAIRMAN: DOROTHY BRIN CROCKER

Director of Music Therapy
Shady Brook Schools, Dallas, Texas

INTRODUCTION

It is our hope that as we discuss music therapy for exceptional children, we think through what it really means to any child to have the joy of music, to have the love of music. We fully realize that each child, regardless of his capacities, i.e., physical, mental, spiritual and emotional, has music as a natural part of his heritage. The value of music can be presented to children in many different ways, with emphasis on the rhythmic, the melodic, and the harmonic, plus the natural association which we expect to find from the children in their responses. As the responses of the children are thought of, with emphasis on these musical ingredients, we are well aware of the fact that children respond creatively and naturally because music is a natural part of their very being. The rhythm, the melody and the harmony in their own bodies, in their own physical makeup, has an affinity to the rhythm, melody, and harmony in the music.
THE RESPONSES OF CHILD PATIENTS TO PIANO IMPROVISATIONS: A MEANS TOWARD DIAGNOSIS AND THERAPY

DOROTHY BRIN CROCKER

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For the past six years a method of using music diagnostically and therapeutically has been developing at the Shady Brook Schools. Under the direction of psychologists and psychiatrists the techniques used were being evaluated and the results being achieved carefully studied.

Many modifications of procedures have been made, but the findings bear out the theory that improvisation at the piano can serve as a means of establishing a relationship with a child that can be beneficial to him. This improvisation is not just a means of establishing good rapport, not just a surface relationship, but it is a means toward a relationship deep enough to help the child work out feelings of hostility, aggression, fears, negative attitudes, etc. This accomplishment, achieved through the medium of music, is aided by the kind of relationship the psychiatrist has directed the music therapist to build.

Maintaining an attitude of warm understanding of the child's inner feelings and a respect for these feelings is nearly always sufficient to avoid any trespassing into the realm of symptoms and defences which should be dealt with only by the psychiatrist or psychologist.

The basic principle of this method is that music composed or improvised especially for a child can break the barrier he has consciously or unconsciously set around his inner "self." It is as if the music therapist expresses in music his understanding of the total needs of the child. These needs have been made clear by the psychiatrist if there has been deviation from the so-called normal developmental stages. In improvising a piece on "Fear," it is as if the music therapist expresses in music the feeling, that this piece, which is the child's "very own," tells all about the things the child is afraid of, even some of those things he cannot explain in words. The child responds, then, either by telling a story or by creating a simple musical composition about fear. It is a means of self-expression, and as Andrews say, "It is
imperative for every child to have adequate opportunity for self-expression.”¹

The method involves four steps. Time does not permit a full description of all four, so only the second step will be discussed.

This non-verbal means of communication may arouse only a physiological or a physical response, such as a motor or rhythmic response, or it may stimulate a verbal response which may or may not be symbolic. Frequently it results in catharsis; occasionally an abreaction occurs. “To many creators and listeners the magical power of music lies in that its tones animate their dreams and lure them to those regions where their most secret desires are fulfilled.”²

The child comes to the music studio for a Music Interview once or twice a week. At the initial interview the music therapist tests the child’s ability to match tones and short phrases in singing, to carry a tune with correct rhythm as well as correct pitch, to clap rhythm patterns after one hearing, to identify high, low, medium, loud and soft after listening, as well as other simple measurements of the child’s musical responsiveness. His responses may change, and from time to time the same kind of test is repeated.

At the initial interview the music therapist says, “I am going to play for you.” The first piece is called “Raining.” When the composition is finished, the question is asked, “Did you hear the rain start pouring down real hard?” The music therapist and child discuss the different parts of the piece, and it is explained that a composer quite often tells a story or describes something or someone in the music, or a composer sometimes expresses in music some of the things he thinks or feels.

Next, the therapist says, “I am going to describe you in the next piece.” The description is spoken as the therapist plays the piano. In successive interviews a few minutes are spent with the child describing various people in fairly general terms of their physical description, with an occasional comment reflecting an attitude or feeling, such as “I don’t like him, he hits me.” The therapist plays what the child instructs him to play—not by note dictation, but by the child wanting a pretty chord

to say "she is sweet" or perhaps by singing a few notes to say "she is pretty."

Also, at the initial interview, the therapist plays a piece and asks the child to tell a story about the music. A careful explanation that there is no right or wrong story nearly always frees the child of fear of making a mistake and eliminates the worry of taking a test. This music, as well as the music improvised in subsequent interviews, is played in a key which corresponds best to the particular child and his treatment of aims. As yet there is no way of determining whether or not the choice of keys is important in evoking a more meaningful response, but every possible means of reaching the child is utilized.

The story elicited by the music and procedure of the therapist is written down as the child dictates, but if this bothers the child, a wire recording is made of the stories told in other sessions. As the child leaves, the music therapist comments appropriately, such as: "I have enjoyed this a lot. I hope you have, too. We'll do it again day after tomorrow." A time is set so the child knows the session is to be a part of his program.

This is a brief introduction to the procedure which progresses to sessions where music is played about anger, fear, love, things or persons the child likes, dislikes. Unhappy pieces are played as well as happy pieces, and many others pertaining to attitudes which need redirecting, undesirable behavior, or areas the psychiatrist has designated as problem areas. The child responds with a story. Failure to respond is also meaningful, and this is noted in reports to the psychiatrist along with the child's behavior and attitude during the sessions, in addition to observations and comments of the therapist.
MUSIC THERAPY FOR THE MENTALLY DEFICIENT

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Read by
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The material in this paper is based solely on experiences with the feeble minded—not the mentally ill. According to the opinions of some authorities it would seem that a music therapy program for the mentally ill would point to an eventual cure with the restoration of the patient to society. The true meaning of the word “therapy” is the treatment of a disease with the purpose of healing or curing it. Therefore, since there is no possible cure for mental deficiency or feeble mindedness, we will only use the word “therapy” in its broadest sense. Why not say treatment for the purpose of possible rehabilitation and successful living in society?

When I think of therapy in music I see a great wilderness, the surface of which has scarcely been broken. I think of a frontier in which we are the pioneers. There is much we can do, and there is much we must yet learn. In order that we may establish a clear picture of our goal, and place its subordinate parts in true perspective, let us try to name an area in which our music program can be most effective in the treatment of a mentally deficient patient. Perhaps some of you will disagree with me or will want to modify my statement. However, I am going to name as our No. 1 aim, by which we can strike most effectively in the rehabilitation of our patients, the area of "social adjustment."

At Muscatatuck State School our music program consists of music appreciation, community sings, rhythm bands, tonette band, fun band, instruction classes on band instruments, a uniformed concert band, drum and bugle corps, a junior choir, and a robed concert choir.
You ask, “Are we attempting to train our instrumentalists and vocalists to earn their living as such?” the answer is “No.” How then may we help these patients with the music program we have to offer? The answer again is social adjustment.

For example, our music organizations make many public appearances in and outside the institution, sometimes amounting to more than forty per year. Here they rub shoulders with people on the “outside.” They eat and visit with them, not as an inmate, but as one of them. They learn how to act and behave as normal individuals. The music they play and sing for their public gives them a feeling of accomplishment. Thus, they gradually lose the terrible feelings of inferiority and defeat that accompany them into the institution, and replace them with feelings of confidence and security.

Members of our music organizations also learn punctuality, self control, emotional stability, how to get along together and work as a team, respect for authority, and courtesy. Their span of attention is definitely lengthened. Their ability to read and calculate is improved and their performance level is raised. In my opinion all of these factors contribute to the social adjustment of a patient.

What contribution can we make toward the future rehabilitation of a mentally deficient patient that is more vital than this? Of course, there is job training to be done at the institution. I sincerely believe, however, that an employer who would employ one of our patients would say, “Give me the boy or girl who is socially adjusted, and I will train him to do the job.”

We have already pointed out how actual participation in music classes can promote emotional stability. Frequently, I have patients report to my classes in an upset or disturbed state of mind, and leave with a smile on their face and a new spring to their step.

One of the easiest ways to reach your patient is with rhythmic music. The members of the drum and bugle corps enjoy marching in parades. The members of the band like to play military marches and other rhythmic selections. In community sings patients respond enthusiastically to “action” songs.

In fairly recent years it has been noticed that the brain itself functions in rhythm. Laboratory research has discovered rhythmic waves in the brain that are constant in frequency and
are influenced by various physical and mental states. It has also been found that musical rhythm has a definite effect on brain rhythm, and therefore on brain function.

Although much that we have to say is still theory, I firmly believe that a well executed music program will not only serve to temper the patient's emotional and spiritual states, but will also stimulate their weakened minds to greater activity. Music can perhaps help remove blocks and barriers that will permit the child who has limited intellectual ability to function closer to his upper limit.

It has been the intent thus far in this paper to suggest that music is a vital factor in helping to stabilize man's emotions; that it has effect on the functions of his brain; and that it has the power to reach the innermost recesses of his personality. Some of the theories of the influence of music on the human personality still need clarification through more complete investigation. The gross aspects of the power of music, however, are easy to observe. If this power is to be effectively used therapeutically its use must be based on sound methods.

My first task at Muscatatuck was to organize a band. I soon bumped into a stone wall when I attempted to teach my boys and girls to read even simple music. Some could scarcely read or write. Some had I.Q.'s of less than 50, but all had some musical ability and a strong desire to play.

One day I noticed a certain boy not looking at his music book, but at a special paper on which some peculiar looking symbols were written. I discovered that he had written an exercise in a code all his own, which he said meant more to him than the music book.

If these crude symbols could assist this boy in playing an E♭ tuba, why couldn't a code system be adapted to all instruments of the band? After a great deal of experimentation such a code was developed and prepared for copy-writing. For the past few years it has been a tremendous help toward teaching patients of low I.Q.'s.

In conclusion may I add that in working with mentally retarded children our approach to a problem should always be a positive one. The negative approach will cause a negative reaction which lowers their level of resistance to defeat and failure, that we are trying so hard to help them overcome.

The positive approach encourages them to strive for that
feeling of accomplishment which in turn vitalizes and energizes their efforts in going from one success to another.

If we can simplify our learning steps so that they are a series of successes, we will have our patient on the successful road to rehabilitation and social adjustment.
MUSIC THERAPY FOR JUVENILE DELINQUENTS

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At the Child Study Institute, a department of the Family Court Center or Lucas County Domestic Relations Court, we deal with pre-delinquent and delinquent children, predominantly of teen ages. Physically handicapped, mentally defective, and psychotic children comprise a very small percentage of the total intake. All of the youngsters, however, who come to the Child Study Institute, have serious social and psychological problems, at home, at school, or in the community in general. Their basic needs for being wanted and loved have been threatened or unsatisfied.

It is the work of the Child Study Institute, as a department of the Court, constantly to study these difficulties while the children are detained and to report all pertinent findings so that the Court Referee can make adequate disposition of cases.

We describe our work by what we call the three “D’s”. These rank in the order of their importance: diagnosis, diversion, and detention. Of course, the work of the Court does not completely stop there. It also includes recommendations after diagnoses have been made, and follow-up of the children long after they leave the Child Study Institute.

How does Music Therapy fit into this picture? There are problems inherent in such an institution as this, because the youngsters are detained for relatively short periods of time, anywhere from a few hours to several weeks, depending upon circumstances. The music therapy program has had to adapt itself to the rapid turn-over of the Institute’s population and the consequent unpredictable changes in individual and group moods.

Music Therapy in conjunction with the first of the three “D’s” (diagnosis) is utilized regularly. The diagnosis is conducted chiefly by probation counselors and psychologists and, in a few serious cases, by our consulting psychiatrist. These staff members are aided by other personnel working directly with the children. The group music activities (group-singing, musical talent shows, musical games and quiz programs, music appreciation classes, hymn rehearsals and classes in auto harp) provide the music therapist and other attending staff members with opportunities to
observe reactions of the individuals of the group to each other, to staff members present and to the total situation. Singing proves to be the most effective group music activity. Popular and hill-billy songs bring about the most favorable results, including emotional release and better social adjustment. Other group music activities, especially talent shows, and musical quiz programs, afford legitimate opportunities for attention-getting and recognition.

When music is presented for diversion, the boys and girls respond to the various music group activities with a good deal of freedom. Because of the very nature of the music used they seem to lose much of their physical and emotional tension and many of their inhibitions. Thus the staff is able to note behavior patterns which might not be manifest during interviews with probation counselors, psychologists, or outside agency case workers. These observations are valuable, of course, when reported to the proper court or agency workers, who frequently gain added insight into their particular cases. Although the personnel at the Child Study Institute make special effort to create a friendly relaxed environment, the children's strong emotional drives frequently overpower and change this atmosphere. Feelings which the children exhibit include the entire gamut of emotions. Combine these emotions as found in fifty-plus boys and girls of assorted ages, interests and backgrounds and you can understand that there are problems which must be met in carrying on a music therapy program at Lucas County Child Study Institute.

A good many authorities stress the primary value of rhythmic responses in group control. My experiences with the children indicate that the unconscious rhythmic responses to music geared to their mood level are of considerable value to the music therapist in gaining attention and modifying unfavorable individual and group moods. Rhythmic responses are also an aid in emotional and physical release of inner tensions. However, I have had to discount partially the value of conscious rhythmic responses with the more sophisticated children. For instance, any obvious plan to secure voluntary rhythmic reactions may evoke the following situation: a small non-conforming group within the main conforming group may determine to alter response to the music activity. Their attempt may take the form of clapping hands, tapping or stamping feet, etc., in a different rhythm.
Possibly this is an indication of adolescent will to be independent, to bid for attention or to attempt to disrupt the group either just for fun or to "get even." In any case it destroys whatever therapeutic values may follow the hoped-for rhythmic responses.

The music therapy program is also of considerable importance when directed toward individual children. Observations of a child's behavior when receiving individual work from the music therapist are reported to the assigned case worker, psychologist, and referee, thus contributing to the diagnosis of the child's problems. Findings pertaining to the nature and degree of musical interest and ability are also given to the proper persons and such information is helpful in planning for the future.

The following case history is a good example of how an individual child is worked with by staff members in the various departments of the Court, and how a child reacts to the Court program. It also points up the role which music plays in helping to bring about a better understanding of the child with serious social and emotional problems.

Thirteen year old Joyce R. was first brought to the attention of the Court in 1952, on a complaint of stealing kitchen utensils from a neighbor. Among her problems were lying, stealing, and disregard for authority. She was considered a problem at home and school. After a Court hearing she was released to her parents, placed on probation and given psychological counseling as an outpatient. She returned to C. S. I. last fall charged with delinquency and admitted having had sex relations with several boys. From this time until late this spring she was in and out of the Child Study Institute several times.

Joyce had a brother seven years younger than she. Her father was steadily employed, was quite active in athletics, was a strict disciplinarian and probably expected too much from the children. Joyce's mother was a more easy going person, and rather ineffectual regarding discipline of the children.

Psychological and social investigations rounded out the picture of Joyce and her problems. It was brought out that her parents did not reward her for good behavior, nor did they praise her sufficiently for tasks well done. Her mother admitted on one occasion that she had never wanted Joyce to be born.

The Wechsler-Bellevue Intelligence Scale for Children indicated Joyce has dull-normal intelligence, I.Q. 82; Verbal 84, and Performance 83. The Rorschach indicated that Joyce is not
Joyce's emotional development seems to have been blocked since the birth of her younger brother for whom she had feelings of hostility. This younger child has always been an aggressive attention getter. Joyce often behaved on his level as evidenced by such infantile mannerisms as crawling around on the floor in an attempt to gain attention. She seemed generally unwilling to act her age. On occasion, however, she has displayed behavior on a more adult level by doing such things as gathering and selling junk. She seemed to want to be identified with boys. It was noted by the C. S. I. staff that Joyce developed crushes on two girls with boyish characteristics as well as on the boys at the Institute.

Because Joyce evidenced an interest in music, she was given Gaston's Test of Musicality. The therapist also devised other tests for her. (This is the usual procedure in such cases.) Joyce often asked to borrow the autoharp on which she would play for long periods. This seemed to relieve her emotional tension. Because of her frequent requests for piano instruction she was given a few lessons, in short periods to fit her extremely short attention span. These lessons were terminated because of apparent lack of interest and musical aptitude. Then, during the winter, a staff conference was held regarding her recent acutely disturbed state. According to one of the reports, Joyce's behavior at C. S. I. went beyond the aggressive behavior of the most unruly girls on the floor. At the conference the staff members present were informed of her manifest interest in learning to play the piano and of her constant requests that the music therapist take her to her office for piano lessons. It was then decided that Joyce should be rewarded for good behavior by being allowed, among other things, to come for lessons and to help with little tasks. This policy was carried out and piano lessons were resumed.

Joyce was, at first, restless at the beginning of a lesson, but would usually become calmer as the lesson progressed. She was able to concentrate for only ten or fifteen minutes. After this period she would become restless and appeared to lose interest, whereupon the music therapist would stop the lesson and let her talk about anything she wished for a few minutes and then return her to her section. Within two or three weeks there was a very marked change in her attention span, as evidenced by her ability to concentrate fully for better than half an hour without
any signs of waning interest or fatigue. She was reluctant to have the instruction period come to an end and called the therapist’s attention to the fact that she had worked at her music for more than half an hour. She was obviously proud of her accomplishment in this regard as well as her achievement in learning to play “Home on the Range” with one hand.

Why did she learn to develop her powers of concentration? Could it be that perhaps she was fulfilling her serious psychological need for the undivided attention of an adult, who worked closely with her and showed genuine interest in her and what she was attempting to accomplish?

Joyce’s assigned psychologist had stated on numerous occasions that this girl responded best to persons who were strict in enforcing rules regarding her behavior. Joyce commented several times that she liked the school teacher at C. S. I. because, as she put it, “she means business, and she lets us kids know she’s the boss”. It is interesting to note that, although Joyce was one of C. S. I.’s outstanding problems, she got along perfectly with the above mentioned school teacher, who has a reputation for being a strict disciplinarian. Joyce was always quick to notice any hesitation or vacillation on the part of anyone in authority and immediately took advantage of the situation by giving the staff members a difficult time. She implicitly affirmed her respect for authority by responding to the consistently more strict handling of her behavior following the above mentioned staff conference. She continued to try her old tactics on occasion by using foul language and threats of violence, which she never carried out.

It should be noted that Joyce gave the music therapist absolutely no difficulty when working with her alone. She was always cooperative, respectful, considerate, and quiet when no other child was present. She was easily led and was very susceptible to even slight agitation in a group but responded very normally when alone with adults. She was affectionate and was not resentful when asked to comply with a request.

Her musical background was fair. There was some interest in music in the home; members of the family all liked to sing; there was a phonograph in the home, but no piano. Her mother told the psychologist that Joyce was always interested in the piano and desired to study. Her parents encouraged her in this, but no action was taken. Joyce expressed interest in participating
in school group music activities, yet stated that she disliked her school music.

Joyce would like to study privately. Piano was her first choice and accordion her second choice. This is easily understood because her behavior in any group activities at C. S. I. was non-conforming and frequently unacceptable.

It is interesting to note, for example, that whenever group singing was held and Joyce's emotional tempo was more rapid than that of the group, she did not respond to the music which was geared to the tempo of the group. She would fidget and try to distract those around her, for instance, by making obscene signs to the boys. However, when the rhythm, tempo, and emotional tone of the music were aimed directly toward her, she responded most favorably but only for a brief period, and it was often possible to modify her unacceptable form of behavior to a more acceptable one.

Music instruction seemed very definitely advisable. Although her capacity in music was seemingly small, her earnest desire for music instruction was a healthy indication and should prove a valuable asset to her as a satisfying pastime, an emotional outlet and a legitimate means of gaining some recognition.

Joyce returned home several times and each time refused to remain there. The Court then attempted to find a suitable foster home. Also during this unsettled period arrangements were made for her to study piano privately with a music teacher who was apprised of the situation and well-equipped to handle her. However, circumstances developed which altered plans. She was released again to the custody of her parents, pending foster home placement. But before any of these arrangements could be completed she became impatient and ran away. She was soon apprehended and returned to C. S. I. where the girls' referee, at Joyce's hearing, decided that she should be committed to a private training school, which would provide maximum security and firm discipline. Of course the plans for a foster home, as well as music instruction in Toledo had to be dropped. However, the customary music therapy report was sent to the school superintendent, along with her psychological and social history. Emphasis was placed on her need for private piano instruction.

Unfortunately, since she was admitted to the girls' training school last spring, she has made a very poor adjustment. Twice she has run away, and frequently she has been the agitator in
For Exceptional Children

plans of groups of girls to run away. All attempts on the part of the school staff to interest her in various extracurricular activities have so far failed. A special effort was made, in accordance with the music therapist's recommendation, to persuade Joyce to take piano lessons, but her response was negative. However, the school superintendent and the case worker have indicated that, though results of their efforts with Joyce have thus far been very discouraging, they are hoping gradually to bring about a satisfactory adjustment.

This story does not yet have a satisfactory ending. The case has been presented because it is typical of the Court procedure.

From foregoing remarks it can be seen that the music therapy program occupies a unique position in the overall diagnostic, diversionary and detention functions of the Child Study Institute. It works as an aid to the chief services of the Court. The results of the music therapy program take the form of small contributions toward solution or better understanding of the numerous problems of socially and emotionally maladjusted boys and girls.

To summarize: Music Therapy gives valuable opportunities for observation of the children. It acts as an acceptable means of diversion, thus easing tensions created by individual difficulties arising prior to and during detention. It assists in establishing healthy relationships among the boys and girls themselves, as well as between them and other staff members. It often makes possible the discovery of musical interest and ability. It modifies unfavorable individual and group moods.

Our Music Therapy program at the Child Study Institute would seem to have its greatest value as a means of communication, contributing toward a fuller realization of the motto of our Family Court: Attitudes are not changed by platitudes, but human conduct is changed by human contact.
“When are you going to take me?” “Take me first!” “It's my turn!” These are just a sampling of the welcoming reception the music specialist received upon entering the Convalescent Cottage of the Children's Center in Hamden, Connecticut.

Convalescent Cottage provides care for children with illnesses requiring convalescent conditions, from complete bed-rest to various degrees of limited activity. The program, planned primarily for rheumatic fever patients, makes provisions for children recovering from cardiac or orthopedic conditions, poliomyelitis, nephritis, asthma, and other diseases requiring short or long term care. There are no racial or religious restrictions at the cottage, which has a working capacity for thirty-five boys and girls, of ages eighteen years and under.

The staff includes a resident physician, attending pediatricians, a pediatric cardiologist, and consultants in various fields. There are two registered nurses, fifteen attendants, an occupational therapist, a part-time physiotherapist, a part-time music therapist, a part-time dentist, and a dental hygienist. The local public school system cooperates in assigning a full-time certified teacher. Plans for admissions, discharges, and case-work services are handled by a medical social worker.

Since convalescent facilities in Connecticut are limited, the medical social worker in selecting new admissions tries to select those who would not be able to obtain good convalescent care in a home situation. This means that the census is generally composed of children who have no homes or who are from broken homes, foster homes or institutions. Because of such difficult environmental backgrounds, the majority are emotionally disturbed and thus require special consideration for their emotional as well as physical needs. Unfortunately, circumstances do not always provide the opportunity to meet both of these needs. Also the children are frequently retarded both educationally and emotionally because of lack of opportunities to develop to their fullest capacities.

Physical conditions of the cottage do not permit the music
specialist to have a room set aside expressly for the program. There are two pianos, one in the living room, which also has a television set, the other on a closed-in porch which is used for six or eight patients. Whenever possible, the music sessions are arranged when these rooms are not in use.

Is the music program therapeutic? A good part of it is diversional and recreational. It is therapeutic in that it had some specific goal-directed activity. This goal-directed activity is recommended through the medium of a weekly staff conference or through consultation with the medical social worker. Let us consider first the case of an eight-year-old Negro boy whom I shall call Billy. Besides the physical complications of rheumatic fever which had left this boy with some heart damage, he had emotional problems stemming from a most disturbed family background. Because of poor living conditions and the constant concern of who would be caring for him from one minute to the next he was unable to concentrate, and the slightest upset would result in a temper outburst. For example, if I did not take him for a session the first thing Tuesday morning, he would interpret this as a form of rejection and work himself up to such a state that it then would be impossible to work with him. The boy was in need of a means of expressing the tensions which he so strongly felt, in a way that would not be damaging to his heart condition. The drums might have been a good musical outlet because he could release tension in the form of rhythmic beats and not have to be concerned with notes and placement of fingers. However, the youngster was determined to play the piano. Many sessions were frustrating to Billy because he was asking for particular songs but could not concentrate long enough to begin to grasp them. Because of this lack of concentration and limited past experience, he was not familiar with the alphabet and, thus, could not read. All the music expression had to be maneuvered for him by ear. We tried all sorts of methods. I would point to the note before he played it, but the resulting sounds were not rich enough and some of the rhythmic stimulation of the faster beat was lost. Finally, we both came upon a game that was satisfying. I would tap out a rhythm on the wooden case of the piano. He would then place his fingers at random on the keyboard and play back the rhythm. Then he would play a rhythm for me and I was to tap it in answer. He resented simple rhythms and my most complicated rhythms with syncopation and irregular accents were barely stimulating enough for him.
Billy had some difficulty in getting along with the other children in a group. He demanded a tremendous amount of individual attention and always enjoyed being the center of attention. We used the rhythmic game as a means of constructive socialization by inviting some of the other children to join us with Billy teaching them the techniques. The other children respected Billy's musical feeling and gradually he was able to participate in such a way that he felt that he was a necessary individual for the group game without constantly having to be the center of attention.

During the boy's stay at Convalescent Cottage, he acquired a good deal of facility at the keyboard. He tried composing and learned to enrich the sonority of the keyboard by the use of octaves in both hands. Just before he left he was thrilled to be able to read a little piano piece in a beginner's book which had three notes - A, B, C. His attention span was increasing and I felt that by correlating reading and music his literary ability might have been stimulated. After leaving, arrangements were made for him to have a piano in his foster home. Billy's physical condition will always dictate limited physical activity so it is important that he have an activity which he enjoys, yet is not harmful. With his social and medical history that goes from the Center to other follow-up agencies, the music therapist included specific approaches, goals, and materials used for this boy.

As another example let us take the case of eight-year-old Judy. She was emotionally disturbed and found bed-rest and the other restrictions at Convalescent Cottage practically impossible to accept. Judy interpreted rheumatic fever as God's way of punishing her for certain masturbation practices. At the time that her illness required hospitalization a sister was born, and the patient interpreted this arrival as a substitute for her place in the family. With the emotional tensions created by these faulty interpretations, and with the concern about her physical condition as well as other emotional tensions from family environment and adjustment to life at Convalescent Cottage, the result was an anxious individual whose anxiety was sometimes manifest in the form of temper outbursts.

Judy needed a satisfactory outlet for her creativeness. When I entered the Center one morning she eagerly showed me a poem that she had written. I suggested that she set it to music. Judy worked and thought so rapidly that I had to catch the melody of
a phrase on first hearing because she was unable to repeat it exactly a second time. The result, which was completely Judy’s own composition, was a well-constructed melody with good phrasing. Perhaps the words will illustrate this child’s need for expressing her feelings of guilt:

*God Helps Us*

We love God and He loves us,
He loves everybody too,
Because we are all brothers and sisters.
Cats and dogs and our pets too,
We love them and they love us.
God will help us to do the things we should,
And make us be good in school.
A-men.

The rest of the children in the Cottage were so pleased with the composition that they all learned the words and the tune. Whereas Judy’s temper outbursts were frightening to the children, her creative talents had drawn the group together and given her the satisfaction she strongly needed.

The following is an outline of specific music activities which have been found helpful in work with exceptional children:

I. Piano. The piano material is designed to illustrate the possibilities the keyboard offers as a means of communication. From a musical standpoint the actual music making is the primary consideration. The recognition of notes, time values, fingering, and the other technicalities involved in “traditional” piano playing are relegated to a secondary position.

A. Specific piano areas:

1. *Color Method.* This method has been accepted by all age groups at the Center. Any requested popular or folk tunes are transcribed into color. The melody line which may be played with one finger, one hand, or both hands is stressed first. The simple accompaniment chords consisting mainly of the tonic, dominant, and sub-dominant are arranged so that there is as little movement as possible in shifting from one chord to another. After some proficiency is acquired in playing the three chords, the next step is to learn to adapt a chordal accompaniment to melodies which are played by ear. (Patients with chorea have received satisfaction from this approach.)

2. A simple *basso ostinato* is effective in illustrating the pleasures of finger dexterity at the keyboard. For example, the following succession of chords, C Major, a minor, d minor, G Major chords.

3. Simple chordal patterns are arranged in a fixed hand position that can be transferred to any register of the keyboard and transposed to other keys:
5-3-1 for the tonic in root position
5-2-1 for the dominant seventh in first inversion
5-2-1 for the subdominant in second inversion
4. Simple duets using step-wise motion and placement of fingers in one five-finger position as well as familiar tunes arranged for four hands are popular.
5. A short individual session is more effective than group piano lessons.
6. A regular practice schedule may have its advantages with one of its benefits being the acceptance of some responsibility.

II. Musical Games.
A. One child as the leader taps out a rhythmic pattern either by clapping or tapping on a piece of wood. Another child tries to repeat the leader's pattern by playing it on the piano in any manner he chooses using one finger or chords. The listeners will accept any tonal idiom for this game. This has been a successful activity for several disturbed children who have strong rhythmic tendencies. In one or two cases this method has helped in increasing attention-span and concentration.
B. Bingo with adapted musical notation has been successful as a medium for constructive socialization and an enjoyable method of gaining facility in reading the first seven letters of the alphabet.
C. A felt board with musical figures cut out of felt provides a pleasurable method for learning some of the basic fundamentals of notation.

III. Group Sings.
A. The variety of musical interests of the children because of differences in age and backgrounds creates some difficulty in organizing successful sings. Small groups with members of approximately the same age may provide a possible solution; however, it is important to take into consideration the fact that some of the children, having been hospitalized before, may be educationally retarded and, thus, behind the normal age group.
B. Song sheets are helpful in holding attention.
C. Group sings are important at parties and social gatherings. If the children have been taught the songs beforehand, each child feels that he is really contributing to the success of the affair.

IV. Music Appreciation.
A. The children, having access to television and radios during their leisure time, are provided with the experience of living with a certain type of music.
B. The development of an appreciation of music providing more aesthetic enjoyment presents many problems. Because of the physical set-up of the Cottage and the limitations of listening facilities, it is impossible to control the type of music that is heard.

V. Rhythm Band.
A. This activity is used for group experience with children under ten. The ability to work with others and the respect for each other's likes and dislikes is encouraged.
B. It is an excellent method for releasing tension in a constructive rather than destructive way. Before returning the children to their beds, it is always advisable to quiet them.

VI. Other Instruments.
A. Song Flute. If interest can be stimulated in this instrument, it is an excellent means for the child to continue music activity after returning home. Note-reading is not stressed unless a child is ready for it, and frequently the number method is easier for a child than the actual reading of notes. A difficulty with these instruments is that sometimes the children are not able to discipline themselves to use the flute at an appropriate time and thus it can create a disturbance.

B. Bell Harp. This is a type of autoharp which has been used both for individual performance and duets as well as accompaniments for group sings.

VII. Marionette Shows.
A. The stage is arranged so that the children on bed-rest can participate either as puppeteers, readers, members of the chorus, or stage crew. A few suggestions are as follows:
1. The performance must be as simplified as possible.
2. The children should do as much of the work as possible.
3. The development of the marionette show from planning stages through the performance should not cover too long a span of time; otherwise, the children lose interest and the benefits of a group experience are lost.
4. If there are too many emotionally disturbed children, a large performance of this type may not be advisable.
5. Once work is begun on a performance, it should be carried through to completion.

VIII. Miscellaneous.
A. Ear training
B. Rote learning
C. Improvisation
D. Composition

A summary of some of the specific goals of the entire music program is as follows:
I. Pleasure in doing, just good fun
II. Socially acceptable means of releasing tension
III. Socialization
IV. Feeling of accomplishment
V. Better orientation and sense of reality; acceptance of intangible handicap and limited restriction in the case of rheumatic fever
VI. Development of hobby and activity interest which may continued after hospitalization is terminated
VII. Opportunity for creativeness
VIII. Improvement of concentration and attention span
IX. Means of communication
X. Satisfaction of personal needs, a substitute for other activities or lack of family ties
XI. Development of motor coordination
XII. Sense of security.

When an emotional crisis arises for a patient who has previously found satisfaction in releasing tension through a musical medium, it is sometimes necessary to rearrange the program and provide the extra attention promptly. The rheumatic fever victims with their somewhat intangible handicap frequently find it impossible to remain on bed-rest. Sitting at the piano and producing sound whether the result is more noise than music is probably less damaging physically than running through the halls. In view of the emotional problems that may arise at any time it is advisable for the music specialist to be fully aware of the medical limitations and social problems.

The music situation, if properly organized, can provide a good learning situation where the individual's positive rather than negative points are stressed. For the youngster who has been frustrated in most learning situations because of emotional stress and other environmental factors, this feeling of accomplishment cannot be measured in material values. Frequently, the most valuable contribution that can be offered to these children is the showing of a high regard for them as human beings, and a sincere interest in their welfare.

Music at the Convalescent Cottage of the Children's Center is not used primarily to achieve artistic goals. It is important to remember that the major concern is the improvement of interpersonal relationships.
MUSIC THERAPY WITH HANDICAPPED CHILDREN
AT THE INSTITUTE OF PHYSICAL MEDICINE AND
REHABILITATION: A DEMONSTRATION

BARBARA DENENHOLZ

Musicians Emergency Fund
New York City

For the past three years there has been a special music project for handicapped children at the New York University-Bellevue Institute of Physical Medicine and Rehabilitation. The project has been conducted under the auspices of the Hospitalized Veterans Music Service of the Musicians Emergency Fund. One hundred and twenty handicapped children have participated in the special music project; their ages ranged from two to eighteen years. The majority of the youngsters were patients with neuro-muscular conditions such as poliomyelitis, cerebral palsy, spina bifida, and muscular dystrophy. Others were affected by such orthopedic conditions as congenital deformities and amputations. Yet other cases were affected with various types of medical conditions such as cardiac involvement and arthritis.

Music was part of a total treatment program for the children, which included medical supervision, physical therapy, occupational therapy, speech therapy, special education, and psychological testing and evaluation. Music was used in individual sessions in many ways, with the goal of meeting each child's individual needs. Music was used as recreation, as education, and as therapy in an effort to aid each child to the fullest possible extent—emotionally, psychologically, and physically.

There has been one strikingly universal reaction in evidence during the three year period: the youngsters love music. Many have been introduced to music for the first time at the Institute. Letters from ten or fifteen former patients indicate that they are continuing their music at home. Eight children have come back to the Institute to continue their music, in some cases for as long as two and a half years.

Piano study is only one of many musical media which has been used. Singing and listening have been extremely useful activities. Rhythm instruments have values other than their recreational value. The collection of rhythm instruments at the Institute includes a small drum with handle and beater, a triangle, several different types of tambourines, several different

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sizes of cymbals, rhythm sticks, gong, wood block with beater, finger cymbals, large drum, small zither with song charts, color xylophone with song charts, bells, and glockenspiel.

Which musical medium will fulfill the greatest function for a particular patient? This has been our chief consideration with the children at the Institute. Is the child's need chiefly psychological, or chiefly physical, or, as in so many cases, is it a combination of both?

The two young people whom you will meet this morning are piano students, out-patients at the Institute. They are both teenagers. One is a post-polio patient, and the other a spastic cerebral palsied patient. Both children have been enthusiastic about music from the beginning. Both are serious, eager students, constructively self-critical, highly receptive, and show remarkably continuous, willing concentration. Both youngsters have displayed considerable initiative in their work, and tend to be perfectionist.

Sixteen-year-old Elaine S., our spastic cerebral palsied patient, was introduced to music at the Institute. After fourteen visits with music as an in-patient, she decided to continue her music at the Institute after returning home to live, despite the fact that there was no piano in her home. Elaine has had a total of forty visits with music in a nine-month period. The physical aims of music therapy for Elaine have been, primarily, to relax her rigid, spastic muscles and to help her develop better coordination of finger and hand movements.

The patient's piano work began with some rote pieces which enabled her to concentrate on proper aiming motions without having to concern herself with note-reading problems. Several weeks later, she progressed easily into the note-reading stage with some jumbo-sized note editions of pieces for alternating hands. The melodies of Elaine's first pieces required the use of only one hand at a time, thus enabling her to comprehend and translate into movement and sound the fundamentals of rhythmic continuity in music. The rhythmic flow of the music seemed to be a great aid in improving muscular coordination and aiming motions.

The simple Etudes to which we later progressed motivated Elaine to try to play with a legato touch. This is fiendishly difficult for a cerebral palsied youngster to master, and apparently far more complicated than the simple muscular act of playing notes which are detached from one another and merely require lifting
the hand to the next note. In legato playing, the shift of weight from one finger to the next happens invisibly, and is felt rather than seen. Elaine is gradually training those fingers to play a smooth legato, and one of these days she is sure to succeed completely.

The patient's progress has been greater than a description of the physical gains implies. Her sight-reading of new music shows marked improvement, and this has increased her confidence. She enjoys listening to records, and identifies themes readily from such works as the Prokofieff *Classical Symphony* and the Schumann *Arabesque*. She is thrilled at the prospect of having a piano of her very own which will be delivered to her home in the next few weeks.

When she comes out to play for you now, notice particularly in the first few Ganschals *Duets* her use of all five fingers in each hand, her success in two-hand coordination, her rhythmic continuity, and the volume of tone she is now able to produce. In the Kasschau *Pedal Etude*, notice her foot-hand coordination, her increase in speed, and the wide range of motion she can now achieve. Notice, too, Elaine's obvious fun and delight, and sense of accomplishment while at the piano.

Fifteen-year-old Evelyn P., our post-poliomyelitis patient, had studied piano for a short while as a young child, but had discontinued it due to lack of sufficient interest. She was assigned to music two years ago at the Institute. The recommendation on the prescription read: "To launch real and lasting interest." Evelyn had sixteen visits with music at the Institute before deciding to continue her music as an out-patient. She has now had approximately one hundred music sessions.

At the beginning, the patient's shoulder and arm muscles were so weak and her endurance so poor that she was barely able to keep her hands on the keyboard even for a few seconds at a time. She could play only a few notes, almost inaudibly, and then her arms would drop in exhaustion. The physical aims for Evelyn were not so much the increase of coordination, but rather the development of greater endurance, greater range of motion, and greater muscle strength. In order to achieve these goals, much thought was given to the selection of the music. The following is a chronological list of the music Evelyn has used:
1. Pieces for beginners
2. Short pieces by Beethoven
3. Opus 39 by Kabalevsky
4. Pieces from the Anna Magdalena notebook by Bach
5. Some 4-hand music
6. Etudes by Bertini
7. Etudes by Cramer
8. Sonata in G major by Mozart
9. Holberg Suite by Grieg
10. Arrangements of music by Vincent Youmans

In the selection of Evelyn's music, the greatest emphasis has been placed on pieces with wide intervals, chords, arpeggios, and liberal quantities of passage work. Four-octave scales have been valuable in helping her to develop greater muscular endurance. Evelyn's music has been especially selected to increase her muscular control and strength of arm, shoulder, finger, and hand muscles. Secondarily, we have worked to strengthen her right leg muscles through pedalling. Evelyn uses an adjustable chair, and a wooden block underneath the pedals which raises her feet to a comfortable and efficient pedal height.

Evelyn's progress in music, however, like Elaine's, has been more than physical. After just a few weeks of music, she was able to follow the score of the Mozart G minor Symphony by herself. She is an ardent subscriber to radio music program booklets such as the ones from New York stations WNYC and WQXR. She has tried her hand at composing, and has completed an original composition entitled "The Planets." She makes trips to music stores to buy her own music and records. Influenced somewhat by the example of her brother who is a music major at New York State Teachers College, Evelyn is seriously considering a music teaching career.

When she plays for you, notice particularly in the Grieg Norwegian Dance the wide range of motion she is now able to achieve through the continual left hand leaps to different registers of the keyboard. In the Cramer E minor Etude, notice her use of the pedal, her assurance and control of gradations of tone, and the muscular strength she is now able to call upon in order to produce a true forte.
FUNCTIONAL MUSIC WITH CEREBRAL PALSYED CHILDREN

VALLY WEEGL

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It is with sincere regret that I am substituting this oral report in place of the demonstration of motor-handicapped and cerebral palsied children, which had been originally planned. I am sure you share my conviction that a live demonstration of the impact of music on such a group of children would have been much more impressive than even the best paper that might have been prepared for you. However, on account of unexpected changes in fund appropriations, the music therapy program which was to be demonstrated, and which has been successfully carried on for the last two years, could not be resumed this fall. Therefore, the children could not obtain official permission to take part in the demonstration.

I had been looking forward to having you watch the children's joyous, spontaneous response, the effect of rhythm on their physical exercises, their redoubled efforts in almost anything they are supposed to do, if pleasurably motivated by music. Like many visitors from other schools, other communities and even other countries, you, too, would have realized that functional music is not a luxury, not a "frill", nor just pleasurable recreation, but that it should have its integral, constructive part in any good rehabilitation program, no matter whether for cerebral palsied, mentally, emotionally or orthopedically handicapped children. So many of these youngsters have to forego sports, dancing, active games, and many other good things in life which normal children take for granted that they need music even more than others to substitute for these "good things" as well as for its therapeutic value.

I have been invited to describe the plan which has been applied with good results to motivate improved function in physically handicapped children through the use of music and the application of rhythm. Part of this report has just been published in the October issue of the Cerebral Palsy Review and as

the time for writing an entirely new report was too short, I obtained the editor's permission to use some of that material for this paper.

"Sullivan divides behavior into two categories, those concerned with security and those giving satisfaction. When an individual is thwarted in the pursuit of these aims, tension and anxiety result. If satisfaction is achieved, tension is reduced." This general concept can effectively be adapted to techniques for working with physically and emotionally handicapped patients in the field of music in rehabilitation.

In the fall of 1952, Dr. William Benham Snow invited me to take charge of the special needs in music at Public School 85, the Bronx, which had in attendance 22 children with varying degrees of handicap. The children ranged from 4½ to 11 years. All school subjects and most fields of therapy (physical, speech, occupational) were in operation except music, and Dr. Snow was eager to have it included because he was strongly convinced of its beneficial value.

Several months prior to Dr. Snow's offer, in a demonstration at Columbia University's Teachers College, I had watched a cerebral palsied girl, who had rather poor coordination, vainly try to catch a ball. Yet, as soon as the ball started bouncing in an even rhythm her face lighted up with joy and she could handle it without further difficulty or feeling of frustration. Wherever I have visited or worked since then, I have noticed many incidents of that kind, as have any one of you who has worked in that field. I will never forget the happy expression of that severely impaired spastic child at the Carolian Center who had sat, dull and drooling, in her wheelchair, but when suddenly she heard the sound of a band she at least could move her head in time and succeed in crashing a cymbal against her wheelchair. This in itself was an achievement in muscle control for her, and an emotional outlet as well.

Indeed, musical stimuli can, at times, carry patients over seemingly insurmountable hurdles and be effective, not only for relaxation purposes, but for accomplishing other goals at the same time. It can serve constructively as an adjunctive aid in strengthening muscles, stimulating activity and improving motor coordination. A definite, carefully planned music program for

such handicapped children will also function as an outlet for aggressive feelings and pent-up emotions. It will clear the way for emotional expression and for integration with the group through adjustment to the tempo of others. Furthermore, participation in any kind of group music, no matter how small the part, can give the individual the feeling of being needed.

Whether you deal with cerebral palsied or other handicapped patients, they all want to be and should be treated as normal individuals wherever possible. Unless they feel that you are really interested in them as human beings—not just as in Case No. "so and so," or as part of your own set plans—you cannot even start to be of real use to them. Once a relaxed atmosphere of mutual trust is established, whatever you try or suggest will more readily be accepted and become more meaningful to them.

In the Public School 85 program we started first with clapping and stamping in simple rhythms, proceeded to a rhythm band; later, group singing and listening to music were added. The children learned to recognize beats, various meters, moods, simple musical forms, and instruments. Little children's songs were acted out—this they especially enjoyed. Use was made of the limbs for beating time or conducting, while supplying exercises to strengthen the weaker limbs. Some of the socially less adjusted children found conducting especially attractive as a means of self-assertion. Walking to a certain rhythm (with or without crutches, depending on the individual’s capacities) was practiced; some who could hardly stand securely or walk, tried a few dance steps.

To encourage children to do that which they enjoy and are able to do assures their cooperation. It gives them self-confidence and enables them to relax, and become more courageous. They gain a feeling of security and achievement, no matter how small this achievement may be. To the cerebral palsied child who constantly meets failure and frustrations and expects not much else, this opportunity for self-assertion is all the more important, and encourages him to go on trying. Effort is an essential component of improvement.

The establishment of a rhythm band can accomplish the goals because the rhythm band requires no previous training and gives the children immediate satisfaction. Drums, sticks, cymbals, triangles, and tambourines are used and the children, whenever possible, should be allowed to choose the instruments they
wish to play. A child’s choice is often a revealing indication of his personality. The timid, more withdrawn child will usually choose an inconspicuous instrument, while the more self-assured or aggressive child will reach for the drums and cymbals which they may need as an outlet for aggression. These children first start pounding at will, but by and by they learn to restrain themselves and to adapt to the rhythm of the ensemble. Also, it is heartening to follow the gradual development of some of the withdrawn and timid youngsters as they dare to handle the “aggressive” instruments and begin to enjoy them more and more.

We begin with a simple two-beat rhythm familiar to them from seeing people walk or swing their arms, in slow enough tempo to give each child time to strike his instrument, relax and be prepared to strike again. The time, however, should never be dragging and must be rhythmical enough to stimulate the children’s enjoyment and interest. Sometimes it may be necessary to have them play on each half of the bar, or even only on the downbeat of a new measure instead of on every beat. Only when 2/4 and 4/4 time have become quite easy and clear to the children should we teach them to beat time for 3/4 compositions.

After the children feel at home with these simple, basic rhythms, we can start combining rhythms with different dynamic effects. This requires greater control of arm and hand movement than before, and a new kind of balance between tension and relaxation. After the differentiation between forte and piano has become clear, we can acquaint the children with the transitions between loud and soft—crescendo and decrescendo. To accomplish this we may explain the idea of a band approaching from far away, reaching us, then fading away again into the distance. They enjoy creating that impression and think it more fun. They respond happily to any such appeal to their imagination and will participate by clapping, tapping or playing and singing.

Children love to recognize beginnings and endings of musical phrases, and to find out by themselves whether a song starts with an up-beat, what mood the music expresses, or what song is being played. It is good to start with easy, well-known children’s, folk or patriotic songs, and progress from there to lesser known, good songs, and also to classical music. Playing records and letting the children recognize instruments, tunes, musical form and structure (at least for the older and mentally alert
ones) is also a good means of capturing their attention and interest.

Whenever the choice is given, I feel that live music, suitable to the children’s pace and attention span, is experienced with more intensity, and elicits better response than reproduced music on radio or records. However, if one plays or sings music which the children have heard previously on records or TV, the pleasure of finding themselves on familiar ground and of recognizing the tunes played will give them much satisfaction.

After the rhythm has been played in unison to begin with, one can divide the children in two groups for playing phrases as questions and answers, just as one does in singing songs in that fashion. One can then proceed to three groups of instruments at different times, i.e., have the triangles start, then have the cymbals join them, climaxing in a combination of all three groups as an orchestrated crescendo; in reverse order they can produce a decrescendo. These are effects which they always enjoy. Picking out little tunes at the piano, then proceeding to the reading and writing of music can be done later as soon as their curiosity and interest has been awakened to know more about “how it works.”

Another important function of music is the instigation of more and better performance in physical exercises. I had experienced this myself when, some years ago after a serious shoulder fracture, just thinking of a rhythm or theme, and coordinating prescribed movements accordingly, helped me overcome the boredom and fatigue of many months of tedious, repetitious exercises. I then devised conducting movements for my impaired arm, and finger exercises for my temporarily useless hand. This helped me regain functional usefulness in both arm and hand. Since then, others have been helped by the same methods.

At Public School 85, likewise, the physical therapists have found that they achieve better results when the exercises are accompanied by rhythmical music and “action songs.” Movements such as stretching and bending, raising and lowering the arms to the tempo and dynamics of an ascending or descending scale, personifying windmills, bicycle riders or airplanes, can also be inserted in the regular music period without the children even suspecting that these might be “physical exercises.”

Other improvements may come simply by the children’s eagerness to grasp and use their instruments. Rita, a very alert but tense little girl, could not make her athetoid hands meet deliberately, but when I gave her some cymbals, which she once
proudly succeeded in clanking, she tried over and over again until she could do so regularly. This helped her toward better coordination of her hands which she can now use better for other purposes in daily life. Then there was Johnny, another athetoid youngster, who at first was hypersensitive to loud noises or music. However, after he once could play the “triangle solo” for the morning bells in “Frere Jacques,” he enjoyed taking part in the rhythm band. After a while he stamped lustily to some accentuated rhythms and even asked for drums and cymbals. When he could play these instruments himself, and knew when to make his entrances, the “noise” did not seem to bother him any longer.

In investigations reported by Schneider of the University of Tennessee, different effects of stimulative and sedative music were observed on athetoid and spastic patients respectively, which would deserve further follow-up. Also, you may be interested in Palmer’s findings in his study, “Musical Stimuli in Cerebral Palsy, Aphasia and Similar Conditions,” that congenitally aphasic children often have a keen sensitivity to musical stimuli, far beyond their ordinary apparent intellectual ability. This study also describes a method of changing the pattern of athetoid movements through acoustic stimuli, thus bringing about, at least temporary, normal relaxation. I should also like to mention here Grunewald’s study, “A Physiological Aspect of Experiencing Music,” in which is mentioned the delaying of the onset of fatigue through acoustic stimuli, as shown by the method of pupillography in pupillary reflexes to light. Other observations on pupillary response have been reported by Slaughter at the East Lansing NAMT Convention who compared pupillary movements of normal and abnormal subjects while listening to different types of music.

Music can further be used as an important adjunct to Speech Therapy. At school we found that, by singing and by thinking of the tune of a song, the children often not only could practice

better breath and vocal control, easier phonation and tone prolongation, but could also overcome at least some of those speech handicaps which are due to emotional blocks. Just as stammerers sometimes can sing a phrase which they would not be able to speak, the children may find themselves pronouncing words more clearly within a song as the rhythm carries them along.

Westlake, Director of the Speech and Hearing Clinic at Northwestern University, Evanston, Illinois, in his study, "A System for Developing Speech with Cerebral Palsied Children," has stressed the importance of getting cerebral palsied children as soon as possible to "establish a good amount of output of sound as an important step toward meaningful oral language." Normal children produce a great deal of experimental babbling and vocal play from which their speech emerges gradually "Likewise, the cerebral palsied child's speech is not apt to emerge from a vacuum of silence." Westlake also emphasizes the value of practicing phonation and tone prolongation through jingles and easy songs as a helpful device in speech training, and I was pleased to find some of our children's favorites, such as "Row, Row, Row Your Boat," "Old MacDonald," and others which we always used at school, on his "recommended list."

Even children with severely impaired hearing and almost no speech can sometimes more easily be reached through rhythm and music than through speech. Robert, one of such cases at the school, was first believed to be almost deaf until one day, as I was playing a rhythmically accentuated march, he suddenly started to beat time and to conduct remarkably well. Later, when I asked, "Who wants the drum?", it was he who first raised his hand, showing that pleasurable motivation could sharpen his sense of acoustic perception of language, which subsequently was further helped by a hearing-aid.

Palmer also reports observations on brain damaged children in whom often the posterior portions of the temporal lobe have escaped back pressure effects and injury. Studies on war injuries seem to have shown these to be areas of the brain subserving, among other functions, musical learning; therefore perception of music even in otherwise severely handicapped patients,

may be quite normal. "Out of the muddle then of the failure of integrative concepts of the injured brain comes the sudden clear concept of music. Obviously this handicapped child must receive great enjoyment in life from this." Palmer also believes the effect can be used to clarify other concepts of language. In the speech training of children with severe conditions the "approach through meaningful intonation rather than words seems to have better results, thus paralleling in space and time the development of the fundamentals of language in the normal child."

In an earlier study "Cerebral Palsy as an Educational Problem," Palmer recommends that "speech should be used in a low, soothing way when the child is about to fall asleep... When the inhibition is just irradiating over the cortex is the moment of greatest acceptance by the cortical areas of language and signals, and the moment of greatest speech motor facilities." It may be that this observation which, of course, applies to "normal" children as well, partly accounts for the fact that bed time stories and mother's lullabies usually are deeper ingrained and stay with us longer than almost anything else in life. This readiness of the mind before going to sleep—an observation which mothers of cerebral palsied children confirmed to me—could well be utilized in institutional and home instruction.

As has been stated before, a very helpful device is to use music in combination with anything that stirs the children's imagination. Have them act out songs with stories—anything the words or the music may suggest: if they sing about a postman, a policeman, etc., and one of them tries to be a postman or a traffic policeman, he will forget his expected stumbling block in trying to walk or in raising his arm, if it is possible. If he only does this a few times, he will feel encouraged to try it over and over again until the block may no longer exist to such detrimental degree.

A role which children especially like to play is that of a conductor, which induces contact with others and at the same time strengthens their ego. I remember Philip, a severely handicapped but intelligent boy, who used to sit tied to his chair, his head drooping listlessly, feeling very much an outsider. The entire posture and attitude of this boy changed immediately when he was asked to conduct the rhythm band in a song which he could choose himself. Having been accepted as a leader made it easier for him to become part of the group and after a while

he could accept others as leaders. Then there was Alexandra, a little Portuguese cerebral palsied girl, who, with both legs in heavy braces and not understanding the teacher's and other children's language, at first cowered shyly in her wheelchair without taking part in anything going on around her. It was in a music class when all children joined hands to sway back and forth in their chairs to "Here we go 'round the mulberry bush," that one first could see her smile and stretch out her hands toward the other youngsters. It was touching to see how she gradually overcame her fear of the "aggressive" instruments such as the cymbals which frightened her at first but which she later learned to handle with great pleasure. Little by little she made friends with several other children who were very eager to help her understand what she was supposed to do, and were proud of her gradual "awakening" and sharing in their fun.

Such effects of music (which, after all, are among the best "socializing agents") are especially important when they do not end with the music class but carry over to the children's attitudes in the general classroom, and towards their companions. According to the other teachers, this has been the case with quite a few of the children, and it is a worthwhile goal for which to work. If youngsters learn to play their part in the community, to develop initiative and self-reliance, to share in responsibilities, to feel accepted and accept others, a school for exceptional children is preparing them as it should. Life ahead will be harder for them than for many others, but participation in, and love for music, can become a real resource for them. They should have more, not less of it than other, more fortunate, "normal" children; let them grow up with music, let music become part of their lives!
DISCUSSION
MUSIC THERAPY FOR EXCEPTIONAL CHILDREN

Discussants: JANET LINDECKER and DOROTHY BRIN CROCKER

Miss Lindecker:

This will be a summary of some of the things we tried to do and say during the preceding demonstration. We hope that some point will not be overlooked which you may have considered important. Dr. Gaston will welcome questions, and you may also supply those important points that have been missed.

In summarizing some ideas, I should like to direct your attention, first of all, to what we would like to have happen to the person who is being treated. You heard discussions this morning about the effects of rhythm, harmony, and melody. Instead of talking about these now, suppose we think of the things that should happen in the patient. We know, first of all, that we must strike a respondent chord within the individual. Therefore, the therapeutic procedure that is used must have the kind of pattern which will somehow affect the patient's understanding and his feelings. Whether he is conscious of that relationship or not, is not always necessary.

As you think through the papers that were read and the demonstrations of the different types of music cited, you will see that the different styles were chosen to stimulate a response from the patients. Because music has meaning only as we learn to know it, it takes a long time for many people to learn to appreciate certain types of music.

First, we must build up a response to a certain pattern within an individual. Second, we realize that we must create a mood. The mood will vary. We usually think of creating a mood that is gentle and soothing in its effect, but we might also, conceivably, want to use music to help a person become less apathetic. Although it was not mentioned this morning, I think that we need to emphasize the point that music can be used to arouse an individual, to disturb him, to bring him into the kind of reaction that at first we thought he was not capable of, because this may be a beneficial release for him. And so we must decide very carefully the kind of mood that we want to establish in order to aid the patient to respond in the way most therapeutic for him. We need always to keep in mind that there is a purpose and a
direction in which to move; we need to realize that there are many things which may influence what takes place.

The distractions in this room are no doubt influencing what I am saying and the way you are perceiving at this moment. The noises from the street while we were having our music demonstration undoubtedly had some effect upon the performance. You could not help but appreciate how well those patients brought forth the abilities that had been developed within them. I think that in the demonstrations by exceptional children which we heard this morning, we observe, on a very fine level, what can be done.

The music for the two patients that you saw at the piano, and the music in the new projective technique demonstrated by Mrs. Crocker, served to release the individuals who participated. The purpose was to give the patients an emotional outlet, and to develop a technique that might lead on to quite skilled performances, at least a performance level which will give a great deal of personal satisfaction to the individual concerned. Thus, we look at the child and decide from the kind of child we have what we are going to do with him.

Exceptional children range from the mentally retarded through the gifted. Among the cerebral palsy children are found mentally retarded and gifted children, and it may be that the girl you saw this morning is one of the gifted children. Among polio cases you have all ranges, because poliomyelitis is no respecter of persons. Neither is the imbalance of the muscular incoordination resulting from cerebral palsy a respecter of persons. As we study the child, we decide what we must do with him and this is where skill of the music therapist must come into play, together with the treatment of the physiotherapist, the psychiatrist, the psychologist, and anyone else involved.

I believe that the most important things that came out of our demonstration are these: the work is individualized, is designed for the individual patient concerned; we do not strive for musical perfection, but seek to aid the child to receive the inner satisfaction that comes from participating, from releasing, and from creating even though it may be on a very elementary level.

There are a lot of problems connected with this work. Perhaps your questions will bring out these problems.
Question:
Should children who are disturbing to the group be removed?

Mrs. Crocker:
When they have to be removed from the group, they can very often be worked with individually. What I mean to say by being removed from the group, is that it is just for the time being; just for a particular group session. Sometimes, of course, the children are removed because of the psychiatrist’s or the counselor’s reasons and may not be allowed to come back to the group because of certain behavior patterns. This is individualized for each child.

Question (to Mrs. Crocker):
How are you able to keep a precise record of what goes on at your meetings? Do you take notes before the session or after, or what do you do?

Mrs. Crocker:
When I work with our psychiatrist he asks me to use a wire recorder. When I follow the psychologist’s instructions, he says, “Please take it down in notes.” Frankly, I do both. The children are not at all disturbed by my taking notes.

Question:
You mentioned that some teen-agers are a little self-conscious about expressing their feelings in telling their stories. Could you give me the methods you use to get them to express themselves more freely?

Mrs. Crocker:
There again, I would have to get a psychiatrist or a psychologist to conduct interviews. Sometimes the rapport is established quickly, and the person trusts you enough so that he will respond. The person is taken back to his earliest recollection of different ages. It is interesting to note that he first does not choose to remember. Then, all of a sudden, before he realizes it, he relates an incident of a certain age, as early as four or even back to infancy. If this does not happen, I try to help him express anger or fear. If that does not work, I play background music and let the child draw what he refuses to tell me, and the psychiatrist or psychologist evaluates the drawings until the point is reached where the child will put his ideas into words.
Comment from member of audience:

In the demonstration, I think we had an opportunity to observe what good rapport there was between patient and therapist. I'm wondering whether the performance by the child with the cerebral palsy was as much benefit to the sixteen year old as it was to us. Emotional strain steps up the nervous tension a little bit more, and I'm wondering if it was a trifle too much for that spastic youngster. I don't know the child well enough to be able to say, but that's the question that I would raise.

Comment from member of audience:

Is it wise to suggest the possibility of the second little girl, the polio patient, pursuing music professionally? There are many things to consider. For one thing, she will have to compete with the normal. Musically, can she advance enough to be able to compete with a normal person on the same level? Will there be job opportunities for a girl in her physical state? I think these are all very important things that we have to take into consideration before we encourage a child to go into music professionally.
PART V

VOLUNTEER SERVICES
IN
MUSIC THERAPY
PANEL: VOLUNTEERS AND NEWCOMERS TO MUSIC THERAPY

CHAIRMAN: INA BACON

Miss Ina Bacon, Arts Consultant, representing the Association of the Junior Leagues of America, Inc., made introductory remarks and introduced the three panel members.
All people have cherished music because of its unique necessity to man's emotional and social well-being. It has offered appropriate emotional commentary on those chief circumstances of his life which most distinguish him as a human being. Man is an animal but he has certain characteristics and functions which clearly mark him off from other animals. It is to these distinguishing characteristics and functions that music is most closely related.

From the lullaby to the dirge music has spoken for him, and to him, when words could not. Music has comforted him, has inspired him. It has enhanced his religion, enriched his relationships, represented often his loves and seldom his hates. It has allowed him acceptable sublimation of unacceptable primordial drives, thus substituting beauty for ugliness. In a tense and anxious world it has enabled emotional catharsis. Sufficiently often it has clothed reality with pleasurable illusion so that man might feel freedom.

From this it is evident why music is so often called upon to accompany man in his attempts to function at his highest or best level. Our concern in music therapy is the use of music either directly or as a tool for this very purpose of helping man to operate in the best manner possible for him. Music used in this fashion has for its purpose something in addition to its necessary aesthetic excellence.

Most, if not all of the music of primitive peoples has some particular psychological or sociological purpose. The aesthetic is present, of course—it must be—but the primary function of the music is not, for example, that of music at a concert, but is for dancing, courtship, religion, planting, patriotism, healing the sick or some other specified function or activity. Music such as this, whose primary purpose is other than the aesthetic, is called functional music. One phase of functional music is music therapy, the utilization of music in the rehabilitation of the sick. It should be clear, then, that the chief purpose of music in any kind of therapeutic situation is primarily to help sick people get well.
The following presentation is not intended to be all-inclusive, nor to be a rigid, systematic approach, but rather a brief listing of a few statements having to do with the usefulness and nature of music in therapeutic procedure so that better understanding may be gained.

Music readily lends itself to therapeutic purposes because it is the most adaptable of the arts. It functions in a multitude of ways for nearly everyone. At the same time it is the most intimate of the arts. Each may take it to himself for his own peculiar needs. It may mean something different for each listener or performer and yet hold these differences within bounds.

In addition to the intrinsic value of music, it is a means toward the more important value of establishing good interpersonal relationship between patient and therapist. It is important to understand that this is music's most important function, and it is for this goal that music is most often used.

Music dissipates "aloneness," at least for the time of the activity, if not longer. It frees one from his environmental and material confines. By diversion it may even help to free him from pain. Music also frees from "aloneness" by allowing a cooperative activity without conflict, thereby making for resocialization.

It is sound without inherent threat, rather than an object, that is responded to, therefore music becomes a part of reality to be enjoyed and trusted without fear. Such a segment of reality is easily accepted, and thus music becomes a common platform whereon patients and therapist may stand without fear and in confidence.

Form and content are one in music. Feeling of form is a feeling of relationship. This feeling of relationship may, in turn, help to bring about a feeling of security.

The learning and performance of music induces in the performer a beneficial sense of accomplishment and gratification.

Music is basically a means of communication and many times succeeds in communicating when less subtle means fail. There would be no music, and perhaps, no need for it, if we could communicate verbally that which we easily can communicate with music. Furthermore, we have little hesitation in using music to express that which we would never express, even if we could, by words. The fine arts, especially music, have always offered man a means for expression more true and deeper than words. Such use is generally beneficial.

Because music is basically communication the performance
of it by patients may offer clues which have diagnostic significance. Even choices of instruments, choices of songs or pieces of music, choices of tone colors may be of diagnostic importance. Certainly music offers an excellent milieu for the operation of group dynamics. Witness the function of music in clubs, institutions, religions, and similar situations.

Music, because of its power to move men deeply, may afford an excellent aesthetic control of behavior. It should be emphasized that this is one of the most powerful and practical uses of music. The effect of music on the behavior of people is an everyday occurrence, yet we often fail to take notice of it. There is a distinct difference between the physical response to highly rhythmical, percussive music, and the physical response to legato music in which rhythm is at a minimum. Judicious application of music may thus afford a very persuasive, non-punitive control of behavior.

Group performance of music provides a Gestalt, or integrated pattern, of sensory, motor, emotional and social components. Physical movement in rhythm with music makes for better motor coordination. The individual performing music achieves a "oneness," a synchronization, a unity of function somewhat akin to the ancient Greek ideal of the harmony of body and mind.

In our enthusiasm for music therapy it should never be forgotten that music is only a part of the therapeutic milieu. There are other aspects of the patient's environment which are often just as important. It is essential, then, that the therapist have some knowledge at least, of the treatment aims prescribed by the doctor in charge.

The introduction of selected music creates a warm and pleasant atmosphere which helps to induce positive attitudes, ease, and acceptance on the part of patients for the hospital environment. This function of music may sometimes be important for the medical personnel as well as for the patients. Music therefore makes a worthwhile contribution to the morale of patients and hospital personnel.

For the most part moods elicited by music derive from the tender emotions. Music may therefore, effectively arouse that which is often at low ebb in patients, i.e., some one or other of the various manifestations of love. This makes it possible for the patient to transfer to the therapist his positive feelings for the
music, thus enabling the therapist to establish a better interpersonal relationship with the patient.

There is little doubt but that other concepts could be added to these few, and that other approaches to the nature of music therapy could be made. In any event these remarks may serve as points of departure for better understanding of the function of music in therapy.

In conclusion: music is a truth as its universality testifies; by consensus it also has beauty. In music, therefore, at a non-verbal level, is found a fusion of truth and beauty. This value may be adopted by each individual, as his own.
CAREER VALUES IN MUSIC THERAPY

ESTHER GOETZ GILLILAND

Chicago Musical College of Roosevelt University
Chairman, Music Department, Wilson Junior College, Chicago

In choosing a career various questions require serious consideration. First of all, self evaluation is necessary. What are your talents, your interests, your personality characteristics? For what type of work are you best fitted? Success in any profession should be measured by increasing satisfaction and prestige value as well as suitable financial remuneration. What are the opportunities for advancement? Where are positions available? What are the living conditions? With what types of workers will you be associated? How much education is required? Where can this be obtained?

The Preface of our first Book of Proceedings, Music Therapy 1951 explained the Development of Music Therapy as a Profession. In assuming that the majority have read this as well as our NAMT Education Pamphlet, “Music Therapy as a Career,” repetition can be avoided, thus allowing more time for further consideration of “Career Values in Music Therapy.” The September 1954 issue of the National Music Council Bulletin contains a comprehensive article by Myrtle F. Thompson, “Education in Music Therapy.”

Let us begin with an unbiased self evaluation. Your interest in this work presupposes that you are a talented musician, by now fairly proficient on one instrument, preferably the piano. Musical skill depends upon years of practice, therefore practice should be begun years before college entrance. Group experience in high school choirs, orchestras and bands is highly desirable. If you have experienced the joy of various types of musical experience with others, you will be more able to transfer this satisfaction to patient groups and to direct them.

Interest in personality development and a desire to help others live a richer life are essential in music therapy. Those who are interested only in themselves and their own success should choose some other career. Interest in medicine and in psychology, together with teaching experience are also helpful. music therapy offers an ideal way of serving all of these interests.

Search your innermost likes and dislikes. Are you sympathetic-
ic to those less fortunate—the physically and mentally handicapped, the mentally deranged—without becoming maudlin or horrified? Do you possess patience and tact? Is your desire to help others through music strong enough to sustain you through four years of training? There are many "do-gooders" who become easily discouraged when they discover that they have to apply themselves diligently in the study and mastery of many areas of learning within and outside of the field of music. Intelligence as well as intensive application is necessary.

If you have any doubts, visit a hospital having an active music program. Observe the patients and the therapists; note the changes that occur while the patients are engaged in music activities; join the group and contribute your talents; talk to the patients and the personnel; offer your services as a volunteer no matter how humble the task assigned; observe the amount of planning and paper work required to maintain an extensive music therapy program. If you are still enthusiastic after these experiences and have the other qualifications, then you can be sure you have chosen the right career.

A hospital music program can be just as extensive as any college curriculum, provided there is sufficient personnel and physical facilities to offer all possible activities. These will be reviewed briefly so that you may evaluate your own potentialities in contributing to such a program which should be recreational and educational as well as therapeutically designed to meet each patient's needs and potentialities. In a large institution having several therapists, specialization is possible, but in a small private hospital with only one music therapist, he must be a veritable "Jack of all trades," able to fill in, plan and direct all types possible.

**TYPES OF ACTIVITIES**

I. Participation

A. Rhythm

1. Rhythm Bands—Drum and Bugle Corps
2. Dancing: Social, Folk, Creative, Interpretive
3. Eurhythmics
4. Exercises accompanied by music

B. Singing

1. Community singing
2. Choirs, Ensembles, Barber Shop Quartet
3. Vocal lessons: private and in class
C. Playing instruments
   1. Bedside: Autoharp, Ukulele, Guitar, Mandolin
   2. Keyboard: Piano, Organ, Accordion
   3. Orchestra and Band, Dance Combos, Small ensembles of all types
   4. Private and class instruction

D. Eartraining and Sightsinging Classes

E. Programs (Talented patients performing for others)
   1. Solos, Ensemble, Rhythm Bands
   2. Concerts by Orchestra, Band, Choir
   3. Dance Programs: Interpretive, Ballet
   4. Drama with musical accompaniment and interludes
   5. Operettas
   6. Puppet shows

F. Musical Games

II. Creative

   A. Composing, Improvising, Arranging
      1. Classes to meet the needs and talents
   B. Writing plays and operettas
   C. Making instruments and repairing them
   D. Creating dances to interpret music
   E. Painting to interpret music
   F. Writing poetry and lyrics
   G. Producing shows: scenery, costumes, staging (with aid of other departments)
   H. Acting out a song

III. Active Listening (Directed attention)

   A. Music appreciation sessions
   B. Study and analysis of music literature of all types
   C. Study of music history through musical examples

IV. Passive Listening

   A. Bedtime Music
   B. Mealtime Music
   C. Music in shops and during chores
   D. Music to accompany finger painting and other creative activities
   E. Music in the operating room
   F. Music in the church service (Partly active participation)
   G. Concerts by patients, visiting artists and music therapists
   H. Music in speech therapy
I. Music in physical therapy
J. Music in insulin and electroshock therapy

From this listing it is evident that acquaintance with all types of music is necessary, together with its specific functions and the influence of music on behavior. A large library of recordings with adequate reproducing instruments are useful in reaching many patients through active and passive listening.

Personal characteristics play a major role in success in any occupation, but in the field of music therapy these are especially important, since most authorities agree that the effect of the personality of the therapist on the patient is even more important than the tool employed, namely music. The patient must have confidence in you and be convinced that you are vitally interested in his welfare.

Do you make the most of your physical appearance? Cleanliness, neatness, good taste in dress and deportment are expected in all professions. First impressions are important. Do you enjoy good health with no communicable disease? How about your mental health? Psychologists have listed the traits that affect mental health as: dependability, friendliness, cheerfulness, honesty, a sense of humor, independent thinking, self-control and self-reliance.

The therapist who is endeavoring to improve the physical and mental health of patients should be a well-adjusted individual. By demonstrating maturity on all levels of personality, he will not only be able to meet his own problems objectively, but will also set a good example of poise and inner power.

Emotional maturity implies the ability to face reality, to accept yourself as you really are without feelings of inferiority or egotistical attitudes, to withstand tension, to channel hostility and aggression into socially acceptable outlets.

Intellectual maturity is evidenced by having worthy goals; by ability to assume responsibility and to stick to a course of action; by ability to regard your work objectively; by ability to admit mistakes and take the consequences without alibis.

Social maturity begins when childhood reliance upon parents is no longer necessary. Other characteristics are: responsibility towards the rights and needs of others; the ability to cooperate with all types of patients and with the staff; the ability to follow orders as well as assume leadership.

Moral maturity depends upon the practice of ethics; upon
having a workable philosophy of life; upon having ideals of conduct and living up to them.

Self evaluation of one’s personal characteristics can be substantiated by taking various psychological tests. Any deficiencies can be improved by counseling. Adequate courses in music therapy should emphasize personality development so that the therapist may better understand the patient’s personality problems as well as his own. By helping others achieve maturity, the therapist himself, will grow. He will in many cases gain more from the patients than they gain from him.

Those who are fortunate enough to choose a career that is suited to their interests, talents and personality will achieve ever increasing satisfaction in their chosen profession, music therapy. I wish time would permit the reading of even a portion of the glowing letters I constantly receive from former pupils voicing the personal satisfaction they are achieving in this work. The enthusiasm of the many participants in this Fifth Annual Conference, the phenomenal growth of NAMT, the ever increasing interest in our work, all testify to the opportunities for great personal satisfaction possible in music therapy.

Possible also is prestige value. Those who appear at these conferences, and whose contributions are published and thereby enjoyed by many others, are achieving prestige not possible in more crowded professions. Not only national recognition, but also local respect is enjoyed. There are many opportunities to share your experiences and findings through speeches to local groups and articles in other professional journals.

Financial remuneration varies considerably, from $2,800 annually to $8,000, depending, of course, upon education, experience and range of duties and responsibilities. The average salary for beginners is $3,400 with directors of the department averaging over $4,000. The Veterans Administration and state institutions on Civil Service offer the greatest security. Positions are available in all parts of the country with California salaries ranging from $3,900 to 4,740 with five levels of increase. Read Quinto’s article in Music Therapy 1953 for details of VA standards. The beginning salary of a GS-5 is $3,410; that of a GS-7 is $4,205 with annual increases.

Most of these institutions furnish excellent living quarters and board at a very nominal fee to those who wish to live on the grounds. This advantage saves transportation time as well as money, especially when the hospital is located far from a town.
or city. Many hospitals provide free medical service to employees.

If you enjoy working with professional people dedicated to helping the unfortunate, you will receive great stimulation in a hospital environment. Many of the employees are interested in music, in fact instrumental and vocal ensembles of nurses, doctors, and attendants have been organized in some institutions, while in others, these musicians join the patient groups. Your musical interests will be a means of providing many friendships. To live and work in such an atmosphere where all are united in a common goal is not only a constant challenge but a source of satisfaction dependent upon the contribution you can make.

The areas of service include mental hospitals, schools and hospitals for physically handicapped children, schools and homes for the mentally retarded, and institutions for delinquents. It is advisable to choose the type of patients in which you are most interested as soon as possible so that you may elect the subjects required. For instance, most states require certain education courses for all teachers of children. These would not be necessary for service in a state mental hospital, but are highly recommended.

Each issue of our NAMT Bulletin lists positions available. The colleges and universities offering training receive many requests for music therapists. When you are prepared for a position, rest assured that there will be a choice available.

In many localities there are opportunities for part-time jobs as instrumental and choral directors in prisons, detention homes, boys' clubs, clinics, etc. Many of my students are applying the principles and practices of music therapy in the so-called "normal" classroom situation with great success and personal satisfaction. One does not have to work in hospitals to find deviates of all kinds.

As more and more college administrators are contemplating the establishment of training courses, the demand for teachers of music therapy will offer opportunities to music teachers with advanced degrees who have had the requisite training and hospital experience. Adequate supervision of internship programs is a necessary adjunct in all training courses. Colleges desiring to set up such curricula should be sure that there is a hospital available with an extensive music program which will provide trainees with all types of experience and proper supervision. Many hospitals are extremely anxious to acquire such
student help in order to extend their own offerings, but care must be taken in setting up affiliations so that the interns are not all on the giving rather than the receiving end.

NAMT publications and committees endeavor to disseminate pertinent information available. Lists of colleges offering training may be obtained from the Chairman of the Education Committee. Every one of you should possess copies of these publications for extended study and constant reference. Developments in music therapy are so rapid that it behooves us all to be prepared for any and all opportunities that present themselves. It is up to you to evaluate your potentialities and then set your goals accordingly.
REAL BASES OF SATISFACTION IN MUSIC THERAPY

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It is perhaps a bit strange that this subject has not been considered specifically at previous national meetings of the NAMT. Those of us who continue to be active and interested in music therapy certainly must have tapped these real sources of satisfaction in our work or we would not continue such activity and interest. Perhaps it is the nature of the work, or of the persons who participate in it, not to try to analyze too deeply the sources of motivation which lead one into the work and the satisfactions inherent in it.

It will be the purpose of this paper, therefore, to consider briefly what this writer believes to be some of the real bases of satisfaction in music therapy, as well as some of the possible false bases of satisfaction. There is no intention to delve deeply into the many psychological motivations of an individual which lead him into such work, but only to survey some of the aspects which might consciously be considered as bases for satisfaction.

At the conferences of NAMT in the past few years this subject has slipped into many of the papers and reports given, even though not specifically pursued, for in talking about various aspects of music therapy and the participation of the therapist in many different kinds of music therapy situations the bases of real satisfaction to the therapist and volunteer form an integral part. In 1952 a panel moderated by Mrs. Myrtle Thompson considered personal gratification as a part of the value of music therapy for patients. Many of the same sources of gratification in music for the patient certainly are available to the therapist. There is more to it than this however, and we shall proceed to try to throw a bit more light on the subject. At the risk of appearing negative at first, some of the “false” bases, or what satisfactions probably will not be found in music therapy situations, will be presented at this point.

The realization of personal musical goals of the therapist or volunteer is not likely to be found in music therapy situations,

nor should it be sought. By definition, functional music places aesthetic goals secondary to utilitarian and treatment goals. One would not find a real basis for satisfaction, likewise, in hoping for self-realization as a musical performer in music therapy work, in spite of the fact that sometimes an ideal "captive audience" seems to be provided. Performance satisfaction however, may become a secondary or incidental outcome of clinical work, but it is not to be expected in the sense of the concert-artist performance. For example, this writer has experienced satisfaction in performance in a hospital situation when such performance was in conjunction with the treatment plan for a patient with whom he performed, or when such performance was part of a specifically planned therapeutic procedure. Even so, it is difficult to separate such performance satisfaction from satisfaction in the results accomplished in terms of the function of the performance.

Just as one should not expect to find satisfaction in music therapy through the realization of personal goals, aesthetically or as a performer, one also should not expect to realize personal goals through musical accomplishments of the patients with whom he works. While sometimes there may be a secondary gain here also, it is not to be regularly expected. So much for what cannot be, or even should not be expected as sources of work-satisfaction in music therapy; let us turn to what can be expected.

Although it has been fairly well established by psychiatrists and psychologists that many persons are drawn to hospital and clinical work for morbid reasons, or to meet certain of their own basic personality needs, it has also been pretty generally agreed that a majority of clinical workers are motivated by constructive drives, which seek to satisfy the need to express love, in the broadest sense of the word, for their fellow mankind. The more common way to describe this motivation is by words such as "humanitarianism," "altruism," and even "magnificent obsession." Such motivation leads to many possibilities for real satisfaction to the music therapy worker, from that of observing warm responses of patients to the worker's efforts, to that of noting actual improvement in the condition of a patient due in some small or large way to his work. As the good teacher takes pleasure in seeing growth and development in his students so the good music therapist receives pleasure in observing treatment progress in patients coming under his influence. Also, the therapist can experience pleasure through empathy with the patient in his
progress toward improved health. And similarly to many kinds of work involving the use of hard-won skills, the clinical musician can gain satisfaction from his own hard work and continuous striving toward goals, as well as in jobs well-done.

To gain satisfaction from any work, much depends on the worker himself, his personality traits and his attitudes toward the work, which are as important factors as any of the foregoing as bases of satisfaction. Certain personality traits which might be considered desirable prerequisites for gaining satisfaction from music therapy are:

1. Good health, physical and emotional
2. Maturity—having experience in the art of living and a feeling for and understanding of the human needs of patients
3. Congeniality—cheerful temperament
4. Optimistic disposition and poise in dealing with trying situations
5. Ability to be objective in dealing with difficulties
6. Patience and tact
7. Sense of humor—to break tensions often found in clinical work
8. Inventiveness, flexibility, and resourcefulness
9. Quiet persistence in work
10. Willingness to collaborate and work with others in treatment teams

Attitudes which might be considered desirable for the person seeking satisfaction in this field could include:

1. Conscious desire to make his energies, knowledge and skills useful in the most intelligent ways
2. Willingness to work with handicapped persons and to gain understanding of their needs
3. Conscious effort to regard handicaps of patients not as barriers but as challenges and opportunities for particularly skillful work
4. Willingness to have his work evaluated in medical rather than musical results
5. Patience to be able to see the long view of treatment, rather than immediate results only

The last is perhaps the most important as well as the most difficult attitude for the clinical worker to gain, i.e., not to be-

come too discouraged with immediate outcomes of his work with the handicapped which often involves many ups and downs in treatment progress. If he can stick with the work over a long enough time he is likely to be richly rewarded by seeing the rehabilitation of sick individuals become actuality, and in knowing he may have made some contribution toward the more enjoyable and constructive existence of such individuals. This presents one of the more difficult bases of satisfaction for the part-time or volunteer worker, yet it has been this writer’s observation that many such persons who have persisted in their humanitarian efforts and have contributed in a variety of ways—from actual participation in treatment situations to providing extra financial assistance in worthwhile activities—can gain much satisfaction.

Besides being able to see results in terms of rehabilitated persons, much satisfaction derives from the doing, i.e., from the freeing of self from personal desires and concerns by doing for others. This may be at the root of all the real bases of satisfaction for music therapy workers. An example of this as well as other types of satisfaction found in music therapy work may be seen in the recent experience of this writer in his work as a member of one hospital treatment team with an individual patient over a period of a year and a half. The patient, after having been almost inaccessible for eight years in institutions, was finally able to regain some ability in relating to others and was able to make a more constructive use of his musical ability as an outlet for his many fears and inner tensions. Although it was impossible to see the final outcome of this case because the therapist left the hospital, it was felt that a significant change in the patient’s condition could be noted and that part of it was due to the therapeuetic relationship between therapist and patient, formed through music therapy. Part of this improvement was demonstrated in a somewhat negative way by the patient’s violent reactions to the therapist’s departure, but this was dealt with by the patient’s doctor in a constructive way and seemed to indicate that the patient had regained some ability to live outside himself, and for having some concern about others. There is satisfaction also in knowing that this patient will continue to be provided opportunities in music therapy as well as in other treatment areas.

Another example of satisfaction obtained from music therapy work over a fairly long period of time is that of the volunteer who was acting as a part-time assistant to music therapists. She gave special help and attention to one patient who was seeking
expression through composing songs. Over a period of more than a year she was able to see the patient get better and eventually she was able to provide valuable support for him when he left the hospital to begin life anew in the community.

There is considerable satisfaction in being able to see theory and principle put into effective action in music therapy, just as there is in many other fields. For instance, observing the influence of carefully selected music as a medium for developing group socialization with severely ill mental patients, or the influence of judiciously chosen music as a sedative factor with disturbed patients, or the influence of music as a medium for co-ordinative rehabilitation for handicapped children—all can be highly gratifying experiences. Recently it was possible to observe the first two above-mentioned influences of music operating with a small selected group of disturbed patients (diagnosed schizophrenic) who met regularly for a record-listening session at the music therapy clinic. With careful planning by the therapist and with his skillful leadership, under continuing advice of the directing physician, the music of these sessions influenced some beginning of group awareness in several patients, and was always able to effect a quieting, soothing function. The latter seemed to carry over into their general ward behavior where less aggressiveness and fewer disturbances attributable to members of the "music group" were noted.

Finally it should be specifically reiterated that a real basis of satisfaction in this work may be found in the pleasures of cooperative work with others who are working toward the common goals of treatment and rehabilitation of patients. This would include all those members of other therapy groups who work on the various treatment teams, as well as all those who lend support to treatment efforts in many ways—volunteers. The feelings of rapport, esprit de corps, identification with such a group, and the challenging goals of our work can produce great satisfaction.

To summarize and conclude, it has been the purpose of this paper to bring to your attention some of the factors which can bring gratification to the worker in music therapy, whether he be full or part-time therapist, volunteer, or teacher. After discussing what not to expect from the work, many things were found in the clinical music situation that can bring great satisfaction. Perhaps the most important thing which one must realize is that satisfaction depends a great deal on the individual and what he brings to the situation. Provided he can assimilate or already has
certain desirable personality traits and attitudes, he can gain the utmost pleasure in being able to free himself from himself in the helping of others, and in being a part of a group of fine persons who are striving toward common goals of treatment and rehabilitation of patients. Such satisfaction is even increased in music therapy as the music therapy worker observes his medium, music, performing influential parts of his work for him.
DEMONSTRATION OF THE AUTOHARP

EDWINA EUSTIS
Formerly Director of Special Projects
Musicians Emergency Fund
New York City, New York

Yesterday you saw and heard three children play the autoharp. They were not exceptional children, as I told you in the very short time that was given to us. They were perfectly normal children who, after they heard me play the autoharp, kept teasing and teasing for months to be allowed to play it. Their interest in the autoharp has never slackened. They own their instruments, by the way, and their interest, I should say, has grown so that two of them have now started the study of other musical instruments, one the piano and cello, and another, the piano.

It has been a revelation to me, something I had never dreamed of, much as I love to use this instrument myself, that through the autoharp it is possible to give children a tremendous appreciation of music and a technique for expressing themselves artistically in music that is simple to learn. You saw that they displayed excellent ensemble work; you saw that they know the basis of transposition; they know what crescendo and diminuendo mean. They have achieved a basis for good, sound musical training in their work with the autoharp.

Now, I am going to introduce some adults who use the autoharp for whom I take certain responsibility. I might say that I had some slight difficulty at first in getting them to learn to play the autoharp and sing. I know what it has meant to them personally, and I can tell you that each of the three has almost made a separate career in hospitals with the autoharp accompaniment to her own work. And now, I am going to let them sing for themselves and speak for themselves through the autoharp. Miss Dorothy Birchard, Miss Athena Pappas, and Mrs. Cecil Sherman:
PART VI

ANCILLARY THERAPIES
AND
THEIR RELATION
TO
MUSIC THERAPY
PANEL:
A MEETING OF ADJUVANT THERAPISTS AND THEIR MUSICAL INTERESTS

CHAIRMAN: MRS. FRANCES L. SHUFF

Occupational Therapist, Assistant to the Executive Director, American Occupational Therapy Association, New York City

MRS. SHUFF:

When we hear music we feel excitement, we feel gaiety, we feel sadness, or pleasure, or pain. We feel music, and because we are affected emotionally by it, it can be used effectively in therapy. Several types of therapy used with the handicapped will be mentioned. All use music, but use it in slightly different ways.

When we say therapy, we mean treatment given to a mentally or a physically ill patient, under the supervision of a physician. The therapist must interpret the prescription. The occupational therapist is medically oriented and works only under medical supervision, but the occupational therapist who is also a trained musician is rare.

What can the occupational therapist do when he is required to introduce a music program? First, consider the mental hospital. If he is fortunate, the occupational therapist can call upon the recreational therapist. If he is doubly fortunate, he can enlist the aid of the educational director. And, perhaps if he is especially blessed, he can call upon some volunteers who are trained musicians. Rarely can only one of this team work effectively. A program including all of the modalities, guided by a medical prescription, can be inaugurated by the coordinated team.

Let us consider the disability areas in which music can be used with most success. In mental illness music activity encourages group activity and social adjustments through group singing, orchestra, dance, band, and rhythm bands. Music in the mental hospital aids in preventing regression and stimulating emotions by aiding the depressed patient, and affording an outlet for the manic.

Let us go to another disability area, the physical disability. Music is a means of physical control. I have worked with patients who suffer from Parkinson's disease. Some of these patients have very little physical control and shake a great deal. We have found that music aids the patients in groups to control their...
movements. We find that they slow up, move in rhythm, and work much more effectively together.

Music stimulates physical activities. We have used it with polio patients. After the polio patient has learned to walk and has a return of muscle power, we get his body to respond again to the rhythm of music. I have worked with children in dancing, where we have had them in wheelchairs dancing from the waist up using their arms and other controllable portions of their bodies in rhythm. We have employed the dramatic elements in music where the music was a means to help interpret a play or a story. We have used music in square dancing both with children and adults. Such activities as the rhythm band, and with the rhythm band the added stimulation of manufacture of the instruments themselves which can be done in the occupational therapy department, have had educational value. Also music appreciation and learning to play an instrument may be therapeutic.

In a hospital where I have worked recently each instrument had to be redesigned to meet the disability. We had one little arthritic who was almost in one solid piece. She had a harmonica on a stand and could only move her head to play it. We had a little blind girl who was also an arthritic, who managed the stop in the harmonica with her tongue. It was a very exciting and touching experience to watch these sorely afflicted patients play in an orchestra, play dance music and play it well.

We can go to the tubercular and cardiac patients. Here music listening and perception is an aid. A program broadcast through a hospital loud speaker system can be the first step in graded programs when patients are forced to stay in bed twenty-four hours of the day.

In conclusion, I may say that music therapy has not yet been fully developed, and for its more effective use no one person can work alone. Therapy requires the musical therapist, the occupational therapist and the recreational therapist. The teamwork is needed here as it is in other services. It has to be developed to its fullest. It must be used wisely by well trained people.
MUSIC IN EDUCATIONAL THERAPY

HUGH E. KILMARTIN

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Brockton V.A. Hospital, Brockton, Massachusetts

At the outset, I must confess that as I approached the date of this party I was somewhat perplexed as to a suitable subject, knowing that I would have before me an audience of skilled personnel with various specialties, leaders in the rehabilitation and music fields.

My principal qualifications for participating in this panel on the adjuvant therapies are two: first, my interest in educational therapy; and second, my interest in music. On the other hand, I am disqualified in a number of ways as I observe the work of a music therapist as a professional field calling for specialized training.

Progress has been made in the treatment of patients with various modalities as offered by the various adjuvant therapies. There is no doubt that the rapport established between the therapist and the patient through various methods represents valuable contributions to mental hygiene. Attending conferences of this type and visiting hospitals and rehabilitation centers makes one aware of needed additional training, and time to report in a scientific way the accomplishments that various therapists are experiencing and attaining in their daily work.

The accomplishments of the adjuvant therapies in the rehabilitation process can be compared to the development of the armed forces, to technology in business, or to our own everyday living, to mention a few examples. It comes to one word—progress. Through progress there is refinement, setting up new objectives, proving old conclusions, eliminations of some procedures, and expanding new ideas and methods that have been found successful. In this growth of living, new technology is developed. For example, after World War I and during World War II we saw the horse eliminated from the Army and the use of the airplane developed. We still have the Army and behold a new force—the Air Force on equal footing with the Army and the Navy to assist in our defense plans, mainly due to the need of specialized equipment and training of personnel to accomplish the mission. To accomplish the mission in rehabilitation there is a need to coordinate research and sift those findings...
that are scientifically acceptable. From this, new specialties in the adjuvant field will develop.

Music therapy in the Veterans Administration is the responsibility of Special Services Division. Educational therapy is a part of the Physical Medicine Rehabilitation Service. Educational therapy is the use, on medical prescription, of educational courses in the treatment of patients to assist in restoring them to the fullest mental and physical capacity compatible with their abilities and disabilities. Heft2 points out that music has been used since 178 B.C. in the treatment of patients.

Who is to carry on musical activities within an institution? It depends on the organizational planning. To be effective, the therapist must be well trained with a musical background, interested in the specialty, and have had experience in a medical setting.

I would like to report on some uses of music in educational therapy. One begins in 1949, when, as Chief of Educational Therapy at Cushing V. A. Hospital, I was invited to set up a group activity in educational therapy using music as a modality to provide opportunity for social interaction. The objective was to get the patients to talk and to provide an *esprit de corps* for group psychotherapy that was to be carried on by the psychiatrist at a later hour. Recordings were used and occasionally, a piano.

The treatment was for one hour duration and the patients were referred by the psychiatrist. The group was limited to ten patients and met twice a week from 1:00 to 2:00 p.m. Through Special Services two volunteers, one for each day, who had excellent musical backgrounds, were secured. Fortunately they had been working as Gray Ladies in the Red Cross at the Hospital for some time and knew hospital routine. Generally present were the volunteer leader, the educational therapist as a participant observer, an attendant, and the patients. All were seated in an oval arrangement without any set pattern. This type of seating facilitates the process of communication. Therapeutically, group size should be restricted to permit face to face communication. The patients were male between the ages of

22 and 53 years with various diagnoses. While at first an attempt was made to select patients with a similar diagnosis, it was later found that this was relatively unimportant. The essential feature appeared to be that this was a discussion group and the material discussed was common, irrespective of the diagnostic categories.

A criterion for patient selection was, primarily, an expression of interest in music as it provided a baseline from which the group could proceed. Another criterion was a general readiness for group participation. Two sessions were held on meeting days; the patients were divided into two groups according to their intellectual level. This made for better selection of musical recordings for group interest and lessened the possibility of a patient being uncomfortable in the presence of other patients who were obviously better endowed intellectually. In relation to the intelligence level was the necessity that the patients selected should have the ability to formulate and verbalize their problems, and have some understanding of the discussion which invariably followed.

The activity was developed in units of twelve treatments. The treatment session varied in content. The patients were encouraged to participate in the planning by expressing their choices of music selections which were to be included in succeeding programs. There were two basic phases in the program; namely, (1) listening to the music and (2) discussion. The discussion phase was considered the most vital, although the music served as a convenient medium to stimulate participation and discussion. The program was conducted much like a music appreciation course having value for worthy use of leisure time.

The musical structure of the program was based on the selection of music having pertinent life themes. Such variety provides a background which could be utilized to stimulate more meaningful discussion. The subject matter, as depicted and interpreted by the music, is limitless. Some of the music used was American folk music, ballads, European folk music, Hawaiian music, operettas, symphonic music, seasonal or holiday music, selections from modern plays, and modern orchestras. Each musical number was preceded by a brief talk by the leader who told something about the composition, the composer, and recording artist. Other pertinent facts such as social setting, historical background, and the context in which the music was composed.
led to lively discussions. Each member of the group was provided with pencil and paper, and a blackboard was used to diagram certain situations. The number of recordings used varied with the discussion.

Immediately after the number was played there was a discussion which revolved about the merits of the selection, the patients' emotional reactions to it or the memories which were recalled by hearing the music. Discussion was initiated on an impersonal level. This impersonality is extremely important because pertinent life problems can, initially, be discussed without direct reference to the individual's personal problems. Impersonal discussion gives the patient a more secure feeling without which he cannot proceed to a discussion of his intimate problems. The objective was to have these come to light in the next hour in group therapy with the psychiatrist.

Occasionally, a patient took over as leader of the group, selecting the recordings and conducting the discussion. A few times a piano was secured in order that patients could play for the group and discuss the selections.

The educational therapist was concerned with observation of the group process with special attention being paid to those factors leading to individual and group development. The psychiatrist was furnished a report of the patient's accomplishments, attitudes, and responses. A permissive attitude prevailed in the group and each new member was orientated as to the composition of the group. Each member of the group was gradually involved in the discussion. Some patients would take several weeks to feel free enough to participate. Depending on the rehabilitation objective, the group had the foundation for a much fuller program with more emphasis on music therapy directed by a music therapist in developing various aspects of a musical program such as: individual training, group singing, orchestras, and public entertainment. One patient became interested in copying music for the chaplain and in studying music through a state extension course. Upon discharge, through the efforts of the vocational advisor and chaplain, he secured a position copying music and was still employed after two years.

Another aspect of music in educational therapy is reported by Weiss and Margolin. Dr. Margolin had the program for

a year. He had the problem of training new volunteers. He added a secretary to the group to record the proceedings, and used an interaction sequence record along with an interaction process chart for an evaluation process.

At Brockton V. A. Hospital there is a music therapy program in Special Services Division. In educational therapy there are twelve different groups varying from ten to twenty-nine patients who meet daily in group activity. The educational therapist devotes one session each week to a music discussion. Recordings are available. Some groups have emerged into music study groups as an outcome of patient request and physician’s clearance. In some instances the patients prepare a presentation and one acts as leader in the discussion. In some cases a written paper is prepared on a given subject guided by the educational therapist. Clippings of musical interest are secured from various sources by patients, and posters and scrapbooks are made. A given composer’s life can be studied. His compositions can be heard from recordings. A work is discussed in relation to other composers of his day, including geographic and socioeconomic conditions of the era.

Some patients have advanced from the group activity to individual work and are taking extension courses offered in the musical field. One objective of the group activity program in educational therapy is to encourage the patient eventually to participate in the activity. The patient derives greater satisfaction and it gives him an opportunity to contribute and express himself. Group reading is encouraged and the therapist can discover to what extent a patient can interpret what he reads. Browne reports many of the same conclusions.1 Patients are taught typewriting with the aid of records to develop rhythm and even stroking.

In some cases a patient is recommended to his ward physician for consideration for assignment to music therapy. It has been observed that patients going to the library seek the music section to hear a favorite recording.

Summary

Music therapy is now recognized by many medical people as an accepted procedure and has a place in the total treatment program of the psychiatric patient. More research is needed to

validate what is being offered in patient treatment as progress is being made. Some things are very difficult to isolate in an effort to ascertain what the factors are that make the improvement. The fact that we have three therapists discussing the core subject of musical interests at a musical therapy conference points out the various ways a modality can be used in achieving the medical rehabilitation objective of a patient as directed by a trained specialist in one's therapy field. This calls for teamwork with the patient's physician to direct the therapist's efforts to help the patient.

Music in educational therapy can be used to stimulate discussions in a group activity program because music can be a common denominator in providing opportunities for social interaction in a permissive setting. It can enrich one's use of leisure time, and individual patients can take courses to enhance this. It can create a desire in the patient to pursue musical activities under the direction of his physician who prescribes the total treatment program.
MUSIC IN RECREATION THERAPY

HAROLD ABEL

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What we use music for.

We use music as:
Entertainment
A Stimulant
A Motivating Aid
A Release of Emotional Forces (in a constructive manner)
An Aid to Create Fellowship
An Aid to Relaxation
An Aid in Group Cooperation, Group Coordination

Where We Use Music

Wards
Gymnasiums
Sport Activities
Social Activities
Special Therapy Groups
Entertainment
In Rhythm and Coordination
In Appreciation and Listening
In Story Telling

Effects of Music

When one considers the fact that a patient undergoing psychotherapy in an institutional setting spends ninety-five per cent of his waking hours in group and social relationships, it becomes immediately apparent that we need to make this time contribute as much as possible to the recovery process.

Experience has shown that the use of music in sports stimulates patient participation. Music arouses potential energy; exercises are carried out for a longer period of time. We know, furthermore, that an individual with an ache or a pain may become less aware of the pain if his attention is focused elsewhere. Music is used as a diversion, for recreation and relaxation, and to induce sleep as when a lullaby is sung or played. It may be used to awaken group response.

It would seem to me that if some bit of medicine could be
given a patient without undue aftereffects, medicine that would change the pulse rate, start the patient swaying, tapping his feet and drumming with his fingers, that would be a miracle. That is exactly what music can and does do.

Music lends itself admirably to group work, the treatment of patients in a group. Because of the forces operating in a group a person may behave there much differently than when he is alone. The growth of group emotion can be facilitated to the end that constructive group action will follow.

Music could be studied as a partner of recreational activities, thus contributing to the general evaluation of morale of the hospital population. When we think of recreation, we, of course, immediately think of music. We could study the role of music in a mental hospital in regard to two main aspects. First, it could be a part of a direct therapeutic approach where music forms the main aspect of the therapeutic process and is directly applied in this function. Secondly, music could be studied as forming part of recreational activities, thus contributing to the general elevation of morale of the hospital population. There is, of course, no sharp line between these two aspects.

Music may stimulate an individual intellectually or emotionally, exciting his imagination, changing the association of ideas, or having other influences. Music is, after all, a part of cultural heritage and so tends to be associated with a person's nationality, race, religion, social status and age. Thus one must be careful not to project one's own musical tastes upon the patient.

**Motivation**

Many people have nothing to occupy their minds and hands and are inclined to daydream. Planned activities can replace daydreaming in the life of the individual and become an important aid in blocking deterioration.

One of the most difficult problems facing those planning activity programs is the problem of securing proper motivation. In order to motivate people, the person leading or planning the activity should have a firm belief in the necessity for the activity. It is impossible to interest people in any activity if the leader is not enthusiastic and confident of his ability. Stressing the entertainment and pleasure that the activity offers will often help to motivate. The opportunity to be of service to others and to be a contributing member may also be a strong motivating factor.

Although most people enjoy music, many need to be re-in-
introduced to the many ways that music can be enjoyed. We have patients’ bands that participate in many activities. They play on the field at baseball games and on field days, at patients’ dances, parades, and even at many social affairs such as dinners. The importance and usefulness of such as these is self-evident.

There is another activity in hospitals that will contribute considerably to the individual’s awareness of himself as an individual, and that is the activity of the volunteers. These volunteers arrange parties and other recreational activities for patients. What appears to me to be one of their most important activities are singing classes. One of the workers accompanies on the piano while two or three others are singing with the patients, old and new songs, the lyrics of which are written on big paper sheets which are on a stand in front of the group. The patients participate most eagerly and some important factors can be observed operating in this activity:

1. **Socialization.** The patients feel they are members of a group.
2. **Protection by the group.** If one does not know the song he can remain quiet until the song is learned.
3. **Recognition as an individual.** They start knowing each other as having common interests; they are recognized as individuals by the outside world, symbolized by the volunteers and by the attendants who bring them to the music classes.

It is really heartwarming to see these patients who often appear quite regressed, taking such strong interest and participating so proudly in this common activity.

Frequently concerts of more serious symphonic music for selected patients who are interested in this type of music are introduced. The concerts are given to patients from male and female services. The time of the concert is announced a few days in advance and all patients who are interested are given the opportunity to come and listen. It is seen too, that all who come are well dressed, thus inducing a festive mood in the participants. The attention is excellent and all patients really have an emotional experience that leaves a deep impression on them. Long after the concert the patients comment and ask that such concerts become a regular activity of the hospital. All patients re-
marked on the deep impression this experience made and how much it meant to them.

It appears that this form of recreation is much more than just a way of passing the time pleasantly. The patients who participate are well aware of the fact that some very specific efforts were made to give them the opportunity for this experience. They really feel that this is not just an institutional routine but something that is offered them as individuals with their individual cravings and hopes.

Far more people are able to enjoy good music than are able to create it. This does not mean, however, that music training should be restricted to those who have an aptitude for music. To learn discipline, to develop aesthetic appreciation, to understand the importance of working with others is good for all.

Music, as the expression of truth and beauty, goes beyond the barriers of race, creed or geography. It is the great socializer. It is a spiritual medium of mutual fellowship for all men, for the rich and poor, for the mighty and the meek, for the old and the young. No other form of expression or communication is more universal in its appeal.

**Need for Music in Recreation**

Recreation facilities and opportunities for mental patients should be as representative of outside culture as possible. Our feeling is that recreation and music are part of normal living, and since we are trying to pattern our hospitals as closely to community life as we can, recreation and music have a place.

Add music to the recreation program and you have added life. The activities become fuller and more meaningful. Without this marriage recreation lacks something.

In our hospitals we need music not only as a means whereby we develop an orchestra or chorus, but also because there is a real and genuine need for it as a means of motivation in dancing, roller skating, for parties, picnics, social gatherings, and activities of similar nature. It is needed sometimes as a means of furnishing an element of excitement, or often as a quieting influence.

I, myself, believe music must be on a very practical basis. We recreation directors do not have the equipment or technical knowledge to make final judgments or conduct scientific experiments. We know that music is an aid to recreation and is sometimes classed by itself as a type of recreation.

Music today is not something that belongs to a select few.
Ancillary Therapies

Used intelligently in our institutions as pure music and as an adjunct to recreation, it will prove to be of great service in the treatment of the mentally ill.

Some Examples of the Work

A creative music workshop was formed in the band room; the participants were nine members of the regular boys' band. Each month a different patient member was chosen to be the director of the two two-hour meetings which were held each week. This left eight other members to play in a number of different combinations by the interchange of different musical scores or different instruments.

The aim of this group was primarily to stimulate better performance ability, to increase self-confidence, to exchange different instrumental techniques, to provide an opportunity to actually conduct a group, to select the program and to make such changes in interpretation of the music as may be deemed necessary for the correct performance of the entire group. These boys have been chosen for the group because of their performance in the regular band, their apparent higher degree of mentality, and their desire to improve their own musical knowledge. The musical scores for this group consist of chorales, standard marches, waltzes and selections.

Go to any state school and you will see a group of children in some formation equal to the band playing make-believe instruments. They have seen the band marching and playing, and they in turn are playing make-believe. This is an influence the band has on the rest of the population. This might be termed an “inoculation” of the patients with music.

We have encouraged the formation of music groups for the employee personnel. It may be a band, choral group or a group anxious to put on a play. Recently at one of our institutions a group of employees banded together and put on a musical, charged admission and the benefits went for the unvisited patients. What a wonderful spirit!

In many of our institutions those who affiliate are requested to give a musical night to the patients before they terminate their affiliations.

We have created traveling units to visit the wards of the sit-ins. I can think of no other words than “Traveling Troubadours.” This is bringing the entertainment to the wards.

In some of the schools we use recorded music and show
adapted pictures to accompany the music, a reverse of the silent movie days. It helps to get a feeling of the music.

One of the things that amazed me greatly in visiting schools is to see the boys and girls playing instruments and reading notes. I know that they cannot read a very simple word, yet they can read the musical notes, play together and bring forth good music that can be danced to or given as a concert. These children are invited to numerous parades, representing various groups. They play well enough to win prizes. These trips have proved to be very educational for the children in meeting other people, sightseeing and getting acquainted with the outside world.

This presentation is not intended to be a discussion of theories regarding music therapy. I wanted to talk about our interests and the recreational point of view.
REPORT OF A GROUP PROJECT,
ST. ELIZABETH'S HOSPITAL

MARIAN CHACE

Dance and Music Therapist
St. Elizabeth's Hospital, Washington, D.C.
Chestnut Lodge Sanitarium, Rockville, Maryland

This past year I have had an experience with group sessions for people who had already become part of a group and felt secure, to a degree, within that group. I have been startled by what has happened. Upon returning from a trip a year ago I was met with a frantic demand, all over the particular hospital building where I work, to go to a group of patients. I thought something terrible had happened. We had had one dance session. Had I been very lacking in my perception of something that had happened. It seemed necessary to see this group of people at once.

They laid in my lap the thing that they wanted to do, a musical show. They already had some parodies written. They said, “We want to do a show about a group of women living together, and the dreams which they have, which must include men.” They said, “We are a group of women who are sick. We are living together in a hospital, and so we would like to do a musical show about a group of women living together in a hospital.”

They were very direct about it. The first parody they showed me made me gasp because I knew they were talking about themselves. They told me they did parodies to familiar songs so that they would not be involved with poor music. One parody was to the tune of “I Hear Music,”

I hear voices, and there is no one there,
I see visions hanging in the air,
I have nightmares in the midday glare,
I wonder why, I wonder why.
Schizophrenia is new to me,
I have a double personality.
The doctors say one is enough for me,
I wonder why, I wonder why.

Then the chorus showed their own feelings. It started like this:
Take the chip off your shoulder
Take your aches and pains to Dr. ——

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Dr. —— can help you too
Long as you can sing and laugh
You can lick most anything, etc.

The other parodies were just as much about themselves. They wanted this show to depict hospital scenes which represented what they had to say, what they had to face, how they had to live because they were sick, and what the contrast would be with what they wanted life to be like.

I was a little bit floored; I have always resisted performances. I always felt that we had to do things because we were the dance department; if one of the other departments in the hospital was doing a show, the dance department could help to do some dances. I imagined, although the patients showed much enthusiasm, some of them would find the pressure of a show too much. Perhaps this was exploiting the patients by demanding something on the basis of a relationship that was established, and they would feel obligated to make me feel happy by doing a good performance. This new project of the patients would mean laying aside some work already contemplated.

The patients' project was mammoth; they had a whole evening, a real musical show, laid out. Did they really want to do it? Was this merely something they had used to take up their time while I was away? How would the medical staff feel about it? In the plan the patients did not make wry fun of themselves as an avoidance of their illnesses. Did they really want to do this?

It was a relief, after getting medical clearance when Special Services had a Christmas show to do, so we could lay aside all of this other idea. The patients were asked if they would do this Christmas show for me. They promised to do the Christmas show only if I would promise that at the end of it we would go into this other show. There was hope, it must be admitted, that this cooling off period would serve to let them forget.

The day after the Christmas costumes were laid aside, I was met by the same patient committee with others now added to it, and told, "Miss Chace, you now have an obligation." And so, I said, "Yes, if you still want to do the show I now have to fulfill my part of our bargain."

A great deal was learned during the next few months. It was found that from the middle of January until the first week
Ancillary Therapies

in May when we gave the show that this group could work together as a group with a common purpose. They achieved great accomplishments.

At first, I was to meet with the show committee from the middle of the afternoon on, in order for me to keep up with the rest of my program, but there was not enough time to do the job in the way the patients demanded that it be done. All of the scenes, all of the dances, all details were worked out on a group basis. This took time, and so was heard, “Miss Chace, you have to give us more time.” So, it was necessary to go to the administration building, tell what was happening and ask for permission to devote my time to it.

Then came the concentrated effort, and I found that the dance department was really working harder with the patients than it had at any other time. Patients had passed through the dance sessions where they had begun to be able to express themselves in movement, and they had established a relationship with me which they felt was a safe one, so that they dared to move on. They, themselves, with a group of about thirty other patients, would offer suggestions for the show, and these would either be accepted or turned down by the committee. They learned that rejection of a suggestion was not a rejection of themselves, but that probably the group would find some other thing for them to do.

It was quite interesting to see the way the patients gave each other support. We all worked hard. We involved all the rest of the departments of the hospital in the preparations for the show, and we came through with a show that was something that belonged to the patients; it had sparkle and spontaneity. In the show they talked about themselves as people with difficulties, but with a sense of humor which was appropriate.

The medical staff was enthusiastic about the show even though the patients had established the psychiatrist as a person who plays a yo-yo and wears blinders—he took off the blinders when he read his roadmap. The nurse they pictured was always someone who was giving orders. They did not bring in the rest of the departments of the hospital, but kept it to themselves, the nurses and the doctors. They came forth with much feeling about how they would like to be. It was a good show.

Because of the therapeutic value from this group work, a pageant is planned based on the life of Dorthea Dix. This was
suggested by the administrative directors. Miss Dix established many state mental hospitals in the United States and also established St. Elizabeth's Hospital.

I have not talked about this work with patient groups before, but now I do have something to say and the work is moving on. These are wonderful group sessions where we discuss patients' problems on a safe level. When the problem reaches a personal level it can be taken to group therapy and discussed by psychotherapists. This work may seem far removed from the work of a dance therapist, but this kind of achievement was based from, and is still dependent on, the positive relationships established in the dance groups.
PART VII

PROGRESS
IN
MUSIC THERAPY
IN VETERANS ADMINISTRATION HOSPITALS
CURRENT STATUS OF THE MUSIC PROGRAM IN VETERANS ADMINISTRATION HOSPITALS

CHAIRMAN: LENARD QUINTO

Chief of Music, Recreation Service, Special Services Veterans Administration, Washington, D. C.

Before introducing the panel members who will discuss the "Current Status of the Music Program in Veterans Administration Hospitals," I would like to review some of the administrative factors pertinent to the Veterans Administration hospital system.

At present there are 175 Veterans Administration hospitals and domiciliaries throughout the United States and Puerto Rico, with a daily patient population of approximately 105,000 patients. These installations range in size from one hundred to thirty-three hundred beds, and in the interest of service to the communities in which they are located, many hospitals accept patients with all types of illnesses. Forty-five of our hospitals employ sixty-five qualified hospital music personnel whose sole responsibility is the effectuation of the music program at the hospital concerned. At other hospitals, the music program is conducted by qualified personnel in addition to their other duties.

The Veterans Administration Central Office is the coordinating and policy making center for all Veterans Administration installations. The Central Office Department of Medicine and Surgery is responsible for the conduct of a medical program comparable to the best hospital civilian care.

Just as no physician on the Central Office staff would presume to dictate to a physician in the hospital how to treat his patients, the Music Director in Central Office would not presume to stipulate what music activity, method, or selection should be used by the music therapist in a given situation. It is the belief of Central Office personnel that the responsible music therapist at the hospital is in the best position to determine what music activity or method is best for his patients. Many physicians have expressed the belief that the important factor in music therapy is not so much the activity in which the patient enters, but rather, interpersonal relationship engendered between the therapist and the patient.

For these reasons you may find in Veterans Administration hospitals music programs composed of different activities and of
varying degrees of development for similar types of patients, being conducted by music therapist and other professional staff members under the guidance of the medical staff.

Mr. Ernest Grisham, music therapist at the Veterans Administration Hospital, Murfreesboro, Tennessee, and President of the South Eastern Division Chapter of the NAMT will now describe the music program at his hospital. His discussion will illustrate the individualistic manner in which music programs are conducted to meet the needs and interests of psychiatric patients and, at the same time, carry on the directions of the medical staff.
A PROGRAM OF MUSIC THERAPY IN A NEUROPSYCHIATRIC HOSPITAL

ERNEST GRISHAM

It is known that human beings tend to develop rhythmic patterns of behavior. From a psychological standpoint, establishing these rhythmic patterns of behavior affords a degree of security, inasmuch as anything that becomes repetitive and is easily performed is capable of providing security. There is a psychological basis for development of rhythmic patterns of behavior. This is evidenced by many physiological activities which have a rhythmic pattern and over which there is no control. It would appear, therefore, that the tendency to develop rhythmic patterns must be very strong within the human organism. Recognizing how rhythm and sound affect people, it is only natural that music therapy should have found its way into hospitals, especially psychiatric hospitals, to be used as a form of treatment. We are of the opinion that persons who are mentally ill should have the same opportunities for gratification, for pleasure, for expression of emotions as those who are normal.

Throughout recorded history and possibly earlier, music has wielded its potent force on the human organism, sometimes consciously so, but more often entirely without heed. The value of music may be an emotional response, it may suggest associations, and it may aid in the personification or identification of a subject. Music is used as a diversion, a recreation, or a relaxation. To induce sleep a lullaby is sung or played to a child or a patient. Music can be, and is used to attract and maintain interest. It may help to initiate group response. Prior to a general anesthesia at the time of an operation the patient can listen to music. The use of music at this time helps to allay the patient’s fears. Subdued music is useful during mealtime. Dance music is a means of relaxation. Music tends to promote a sense of belonging. It facilitates group participation and it aids in socialization. The idea that music has therapeutic potentialities has been accepted from time immemorial. Music has been, and is being used to relieve long and lonely periods of hospitalization for the physically and mentally ill.

Mentally ill patients are often hard to understand and seem to behave in an unusual and puzzling way. This is because they act so differently from the way they would if they were well.
They are acting the way they do because of the nature of their illness.

In my opinion psychiatric patients are usually more sensitive to music than they are to what people say and do. In support of this statement personal experience has, at times, shown that music was the only agent that established contact and communication with acutely disturbed and unapproachable patients. One example may suffice to show this use of music.

Patient X was a World War I veteran from the hills of Tennessee. The first time I saw him he was in such a condition that no contact whatsoever had been or could be established. His status was such that he was continually squirming, yelling, cursing, kicking and fanning the air. It was necessary to restrain him to prevent him from harming himself. Upon entering the ward where this patient was I was told “You won’t be heard today, there is too much noise”. I said: “I’ll try anyway.” I rolled the spinet organ as closely to this patient’s chair as possible and began to play the tunes I thought he had heard or enjoyed. Several minutes of this transpired without any results. The music was continued and the rest of the patients in the ward had become quiet and were listening to the music as much as was possible. I started playing a selection titled “Darling Nellie Gray.” Through the first stanza and chorus, nothing happened. The second time through I noticed that patient X’s foot began patting the floor in rhythm with the music, then a gradual swaying from side to side began, and suddenly the patient began to whistle along with the organ. The nurse, who in the meantime had come into the ward, noticed him. I softly spoke to the patient, saying: “Do you like this music?” A nod of the head was the only response. Then I asked: “Does this tune bring back memories to you?” The patient, to everyone’s surprise, answered: “Unh-hunh! My wife used to play that tune on the guitar and I would whistle along with her.” Rapport had been established. The music was continued and the nurse talked with the patient. He began to relax and talk more freely. This music served as a non-verbal communication, a primitive bridge to a withdrawn patient.

Our hospital music program covers many phases. No forceful methods are used to encourage participation. Friendliness, suggestion, a pleasant voice, a sunny smile, the respect which the patients hold for the music therapist, and the rhythm and melody
association of the music are the factors upon which our participation is based.

Dr. Samuel E. Abel, Chief of Professional Services of this Hospital, makes this statement:

I have often maintained and repeatedly stated that it is not only the activity in a hospital which brings about the desired effects, but even more important it is the individual who is responsible for and supervises the activity. For example, we may have two music therapists who, technically are equally skilled, but one has enthusiasm for his work. He loves to work with people and has the facility to establish excellent relationships with people who have lost their ability to communicate with others in a normal manner. Although the other musician is technically skilled, the results achieved will be as different as day is from night. Our work requires persons who have strong feelings for those who are mentally ill, and are willing to work with them.

Complying with the physician's request, music is used quite extensively in the waiting, treatment and recovery rooms used in electro-shock therapy. The music therapist, by careful selection of his material, is able to establish a cheerful atmosphere in the pre-shock waiting room. The live type of music, rather than records is preferable here, because the patient is able to see the musician actually perform and can make requests for his favorite music. Patients still have, even though concealed, the consenting attitude to admire the "maestro," so in the waiting room the spinet organ, piano or other various musical and rhythm instruments are used. Patients are, also, encouraged to participate in group singing or to play instruments. In this type of program the patients' apprehensions, fears and disturbing thoughts are allayed and diverted from the on-coming treatment. Recorded music is used in the recovery room in accordance with accepted principles. Soothing, sleep-inducing recorded music with a regular, smooth, rhythmic beat is used continuously during insulin coma therapy. It is the opinion of the therapist that the excitement stage of the treatment has been modified with gratifying results. This same type of recorded music is used in the neutral pack and hydro-therapy rooms.
Groups of patients, designated by the ward physician, are brought to the music room for prescribed group participation. It is also in the music room that prescribed groups or individuals are offered listening, quiet hours and music appreciation periods. Here they are encouraged to make their own selections of music they would like to hear. When asked their reasons for wanting to hear a particular selection their answers invoke a great amount of interpersonal discussion in the group which helps resocialization.

Musical instruments are taken into the wards and day-rooms, and the patients are invited to participate for their own entertainment as well as to entertain the entire group. Musical talent is readily discovered and developed through this media.

Our use of music in the dining rooms at mealtime is prescribed by the physician. Semi-classical selections and selections of the popular type that have an even, flowing rhythm, when presented in a subdued, yet audible manner, produce a relaxation among the patients that promotes better table manners, a more healthy appetite and a warm friendly feeling throughout. A much more restful attitude prevails in the dining room during the entire meal.

Subdued music is used in the library by means of recorded programs carefully chosen by the music therapist. Organ recordings are the most suitable here, for organ music, especially from classics to popular to hymns, softly played, has no distraction to readers; at the same time it is entertainment to non-readers who are usually too disturbed to read.

Community sings are presented prior to movies. An effort is made to include as many songs used in the movie as possible. This tends to create a greater interest in the movie.

Orchestras and small ensembles are formed for patient participation. Rhythm bands are formed with the more regressed patients.

Classes of related instruction, musical theory or vocal study are presented to those patients who are interested in or express a desire to study music in this form. Our patients are encouraged to relate music to their everyday living, thereby giving them an outlet in relaxation, group work and restful thinking. During the postlobotomy education period, familiar music, such as folk music, folk songs or rhythmic music is used with these patients.
They are encouraged to participate, even to singing or playing instruments.

One evening each week is devoted to a session called "Music Open House." Sometimes pertinent musical films are shown and discussed. At other times musical games and quizzes are enjoyed.

For the common things of every day
God gave man speech, in the common way.
For the deeper things men think and feel
He gave the poet things to reveal.
For heights and depths no words can reach
He gave Music—the soul's own speech.

Mr. Quinto:

For the purpose of seeing how one hospital through the use of patient behavior scales improved its service to patients through music, and at the same time improved the therapist's relationship with the responsible medical staff, a paper prepared by Mr. James Gregory concerning this phase of his work while he was at the Veterans Administration Center, Waco, Texas, will now be read by Mr. Jacob Glazer, Director of Music at the Veterans Administration Hospital, Perry Point, Maryland. Mr. Gregory is now the Supervisor of Music and Radio at the Veterans Administration Hospital, Salisbury, North Carolina.
THE USE OF PATIENT BEHAVIOR SCALES IN THE MUSIC SHOP, VA HOSPITAL, WACO, TEXAS

JAMES GREGORY

The 2,040 bed psychiatric hospital which is part of the Veterans Administration Center at Waco, Texas, has a meaningful music activities program consistent with current medical policies, and which meets the treatment needs of patients in that hospital. The music program is under a music director who supervises one psychiatric aide assigned to transport patients to and from the music shop, as well as two volunteers assigned to the music shop to give private instruction. Patients participating in music activities include those who have had lobotomies, are undergoing insulin or electric shock, have tuberculosis, or are senile, and the physical and mentally handicapped. Music activities include ward sings, a hill-billy band, choral groups, rhythm bands, and private instruction in various instruments.

Before the use of patient behavior scales was begun in the music shop eight months ago, it was the policy of the ward physicians to refer patients without asking for any monthly reports on the behavior of the patients in music activities. One reason for this was that, previously, no provisions had been made for sending out such monthly reports to the physicians. Due to the crowded schedule of the ward physicians it was difficult for the music director to confer with physicians in staff conferences regarding the behavior of patients while engaged in music activities. Therefore, the physicians were not always aware of the behavior of their patients assigned to the music shop. However, when patients interested in music activities were referred to the music shop the music director contacted the appropriate ward physicians who signed the clearances for those patients to participate in music activities.

In the hope of creating a better liaison between medical personnel and the music director regarding behavior of patients participating in music activities as well as having the music program recognized for its therapeutic as well as recreational value, the music director decided to use a rating scale for patients participating in music activities which could be sent to the proper physicians once each month. After some deliberation, it was decided to use part of the Patient Behavior Scales devised by Lorr, and his colleagues in the Veterans Administration. These Patient
Behavior Scales were intended primarily for the systematic recording of patient behavior by psychiatrists and psychologists. The ward behavior section of the scale may be used by nurses and psychiatric aides who know the patient well. It was found that this particular set of scales could also be used by music personnel, for the checking of patient progress in a music program.

In the selections from, and modifications of the Lorr Patient Behavior Scales which were used in the VA Hospital in Waco, patients were rated on eleven items: appearance, activity interest, cooperation, speech production, social behavior, mood level, assertiveness, friendliness, self-sufficiency, emotional behavior (appropriateness), and attention. Most of the evaluations are made on a six-point scale. Ratings of "A" and "F" are assigned to extreme deviations of behavior, while ratings of "B" and "E" are given to intermediate or mild deviations of "normality." If behavior is relatively normal the ratings given are "C" and "D" depending upon the direction in which the patient's behavior tends.

Item 1, APPEARANCE, is rated on the patient's appearance as observed in his activities in the music shop as well as on ward music activities. This item is especially observable when the patients with privileges make off-station trips for music activities.

Item 2, ACTIVITY INTEREST, is rated on the amount of interest shown by the patient in his music activities. The scale of activity interest ranges from the patient who shows no interest in music activities around him and stops activity immediately if supervision is relaxed, to the patient who tends to become completely absorbed in, and enthusiastic about the music activity in which he engages. The latter-type patient is usually the patient who actively voices his desire to participate in all music activities as well as helping the music director in the planning of musical programs.

Item 3, COOPERATION, is rated on the cooperative attitude of the patient and varies from the patient who is actively cooperative and willingly follows the music routine, to the patient who is passively resistant and tends to become difficult, requiring urging and persuasion before complying with the music activities routine.

Item 4, SPEECH PRODUCTION, is rated on the patient's speech production in the music shop and as observed in social recreation parties when the patient is actively participating in a
music activity. Speech production varies from the patient who is noisily overtalkative, shouting and yelling, to the patient who is mute for one or more music activity periods at a time.

Item 5, SOCIAL BEHAVIOR, is rated on the patient's social behavior as observed in the music shop as well as on musical recreation parties on the wards. The social behavior of a patient varies from the patient who is constantly with others and avoids being left alone, to the patient who is nearly always seclusive and isolated, never talking or playing with the group. The latter type of patient is usually the one who stays on the fringe of the music group during rehearsals and performances, moving away from people in social groups. Patients who are enrolled in private instruction only, are not rated on social behavior due to the fact that this item is not noticeably observable when a group is not present.

Item 6, MOOD LEVEL, is rated on the patient's mood as observed during the music activity periods. The mood level varies from the patient who is gay and exuberant, ignoring the unpleasant aspects and difficulties of a situation, to the patient who is very depressed, melancholic and cannot be cheered.

Item 7, ASSERTIVENESS, is rated on the patient's assertive attitude as observed in the music activities. At one extreme is the patient who orders other patients around and/or tells the music director what to do. In this category is the patient who, when entering the music shop to join a group music activity, walks over to another patient and takes his musical instrument away from him. The opposite extreme is the patient who is submissive and docile and easily pushed around or dominated by other patients.

Item 8, FRIENDLINESS, is rated on the patient's friendliness as observed during the music activity periods in the music shop and on the wards. The friendliness of a patient varies from the patient who is approachable, trustful and free of suspicion as well as easy to speak to and to get along with, to the patient who is usually difficult to approach or to get along with, suspicious and unreasonably hostile without apparent justification, and who may feel persecuted.

Item 9, SELF-SUFFICIENCY, is rated on the patient's self-sufficiency in music activities. At one extreme is the patient who does not depend upon others in situations calling for independent decisions and action. This type of patient will accept respon-
ibility and does what he says he will do. He is usually dependable and consistent in his day to day behavior. At the other extreme is the patient who is completely dependent for support and direction of all activities. He is usually unable to make his own decisions and cannot be depended upon to carry out even simple tasks.

Item 10, EMOTIONAL BEHAVIOR: APPROPRIATENESS, is rated on the appropriateness of the patient's emotional behavior while engaged in music activities. Emotional behavior of patients varies from frequent and unpredictable silly giggling or laughter without appropriate stimulation, to spontaneous and natural responses to the demands of the situation.

Item 11, ATTENTION, is rated on the attention of the patient while engaged in music activities. Attention of patients ranges from the patient who is markedly distractible by internal and external conditions, and who finds it difficult or impossible to focus his attention on any objective, to the patient who is completely withdrawn and apparently occupied with his own thoughts, and cannot be influenced to pay attention. Between these two extremes are the patients who are normally alert to changes in the environment, show the usual attention span and who are able to give attention.

Prior to filling in the monthly patient report sheet, the music director confers with the psychiatric aide and volunteers assigned to the music shop. In these conferences, the behavior of patients participating in music activities is discussed. Once each month, the patient behavior scales are filled out; one copy is sent to the patient's ward physician, and the other copy is filed in the music shop for reference regarding the patient's progress.

The use of patient behavior scales in the music shop has brought closer cooperation between medical personnel and the music director. Recent patient prescriptions from the medical staff for music activities have included the patient's diagnosis, some of his background, and immediate treatment aims. The music program at the Veterans Administration Center, Waco, Texas, is now being recognized more fully by medical personnel for its therapeutic value. This could not have been accomplished in the space of six months without the proper use of patient behavior scales in the music program.

Mr. Quinto:

At still another Veterans Administration hospital, certain
factors influenced the medical staff to change their emphasis from individual work with patients to group work. How this was accomplished will now be discussed by Mr. Donald Michel, former Director of the Music Therapy Department at the Veterans Administration Hospital, Topeka, Kansas. Mr. Michel has recently assumed his duties as Assistant Professor of Music Therapy, Florida State University, Tallahassee, Florida.
Neither group therapy nor the use of music in groups for therapeutic purposes is new. At the 1953 NAMT conference, Dreikurs spoke on the possibilities for the use of music in group therapy and urged further exploration of such possibilities. During the past year there appears to have been an upsurge in general interest in the use of group therapy in clinical practice at various places in the country. It has been this writer's privilege to observe and experience some of the results of this resurgence of interest at the Veterans Administration Hospital, Topeka, Kansas. Here therapists were urged to try group therapy methods, not as the method of economy or convenience, i.e., to reach large numbers of patients, but as a treatment of choice, along with other treatment approaches already in use. Group leaders organized special groups, or made use of already existing groups such as one ward of patients, and began application of group therapy methods. One of the important developments was the reawakening of interest in the use of "activity" groups as media for specifically applied group therapy methods.

Out of this developed "project groups," i.e., a group would decide upon a useful project and pursue it as a group, using discussion periods and "social" hours to work out project problems, which resulted often in approaching problems as a group that perhaps could not have been approached individually. Within this framework it was possible to reorient certain already functioning hospital musical groups and to organize certain special activities involving music, in which and through which it was possible to apply group therapy principles. There is yet much to be learned, but a few observations of a general nature were possible and it is the purpose of this paper to present them for whatever value they may have at this point.

It might be worthwhile first to point out a few of the benefits claimed for the group therapy approach. Some of these are: the group presents a medium for stimulation of socialization; the group helps the isolated person to begin to relate to others; the

group provides a collective 'ego-strength with which the individual can identify himself; and the interaction of a group discussion may help to generalize problems which have been previously thought of as specifically and peculiarly those of the individual. In considering the use of music in groups for therapeutic purposes it is first necessary to consider what music can offer in different situations and where there might be a demand for the use of music in such groups. It was speculated that music in various forms had much to offer both to groups organized as discussion groups and project groups, and, as a medium for the organization of special project groups. In the former it was believed that the mood-influencing qualities of music could prove useful and in the latter, that many forms of music activity of varying degrees of participation from record listening to rhythm bands could be employed.

Several opportunities presented themselves for the application of functional music in both types of situations. On a ward of regressed, "chronic" schizophrenic patients one physician was favorably impressed with the effects of a fifteen-minute recorded music program played through overhead speakers on the ward immediately preceding his group therapy meeting. Although no attempt at scientific evaluation was made, it apparently was possible either to stimulate the group into effusive conversationality or to sedate them into reticence through this musical program. Out of the physician’s interest and observation of these phenomena there was later developed a specifically selected group of eight or ten patients on another ward for record-listening activity. These patients were considered the most disturbed and most combative patients on the ward, yet all of them questioned, had expressed an interest in listening to records. The group met twice a week at the music clinic and it was a period of almost four months before it was realized that there was no need for the special attendant who had been accompanying the group in case disturbance developed. No fights or disturbed instances occurred over this period of time and it was felt that rapport, group interaction, socialization and group identification were beginning to take place in this group of very ill patients. Follow-up with more intensive group therapy was planned.

Music as an adjunct to several project groups seemed to work out successfully and to become an important part of the total program of group therapy in the hospital. For example, a
women's occupational therapy project group which had completed several worthwhile projects such as making "scuffies" for other women patients and making doll clothing for dolls to be given to orphans, expressed a need for group singing during their social hours, which served also as therapeutically valuable discussion periods. A music therapist was assigned and chose carefully planned music to be sung, not only according to the interest and desires of the group but also with consideration given to those songs which would help increase feelings of fellowship and express relatedness within the group. Consideration was given also the mood effects of the songs used. The group "sing," held weekly, was considered to be an important contribution to this form of group therapy.

In another instance, a men's occupational therapy project-group encountered difficulty in getting organized and in finding a suitable group project. A music therapist was requested to furnish background music preceding the group meeting and some success was found in stimulating conversation in the group. The conversation turned frequently to the music and to requests for special selections by some of the patients. Eventually, rhythm instruments were introduced and patients were encouraged to participate rhythmically with the music which was played from recordings. From a tactful suggestion by the group leader, the patients became interested in making their own percussion instruments and this turned into the first real "project" for the group. This project seemed to enhance the further accomplishment of group therapy aims with this particular group.

In addition to these approaches to the use of music in group therapy, some consideration was given to the study and use of group therapy methods in existing musical groups such as the hospital dance orchestra. Discussion of some of the "superficial" problems of the group and its activity by patient-members of the group was encouraged. Significant remarks made by individual patients were noted and later reported to their physicians or psychotherapists in order that an opportunity for further work on the problem indicated might be followed up. Also, by this means music therapists were able to seek direction and help from physicians in encouraging or discouraging further discussion of a particular subject by individual patients within the group.

In order to obtain more complete and significant evaluation of group therapy methods with music therapy it would seem that
there are several prerequisites. In the first place, it appears that this is a field for investigation by serious research, carefully and scientifically designed. Secondly, there is an obvious need for those of us who would try to use group therapy methods in music activities, to study such methods and become skilled in using them, so that more than a cursory approach can be made to their application. And, finally, it would seem that there is a need for closely cooperative work between music therapists who would use music as an adjunct to other forms of group therapy and those therapists who desire such usage.

In this paper an attempt has been made to report briefly some of the applications of group therapy methods with music therapy as they have been observed in one hospital. Very little significant evaluation can be made until more serious research is done in this area, but it would seem that the field is one of considerable interest and offers many possible interesting leads if further pursued.

Mr. Quinto:

An idea left to follow is sheer waste. And, we in the Veterans Administration would be accountable, as a government agency with the largest hospital system, if we did not encourage discussion, pilot studies, and research. Mr. Norris Birnbaum, Director of Music Therapy at the Veterans Administration Hospital, Lyons, New Jersey, has developed, in cooperation with the hospital's medical staff, a thematic projection test employing music.
THE MUSICAL THEMATIC PROJECTION TEST

NORRIS BIRNBAUM

The Musical Thematic Projection Test used during the past year at the Veterans Administration Hospital, Lyons, New Jersey, was developed by Dr. Sidney B. Jenkins, resident in psychiatry, and Mr. Norris Birnbaum, Director of Music Therapy. Since Dr. Jenkins' transfer from the hospital, Mr. Birnbaum has revised the test and has been administering it under medical guidance in its revised form.

The test, which takes less than a half-hour to administer, consists of a series of ten recorded musical excerpts, all under one minute in duration, selected from the standard classical and modern repertoire, but carefully differentiated with respect to melodic and harmonic idiom, dynamics, tempo, and expressive content. The composers represented are Handel, Gluck, Beethoven, Brahms, Franck, Debussy, Khatchaturian, Milhaud, Thompson, and Stan Kenton.

After each selection is played, the subject is asked the following three questions and his responses are recorded by the examiner:

1. What does this music make you think of?
2. What part of the music brings that to mind—the first, the middle, the last parts?
3. What do you think there is in this music that brought those thoughts to mind?

To date, the revised test has been given to a relatively small number of mental patients and to a small group of employees as normal controls. It is believed, however, that the trend of the responses already obtained justifies the administration of the test to a large sampling of individuals. Further, on the basis of what has been done thus far, it is felt that with continued analysis and evaluation and the establishment of norms, additional means for the description and classification of mental illness might be provided.

Mr. Quinto:

An idea which was harnessed and developed into a research problem has recently been completed at the Veterans Administration Hospital, Albany, New York, by a psychiatrist, psychologist and a music therapist. Mr. Wallace Kotter, the music therapist working with this study and one of the professional assistants
sent to our hospitals by the Hospitalized Veterans Music Service, Musicians Emergency Fund, will now discuss the work that he, Dr. Leo Shatin and Dr. Thomas Gilmore accomplished during their study of the relationship between music and post-electro-shock awakening.
A STUDY OF THE RELATIONSHIP BETWEEN MUSIC AND POST-ELECTROSHOCK AWAKENING

WALLACE KOTTER

This study was undertaken at the Veterans Administration Hospital, Albany, New York, by Dr. Leo Shatin, Chief of Clinical Psychology, Dr. Thomas Gilmore, Assistant Chief of Psychiatric Service, and the writer, working with the doctors as a representative of the Hospitalized Veterans Service of the Musicians Emergency Fund of New York. The results of this study were published in the medical journal, Diseases of the Nervous System.¹

After having read much of the literature concerning music with shock treatments by pioneers in the field, such as Altshuler, Van der Wall, Leedy and Leedy, Price, Mountney and Knous, Browne, Eustis and others; Doctors Gilmore and Shatin became interested in conducting an experiment to determine a proven answer to one small aspect of the many problems encountered in investigating scientifically the use of music with shock treatments.

Viewing the immediate post-convulsive state as physiologically induced regression, we became interested in the effect of musical rhythm on patients recovering from electro-shock treatment. A research design was then organized to test the hypothesis that:

Speed of awakening after electro-shock treatment is related to the presence and type of music played during the administration of the treatment, and during recovery. Three conditions were created: Silence, Music A, and Music B.

Music A consisted of smooth, orchestral arrangements of classical and lighter quiet selections, such as Tchaikowsky’s “Andante Cantabile,” Kreisler’s “Liebeslied,” and St. Saen’s “The Swan.”

Music B was made up of bright, loud, jazz arrangements of selections such as “Wildroot,” “Limehouse Blues,” “Hobnail Boogie” and “Jungle Drums,” played by the popular bands of Woody Herman, Count Basie, Gerry Mulligan and by small Dixieland groups. The music was pre-recorded and played from

a tape machine in the recovery area. It could also be heard at the treatment table.

The jazz was probably more familiar to most of the patients we were treating, Korean and World War II veterans, who probably had heard such music over radio, TV, and juke boxes.

Electro-shock treatment is administered at VA Hospital, Albany, New York every Monday, Wednesday and Friday morning. The experimental design was as follows:

1st Week: Monday—Silence; Wednesday—Music A; Friday—Music B.
2nd Week: Monday—Music A; Wednesday—Music B; Friday—Silence.
3rd Week: Monday—Music B; Wednesday—Silence; Friday—Music A.

In this way the two types of music and the silent period were staggered, so that a different listening situation was created on the same day of each week.

Pre-medication and sedation as required were constant for each individual patient. As there never had been pre-shock music at this hospital, none was used during this study in order not to interfere with the findings on post-shock music. However, prior to shock, patients continued to have group meetings with the doctor.

Meetings were held with the doctors, nurses, and attendants of the electro-shock treatment team. The method and purpose of the study was explained, and possible sources of error were discussed.

A card was prepared for each patient who received treatment, providing space for the date, numerical order in treatment series for that day, time of administration, time of first awakening, time of leaving the recovery area, and special remarks. These entries were made by the nurse at the treatment table and the attendant in charge of the recovery area. All time records were accurately maintained to the minute by synchronized watches.

The recovery procedure utilized for this study was similar to that regularly followed at the hospital except for the addition of the music. After the patient left the recovery area, he was given breakfast, and then had a brief interview with the clinical psychologist, who saw the patients in the order in which they had received treatment. He interviewed each patient individually in a small office on the ward, asking these questions:

Do you remember hearing any music today?
What kind of reaction do you have to it?
Is there anything you would like to say about it?
How long were you asleep this morning?
When necessary, the interviewer asked additional questions to clarify the patient's response.

Although many patients received treatment during the period of the experiment, statistical analysis was necessarily limited to small samples for several reasons:

1. Patients were discontinued from treatment at various points during the investigation.
2. Some were on maintenance dosage rather than full course of treatment.
3. Medical illnesses played a role in decreasing sample size.

Inspection of the findings suggested marked individual differences in speed of recovery. It was therefore necessary to limit most of our analyses to those patients who had gone through all procedures, i.e., Music A, Music B, and Silence, during the complete test, so that results would not be altered by substitution of subjects among the various methods. For these reasons, small sample techniques were mandatory.

There are four statistical tables in the report in Diseases of the Nervous System giving:

1. Comparisons in the speed of awakening after shock with the two kinds of music and silence.
2. Probabilities drawn from t-tests of the significance of difference in the recovery times.
3. The proportion of patients recalling music after treatment, both when there had been music, and when there had not.
4. Chi-Square tests showing the significance of the patients' responses.

The charts are rather involved for explanation here, but they do show that chances are 95 out of 100 that the bright jazz definitely leads to more rapid awakening than silence. Furthermore, they show that the chances are 999 out of 1,000 that the jazz induces the patients to leave the recovery area more speedily. The proportion of patients recalling whether or not they had heard music was an unusual finding. When there had been no music, 87% properly replied "No," when questioned after recovery. After quiet Music A, 67% replied "Yes"—and 33% said "No." But, after Jazz Music B, 73% replied "No, they had not heard any music."

1. Wallace Kotter, op. cit.
It is therefore reasonable to infer that such jazz music accentuates the confusional effect of electro-shock treatment, insofar as a confusion effect is reflected in the misperception or recall of the presence of music.

In answer to the question: “How long were you asleep this morning?”, it was found that only when there was silence were the patients able to make an approximately valid judgment of the length of time they remained in the recovery area, thus, reinforcing the inference that music, particularly jazz, accentuates the confusional effect.

Because each individual varied considerably in his time of recovery, even under the same procedure, each patient was compared with himself for speed of recovery under each condition. The conclusion was that bright jazz evokes greater consistency in recovery time for the individual patient. In other words, it means that an individual patient’s speed of recovery may be more readily predicted under bright jazz than under conditions of silence or quiet music.

The initial hypothesis for this study may be answered affirmatively: (1) music during administration of and recovery from electro-shock treatment does affect speed of awakening; and (2) types of music may be differentially important in this regard. The individual component aspects of music require investigations in order to determine what are the differential effects of variations in volume, timbre, pitch, and varying rhythms. Although music constitutes a configuration which goes beyond the sum of its individual parts, it is possible that analytic investigation of its components might yield data such that the effect of an individual piece of music, played at a certain tempo, and by certain instruments, upon speed of post-electro-shock awakening could be predicted.

In this study only bright jazz was used to compare with silence and smooth, quiet music. Was it the rhythm, or the volume, or the familiarity of the jazz which made the difference? Perhaps symphonic music, or exciting drum rhythms, or just plain noise would bring about similar, or even greatly different results.

The findings here reported suggest that music potentially can increase the confusional effect of electro-shock treatment, an effect considered by many physicians to be one of the most important ones of the treatment. It was noted that bright jazz caused a significantly great proportion of patients to forget or to
misperceive the presence of music. It was also noted that only where there was no music could the patient make a relatively accurate estimate of the time he had been asleep. Should other investigations verify that confusional effect which follows electroshock treatment is accentuated by certain qualities of music, then implications follow concerning the spacing of treatments, such as in the "regressive method" which attempts to induce confusion completely and quickly. In this method the patient is given shock every day, and sometimes more than once a day for a short period. If music can aid in producing the desired confusion, the number of actual shock treatments might then be reduced.

You may be sure the authors realize that the findings of this experiment point to continued study and are planning further research in this field.

Mr. Quinto:

And now you have the current status of the music programs in Veterans Administration hospitals. It is the sincere hope of the Veterans Administration that we are meeting the challenge which you, as taxpayers, can rightly expect of us.
PART VIII

THE MUSIC THERAPY EDUCATION PROGRAM
Each of the three members assumed a particular responsibility during the past year. Dr. Gaston established contacts with the Education Committee of the American Psychiatric Association and prospects are bright for counseling from that group concerning our education requirements. Even though such advice may be unofficial it should aid us in adhering to sound educational program.

Mrs. Harbert was given the assignment of studying the clinical training programs in music therapy of various hospitals. Some information was revealed, but a true picture will not be possible until the comprehensive hospital study now under way is completed. It is hoped by our committee that every effort will be made to expedite this study.

Your chairman was responsible for answering requests for information forwarded to him by other members of the committee and various officers, members of the Executive Committee, and the Allen Press. In all, more than three hundred fifty personal letters went out and approximately 2500 career brochures were distributed. A gradual rate of increase in the number of requests is noted. Even though many of these requests are made from sheer curiosity it is felt that the time, effort, and money spent on the dissemination of accurate information about music therapy is well spent. It is hoped that a considerable increase in the number of people choosing this field as a career will result. However, until the beginning pay of a trained music therapist compares favorably with beginning school teachers who work on a ten month basis, or with other professional therapists, we cannot be too optimistic. It must be admitted that the pay scale of all employees in mental hospitals is low, and it is not a problem this association can solve by itself.

Respectfully submitted,
Wilhelmina Harbert
E. Thayer Gaston
Roy Underwood, Chairman
THE PRESENT STATUS OF CLINICAL TRAINING IN MUSIC THERAPY

WILHELMINA K. HARBERT

Professor of Music Education
Director of Musical Therapy Clinic
College of the Pacific, Stockton, California

According to our constitution, the National Association for Music Therapy has four main objectives: the progressive development of the use of music in medicine through:

1. Advancement of research.
2. Distribution of helpful information.
3. Establishment of qualifications and standards of training for therapists.
4. Perfection of techniques of music programing which aid medical treatments most effectively.

The Education committee of NAMT is especially concerned with the third objective, “Establishment of qualifications and standards of training for music therapists.”

To present an adequate report to this meeting on the present status of clinical training in music therapy one would have needed a grant for a year, and one assignment only to visit all the hospitals, residential institutions and clinics where training is being offered and discover what the real situation is. From the letters which I have received thus far, may I say that apparently we have much variety but little coherence in our training programs. Since effective clinical training in music therapy assumes an adequate educational background, we must first examine our college training programs which are supposed to provide sufficient foundations for our potential music therapists.

In order to bring some pertinent information to this meeting, Dr. Roy Underwood, Chairman of the Education committee, provided me a list of eleven colleges and universities which have in the past or now do provide courses in music therapy. We realize that there may be other schools offering training in this field, but so far we have had responses only from the eleven from whom we sought information. One of the schools reports that they do not offer any courses in music therapy at the present time. Therefore, I shall present information only from those schools which have curricula leading to the professional degree
or who offer graduate work in the field and who have clinical affiliations with hospitals which provide in-service opportunities for our music trainees.

The basic curricula of our colleges and universities in music therapy vary all the way from one course of a few weeks duration to a complete four year sequence leading to the Bachelor’s degree, plus six months to a year of clinical training in neuropsychiatric hospitals. It is heartening to note, however, that all colleges and universities offering programs in music therapy seem to recognize the need for a firm foundation in music education, adequate sequences in psychology and sociology, and applied music with emphasis on piano, organ, voice and other instruments. In reading our most recent college bulletins today, we discover what seems to be better conformity to the educational requirements as adopted by this association. However, we must admit that it is not what looks well in print which provides the basis for final judgment of a program of professional training, but rather observation of the program in action which will help us most in setting up better and more unified standards.

To give you a clearer picture of the general patterns of training programs now being offered in music therapy, I shall discuss these under four general classifications:

1. Those which tie in closely with Occupational Therapy programs in our hospitals.
2. Those which use the Bachelor’s degree in Music Education as the basis for intern requirements.
3. Those which emphasize training for the professional field of music therapy with the addition of some education courses.
4. Those which provide for clinical training in music therapy only at the graduate level.

In this report we are not giving the names of the schools. At the present time it seems best to make some general statements about these colleges whose training programs we are evaluating. It is the hope of the Education Committee that we shall be ready to give you a much more detailed and specific report at our next annual meeting.

The first school on the list indicates a well-balanced curriculum with a sequence leading to the Bachelor of Music degree in music therapy. This is followed by a six month’s period of clinical training in a nearby hospital. From this hospital comes
the following report: "This hospital has an active music program as a part of the total adjunctive program which is threefold: diversional, educational, and occupational, and is geared to the ward programs, small group programs, and the intensive individual treatment. The emphasis is always on the use of music as a medium for promoting healthy attitudes and constructively channelling emotions into pleasurable experiences—all a part of the hospital effort toward rehabilitation."

From one of our universities, which has recently inaugurated a music therapy program, we received the following information: "With regard to our curriculum in music therapy here, it meets with NAMT-NASM recommended curriculum while meeting certain of our university requirements such as general education . . . Our clinical training facilities are not yet established, so we could not make a report on them at this time. However . . . we should be able to make some announcements about it soon."

Since 1946, one of our state-supported schools has provided a four year sequence leading to the Bachelor of Music or Arts degree in Music Therapy. This is followed by six months internship or clinical training by arrangements with three well-known hospitals.

Another state-supported school sent in the following statement. "Our program is based upon the Bachelor of Music Education degree. The amount of clinical practice necessary for a degree is, at the present time, in a stage of flux. We are attempting to have students start some activity work in hospital practice at the sophomore level, and having them continue this practice in their junior or senior years. The amount of credit offered for this activity is not sufficient to warrant the time each student puts in, but as yet, we have found no way to find room in adding more credit hours."

A long-established program leads to the Bachelor of Music Education degree with teaching and certification in that field as an asset for the would-be therapist. Quoting from a letter from the Director of this program we have this statement: "Our students may get their clinical training at V.A., State or County hospitals. We also have an arrangement with a children's hospital school, and many students have received valuable experience there with handicapped children. The internship may be taken

*NASM: National Association of Schools of Music.
after the third or fourth year, depending "upon the completion of certain courses. Six months practice in mental hospitals are required conforming to NAMT regulations."

One of our private colleges reports a four year plan with the Bachelor of Music Education degree to be followed by clinical training under the occupational therapy department in a psychiatric hospital. The length of time for this training is not indicated.

One of our conservatories connected with a liberal arts college offers a four year sequence conforming to NAMT and NASM requirements, leading to the degree of Bachelor of Music in Music Therapy or the Bachelor of Arts with the major emphasis in music therapy, and a possible teaching credential or certificate. This course was inaugurated in 1946, and now provides for graduate work during the period of clinical training, which must include work in clinics or hospitals for exceptional children as well as the six months training in a psychiatric hospital.

Another conservatory uses the Bachelor of Music Education degree as the basis for the Master of Music Therapy degree. "During the clinical training period the following courses are taken under the direction of staff psychiatrists: Clinical Psychiatry and Medical Psychology. Nine months internship follows in various Occupational Therapy programs. In conjunction with the above courses, the student will be expected to continue his musical studies."

A new undergraduate program in one of our conservatories provides a sequence leading to the degree Bachelor of Music in Music Therapy. Quoting from the information recently received, "Courses of professional training for music therapists include clinical affiliations for its students at a well-known hospital. This program has been established since 1946. At this time, in addition to these trainees, the hospital employs a full time music therapist, and uses a great many volunteer workers."

One of our state universities reports the Bachelor of Music Education degree as a prerequisite for work to be done in the professional field of music therapy. This must be done at graduate level. Students intern at a State, V.A., or private hospital, completing their graduate work including the thesis during this period, and having the benefit of the services of a music therapy consultant and director of their graduate work.

Of the ten schools reporting to our committee at this time,
we find that five of them require the Bachelor of Music Education degree as a prerequisite to clinical training in hospitals; three schools provide for the sequence leading to the Bachelor of Music degree in Music Therapy to be followed by clinical experience; two schools stipulate that all work in Music Therapy shall be at graduate level; students from four of the schools do their clinical work in hospitals under the supervision of the Occupational Therapy Department; trainees from four of our colleges and universities are under the direct supervision of a Music Therapist during their internship, and two schools did not report on this.

It is evident from this report that we do not have uniform standards of training for our students. We are well aware of the fact that much more thorough investigation on our part is needed to do justice to our leaders who are making many efforts to improve the situation. We welcome your cooperation in giving us helpful information and constructive criticism which will lead to higher standards of training for our music therapy students today, and thus will mean better qualified professional music therapists of tomorrow.
A CLINICAL TRAINING MODEL FOR MUSIC THERAPY

WAYNE W. RUPPENTHAL

Director, Psychiatric Music Therapy
Topeka State Hospital, Topeka, Kansas

The Psychiatric Music Therapy department at Topeka State Hospital was inaugurated in 1949 and, having been established in a training and treatment hospital, from the beginning it was expected that the department would have a clinical training program as many other hospital departments have. Without guides, other than a limited experience at Winter Veterans Administration Hospital, this program was set up on an apprenticeship basis. Thus, the student would spend six months working with patients. This might or might not include his research project. He would attend staff conferences, consult with other staff members, and in general obtain psychiatric hospital experience in the use of music.

After four years of experience with this kind of a program, during which time four interns were trained, it became apparent that the internship experience could be made much more fruitful and meaningful if it were structured in such a way that each intern would be assured of a well rounded, well defined set of experiences which would serve as a complete foundation for later professional work. Without such organization it was difficult to maintain a common core of experience for all interns and to make certain that each intern took full advantage of the maximum learning possibilities within the hospital.

Furthermore, as the hospital’s education program developed, each of the other professional training programs became more refined and more formal as each discipline sought to make its training program as professional in character as possible. Thus, in order to maintain and increase its professional stature, the Music Therapy department also had to refine and develop its training program.

The need to develop further the music therapy internship in keeping with these circumstances demanded that the entire internship be thoroughly reconsidered and that the internship be firmly established on solid theoretical and clinical grounds. For this purpose a series of meetings was held between Dr. Gaston, representing our affiliated school, the University of Kansas, Dr. Levinson, representing the hospital’s professional education de-
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partment, and myself, representing the music therapy department. From these meetings came the following statement of principles:

Introduction

All people have cherished music because of its unique necessity to man's emotional and social well-being. It has offered appropriate emotional commentary on those chief circumstances of his life which most distinguish him as a human being. From the lullaby to the dirge music has spoken for him, and to him, when words could not. Music has comforted him, has inspired him. It has enhanced his religion, enriched his relationships, and represented his loves and his hates. Sufficiently often it has clothed reality with "delightful illusion" so that he might feel freedom and experience pleasure.

By far the greater part of music has some psychological or sociological aim in view other than the purely aesthetic. Music whose primary purpose is other than the aesthetic is called functional music. One phase of functional music is music therapy, the utilization of music in the rehabilitation of the sick.

Music readily lends itself to therapeutic purposes. Its usefulness in therapeutic procedure rests upon several principles among which are the following:

1. Because of its great subjectiveness music becomes the most intimate of the arts, yet it is the most adaptable of the arts because it functions in a multitude of ways for nearly everyone. For these reasons music has wide application even in clinical usage.

2. Music dissipates "aloneness", for at least the time of the activity, by reestablishing emotional ties.

3. It is sound without inherent threat rather than an object that is responded to in music, therefore music becomes a part of reality to be enjoyed and trusted without fear.

4. Form and content are one in music. Feeling of form is a feeling of relationship. This in turn, then, may bring about a feeling of security.

5. Music participation, either listening or performing, provides an easily accepted segment of reality, and thus a platform of reality whereon both patient and therapist
may stand without disagreement and in confidence.

6. The performance of music generally induces in the performer a beneficial sense of accomplishment and gratification.

7. Music, because of its power to move man deeply, affords an aesthetic control of behavior. Judicious application of music may thus enable a patient to behave on a higher plane.

8. Music is a truth as its universality testifies; by consensus it also has beauty. In music therefore is found a fusion of truth and beauty at a non-verbal level. This value may be adopted by the individual, as his own.

9. Music is basically a means of communication and often succeeds where less subtle means fail.

10. Music allows patients a cooperative activity without conflict thereby making for resocialization.

11. Music is only a part, although an important part, of the therapeutic milieu.


13. Moods elicited by music derive from the tender emotions. Music may, therefore, effectively arouse that which is often at low ebb in patients, i.e., the various manifestations of love. This makes possible the transfer of positive feelings for the music, to the therapist.

14. Despite the intrinsic importance of music, in a clinical context it is a means toward the more important aim of establishing therapeutic interpersonal relationships between patient and therapist.

15. The introduction of selected music creates a warm and pleasant atmosphere which helps to induce a positive attitude on the part of the patients toward the hospital environment. This function of music holds true for the medical personnel as well as for the patients. Music thus makes an important contribution to morale and to patient care.

With these principles in mind, the purposes of the clinical training program were defined as follows:

This training program in music therapy is planned for students who have completed the academic requirements of the affiliated school for students of music
therapy. It is designed to give the student a knowledge of:

1. The application of music in the treatment of the mentally ill.

2. An understanding of the causes, development, and treatment of mental illness.

3. Clinical experience as a participant, under close supervision, in an active psychiatric treatment program.

Emphasis will be placed on acquainting the student with the dynamics of personality development with special attention to behavioral pathology. He will have the opportunity to apply and evaluate various principles of music therapy with the mentally ill, and to gain an appreciation of the milieu treatment concept.

From the knowledge and experience gained in this course, the student will also have a better understanding of himself as a maturing individual, and of the importance of his own attitudes, feelings, and actions as they affect himself and those with whom he comes in contact.

The clinical training program was divided into four units totaling 1,092 hours. Unit I, consisting of 38 hours, was designed as an orientation period with four objectives:

1. To become familiar with the physical facilities and the objectives of the hospital.

2. To develop a feeling of security in a new situation.

3. To instill a concept of professional ethics and professional responsibility.

4. To develop an understanding of the objectives and requirements of the training program.

These objectives were implemented by adapting a part of an existing program for the orientation of other student groups in Psychiatric Nursing, Occupational Therapy, Psychiatric Social Service, and Ministerial students, among others. It included a welcome to the Topeka State Hospital psychiatric family by Dr. Karl Menninger, Dean of the Education Committee, and by our clinical director and our superintendent. Several hours were devoted to the history of the hospital, its present organization, and its education program. There was an orientation to the professional library and its staff. Meetings were set up with department heads to explain the role and function of the Adjunctive Thera-
Educational Program

pies, Physical Therapy, Nursing Service, Social Service, the Chaplain, Volunteer Service, Practical Arts, Music Therapy, Adjunctive Therapy on the Children's Service, Recreation Therapy, the Psychology Department and the Out-patient Department. There was a tour of the Menninger Clinic, the Physical Medicine Rehabilitation section of Winter Veterans Administration hospital, the Rehabilitation Center for the Blind, and each of the four major sections of Topeka State Hospital to include the observation and explanation of insulin shock therapy and electro-convulsive therapy.

Unit II in Clinical Psychiatry consisted of 18 hours. It was a formal lecture course on the genesis and symptomatology of mental illness, taught by a staff psychiatrist, and planned to give the student the opportunity to:

1. Establish a frame of reference for the application of music in the treatment of psychiatric patients through an understanding of the history and development of psychiatry and mental hospitals.
2. Obtain an understanding of personality development, structure, function and malfunction.
3. Learn something of the more common treatment procedures undertaken in a psychiatric hospital.
4. Understand the relationship between psychiatry and its allied disciplines.

Unit III, in Psychiatric Music Therapy, had as its purpose the professional and personal development of the trainee with the following specific objectives:

1. To become skilled in the observation of patients and to learn to record and report behavioral manifestations objectively.
2. To attain a systematic, scientific point of view toward the study of the individual patient.
3. To obtain a better understanding of one's own reactions to others and their relationship to one's own personal goals, capacities, feelings, beliefs, ideas, and attitudes.
4. To obtain a knowledge of the role of the music therapist as a member of the therapeutic team.

These objectives were to be accomplished through:

1. Supervisory-advisory conferences twice a week with the Director of Psychiatric Music Therapy.
2. Assigned readings and discussion.
3. Weekly meeting with the Music Therapy staff and the Chief of Psychology on "The Psychology of Group Dynamics", directed toward a better understanding of how the therapist's own feelings, ideas, attitudes, capacities, and personal goals affect his interpersonal relationships with patients.

4. Music therapy staff meetings, adjunctive therapy team and group meetings, ward meetings and consultant's conferences where advisable, to include admission conferences, diagnostic and appraisal conferences, and discharge planning.

5. Conferences with our Music Therapy Consultant from the University of Kansas.

Unit IV, 841 hours, was intended to bring together the theoretical principles described above and the trainee's clinical experience with these objectives:

1. To understand that patients are individual human beings with specific individual psychological needs, some of which may be met by the relationship which the music therapist establishes with the patient under the guidance of the psychiatrist and in the context of which principles of music therapy are applied.

2. To become skilled in the application of music therapy principles and techniques and adapting them, guided by prescription, to the needs of the individual patient.

3. To have the opportunity to test and evaluate music therapy principles in a variety of treatment situations in order to learn their degree of applicability in the treatment program.

This unit provided the experiences of direct therapist-patient contact in a supervised situation and included:

I. Individual patients
   A. Piano
   B. Voice
   C. Instruments (other than piano)
   D. Music Listening

II. Ward music groups
   A. Rhythm bands
   B. Group singing
   C. Music listening, passive and active groups
   D. Eurythmics groups
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E. Background music for ward parties, insulin and ECT, and other functional uses

III. Central music clinic activities
   A. Men's vocal groups
   B. Women's vocal groups
   C. Mixed vocal groups
   D. Instrumental groups
   E. Music listening groups
   F. Church choir

IV. Participation in department management
   A. Operation of equipment
   B. Selecting, ordering, and cataloging phonograph records and other music materials and supplies
   C. Compiling song sheets for ward work
   D. Preparing tape recordings for ward work
   E. Working out activity schedules
   F. Writing progress notes, process recordings; keeping and compiling activity participation and attendance records

A basic reading list was formulated to supplement the trainee's clinical experience.

The clinical training program as outlined above has been in effect almost a year. One student has completed it and three are now participating. Our reaction thus far is that it is a decided improvement over the less structured program that preceded it. We feel that we now have a more well-rounded, well-defined common core of experiences within which each intern can operate toward maximum learning within the limits of his individual capabilities and capacities. We have a training program that is more equated in structure with the other training programs in the hospital, thus making for fewer administrative difficulties. The student who completes the program can point to a formal program which spells out the areas he has covered. And he will have the satisfaction of knowing that he has contributed toward the further refinement of the training approach, for each student enters the training with the knowledge that his final project will be the writing of a critical evaluation of the training course.

These evaluations will point the way to further refinements in the program. We are now in the process of setting up a weekly seminar with the Director of Research and Education to discuss various pathological syndromes in terms of specific patients
with whom the students are working. This will be an attempt to
bring to life some of the hypothetical cases that are related in
the psychopathology textbooks and give the student a better un-
derstanding of how his own actions, reactions, and feelings con-
tribute to or detract from the therapeutic aspect of his relation-
ship with his patients.
PART IX

RESEARCH IN MUSIC THERAPY
INTRODUCTORY REMARKS TO RESEARCH IN MUSIC THERAPY

ABE PEPINSKY, PH.D.

Chief of Psychological Services, Norristown State Hospital, Norristown, Pennsylvania

We have come to an important crossroad on our path toward a search for truth in Music Therapy. We are leaving behind us those who are still given to ruminating on the virtues of David's treatment of Saul's depression with his playing of a few well chosen selections on his harp. The psychiatrist is amply justified in his scathing criticism of repeated emphasis of uncontrolled observation and wishful thinking. He will, however, give due credit to more scientific studies and controlled experimentation. We fail in our attempt at flattery when we paraphrase selected passages from Freud and unobtrusively include bits of musical terminology. This is not an adequate substitute for research and it fails to add to our prestige. The psychiatrist resents unproven statements such as, "It has been found that music lessens the fury of the most violent cases." This sounds suspiciously like the premature claims made for some of the new wonder drugs like thorazine and serpasil. Does the psychiatrist fear the threat of possible inroads on his professional monopoly? I think not. He must, of necessity, beware of contra-indications and unwanted side-effects. Yet, even the psychiatrist is discovered to lack rigorous controls in the design of his experimentation and regretfully admits this unfortunate state of affairs in their professional symposia.

The comprehensive survey being conducted by Myrtle Fish Thompson will give us some idea of the scope and the use of music in our hospitals. We may even be able to wring a statistic or two from the mass of data but we still must face the task suggested by Gutheil in properly defining Music Therapy as a specific symbol of communication among scientists. Masserman warned that we have no verification of foci of influence of music in the cerebral processes. In fact, we still have to answer the baffling question as to how music really affects the mind. I have stated on another occasion in these meetings that research in music therapy cannot proceed any faster than true research in psychiatry, and it is admitted that this is too slow for real progress.
in psychiatry. We are working under and with the psychiatrist, and it behooves us, therefore, to subordinate our therapeutic planning to the program of the psychiatrist.

We must be grateful for the basic studies of emotion stimulated by music. It was, however, necessary in such experiments to reduce the number of variables to a minimum for an unequivocal evaluation of the response to simple musical stimuli. It is for this reason that I am asking E. Thayer Gaston to give us an overview of the projects undertaken with his guidance. Then I will ask Arthur Fultz to explain the application of his thoughts on communication theory to music therapy.

This brings us to the crossroad to which I referred. Where do we go from here? To the left, we will be urged to do more and better basic research. To the right, we will be tempted to evolve better theoretical considerations of stimulus-response. It is important that we make frequent excursions in both these directions. After the interpretations made by my colleagues and the discussion by participants in the audience, I look forward to the second session devoted to research in Music Therapy, to tell us what we may look for in the road straight ahead. We eagerly solicit the advice of those who are interested to help point the way to research in the global effect of music on the disturbed person. We have been favored with excellent clinical observations. Such observation is, of course, extremely important but when music is utilized together with other adjuvant therapies it is quite difficult to give unbiased credit to the part played by music in therapy. Yet our road must be chosen to bridge the gap between the studies of specifics in basic research and an evaluation of the changing dynamisms in the patient.
THE DEVELOPMENT OF A RESEARCH PROGRAM

E. THAYER GASTON, PH.D.

Chairman, Department of Music Education
University of Kansas

In retrospective consideration of the development of research in functional music at the University of Kansas there is great temptation to begin this paper with rather profuse apologies for weaknesses and omissions. Such temptation will be foregone except to state that there is awareness that many criticisms are justified.

For several years before the establishment of the curriculum to train music therapists there had been a growing interest on the part of graduate students in music education as well as staff, in the influence of music on behavior. In fact, a course, The Influence of Music on Behavior, had been set up as an elective for master degree students and a required course for doctoral candidates.

Shortly after World War II the idea of establishing a curriculum to train music therapists began to be developed. It was immediately apparent, however, that there was little use to set up the academic program until a suitable place for clinical experience could be secured. With this in mind, key personnel at the Winter V.A. Hospital in Topeka, Kansas, were contacted and many conferences took place. After two years arrangements were completed to the extent that it was possible to send the first intern.

During this time and after, a number of discussions took place between the Director of Education and myself as to the function of the academic and clinical training. Several other university and hospital staff members were asked for opinions. It was a unanimous decision that research should be a part of students' academic training.

This was not only possible but desirable from the viewpoint of the university, because the specific training in functional music was to be done at the graduate level, leading toward the degree of Master of Music Education with a major in Functional Music. (The undergraduate degree was to be a B.M.E. or equivalent.) This relieved the necessity of setting up a new degree and followed the requirement that M.M.E. candidates should write a thesis.
In a new field of formal training such as music therapy it seemed doubly important that research should be done. It was equally apparent that the university could here serve uniquely by enabling basic research of such a nature as would not ordinarily be done in a hospital where the staff, because of its work, has little time to carry on research except that specifically related to clinical situations.

It will be remembered that some seven or eight years ago there was much more skepticism as to the use of music as an adjunctive therapy; it was not accepted as it is today. Because of this it was necessary to do, at least some, basic research in order to show that music did have influence on human behavior. This explanation may help to explain the logic of why certain research studies were later carried on.

Some of them, of course, seemed to be attempting to show that which was already apparent. This is granted, but the studies had to be done anyway, to help provide and make more secure the springboard for further, more complex research. This is why many basic, non-clinical types of research were done first. It was felt by all concerned that here was an important function of the university part of the team, that of providing what could best and most efficiently be done by graduate students.

These admittedly small pieces of research would provide much needed evidence at the time; they would orient the young music therapist toward research and arouse his endeavors later in further research; they would acquaint him with at least the elementary necessities and disciplines of research; they would finally, it was hoped, provide a more stable platform from which to launch the more complex, clinical research.

In accordance with these foregoing thoughts and beliefs, then, three items were included in the curriculum which had to do with research.

The first of these, a laboratory course in psychology of music (preceded by a first course in psychology of music) had the least research in functional music; however, every student does do several miniature pieces of research. This is a most important course because in it the student learns to use the more common electronic equipment, how to assemble it, and how best to use it in practical situations as well as using it in research studies.

The second course, The Influence of Music on Behavior II, is a course particularly designed for research. Each student must
learn how to handle laboratory equipment, write proposals for research, select subjects, etc. Three pieces of research must be done by each student. Admittedly they must be small, many times inferior in sampling and control, but these deficiencies must be noted by the student, and the study written up as perfectly as possible.

At the end of this paper is a partial, but somewhat representative list of the studies done in this class. It will be seen that many of the studies fall in the category of non-verbal response to music, such as drawing, painting, molding and posture. A second category is more concerned with physiological responses such as muscle tension, pilomotor responses, pupillary dilatation. A third group are those done in clinical situations. Many of the studies overlap so that classification is difficult.

The master's thesis, required for the completion of the degree, may be done on campus before the student goes to his clinical training, or it may be done at the hospital if it is clinical in nature. If it is done at the hospital a proposal for research must be submitted to the committee on research of the hospital and approved by them before the study can be begun.

Following the list of small studies is a list of theses. In a case or two as noted in the list the candidate was not working toward a degree in functional music.

Whatever the value of the individual pieces of research one thing is certain, beneficial development of the students doing the research occurs. They are better oriented toward research; their attitude towards it is firmly positive and they are much more interested in the research of others and better able to understand it. Dealing at first primarily in an art, music, they have come to understand more fully the scientific method.

RESEARCH PAPERS

1951

Garder, Clarence E.—"Transfer of Feeling from Music to Watercolor Painting."
Garder, Clarence E.—"Influence of Music on Physiological Reaction."
Hansen, Louis A.—"A Study of Response to Masculine and Feminine Endings in Musical Cadences."
Hansen, Louis A.—"A Study of the Effect of Classical Music on the Mental Efficiency of Persons Highly Trained in Music."
Pytlar, Olga—"Survey of Existing Music Programs in Special Schools."
Slaughter, Forrest—"A Study of the Effects of Stimulative Music on the Pupillary Reflexes."
Slaughter, Forrest—"A Study of Sex Association with Stimulative and Sedative Music."
Slaughter, Forrest—"A Study of the Effects of Music on the Time Required for the Perception of Warmth and Pain."

Stephenson, Jack—"Influence of Fast and Slow Music on Eating."

Stephenson, Jack—"Children's Expressed Reasons for Preferring Certain Music."

Van Deman, Maryo—"A Study of the Effect of Sedative Music on Fatigue."

Van Deman, Maryo—"A Study Comparing Duple and Triple Motor Patterns."

Zack, Melvin—"Sex Differences in Listening Preferences for Instrumental Tonal Colors."

Zack, Melvin—"The Effect of Music on Drawing."

Zepp, Raymond H.—"The Intensity of a Musical Stimulus and its Effect on Musical Response."

1952

Benedict, Lois—"The Effects of Music on Molding."

Benedict, Lois—"Subjective Judgments of Physiological Sensations Experienced as a Result of Listening to Music."

Benedict, Lois—"A Study to Ascertain a Few of the Major Effects from Listening to 'Bebop' Music."

Brick, Samuel E.—"A Study of the Relation of Duple and Triple Meters to Basic Emotional Expression Through Music."

Brick, Samuel E.—"The Effect of Music Upon Warmth and Pain Thresholds."

Brick, Samuel E.—"The Effect of Music on Free Drawing."

Gregory, James S.—"The Effects of Consonant and Dissonant Harmonization on Crayon Drawing."

Gregory, James S.—"Relationship of Synthetic Abstract Pastel Drawings to Stimulative and Sedative Music."

Gregory, James S.—"The Subjective Location of the Primary Physiological Sensations Experienced when Listening to Music."

Humfeld, Neill H.—"The Effect of Music on Memorizing and Retaining Poetry."

Humfeld, Neill H.—"The Effect of Music on Painting."

Humfeld, Neill H.—"The Study of Relationship Between Certain Types of Music and Abstract Art."

Kromminga, Louis U.—"The Influence of Music on Induction of Physiological Changes."

Kromminga, Louis U.—"Relationship Between Art Expression and Sedative-Stimulative Music."

Kromminga, Louis U.—"Tempo Preference in Music."

Michel, Donald E.—"The Relationship of Abstract Pastel Drawings to Stimulative and Sedative Music."

Michel, Donald E.—"Effects of Familiar and Unfamiliar Music as Shown in Seventh Graders' Crayon Drawings."

Michel, Donald E.—"Effects of Stimulative and Sedative Music on Respiration and Psycho-Galvanic Reflex as Observed in Seventh Grade Students."

Orton, Danny—"Influence of Music on the Pilomotor System."

Orton, Mary—"Experiment Concerning the Correlation Between Elements of Art and Sedative-Stimulative Qualities of Music."

Orton, Mary—"The Effect of Music on the Movements of Interpretative Dancers."

Sears, William W.—"An Attempt to Correlate Several Selected Studies in the Field of the Influence of Music on Behavior."
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Glover, Barbara—"A Study of Response to Masculine and Feminine Qualities of Music."
Glover, Barbara—"The Effect of Music on Muscle Tension."
Shrift, Donald C.—"The Effect of Music on the Nervous Potential in Striated Muscle."
Shrift, Donald C.—"A Study of the Effect of Intensity in Music."
Shrift, Donald C.—"A Study of Experience in Musical Activities and the Affective Response to Stimulative Music."
Swinchoski, A.—"Rhythmic Reactions of a thirteen-month old Child to Music."

1954

Flournoy, Mary Jo—"Music Education Student Preferences to Programmatic Aspects of a Band Concert."
Flournoy, Mary Jo—"The Use of Music in Medical Reception Rooms."
Flournoy, Mary Jo—"Use of Piano Practice Sessions for the Expression of Disturbing Emotions."
Glover, Ray—"Differences in Emotional Responses Elicited by Different Instruments."
Glover, Ray—"The Duration of an Experienced Mood Induced by Music."
Glover, Ray—"Problem Solving With Noise Distraction and With Noise Masked by Music."
McCarty, Philip—"Pitch Change of a Sustained Musical Tone Created by Clenching the Jaws."
McCarty, Philip—"Intensity Levels at Which Sensations of Pleasantness and Unpleasantness are Determined by Means of a Verbal Response."
McCarty, Philip—"Transfer of Learned Motor Skills From One Muscle Set to Another."

THESES

Perry, Doradeen, 1945—M.M.E.
Swinchoski, Albert A., 1947—M.M.E.
Affective Responses to Certain Keys.
Morehead, Jean Klussman, 1948—M.M.E.
A Study of Sex Differences in Preference for Musical Tone.
Ruppenthal, Wayne W., 1948—M.M.E.
A Study of the Subjective Organization of Rhythm in Musical Context as Indicated by Motor Activity.
Cater, Maurice L., 1949—M.M.E.
The Effect of Music on Painting.
Church, Ellen Wagenfield, 1949—M.M.E.
A Study of Sex Differences in the Music Interests of Junior and Senior High School Students.
Michel, Donald E., 1950—M.M.E.
A Study of the Sedative Effects of Music for Acutely Disturbed Patients in a Mental Hospital.
Scheihing, Geneva Rose, 1950—M.M.E.
A Study of Spontaneous Rhythmic Activities of Pre-School Children.
Unkefer, Robert F., 1950—M.M.E.
The Effect of Music in Insulin Coma Therapy.
Livingston, Frances Sartori, 1951—M.M.E.
A Study of Musical Responses to Pictorial Stimuli.
Sears, William, 1951—M.M.E.
Postural Responses to Recorded Music.
Gregory, James S., 1953—M.M.E.
Masculine and Feminine Characteristics of Musical Instruments.

Orton, Danny E., 1953—M.M.E.

Orton, Mary Ryder, 1953—M.M.E.

Gray, Richard M., 1954—M.M.E.
The Pilomoter Reflex in Response to Music.

Hahn, M. E., 1954—Ph.D.
A Proposed Technique for Investigating the Relationship Between Musical Preferences and Personality Structure.

MacMillan, Barbara Glover, 1954—M.M.E.
A Case Study on the Use of Music Activities for a Brain-Injured Child.

Sears, Margaret Scholz, 1954—M.M.E.
A Study of the Vascular Changes in the Capillaries as Effected by Music.

Shrift, Donald C., 1954—M.M.E.
The Galvanic Skin Response to Two Contrasting Types of Music.

Slaughter, Forrest, 1954—M.M.E.
The Effect of Stimulative and Sedative Types of Music on Normal and Abnormal Subjects as Indicated by Pupillary Reflexes.
SMALL GROUP SOCIOMETRIC MOTIVATION IN MUSIC THERAPY

ARTHUR FLAGLER FULTZ

Chairman, Department of Music Therapy
New England Conservatory of Music

It has been increasingly apparent that in the large hospital it is necessary to discover that proportion of "operational time" that will reach the largest number of patients most effectually. Obviously, music therapy operations that meet the needs of groups of patients are more economical in point of time spent than those which meet only the needs of individuals. But economy of the therapist's time is not the foremost consideration in point of importance. A more suitable question to raise would be, "Are the operations efficient and effectual? Is there a point at which groups become too large in this respect, or too small to be economical?"

As a working hypothesis in this connection, we have adopted a 1:3 ratio as the criterion for economy, efficiency, and effectualness. That is to say, we believe that the number of patient-hours gained by our operations should be not more than three times the operational-hours spent in employing them. This means that a music therapist must plan his operations around small groups of patients of less than fifteen persons each. A little margin should be allowed for those who may be absent for one reason or another so as to guarantee approximately ten persons in a group situation.

Besides the actual distribution of time for operations, and the choice of music therapy operations to be used in each situation, there is one central problem that is related to making these operations effectual. This is the problem, and its corollary problems, of making the social system represented by the specific group situation productive of better interpersonal relations among its members. Making the interaction in the social system in a given group effectual must first be accomplished in terms of the level of its individual members. Thus, interaction within a social system made up strictly of catatonic schizophrenics presents one kind of problem, while interaction between individuals in a group of neurotic hypochondriacs presents an entirely different one.

This places the problem squarely in the field of Group
Dynamics. The same laws may be expected to operate in this sort of a situation as govern any other small group activity. Furthermore, it is extremely illuminating and refreshing to find a frame of reference into which various facets of our music therapy needs can be fitted without getting involved in either mystical or mythological concepts. From a scientific point of view, Group Dynamics, however, is so new to the laboratory of social science that there are but a very few clear-cut concepts that have emerged to date. A few have become fairly well established, so that it is possible to chart our thinking with the assurance that we may now be organizing it in areas of fundamentally significant dimensions. This is most encouraging and it is hoped that many studies will be carried forward in this frame of reference.

We have always held that it was an important part of the music therapist's job so to structure group situations as to increase the probability of interpersonal communication between members and to lessen the chances of intrapersonal isolation. This has been a particularly difficult thing to accomplish, especially in the case of very regressed mental patients, patients whose degree of regression has risen like a wall between themselves and every other creature. Actually, of course, we all have such walls behind which the real self retreats to play a sort of Pyramus and Thisbe game through the chink with all those who pass by on the other side. Most regressed patients, having once recoiled from all interpersonal relationships, have become reconciled to living on an intrapersonal level of communication.

This condition of apathy and psychological isolation can be easily recognized on the "back wards" of any mental hospital. All that is necessary to identify it is to seek out and check the origins and destinations of virtually any of the signals sent by these patients. It quickly becomes apparent that the individual is trying solely to influence himself by his singing, his playing, his dancing. The entire action-pattern of these persons is oriented toward themselves as the only objects representing safe, albeit, limited potentials for the gratification of their needs. In this way, by relying more and more upon their own selves for sources of gratification, they tend ever to intensify their use of the intrapersonal network of communication, a strategy by which they move more and more toward that halcyon infantile state of complete irresponsibility and total dependency.
When groups of such patients are organized for a music therapy activity, the production usually manifests only the most disorganized, disoriented sort of action. This picture is not only discouraging, but is particularly baffling to even the most ingenious of therapists. This is the setting for the study we cut out with careful regard to design, extent, and purpose. One event is always evident in such situations, however. Each of these persons invariably produces a certain amount of activity. What might this fact lead to? Upon analysis, one could see that the individuals could be classed according to the level of their production during the group session. Each one could certainly be ranked according to the degree of activity produced in compliance with the therapist's directions. Perhaps this might provide the needed base of action on which to approach the task of structuring the group activity effectually. The production level seemed a logical guide to understanding the presented group structure (organization), and also the logical basis for restructuring and controlling it.

We may expect the same factors to be operative in this kind of a group as to its structure as those which are controlling influences in any other group. Cartwright and Zander point to four concepts by which group structure may be described: (1) communication network, (2) sociometric structure, (3) power structure, and (4) locomotion structure. There is not space here to elaborate each of these concepts, but it will suffice to point out that every group represents certain potentials in the setting up of these four classes of events. In our non-communicative group the only type of communication potential is limited to the intrapersonal network. There is virtually no forming of cliques, or choosing of others (sociometric structure) in such a situation. Power over others is delegated to constituted, authoritarian therapists and official staff members, so that the characteristic role of the patient stems from the fact that he is continually under the power of someone above him. Finally, any changes in his position from lower to higher levels in the group structure are limited at all times by the power structure which in this respect further prescribes the extent and nature of communication, interpersonal choice relationships, and "promotion" within the group structure.

In order to make his group activity effectual, then, the thera-

pist must gain control of the processes structuring the group organization, with the multi-purpose of bringing regressed patients into better contact with reality, of improving the chances for satisfying interpersonal relationships, and of advancing the cause of social competence in each member of the group to as high a point as possible. With these goals luring us on, the study was outlined, hoping that, if successful, it might serve as a model for further investigation in addition to providing us the data upon which we might establish our own operations upon sounder foundations and with a higher level of assurance of their outcomes.

With regressed patients at our hospital, the general therapeutic aim is merely to encourage enough progress to justify placing them in more active groups in which they will be ready to rely more and more on interpersonal communication networks in place of the intrapersonal level on which they now operate. Hopefully, one day they may "graduate" into situations where exchanges of signals can be made also on group and cultural levels of communication. All of this is in keeping with the long-range goals of music therapy as we conceive it, namely, to prepare the patient for the transfer of learning in various forms of communication activities, and at various levels so that he may enter a more significant role-structure in his living that will make him able to function competently and satisfyingly within the broader, less predictable social community rather than only within the sort of community provided in the controlled environment of a hospital.

One of the major projects of the Research Division of Musical Guidance at this time is aimed at studying the effects of certain operations which are calculated to gain control of the structure of a given group. So the study reported here is actually related to a larger research plan concerned with seeking data on group dynamics. Admittedly, all four of the aspects of group structure referred to above, must necessarily be affected by changes in any one. It is possible, therefore, to observe what regularity or uniformity exists in the one by treating another, especially, if, as in the present circumstances, the one is not as readily accessible as the other to treatment.

The present study proposed the possibility of examining modifications in the communication network potentials of the

group by varying its sociometric relation potentials. Later, it may be appropriate to reverse this procedure, and successively to test the relationship between sociometric structure controls and the power and locomotion structures, respectively.

In the present instance, we have formulated our null hypothesis in terms only referring to communication structure and sociometric structure as follows: Sociometric motivation in small group musical situations attained by matching group members on the basis of equated action production levels will not result in significant changes in communication networks adopted by regressed female patients.

Three restrictions were prerequisite for carrying out our design: (1) The subjects of our study were limited to regressed female patients. This means that we were to differentiate between regressed and fixated persons. Regressed persons were those who at some time or other had grown to an advanced level of development, but for one reason or another had sought refuge and security by regressing back to a former state of supposed protection and support. Fixated persons were those whose development stopped at an immature level, or whose progress was arrested before they had a chance to achieve maturity. (2) Standard MOT\textsuperscript{1} operations selected for this group situation were limited to those offering the largest opportunities for forming sociometric choices; they were also tempered by the level of activity that was expected from the patients, for whom they were designed. (3) The maximum number to be handled in each group did not exceed ten persons. Small group analysis actually should not be attempted with this many, but it will be remembered that we were in reality, considering but five pairs of individuals, with the pair being the unit of observation.

The assumptions under which our hypothesis is formulated are: (1) that the degree of participation manifested by a person in any given musical situation is an index to his potential identification with another person of the same level. This is to say that his friendship choices, his sociometric orientations, may be expected to be less frustrating to him with someone capable of interacting with about the same degree of function as himself; (2) that sociometric choices occur between participants in each pres-

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ent activity, i.e., the people who develop into friends are generally those who work together in an activity, not those who are absent from it; (3) that movement from intrapersonal to interpersonal communication networks can emerge if the action-equated pairs are confronted with each other as partners often enough; and (4) that control by the therapist of the group can be an attribute of "rigging" the group situation so that productive sociometric choices are increasingly likely to happen.

In our experimental design it was arranged to work with two small groups of female patients, ten persons in each group, as nearly comparable as possible in their degree of regression and inactivity. In this exploratory study, no procedure was introduced to guarantee randomization. All these patients were inactive, non-communicative, and/or non-musical. Group I was used as a control group, and Group II as an experimental group. In the latter, estimates of the action levels for the several patients were obtained by observation of their participation in the first week of work together. The operations were then so organized in the experimental group that Patient A and Patient G, for example, whose scores classed them together, were always confronted by each other, while the patients in the control group were allowed to form their action independently of any face to face occurrence.

The operations selected were: Musical Games, including calisthenics, Rhythm Band, Square and Folk Dancing, Informal Group Singing, and Dancing— solitary, creative, interpretive. Three critical tasks were planned under each of these activities, making a total of fifteen critical tasks organized under five Standard MOT1 Operations. Sessions never exceeded one hour in duration, were always held at the same time of day in the same room on Mondays, Tuesdays, Thursdays, and Fridays for five successive weeks.

The observation consisted in ranking each patient in both groups according to our Musical Guidance Production Scale1 in two ways: (1) The Recreation Therapist made a "general ranking" of the production of each patient on each of the four days of the week; and (2) this was verified by a "general ranking" made by the Music Therapy director each Friday based on his observation of each patient's behavior in the fifteen critical tasks. The Production Scale set up was quite simple:

1. A. F. Fultz, op. cit.
1—Very active, takes the lead
2—Noticeably active
3—Group norm
4—Less than norm; needs prodding
5—Just barely active
6—Inactive

A record was also kept of all acts performed on an interpersonal level of communication so that they might be correlated with the experimental treatment. Experimental treatment consisted in organizing the music therapy operations so as to permit pairs of patients to work opposite each other without comment from the therapist. Anecdotal accounts of face to face experiences were made as they were observed.

For a statistic we selected a t-test of significance of difference of the means between the two groups, accepting the 5 per cent level of significance as adequate for testing our hypothesis in this exploratory study.

Our preliminary findings in this study were such that we are forced to accept our null hypothesis. The data did not show that sociometric pairing brought about in the manner described produced any changes in communication level among these patients other than would have been expected by chance alone.

Certain comments can be made about this negative finding:

(1) There were gross inconsistencies during the period of the study in the leadership of the groups, in the administration of the operations, and in the keeping of the records of rankings. This was due to the unpredictableness of ward attendants in having patients dressed and shod so they might walk from their wards to the O. T. Recreation Center. Three times during the five-week period personnel changes occurred in the group leadership. This made for unequal understanding and application of operations. Serious omissions and changes occurred in the operating plan that would conceivably invalidate the observations. Finally, record-making, though organized into uniform report sheets, was subject to further loss of uniformity. It is believed that a properly conducted experimental procedure might produce both reliable measurements and significant differences.

(2) One excellent result of this project was the invention of a series of ingenious critical tasks with which to employ the five Standard MOT Operations. It was observed that although the women were obviously regressed, some being in almost a con-
stant stuporous condition, they showed boredom and disinterest in activities that were childish and meaningless, as in one instance where the therapist laid squares of wall-paper on the floor and asked the patients to leap with the music from one "cake of ice" to another. This was too far-fetched for even normal people to imagine. Furthermore, there was little or no opportunity for paired matching. Our patients were also too obsessed with their own thoughts to catch the play spirit. It was, therefore, recommended that the critical tasks selected should make sense, be dignified, and on a mature level. Some posters from a travel bureau were set up depicting different countries. These were arranged at wide intervals across the gymnasium floor. When Swedish folk music was played, the patients were taught to gather in front of the Swedish poster; likewise, Swiss pictures were matched by recognition of a yodelling song, Italian pictures by Italian folk songs, and so on. This formed the background for a communication, "I'll meet you in . . ." (here the characteristic song was hummed or "la-la'd"), and rendezvous was arranged between matched pairs. In another musical game, the patients were each given a card on which was painted one of Rhine's five symbols used in the Extra-Sensory Perception studies. Each symbol was duplicated and the matching card was distributed to the other member of the pair, so that A and G, for example, held the same symbols. A was supposed to search for whoever held the matching card, who invariably turns out to be G. When A finds G, the two go to a table on which up-ended shoe boxes were placed, each with a small peep-hole in the lid, and painted on the bottom (inside) of the box was one of the symbols. When they find the box inside of which their symbol was painted, they place their card face up on the table in front of it and are praised for their cooperation and good fortune to have thus restored a semblance of order by getting the "mixup" straightened out. This latter game was carried on with musical signals as well, with the reward being the playing of a special number on the piano or on the phonograph in special recognition of the performance of the pair in question.

(3) It has been suggested that an improvement in our experimental design could be made by pairing patients with different levels of production as ranked on the Production Scale. This

would result in a fairly active patient becoming a motivating influence upon one not so active, and might be a more logical sociometric selection.
APPENDIX
SUMMARY OF
BUSINESS SESSION RECORDS OF
THE FIFTH ANNUAL CONFERENCE OF NAMT

ARTHUR FLAGLER FULTZ

President, NAMT, 1954-55

This is a summary of action taken in the business and executive committee meetings at the Fifth Annual Conference of the National Association for Music Therapy.

At the opening business meeting in the Tudor Room of the Henry Hudson Hotel in New York City, at 9 a.m., October 13, 1954, the invocation was given by the Reverend Robert Reeves, newly appointed Head Chaplain of the Presbyterian Medical Center. The members of the conference were welcomed by Dr. James A. Brussel, Assistant Commissioner of the New York State Department of Mental Hygiene.

According to the treasurer, Donald E. Michel, the total income for the year was $5,132.13; expenditures, $1,499.13; balance as of October 10, 1954, $3,633.00. The report had been duly audited by Frederick Vaught, auditor, from Topeka, Kansas. Mr. Michel reported that the Constitution, Bylaws and Treasurer's Books had been approved by NAMT's lawyer in East Lansing, and that he had submitted the application for incorporation to the Securities Commission of the State of Michigan.*

Dr. E. Thayer Gaston, chairman of the Nominating Committee handed the recommendations of his committee to the secretary and the following slate of officers and members-at-large of the Executive Committee was read:

President: Arthur Flagler Fultz
1st Vice-president: Dr. Jules H. Masserman
2nd Vice-president: Dorothy Brin Crocker
Recording Secretary: Hermina E. Browne
Treasurer: Lenard Quinto
Executive Committee: (3 to be elected): Louise Weir, Virginia Carty, Ernest Grisham, Donald E. Michel, Erwin Schneider, and E. Thayer Gaston.

Action was officially taken to have the association insignia, previously adopted, copyrighted and printed on NAMT stationery. Members were to be instructed to use the design with

* Editor's note: Incorporation completed January 14, 1955.
permission of the Officers and Executive Committee. However, at the second Executive Committee meeting on Friday, October 15, 1954, the machinery was set up whereby the insignia might be used. It was voted that any person classified by the Membership Classification Committee as an active member of NAMT should become eligible to wear an official arm-band bearing the insignia of the Association. Sister Xaveria was appointed chairman of a committee to produce and distribute these. A committee was also appointed to work out a student intern arm-band.

Miss Edwina Eustis, in charge of arrangements for the conference, reported at the closing Executive Committee meeting 267 total registration for this Conference.

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Dr. Roy Underwood, at the second business meeting, Friday, October 15, 1954, re-read the amendments proposed by the Constitutional Revision Committee, the same having been submitted to the members of the Executive Committee four weeks prior to the meeting, and having been read at the first business session of the Conference. The revisions were accepted as read, and appear in the published Constitution and Bylaws printed in this volume on Page 269.

The slate of officers above was elected by a unanimous ballot upon motion to suspend the rules in order to carry out this procedure. Hermina Browne, acting as teller, announced that the Conference had elected to the Executive Committee (by ballot), Virginia Carty, E. Thayer Gaston, and Donald E. Michel. Since Dr. Gaston automatically became a member of the committee by virtue of his appointment as NAMT Editor, Ernest Grisham, who received the next highest ballot, was added in his place.

Mr. Michel reported that the 750 copies of the 1953 Book of Proceedings had brought a profit of $1,882.50. A special letter of appreciation was sent to Harold Allen of the Allen Press, Law-
rence, Kansas, expressing our gratification at the efficient handling of our printing needs.

Dr. Ira M. Altshuler extended an invitation on behalf of the Wayne County General Hospital to the Association to hold its Sixth Annual Conference in Detroit. The invitation was accepted.

Especially gratifying is the organization of local regional chapters of the Association. Mrs. Freda Dierks, 2nd vice-president, reported a total of seven such organizations: Mid-Atlantic, Mid-Western, New England, Southern California, Northwestern, Southeastern, and Great Lakes.
OFFICERS OF THE
NATIONAL ASSOCIATION FOR MUSIC THERAPY, 1954-55

Elected Officers

President:
ARTHUR FLAGLER FULTZ, Director, Musical Guidance, a Center for Functional Music in Boston, 41 Mt. Vernon Street, Boston 8, Massachusetts; Chairman, Department of Music Therapy, New England Conservatory of Music; Director of Music Therapy Affiliate Training, Boston State Hospital; President, New England Regional Chapter, NAMT.

First Vice President and Program Chairman:
JULES H. MASSERMAN, M.D., Professor of Neuropsychiatry, Northwestern University Medical School, Chicago; Co-Chairman, Dean's Committee in Psychiatry and Director of Post-Graduate Training, VA Hospital, Downey, Illinois; Senior Consultant in Psychiatry, U.S. Naval Hospital, Great Lakes, Illinois; Scientific Director, National Foundation for Psychiatric Research; Ex-president and Councillor, Illinois Psychiatric Society; Fellow, American Medical Association; President-elect, American Association for Group Therapy; Vice-chairman of the section on Psychotherapy of the American Psychiatric Association. Special Consultant in Psychiatry to the World Health Organization; assigned to a lecture tour of the South American universities. His new book, Practice of Dynamic Psychiatry, has just been published by W. B. Saunders.

Second Vice President and Membership Chairman:
DOROTHY BRIN CROCKER, Director of Music Therapy, Shady Brook Schools, Dallas, Texas; Lecturer in Music Education at Southern Methodist University, Dallas, Texas, and Texas State College for Women, Denton, Texas.

Recording Secretary:
HERMINA E. BROWNE, Director Music Therapy Department, State Hospital, Marlboro, New Jersey; President, Mid-Atlantic Regional Chapter, NAMT; Director, Opera Work Shop, Eastern Conservatory of Music and Arts, Roselle, New Jersey.

Treasurer:
LENARD QUINTO, Special Service, Department of Medicine and Surgery, Veterans Administration, Washington 25, D. C.
Appendix

Appointed Officers

Editor:
E. THAYER GASTON, Ph.D., Chairman, Department of Music Education, University of Kansas, Lawrence; Member, Committee on Psychology of Music, Music Teachers National Association; Member, Committee on Graduate Study and Research in Music Education, Music Educators National Conference; Member, Music Education Research Council, Music Educators National Conference; Consultant on Music Therapy, Winter VA Hospital, Topeka State Hospital, and The Menninger Foundation. Past President NAMT. Associate, American Psychological Association.

Assistant Editor in charge of BULLETIN:
ERWIN H. SCHNEIDER, Associate Professor, Music Education, University of Tennessee, Knoxville.

Corresponding Secretary:
A. IRENE WHITNEY, Executive Secretary, Musical Guidance, a Center for Functional Music in Boston, 41 Mt. Vernon Street, Boston 8, Massachusetts.

Archivist:
HARRIET CARTWRIGHT, 225 West 106th Street, New York, N.Y.

Parliamentarian:
HAZEL SILVEY HILL, 2524 E. 17th Street, Indianapolis 18, Indiana.

Publisher, and Acting Business Manager:
HAROLD ALLEN, The Allen Press, Lawrence, Kansas
MEMBERS-AT-LARGE OF THE EXECUTIVE COMMITTEE

MYRTLE FISH THOMPSON, Immediate Past President, NAMT; Director of Music Therapy, Essex County Overbrook Hospital, Cedar Grove, New Jersey. (1955)

IRA M. ALTSHULER, M.D., Director, Group-Music Therapy Department, Wayne County General Hospital, Eloise, Michigan; National Diplomate in Psychiatry; Fellow, American Psychiatric Association; Member, Michigan Society of Neurology and Psychiatry, Wayne County and Michigan State Medical Societies, Michigan Academy of Arts and Sciences, and Detroit Philosophical Society; Honorary Member, Detroit Federation of Musicians. (1955)

VIRGINIA CARTY, Dean, Peabody Conservatory of Music, Baltimore, Maryland. (1957)

FREDA HARTWIG DIERS, Chairman, Music in Hospitals, National Federation of Music Clubs, 5050 Oak Street, Kansas City, Missouri. (1956)

EDWINA EUSTIS, 30 East 81 Street, New York 28, N.Y.

ESTHER GOETZ GILLILAND, Lecturer in Music Therapy, Chicago Musical College of Roosevelt University; Chairman, Music Department, Wilson Junior College, Chicago; Music Therapy Counselor of Sigma Alpha Iota; Member, Committee of Music Education for Exceptional Children, Music Educators National Conference; Fellow, American Society of Group Psychotherapy and Psychodrama; Past President and Editor, NAMT. (1955)

ERNEST H. GRISHAM, Director of Music Therapy, Veterans Administration Hospital, Murfreesboro, Tennessee; President, Southeastern Regional Chapter, NAMT. (1957)

WILHELMINA K. HARBERT, Professor of Music Education and Director of Music Therapy Clinic, College of the Pacific, Stockton, California; Chairman, Committee on Music Education for Exceptional Children, Music Educators National Conference. (1956) President, Northwestern Regional Section, NAMT. (1956)

KARL A. MENNINGER, M.D., The Menninger Foundation, Topeka, Kansas. (1955)
DONALD E. MICHEL, Assistant Professor of Music Therapy, School of Music, Florida State University, Tallahassee, Florida. (1957)

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CHARLES U. LETOURNEAU, M.D., Editorial Director, Hospital Management Magazine, 105 West Adams Street, Chicago 3, Illinois.

MUSIC THERAPY RESEARCH COMMITTEE

ABE PEPINSKY, Ph.D., Chairman; Professor Emeritus, Formerly Head of Department of Psychology, Haverford College, Haverford, Pennsylvania; Chairman, Committee on Psychology of Music, and Member, Committee on Music in Therapy, Music Teachers National Association; Psychological Consultant, Human Factors Division, U.S. Navy Electronics Laboratory, San Diego, California; President, Mental Hygiene Society of Montgomery County, Pennsylvania; Member of Board, Mental Health Association of Southeastern Pennsylvania; Consultant on Juvenile Delinquency, Big Brothers Association of Philadelphia; Fellow, Acoustical Society of America; Associate, American Psychological Association; Member, Minnesota and Iowa Academies of Science; Past President, Mid-Atlantic Regional Chapter, NAMT; Senior Psychologist, Norristown State Hospital. (1957)

RUTH I. BARNARD, M.D., Ph.D., Formerly Senior Psychiatrist, Department of Adult Psychiatry, The Menninger Foundation, Topeka, Kansas; Psychoanalyst, Los Angeles Area, Assistant Clinical Professor of Psychiatry at U.C.L.A. (1958)
MARTHA BRUNNER-ORNE, M.D., Medical Director, Westwood Lodge, Westwood, Massachusetts; Chief Psychiatrist, New England Hospital.

E. THAYER GASTON, Ph.D. (See Officers) (1956)

JULES H. MASSERMAN, M.D. (See Officers) (1955)

THE EDITORIAL COMMITTEE

ABE PEPINSKY, Ph.D., as Chairman, Music Therapy Research Committee.

ROY UNDERWOOD, Mus. D., as Chairman, Music Therapy Education Committee.

MARCUS HAHN, Music Education Department, University of Kansas, Lawrence (1957)

LENARD QUINTO (See Officers) (1956)

ROBERT UNKEFER, Music Education Department, University of Kansas, Lawrence (1955)

MUSIC THERAPY EDUCATION COMMITTEE

ROY UNDERWOOD, Mus. D., Chairman; Director, Division of Fine Arts, and Head of the Music Department, Michigan State University, East Lansing, Michigan; Member Committee on Music Therapy, Music Teachers National Association.

E. THAYER GASTON, Ph.D. (see Officers)

WILHELMINA K. HARBERT (see Executive Committee)

THE AUDITING COMMITTEE

MARIAN CHACE, Chairman; Dance Therapist, St. Elizabeth Hospital, Washington, D.C., and Chestnut Lodge Sanitarium, Rockville, Maryland.

JACOB GLAZER, VA Hospital, Perry Point, Maryland.

DOROTHY ADDA, Sheppard Pratt Hospital, Towson 4, Maryland.
THE BUDGET COMMITTEE

VIRGINIA CARTY, Chairman; Dean, Peabody Conservatory of Music, Baltimore, Maryland.  
BEN CAMPBELL, Spring Grove State Hospital, Baltimore, Maryland.  

THE PUBLIC RELATIONS COMMITTEE

MYRTLE FISH THOMPSON, Chairman (see Executive Committee)  
LOIS BENEDICT, Music Director, Los Angeles City Jail, Women’s Division  
MARIAN CHACE, St. Elizabeths Hospital, Washington, D.C.  
DOROTHY BRIN CROCKER (see Officers)  
FREDA HARTWIG DIERKS, 5050 Oak Street, Kansas City 2, Missouri  
A. FLAGLER FULTZ (see Officers)  
WINIFRED DIXON HANSEN, Unit Leader, Education, Adjunctive Therapy Department, Education  
WILHELMINA K. HARBERT (see Executive Committee)  
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PAT OTTO, Beatty Memorial Hospital, Westville, Indiana  
ABE PEPINSKY (see Research Committee)  
WILLIAM SEARS, Washburn University, Topeka, Kansas  
LOUISE WEIR, Devereaux Ranch School, Goleta, California

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ADA HOLDING MILLER, President, National Federation of Music Clubs, 28 Everett Street, Providence, Rhode Island.
MU PHI EPSILON, Mrs. Ralph J. Oechsler, 6604 Maplewood Avenue, Sylvania, Ohio
MUSICIANS EMERGENCY FUND, INC., Steinway Building, 113 West 57th Street, New York 19, New York
SIGMA ALPHA IOTA, c/o Mrs. Kathleen Davidson, President, 1009 25th Street, Des Moines, Iowa
Appendix

PUBLICATIONS OF THE NATIONAL ASSOCIATION FOR MUSIC THERAPY

MUSIC THERAPY 1951

The book of proceedings of the Second Annual Conference of NAMT, held in Chicago, November 9-11, 1951, is available from The Allen Press, P.O. Box 4, Lawrence, Kansas, for $3.68 postpaid U.S.A.

Preface—The Development of Music Therapy as a Profession

Part I—Music to Aid the Handicapped Child
Part II—Demonstrations
Part III—Scope of the Hospital Music Program and Professional Opportunities
Part IV—Volunteer Music Service in Hospitals
Part V—Musical Creativity and Emotional Conflict
Part VI—Patient Benefits of Community Concerts
Part VII—Report of Research Committee
Part VIII—Bibliography on Music Therapy
(600 Classified Items)

MUSIC THERAPY 1952

The book of proceedings of the Third Annual Conference of NAMT, held in Topeka, Kansas, October 30-November 1, 1952, is available from The Allen Press, P.O. Box 4, Lawrence, Kansas, for $5.20 Postpaid U.S.A.

Preface—NAMT Accomplishments and Future Possibilities.

Part I—Psychiatric Viewpoints on Music Therapy
Part II—Music in Mental Hospitals
Part III—Music Therapy for Tuberculous Patients
Part IV—Music in Correctional Institutions
Part V—Music for the Mentally Retarded
Part VI—Music for the Physically Handicapped
Part VII—Music for the Emotionally Maladjusted Child
Part VIII—Volunteer Services
Part IX—Research
MUSIC THERAPY 1953

The book of proceedings of the Fourth Annual Conference of NAMT, held in East Lansing, Michigan, October 19-21, 1953, is available from the Allen Press, P.O. Box 4, Lawrence, Kansas, for $5.20 postpaid U.S.A.

PART I—The Dynamics of Music Therapy
PART II—Applied Techniques of Music Therapy
PART III—Music Therapy with Children
PART IV—Music in Geriatrics
PART V—Music Therapy for Tuberculosis Patients
PART VI—Music in the Religious Program
PART VII—Music in Surgery
PART VIII—Volunteer Service
PART IX—The Music Therapy Education Program
PART X—Research

BIBLIOGRAPHY ON MUSIC THERAPY

Separate, $1.10 postpaid U.S.A., available from The Allen Press, P.O. Box 4, Lawrence, Kansas.

BULLETIN OF THE NATIONAL ASSOCIATION FOR MUSIC THERAPY

The official bulletin of the Association, formerly known as HOSPITAL MUSIC NEWSLETTER, is issued in January, May and September at 50 cents per copy or $1.25 for a yearly subscription. All members in good standing are entitled to receive the bulletin free of charge. Selected back issues are available at the single copy price. All subscriptions and orders for back copies should be addressed to National Association for Music Therapy, P.O. Box 4, Lawrence, Kansas.

PAMPHLET—MUSIC THERAPY AS A CAREER

Prepared by the Education Committee of NAMT for free distribution, this pamphlet gives opportunities for employment and outlines personal and educational qualifications. It is available from the chairman of this committee, Dr. Roy Underwood, Michigan State College, East Lansing, Michigan.
CONVENTION ACKNOWLEDGMENTS

During any convention there are many individuals and members of groups who contribute immeasurably to the success of the meetings, but whose contributions frequently are not reflected in the book of proceedings. At the New York Conference many such people served tirelessly to insure the success of the meeting and to bring pleasure to those in attendance. Those who are not noted elsewhere in this volume are credited here.

James A. Brussel, M.D., Assistant Commissioner, New York State Department of Mental Hygiene extended greetings at the opening General Session.

Mme. Yolanda Mero-Irion, executive director, and Miss Gladys Douglas, director of hospital projects, Musician’s Emergency Fund, arranged a reception and musicale.

The Goldwater Memorial Hospital Trio presented an abridged version of Oklahoma.

The Committee on Arrangements:
Program Chairman: Arthur Flagler Fultz
General Chairman on Arrangements: Edwina Eustis
Vice Chairman: Alice Phelps
Publicity: Norris Birnbaum, Phyllis King Noble, Barbara Denenholz
Registration: Hermina E. Brown, Chairman; Wallace Kotter
Exhibits: William Ulrich
Luncheons and Banquet: Mrs. Ernest Fifield
Demonstrations: Gladys Douglas
Mailing: Sarah Seward, Dorothy Hall, Dorothy Griffin
Hosts and Ushers: Harriet Cartwright
Publications: Esther Goetz Gilliland
Membership: Mrs. Hartwig Dierks

The Advisory Committee:
Carl Haverlin, President, Broadcast Music, Inc.
Gretchen Haller, President, New York Chapter, Sigma Alpha Iota
Mrs. George F. Richardson, President, New York Chapter, Mu Phi Epsilon
Carleton Sprague Smith, Chief of Music Division, New York Public Library
CONSTITUTION AND BYLAWS OF THE NATIONAL ASSOCIATION FOR MUSIC THERAPY
Revised, 1954

ARTICLE I
Name
The name of the organization shall be National Association for Music Therapy.

ARTICLE II
Purpose and Objectives
SECTION 1. The purpose of the Association shall be the progressive development of the use of music in medicine, and the advancement of research, interests, and standards of music therapy.
SECTION 2. The objectives of the Association shall be those which aid medical treatment most effectively toward patient welfare, improvement, and rehabilitation.

ARTICLE III
Membership
SECTION 1. Membership in the Association shall be of eight classes: active, associate, student, contributing, sustaining, life, patron, and honorary.
SECTION 2. Membership privileges and annual dues shall be prescribed in the Bylaws of the Association.

ARTICLE IV
Officers
SECTION 1. The officers of the National Association for Music Therapy shall be elective and appointive. The authority and duty of each official shall be such as is defined in the Bylaws.
SECTION 2. The elective officers of the Association shall be a President, two Vice-Presidents, a Recording Secretary, and a Treasurer. They shall be elected by ballot during the annual meeting and continue in office for a term of one year, or until the next subsequent election.
SECTION 3. No elective officer with the exception of the Treasurer shall hold the same office for more than two consecutive terms.
SECTION 4. Elections shall be conducted as stated in the Bylaws.
SECTION 5. The appointive officers of the Association shall be a Corresponding Secretary, an Editor, an Archivist, and a Parliamentarian. They shall be appointed by the President, with the approval of the Executive Committee, during the first month following the Annual Meeting.
SECTION 6. Appointive officers, with the exception of the Corresponding Secretary, may hold the same office for more than two consecutive terms at the discretion of succeeding administrations.

ARTICLE V
Executive Committee
SECTION 1. The Executive Committee shall consist of twenty members: the President, the immediate Past-President, the two Vice-Presidents, the Recording Secretary, the Corresponding Secretary, the Treasurer, the Editor, the chairman of the Research, Education and Public Relations Committees, and nine members-at-large, of whom three shall be elected annually each to serve a three-year term.
SECTION 2. The Executive Committee shall have power to transact the general business of the Association, shall be responsible for the management and control of its funds, and shall be empowered to appoint assistants to any officer of the Association.
SECTION 3. Any vacancy existing on the Executive Committee at the time of the Annual Meeting shall be filled by the Convention at its regular
election. A vacancy occurring during another time of the year may be filled by Executive Committee appointment to complete the prescribed term of service.

ARTICLE VI
Advisory Board

SECTION 1. There shall be an Honorary Advisory Board of five members for consultation on major policies. They shall be appointed annually by the Executive Committee to serve for one year, to be chosen from suggestions offered by the general membership, and may be appointed to succeed themselves immediately, or subsequently, at the discretion of succeeding Executive Committees.

ARTICLE VII
Meetings

SECTION 1. Annual meetings of the Association shall be held at such time and place as shall be determined by the Executive Committee.

SECTION 2. Special meetings of the Association shall be called by the President if requested by seven (7) members of the Executive Committee or upon a signed petition by fifty (50) paid-up active members of the Association. The call for the special meeting must state the business to be transacted and no business shall be transacted except that specified in the call.

SECTION 3. Special meetings of the Executive Committee may be called by the President, or upon the joint request of not less than seven (7) members of the Executive Committee.

ARTICLE VIII
Quorum

SECTION 1. Executive Committee. Seven (7) members of the Executive Committee of which at least three must be officers, shall constitute a quorum.

SECTION 2. The normal quorum of the Executive Committee plus five per cent (5%) of the active membership of the Association shall constitute a quorum for the annual business meetings. At no time shall the lack of a quorum at a non-business session prevent those present from proceeding with the program of the day.

ARTICLE IX
Amendments

SECTION 1. This constitution may be amended at any Annual Meeting by a two-thirds vote of the active members present, the proposed amendments having been submitted to the membership at least four weeks in advance of the meeting.

SECTION 2. Bylaws may be adopted, amended, or repealed at any session of an Annual Meeting by a two-thirds vote of the active members present, the proposed changes having been announced at least twenty-four hours prior to said session.

BYLAWS
ARTICLE I
Membership

SECTION 1. Active membership shall be open to all persons professionally engaged in the use of music in therapy including music specialists, therapists, physicians, psychologists, administrators, or educators, and shall provide the privileges of participation in the activities of the Association, the right to vote, to hold office, and to receive all issues of the NAMT BULLETIN.

SECTION 2. Associate membership shall be open to music volunteers or individuals who are not professionally engaged in the use of music in therapy and who wish to support the program of the Association. Such
membership shall provide for admission to conventions of the Association and all issues of the NAMT BULLETIN, but does not include the right to vote or to hold office.

SECTION 3. Student membership shall be open to bonafide students enrolled in music therapy training courses at the college level. Student members are entitled to receive all issues of the NAMT BULLETIN and to attend meetings and programs of the Association but shall not have the right to vote or to hold office.

SECTION 4. Contributing membership shall be open to individuals who contribute $25.00 annually to the support of the Association, and shall have rights and privileges at whatever type of membership he qualifies.

SECTION 5. Sustaining membership shall be open to individuals, organizations, institutions, or business firms which contribute $50.00 annually to the support of the Association. Sustaining membership may include an individual membership assigned to a person designated by the sustaining member organization, institution, or firm. Such individual membership shall convey to the person to whom it is assigned rights and privileges at whatever type of membership the designate himself would qualify.

SECTION 6. Life membership shall be open to individuals upon the payment of $100.00. A Life member shall have rights and privileges at whatever type of membership he qualifies.

SECTION 7. Patron membership shall be open to individuals, organizations, institutions, business firms, or Foundations contributing $500.00 or more. These funds may be used for scholarships, endowments, research, or special projects as designated by the donor with the approval of the Executive Committee. Patron membership may include an individual membership assigned to the person designated by the organization, institution, firm, or Foundation. Such membership shall convey to the person to whom it is assigned rights and privileges at whatever type of membership the designate would himself qualify.

SECTION 8. Honorary life membership may be conferred upon any person in recognition of distinguished service in the field of music therapy. Such election shall be made by the Executive Committee and be confirmed by the Association at a regular business session. Honorary life members who qualify for active membership shall have all the rights and privileges of such membership without the payment of annual dues. Honorary life membership shall not be conferred upon more than one person in any one fiscal year.

ARTICLE II
Dues

SECTION 1. Annual dues for Active members shall be five dollars ($5.00), for Associate members three dollars ($3.00), and for Student members one dollar and twenty-five cents ($1.25).

SECTION 2. The membership year shall coincide with the fiscal year.

SECTION 3. Members failing to pay dues by December 1 shall be sent a second notice by the Treasurer, and those not paying by February 1 shall forfeit all rights of membership.

ARTICLE III
Duties of Officers

SECTION 1. The regular term of office of all officers shall commence at the adjournment of the Annual Meeting at which they are elected.

SECTION 2. The President shall preside at Annual Meetings or conventions of the Association; call and preside at meetings of the Executive Committee; appoint, with the approval of the Executive Committee, all appointive officers, and all Standing and Special Committees with the exception of the Research Committee, designating the Chairman of each except
where otherwise indicated by the Bylaws, and be *ex-officio* member of the same without a right to vote; and perform the other duties implied by his title.

**SECTION 3.** The First Vice-President shall assume all duties of the President in case of the resignation, disability, or absence of the President; serve as Program Chairman, taking complete charge of program planning for the Annual Meeting, conferring on all details of management with his Chairman of Arrangements and special Convention Committee, and supervising the finances of the Convention; and shall have such other duties as may be assigned to him by the President and the Executive Committee.

**SECTION 4.** The Second Vice-President shall succeed to the Presidency in case of the disability or resignation of both the President and the First Vice-President; serve as membership chairman; and carry out such other duties as may be assigned by the President and the Executive Committee.

**SECTION 5.** The Recording Secretary shall keep the minutes of all business meetings of the Association and all meetings of the Executive Committee; send copies to each member of the committee within thirty (30 days); collect all papers presented before the Association and deliver them to the Editor, or appoint a reliable person for this responsibility, with the approval of the Program Chairman and the Editor.

**SECTION 6.** The Corresponding Secretary shall notify all officers of their election and committees of their appointment, and in general, conduct the correspondence of the Association.

**SECTION 7.** The Treasurer shall pay all bills authorized by the Executive Committee; keep an itemized account of all receipts and disbursements; send statements of dues to all members on September 1; notify delinquent members on December 1 that their names will be removed from the rolls if dues are not paid by February 1; present a monthly financial report to the President, and a statement to the Executive Committee each six months; and present a written report to the Association at the first business session of the Annual Meeting. The book in which the record of receipts and disbursements for the year has been kept, together with the checks and vouchers, also the annual report of the Treasurer, shall be submitted to the Auditing Committee in sufficient time for an accurate report by that committee at the Annual Meeting of the Association.

**SECTION 8.** A. The Editor shall be responsible for editing and supervising the publication of the Bulletin and the Book of Proceedings.

B. The Business Manager shall be responsible for the distribution and billing of the Bulletin.

C. The Publisher shall be responsible for publishing the book of proceedings and for its promotion, sales, and distribution.

**SECTION 9.** The Archivist shall keep in a secure place all items of historical interest to the Association, such as programs, newspaper and magazine articles, photographs, items of correspondence, and supervise suitable displays, as requested, for NAMT and other Conferences.

**SECTION 10.** Officers, upon retiring from office, shall arrange to confer with their successors during the Annual Meeting, to clarify procedures and responsibilities, and shall deliver to their successors within two weeks all record books, papers, and other property belonging to the Association.

**ARTICLE IV Committees**

**SECTION 1.** There shall be six standing committees: Auditing, Budget, Education, Editorial, Research, and Public Relations.

**SECTION 2.** The Auditing Committee shall consist of three members one to be designated as chairman, appointed by the President with the approval of the Executive Committee for a term of one year. This Committee
shall audit the Treasurer's books during the week prior to the Annual Meeting and shall report at the first business session.

Section 3. The Education Committee shall consist of three members appointed by the President with the approval of the Executive Committee. Each member shall serve for a period of three years and the appointments shall be made in such a manner that one new member is appointed each year. This Committee shall annually choose its chairman for the year. The chairman of this committee shall automatically become a member of the Executive Committee. The Education Committee shall study and make recommendations to the Executive Committee and the Association concerning the training of Music therapists and music aides; confer with the Education Committees in related fields of other Associations; make periodic surveys of the hospital facilities available for interns in music therapy; and assume such other duties in the field of Education as the Executive Committee may direct.

Section 4. The Editorial Committee shall consist of five members, three of whom shall be appointed by the President with the approval of the Executive Committee. Each member shall serve for a period of three years and the appointments shall be made in such a manner that one new member is appointed each year. The chairmen of the Research and Education Committees shall automatically serve as members of this committee. The Editorial Committee shall serve as an advisory body to the Editor and shall seek and recommend articles for publication in the Bulletin; and be responsible for a periodic revision of the Bibliography in close cooperation with the Research Committee and the Editor, and thereafter include annually in each new Book of Proceedings a list of suitable articles and books printed during that year.

Section 5. The Research Committee
A. The Research Committee shall consist of five members elected by the Executive Committee. At the Annual Meeting for the year 1952, one member shall be elected for a period of one year, one for a period of two years, one for a period of three years, one of a period of four years, and one for a period of five years. Thereafter, one member shall be elected annually for a period of five years. Any vacancy existing in the Research Committee at the time of the Annual Meeting shall be filled by the Executive Committee, upon the recommendation of the Research Committee.
B. No member of the Research Committee who has completed a five-year term may immediately be elected to succeed himself.
C. The Research Committee shall, by means of its own membership and such Association committees and other members as it may call into cooperation, conduct studies and investigations in the use of music in all forms of patient treatment, both by itself and in conjunction with other therapies; in the effect of music upon normal and abnormal people; and in such other fields that might have a direct bearing upon music as a therapy. It shall report and make recommendations to the Executive Committee, and shall serve in an advisory capacity to that body. All publications of the Committee shall require the approval of the Editorial and the Executive Committees. The Research Committee shall convene at the time of the Annual Meeting and at such other times and places as may be deemed necessary by the Committee. The Committee shall elect its own chairman each year. The chairman of this committee shall automatically become a member of the Executive Committee.
D. The Research Committee shall be responsible for the annual revisions and additions to the Bibliography to be included in the Book of Proceedings.

Section 6. A Public Relations Committee, with one member desig-
nated as Chairman, shall be appointed annually by the President, with the approval of the Executive Committee, for a term of one year. The Public Relations Committee shall be responsible for disseminating information concerning Association activities to the public through the press and other agencies, assist in the publication of Pamphlets and Brochures when requested by the Executive Committee, and shall foster favorable relations between the Association and appropriate organizations, and the public at large.

SECTION 7. The President, with the approval of the Executive Committee, may select other committees from time to time for which there is a special need.

SECTION 8. Only active members of the Association are eligible for membership on any standing committee.

ARTICLE V
Elections

SECTION 1. A nominating committee of five members shall be appointed by the Executive Committee, one of whom shall be designated as chairman by the President.

SECTION 2. The nominating committee shall present the name of one nominee for each of the five offices. Additional nominations may be made from the floor.

SECTION 3. The nominating committee shall present six candidates for membership on the Executive Committee, with due regard for geographical representation. The three nominees receiving the largest number of votes shall be declared elected.

SECTION 4. The nominating committee shall make its report at the opening general business session of the Annual Meeting. At least twenty-four hours shall elapse between the report of this committee and the election.

SECTION 5. Election shall be by ballot of members present.

ARTICLE VI
Official Organ

SECTION 1. The official publication of the Association shall be THE BULLETIN of the National Association for Music Therapy.

ARTICLE VII
Auxiliary Organizations

SECTION 1. The Executive Committee may, at its discretion, authorize the formation of local, state, and/or regional divisions of the National Association for Music Therapy. The relations of such divisions to the Association may be defined from time to time by the Executive Committee.

ARTICLE VIII
Fiscal Year

SECTION 1. The fiscal year shall be from September 1st to August 31st.

ARTICLE IX
Rules of Order

SECTION 1. Roberts Rules of Order Revised shall be the authority for all questions of procedure not covered by these Bylaws.