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FOR
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PURPOSES AND OBJECTIVES

of the

NATIONAL ASSOCIATION FOR MUSIC THERAPY, INC.

The progressive development of the use of music in medicine, through:

—Advancement of research

—Distribution of helpful information

—Establishment of qualifications and standards of training for therapists

—Perfection of techniques of music programming

which aid medical treatment most effectively
EDITOR’S PREFACE

In the fall of 1956 at the annual meeting of the National Association for Music Therapy in Topeka, Kansas, a matter of serious consideration for several years was brought formally before the members. This matter of consideration was the registration of music therapists. (By music therapists were meant those whose activities chiefly employed music as a means or modality toward therapeutic ends.) Such a step seemed necessary and essential, not only for the enhanced status of the individual but for the beneficial growth and stabilization of the profession.

Acting in accordance with this desire for registration, a committee of three was nominated and elected from the floor at the business meeting, and was directed to set up the plan and means for registering music therapists. In 1957, at the annual meeting in East Lansing, Michigan, these plans and means, having been worked out by the Committee on Registration, were brought before the Executive Committee of NAMT for review and change, where thought necessary. After consideration and some changes by the Executive Committee, the plan was brought before, and shown to each member at the business meeting, and after explanation and discussion, unanimously adopted. The Committee on Registration was forthwith instructed to carry on through the following year the registration of members who met the qualifications set forth in the plan adopted unanimously by the membership.

The development and carrying out of the registration has seemed so significant that some account of it should be set down. Because such account does not appear in the main body of this book it was thought proper to do so here.

In the Appendix will be found a copy of the Plan for Registration of Music Therapists which was sent to every associate and active member of NAMT. Also contained in the Appendix is a copy of the Application for Registration which was sent to every associate and active member. Both “Plan” and “Application” contain profuse details of information and direction.

The professional registration of music therapists as described in the “Plan” and “Application” is now in progress.

E. THAYER GASTON, Ph.D.

Lawrence, Kansas
May, 1958
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ANNUAL BANQUET ADDRESS
That irrepressible Irishman, James Joyce, once remarked “Americans are jung, and easily freudened.” If we ponder upon this punction, what Pundit Joyce meant becomes preponderately clear: Americans, like Jung, prefer to deal in myths and parables and, with Freud, fabricate fascinating fairy tales and then substitute them for sober sense.

And what are these fairy tales? Couched (as I have been) in Freudian concepts, we are prone (and I use such entendres Joycely) to blame our obtrusive obnoxiousness not on ourselves, but on some demon called, with monosyllabic and monothetic simplicity, the “Id.” Next, to cover learning and intellectual function, we dip into elementary Latin for “I” and achieve the “Ego”, not unrelated to the term Egghead. Finally, by adding not the Nietzschean but the Boyscoutian idea of superiority, we achieve the quadrisyllabic “Superego”, representing until recently the highest reaches of psychoanalytic metapsychology. These three arcane abstractions—Id, Ego and Superego—are then literally pictured (in what might be called science friction) as struggling among themselves for the possession of priceless Man, much as in ancient mythology pernicious Seth, practical Osiris or portentous Ra contested for the soul of the Egyptian in Nilotic legend; Siva, Vishnu and Brahma in the Land of Ind; or Loki, Thor and Wotan in the Valhalla of our Norse ancestors. And

1. The term idea incorporates the same root “id” that contributes to the formation of identity and idiot, and it is in this sense that I wish to acknowledge in this musical footnote that a few of the idiosyncrasies in this paper (which, in some of its style, is also an argument against avid alliteration) were borrowed and modified from some of my previous writings—particularly “Music and the Child in Society” and “Music as a Tool of Delightful Delusions.” However, since these ideoms were not born with me and therefore must have been appropriated from others who in turn stole them from still other perspicacious predecessors, all such acknowledgements of literary indebtedness take on a cast of infinite regression to old Idam—who, by ribbing humanity on the Eve of its innocence, was the penultimate source of all our troubles.

2. Professor of Neurology and Psychiatry, Northwestern University, Chicago. President, Society of Group Therapy 1956–57, Academy of Psychoanalysis, 1957–58, and Society of Biological Psychiatry 1957–58. (The theses here propounded were, commendably, supported by no grants-in-aid whatsoever.)

3. Derived from George Groddek’s das Es, “the It,” but rendered in babytalk as “the Id”.

SAY ID ISN’T SO—WITH MUSIC¹
JULES H. MASSERMAN²
Music Therapy 1957

just as in those ancient tales sinful Seth, subversive Siva and lawless Loki generally emerged victorious, so also in our Fables according to Freud does Ole Debbil Id, with only a thin cloak of intelligence, conscience and idealism, really retain control over all human conduct—whether frankly atavistic or falsely altruistic, or covertly gynecologic while overtly gentlemanly.

But oh my literate colleagues!—is Id necessarily so? Is all reaching for human brotherhood merely that for the humid breast, all search for justice a juristic jest? Is there truly no creativity other than procreativity, no sublimity other than sublimation? Or, to leave such sophistries aside and return to what really interests us (our pleasures) can we never enjoy, without being self-conscious about our Unconscious, the beauty of art, the illumination of poetry—and the highest expression of both in music?

Obviously these questions are rhetorical (i.e.: loaded), but they are not academic in the regrettably emergent meaning of “academic” as vacuous and futile. For our joys are important to us and, as we get older, those derived from literature, art and music become relatively more so. We must, then, defy this slurring challenge and champion our zest of life with increasing arder in their ascending order: literature, art—and music.

Let us begin with an example in the category of cherished literature—say, Alice in Wonderland. We can, perhaps, withstand one analyst’s lugubrious interpretation to the effect that when Alice went down the rabbit hole to reach the anteroom to the garden of her dreams, she was “really returning along the birth canal to the womb”—where, to prove the point, she promptly shrank to embryonic size. To those of a whimsical turn of mind, it is mildly diverting to observe a lesser man try to engrave his own tubularly constricted fantasies on Lewis Carroll’s delightfully sophisticated ones, and we can dismiss the matter on that tolerant basis. Nor, in the field of art, are we greatly disturbed to read that Freud himself, in his myopic misinterpretations of Michelangelo’s magnificent statue of Moses, failed to notice the symbolic horns of Pan jutting out with irrepressible cockiness from that Patriarch’s august skull as he sat letting stuffy old Yahweh’s Ten Commandments slip from his fingers. But all lovers of music must begin to bristle just a little when some analytic scotophiliac equates a phrase on a flute with flatus, or some other pedant proposes (as one once did to an audience under my chairmanship) that all musicians “must have
been frightened by a loud noise in the nursery" and thereafter "spend their lives playing at sounds so they can overcome this repressed infantile trauma." Indeed, I resent such garrulous gaucheries doubly because I, too, am a card-carrying analyst, wish to be proud of it, and must therefore deeply lament the fact that a few of my colleagues may, on rare occasions, display more breath than wit or depth outside their restricted citadels of competence.

Science as well as chivalry, then, demands that the character of the most beauteous and noble of the Muses be preserved from all such vandalisms. I realize, of course, that a merely verbal defense (and I contemplate nothing more vigorous here) frequently fails to phase fanatic Freudians; many of them, when challenged, simply do not deign to listen at all, or else after a minute or two conclude somberly that inasmuch as the brash questioner seems still concerned about facts and logic, he is, if not altogether unanalyzable, certainly in need of more hours of horizontal exhortation by a more exhausting psychoanalyst. Rebuttals merely prolong this futile sport with rather uninteresting opponents. Instead, therefore, I have selected this as a (ahem!) more broadly oriented, sophisticated and esthetically sensitive audience, possibly receptive to a deeper exploration of the protean depths, beauties and meaning of music.

But your greater qualifications, as always, carry their own risks. For I propose not only to speak about the wisdom and the art of music, but perhaps to traduce the very character of what I celebrate by playing illustrative musical passages on the two instruments you see resting helplessly before you—violins and violas. Consider well if there can be a greater test of all concerned—music, instruments, or audience—than what I shall essay: to play, with unschooled and unpracticed amateurishness, only a few measures of undeveloped melody, without harmonic or contrapuntal depth or the infinite resources of orchestral timbre. But perhaps these very circumstances may help prove my point: if the essence, grace and meaning of music can still shine through all this, the almost indestructible beauty and significance of this art will be irrefutably demonstrated.

First, a sacrificial bow to the two innocent instruments to be publicly prostituted tonight.

1. A most expressive term derived from the Greek roots for "mind" and "break up"; orthodoxy—meaning straight speaking—does not seem altogether appropriate.
Here in my hand is one of my cherished possessions: an Albani violin built with consummate care and skill in 1708 when that Tyrolean master was over seventy years old. In its quarter millennium of existence it has outlived scores of lesser craftsmen who have left the imprint of their repairs on its body, and ten generations of other owners—yet here it still reposes with a perfection of form and tone that modern science or workmanship cannot equal. Soon it will reproach me with its warm, deep, resonant voice for my inability to release the full beauty of its ageless song.

And here is the rest of the miracle—an Albani viola which, through the undeserved kindness of one of my musical friends, reposes, after a quarter millennium of time and half a world of separation, once again beside its more delicate sibling to complete perhaps the only pair of perfectly matched Albanis in the world. Larger in size, more virile in voice, violas nevertheless have their own tradition and individual charm. They are descendents of the effeminate viola d’amour which, perhaps, derived its association with love-play from the fact that sensitively attuned cords just inside its bodily apertures responded resonantly to properly executed external manipulations. pitched a fifth lower than the violin, the modern viola can rasp as scoldingly guttural and harsh as its German designation, Bratsch; in contrast, a virtuoso like Primrose can make it sound as dulcet and seductive as its Gallic name, Viola. How will it fare in my hands? Frankly, since I am not a very good instrumentalist, anything can happen, often regrettably. For that matter, I am not very good at anything much except, perhaps, sailing a small boat. My minor successes in other fields have apparently derived from the simple trick of combining quite ordinary talents in some unusual way, as for instance applying a little common sense to the practice of psychiatry and adding a liking for people and a love for music. Forgive me then if, with some duplicity, I misuse these graceful instruments, and so perhaps borrow from composer and luthier an eloquence that my verbal discourse would quite resoundingly lack. In this manner, let us consider more specifically the unique earthly and ethereal qualities of music in their relation to the ideas, ideals and behavior of man.

1. Personal communication from Robert Kagan, music-lover extraordinary.
THE UNIQUE QUALITIES OF MUSIC

Universality: As I have stated elsewhere, "it is perhaps more than a poetic premise that the dynamics of music may be identical with those that actuate the cosmos, from the rhythmic counterpoint of protons and electrons, through the restless Brownian movements of microscopic particles and the melodies of winds and seas to the eternal symphonies of the constellations—or from the simple beat of the tiniest heart to the electronic organ of the human brain." The ancients knew this, and so worshipped Apollo not only as the god of science and healing, but also as the expression of both in music. Pythagoras knew it too, and in his philosophy considered music the highest mode by which humans can experience the exquisite mathematical perfections of the universe. And thus it has been that music in all ages has given mundane man a sense of mystical but immediate kinship with the transcendent and the universal.

Sensory Pervasiveness: Perhaps, for this reason, the kinesthetic appreciation of rhythm and the auditory perception of pitch, timbre and volume are among the few experiences from which the body has provided no means of ready insulation. One cannot exclude sound even by closing the ears; literally, one then feels the vibration in one's very bones. And perhaps that is just as well; actually we walk, talk, sail a boat, play the piano and discharge other important functions by the silent but efficient method known as the inner feel of things.¹

Let me illustrate the response to rhythm alone by simply tapping the back of the viola with my knuckles in a primitively accented 2-4 (i.e. Elvis Presley) beat of about 72 per minute—the average pulse of this audience. Within a short time most of you would begin showing somatic or motor responses, which in some cases might become sufficiently strong to incite you to action—quite possibly directed toward me. Or, I shall merely tune these instruments. Close your eyes; put your fingers in your ears; or, for that matter hold your nose—all to no avail. In fact, you must literally leave this earth to escape its sounds—and even then risk the interminable psalms of the angels if not the wails of the damned.

MUSIC AND THE BASIC YEARNINGS OF MAN

But sounds have many functions other than as simple sensory

¹. In yachting, "sailing by the seat of the pants"; in psychoanalysis, "intuitive techniques."
links between man and physical reality. And in these functions music, perhaps in its broadest sense man's highest esthetic experience, plays an essential role in certain ubiquitous and immutable fantasies that man cherishes about himself and his relationships to the universe. I have called these fantasies the *Ur-defenses of man* and have described them in some detail elsewhere; here, however, we shall consider only how music is deployed by these Delightful Delusions as their most charming handmaiden.

**The Delightful Delusion of Omnipotence:** The first and perhaps dearest fiction that man cherishes about himself is that, after all, he is not a weak, transient, insignificant aggregate of unstable chemical compounds vulnerable to almost any variation in their immediate surroundings, but is instead an imperishable and altogether exceptional being capable of understanding, ordering, and controlling all he surveys. From this illusion spring many of man's puny strivings toward power and immortality: his absurd mausoleums, his obscenely named "testaments" and puny "wills" directed to "posterity", his scramblings for what he hopes will be deathless fame and his arrogant card-indexing and cross-filing of his limited experiences into scotomatous sciences and pompous philosophies to which the cosmos is then supposed to conform. Delusional or not, however, the softening strains of music fit into and mellow these wishful concepts beautifully—and I use the adverb advisedly—in the following ways:

**Music as a Science:** Where in man's experience is chaos better changed into wondrous order than through the rhythm, form, melody, chord succession, counterpoint, symphonic progression, and satisfying resolutions of music? And in what science can the man-made "rules" that govern these events be more simply and clearly formulated and then so quickly translated into the reality of "objective" experience? For example, convert the simple additive arithmetical progression 2:3:5:8 into vibration frequencies and play it, and we have either the pleasingly familiar musical arpeggio or the vibrant G-major chord: G D B G (illustrated on the viola). Such seemingly fixed and predictable relationships are more than an aid to young composers—the principles of mathematical certainty they seem to invoke are a stout staff and a deep comfort to all mankind.

**Music as Ubiquity and Power:** But the content of music is not arrogated by arithmetic nor stultified by space, time or mortal...
existence. With Sibelius, the sedentary traveler in notational imagery can explore endless vistas of forest, lake and crag; so also, the musical adventurer can plumb ageless ocean depths in Debussy’s “La Mer”, or soar on tireless avian wings among Respighi’s “Pines of Rome”. Yet more: employing the magic of Beethoven in his “Pastoral” or Strauss in his “Alpine” Symphony, man can create awesome storms and then, with Jovian ease, also command that their cataclysmic furies begone. It is perhaps not irrelevant that all the atomic scientists I know are covertly, but thoroughly frightened men—and nearly all love the deep consolations of music.

Music as Restitution: Mozart, still enchanted but hardly devastated after his rebuff by the fickle Aloysia Weber, could write a “Symphonie Concertante” in the heart of which the tender voices of a violin and a viola are blended exquisitely against a background of embracing harmony. This rhapsody mounts to a passage of pleading aspiration; but when this is not resolved, there is a shrugging sforzando and the whole affair ends in a light-hearted dance. Listen to the two themes: first, the quiet plea of masculine appeal and longing in the viola:

Theme 1, Mozart, K320 D, Andante (played on the viola)

Then the final carefree bound of emancipation and gaiety:

Theme 2, Mozart, K320 D, Presto (violin)

But music can do more than dissipate disappointment in a delightful dance; it can deal almost as lithely with Death itself. Mahler, mourning a dear friend, figuratively restored him to life by composing the “Resurrection” Symphony. And Strauss, anticipating his own demise, could deny it in advance by writing the immortal tone poem “Death and Transfiguration”.

Music as Esthetic Creation: Immanent in all these strivings there is also what we like to think of as a yearning after the good, the beautiful—and therefore the true. Possibly man, in reaching for the powers of creation and perfection, not only reassures and heartens himself immeasurably in music, but many indeed have struck a faint spark of thaumaturgy actually reserved for the divine.

The Second Delightful Delusion, The Ur-defense of the Omnipotent Servant: But unfortunately, man could not rest in peace

1. Musical notations are found at the end of this paper.
with just his sciences, his philosophies or even his poetic demi-
urges—his limitations in all three spheres were too manifest to
be altogether denied. Therefore, man had to invent boundlessly
all-wise and all-powerful Beings, grant Them human form, assign
Them names to which they must answer, and place Them in
various pantheons within easy reach. Conveniently, these Fig-
ures could be controlled by the very same methods with which
all children control their parents—flattery, bribery, threats, or
if absolutely necessary, proper conduct. Thus managed, these
omniscient, omnipotent but remarkably gullible deities would
grant man everything he wanted—including permanent posthu-
mous retirement in a luxurious penthouse in a heavenly climate.

As may be anticipated, music is also bound up with this second
system of Delightful Delusions. It is, indeed, amazing how
closely the deeply calming litanies, chants and hymns of religious
services follow the slow hypnotic rhythms and simple repetitive
melodies of the lullabies troubled children wish to hear from
those they trust and under whose all-embracing protection they
seek security and repose. Let us listen to but two simple themes
epitomizing the leading religions of the Judeo-Hellenic tradition.
Can anyone of us miss the appealing sorrow in the ancient
Hebraic plaint of Eli, Eli, Lomoh Azahwtoni (Lord my God,
Why has Thou Forsaken Me?) echoed by the King of the Jews
in His agony on the Cross?

Theme 3 (violin)

or the Kol Nidre that unites all Israel in the Day of Mourning:
Theme 4 (viola)

or, in contrast, the soul-satisfying perfection of a Vivaldi church
cantata, or the tranquil devotion of Schubert’s Ave Maria:
Theme 5 (viola)

or the call to adoration of the Adeste Fideles.
Theme 6 (viola)

True, such music, through sacred associations, acquires a glory
and majesty of its own. Yet is it very different from the yearning
tenderness between parent and child embodied by Brahms in his
poignantly simple Lullaby?
Theme 7 (violin)

But to prepare for the latter occasion, certain devout obstet-
ricians are recommending that pregnant women, for the welfare
of the child’s soul, should listen to religious music through the
day and sleep to its inspirational strains at night. Nor, even after
the child has been delivered from this confinement as a captive audience is he to be deprived of similarly incessant influences in later life. Indeed, during most of his education much of the pedagogic persiflage to which he will be exposed will consist of reverberating sonorities intended to be received with the awed paralyses of thought with which one succumbs to a cathedral organ. Listen, for example, to the current mumblings of pseudo-“psychological” or pseudo-“philosophic” pronunciamentos, such as Freud’s piping trebel: “Where Id was, there shall Ego be!” Or to Heidegger’s baritone buffo: “The word existence designates a mode of Being; specifically, the Being of those beings who stand open for the openness of Being in which they stand by standing it!” Are such cryptic atonallties really wondrous words of wisdom, or little more than sounding trash and tinkling symbols? In any case there seems to be no surcease; now that there are deciduous decibels in delivery rooms, organs in undertaking parlors and carillons in cemeteries, the cycle of cacophony from conception to consignment is complete.

The Third Delightful Delusion, Man’s Trust in Man: But man has still a third and final Ur-delusion, busily concerned with denying the fact that none among us is ever absolutely certain of the friendship of his fellow-man, or brave enough ever really to admit this doubt even to himself. It is still, indeed, the paradox of our age that while we must advocate and sometimes profess to believe in universal love, we had better act as though each man is not only a potential rival, but possibly, also, an enemy. To mitigate such fears, we seek each other out, extend our right hands to each other to show the temporary absence of weapons, congregate in uneasy assemblies, and plan hopefully for ever larger and better-regulated societies for the future. All this requires communication—apparently a frantic and properly ambiguous amount of it—and here, too, music serves a number of essential functions. Let us list and listen to these briefly:

First, the sharing of basic experiences: think of the rich communal significance of the children’s play ditty, the school song, the graduation ode, the dance, the love serenade, the patriotic

1. Freud only occasionally seemed concerned about the antithesis of this proposition, as enthusiastically applied by some analytic patients under the tutelage of their mentors: “Where Ego was, there shall Id be!”

2. I did not find this gem myself; it was unearthed and put in an appropriate setting by W. Kaufman in his “Existentialism from Dostoevski to Sartre” (1956).
anthem, the military march—or finally, the mourning dirge. Hear them in rough biographic order; is any one without poignant meaning?

The Farmer in the Dell or London Bridge is Falling Down Themes 8a and 8b (violin, pizzicato)
The University of Michigan School Song Theme 9 (violin)
Viennese Waltz Theme 10 (violin, arco)
Sailing Lullaby Theme 11 (violin)
Schubert Serenade Theme 12 (violin)
Wedding March Theme 13 (violin, pizzicato)
Home Sweet Home Theme 13a (violin)
Star Spangled Banner Theme 14 (violin)
Over There Theme 15 (violin)
Funeral March Theme 16 (violin)

These themes are but fragmentary introductions to elementary musical ideas; nevertheless, they are instantly significant and emotionally eloquent to nearly everyone. One possible exception was the Sailing Lullaby refrain just after the waltz; this trifle of Romantic-period Masserman can have personal connotations only for me, and yet, because of its simple undulant melody, it might evoke a vernal atavistic,thalassic restlessness in the land-bound sailors among you. Can we, indeed, conceive of any important human experience without its musical obligato?

But music also transcends the memories of merely mundane experiences, and invites the participant to vistas beyond. Where else on earth can we share as well the feeling of mastery and fulfillment afforded us by a Bach fugue, or the consummate grace of a Mozart sonata, or the Dionysian abandon of Stravinsky’s Rites of Spring or the ineffable peace and sublimity of a late Beethoven quartette? I can here attempt to sketch on a single instrument only a hairline shadow of one such masterpiece, but let us take, for example, the ethereally haunting Andante of the Rassoumoffsky Quartette, Op. 59, no. 3:

Theme 17 (violin, muted)

Let me ask again: are there fairer wings on which to soar from the pedestrian rounds of earthly living?

Finally, music is a wondrous social bond—a quality which, with Terpsichore, uniquely differentiates her from other arts in aggregating and cementing social groups. It takes only one
painter to limn a picture, one sculptor to form a statue, one architect to design a cathedral, one author to write a book—the framing, mounting and duplication of these works are industries, not primarily arts. But it takes group empathy and conjoint artistry to play a quartette, sing a chorus, or perform a symphony—and the experience is sought, appreciated and treasured as a jointly existential *einfühlung und erlebnis* by all concerned. And in such groups many of the essentially constructive relationships of society can be explored and mastered—the roles of leader, adjutant, partner, follower, or teacher; yes, even those of the friendly rival, the willing foil or the martyr professedly dedicated to the good of the whole. And all these are as close beneath the brassy surface of a lodge band or a swing combo as to the polished sheen of a philharmonic orchestra. In effect, people learn not only art and poetry through music, they learn self-discipline, culture and social role; in short, how to be human. And it is through these insights and relationships that men, no longer jejunely jung or freudened, may proclaim: *Id Isn’t So with Music!—* and prove it by arranging an ever more harmonious Eden on earth. Then, as in a vast Ninth Symphony of human history, the half-articulate yearnings and restless seekings of the early movements will be resolved as the greatest of musical geniuses built his Finale: a triumphant Ode to Joy in the Ultimate Brotherhood of Man.
THEME 1.  MOZART  SINFONIA CONCERTANTE  K 320  D (formerly K 364)  Second movement

THEME 2.  MOZÁRT  SINFONIA CONCERTANTE (last movement)

THEME 3.  ELI, ELI

THEME 4.  KOL NIDRE

THEME 5.  SCHUBERT  AVE MARIA
Annual Banquet Address

THEME 6. ADEST FIDELES

(Vn)

THEME 7. BRAHMS LULLABY

(Vn-pizz.)

a. (Vn-pizz.)

b.

THEMES 8a. AND 8b. FARMER IN THE DELL AND LONDON BRIDGE

(Vn-pizz.)

THEME 9. UNIVERSITY OF MICHIGAN MARCH

(Vn-pizz.)

Tempo di Valse

THEME 10. IVANOVICI WAVES OF THE DANUBE
THEME 11. MASSERMAN SAILING LULLABY

(Vn-Bow)

THEME 12. SCHUBERT SERENADE

(Vn-pizz.)

Con moto moderato

THEME 13. WAGNER BRIDAL CHORUS (from “Lohengrin”)

(Vn-pizz.)

THEME 13a. HOME SWEET HOME
THEME 14. THE STAR SPANGLED BANNER

THEME 15. OVER THERE

THEME 16. CHOPIN FUNERAL MARCH (Piano Sonata Op. 35)

THEME 17. BEETHOVEN STRING QUARTET OP. 59 N. 3 (Second movement)
Since we are running behind schedule, I shall forego the dubious pleasure of a formal presidential address and merely chat informally with you for a few moments concerning some of the immediate needs of our Association.

First of all, we need money. I do not mean to imply that we are bankrupt by any means. Our treasurer reports a good balance on hand and good business procedure demands that such a balance be maintained at all times. Not only that, but we should strive to set aside some amount each year to build up a reserve which would tide us over rainy days. Moreover, additional funds must be found if we are to do many of the things we must do to accomplish our aims.

Much has been said about the need for a national office and secretarial staff. No one can question the value of such an office, but can we at present support such an office? In my opinion, it is most unlikely that any foundation is going to finance such an office. But even if funds were granted for a one, two, or three year period, what happens then? Such an office is a costly project and if we were unable to continue it on our own we would likely be worse off than we are now. Like similar professional groups, we will simply have to pull ourselves up by our bootstraps and depend upon volunteers and draftees for the necessary hard work. As a matter of fact, we must prove by our own devotion that we are worthy of aid before we anticipate it.

What, then, is to be the source of our income? I think you will agree with me that it will be years before we can count on sufficient active memberships to support the Association. It may be years before the salaries of music therapists reach a level that permits us to increase dues substantially or to make special assessments. Contributing memberships probably will remain comparatively negligible. May I suggest an important source of revenue that remains virtually untouched—the Associate Membership. There are thousands of people in this country who would profit by such membership. First of all, consider the hundreds of volunteers who assist in music programs. Although
they are not eligible for Active Membership, they most certainly should be a part of our Association. Think, too, of the thousands of teachers in special schools. Some of them are aware of the value of music in their programs, but many of them are not. Membership would benefit them all through our publications, conferences, and workshops. Let us not forget, also, those who are active in mental health organizations, rehabilitation organizations, as well as professional groups of psychologists, psychiatrists, medical men, occupational therapists, physical therapists, etc. Finally, the Music Education people have unparalleled opportunities if they can be made to realize the full potentialities of music. Many of these people could be interested in membership.

Who is going to secure all these members? You and I have this privilege. The NAMT must do everything possible to establish its position and prestige, but it is up to each of us as individuals to build up membership, not just Mrs. Harbert and her committee.

The prospects of recognition are bright. Mr. Unkefer will report to you on a recent meeting of an Interdisciplinary Study Group in New York. This, and future projected meetings, are encouraging. There will be presented, for formal action at this conference, plans for the Registration of Music Therapists, the certification of college and university training programs, and the certification of clinical training facilities. We are fortunate in having the complete cooperation of the National Association of Schools of Music in the matter of Education for Music Therapy. This recognized and highly respected association deserves our sincere appreciation for its interest in the NAMT and its desire to work hand-in-hand with us in this field. The certification and accreditation of training, and the registration of music therapists will increase very much our stature as a profession. We should add to this the close association and cooperation of all adjunctive therapy groups. We should take out a membership in the World Mental Health Federation and participate in as many national conferences of allied groups as opportunity and finances permit. We must encourage research and seek funds for this purpose. The combination of these various objectives cannot fail to give us the recognition we seek and deserve.

Again, may I insist that we dare not sit back and depend upon "George" to do it. Every member, and I mean every last member, must roll up his sleeves and go to work.
PART I

THE DYNAMICS OF
MUSIC THERAPY
FACTORS CONTRIBUTING TO RESPONSES TO MUSIC

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There is a saying attributed to the ancient Persian, Zoroaster, which is as follows: “The poet is one who inscribes things unapparent in apparent fabrications.” This might be paraphrased to read: The musician is one who elicits the unapparent in apparent musical fabrication. The word, “unapparent,” in the paraphrase refers to the feelings engendered by music, the wordless meanings of music, sometimes called aesthetic feeling, musical emotion or subjective musical response.

These feelings are, of course, not the notes, the harmony, the melody, the architectonics, but each person’s own, individual response. What these feelings are has been the subject of philosophical controversy from pre-Platonic times to the present. These feelings are very real to each of us and yet one finds it very difficult, if not impossible, to talk about this true part of our experiences. Some fifteen years ago Langer1 made an important attempt toward an understanding of the nature of such experiences by speaking of music as connotational, nonrepresentative, not purely sensuous. Although art (music) is significant, what it signifies cannot be said, but is based on fundamental human needs. It is more than just self-expression, “because self-expression requires no artistic form.”

In a more recent work Meyer2 has been at some pains to point out three interrelated errors which have plagued psychology of music: hedonism, the confusion of sensuous pleasure with aesthetic experience; atomism, the attempt to explain and understand music as a succession of discrete notes; and universalism, “the belief that responses obtained by experiment or otherwise are universal, natural and necessary.”

These opening sentences are not to serve as an introduction to a philosophical discussion, but to call to mind, briefly, the difficulty of explanation of so-called “musical emotion” or “mood.” Consideration of such difficulty of explanation leads to the purpose

of this paper which is to discuss briefly three factors inherent in musical response, and in the light of this discussion, to pose several questions as to the nature of that part of musical response which is the wordless meaning of music.

The first factor concerns a sociological viewpoint of music. The second factor derives from some recent findings in neurophysiology, and the third factor from researches in endocrinology. If any integration of these three factors can be achieved then, it would seem, we are more nearly ready to suggest more specific questions as to the nature of musical response.

At the outset it needs to be made clear that aesthetic expression is a universal need of man. From the anthropological viewpoint Linton\(^1\) has stated that

The area in which evolutionary development is least clearly recognizable is that involving the psychological needs of individuals. . . . Needs for some sort of aesthetic expression and for escapes from reality . . . seem universal, and each of the various cultural lines has developed its own solutions and has set its own goals.

Masserman's\(^2\) first Principle of Biodynamics is, "Motivation: All behavior is motivated by physiologic needs: survival, procreation and, possibly also, esthetic creativity—in various configurations of contingency and urgency." Somerset Maugham,\(^3\) a physician, but best known as a novelist, has written that, "If beauty is one of the great values of life, then it seems hard to believe that the aesthetic sense which enables men to appreciate it should be the privilege of only [one] a class."

Man must learn the music of his culture, whatever it is. His music is one of his folkways. It is not something transcendental. It is not universal, existing in all cultures. He must learn his music as he must learn his language. Mueller,\(^4\) perhaps, best expresses the "empirical-sociological" approach to music. Music is a human invention which is constantly subject to change. To be guided by an "aesthetic conscience demands a well-conditioned group member."

\(^4\) J. H. Mueller. *Basic Concepts of Music Education*, etc., to be published in 1958 by NSSE.
It is only because tastes in music last for so long that we tend to ascribe permanence to them. To quote Somerset Maugham\(^1\) again, “One of the most curious things that has forced itself on my notice is that there is no permanence in the judgment of beauty. —Beauty is relative to the needs of a particular generation.”

An earlier paragraph pointed out Meyer’s contention that universalism was an error that plagued psychology of music. Continuing this same contention he says: The “studies of comparative musicologists, bringing to our attention the music of other cultures, have made us increasingly aware that the particular organization developed in Western music is not universal, natural, or God-given,” in the sense of a specific.

It must be clear from all of this that what we are musically, and what we respond to, have been the result of learning and conditioning. To each musical experience is brought the sum of an individual’s attitudes, beliefs, prejudices, conditionings in terms of the time and place in which he has lived. To each musical response, also, he brings his own physiological needs, unique neurological and endocrinological systems with their distinctive attributes. He brings, in all of this, his total entity as a unique individual and he reacts in terms of these.

Masserman’s second Principle of Biodynamics supports this viewpoint. Adaptation: “Every organism reacts not to an absolute reality, but to its own interpretations of its milieu in terms of its past experiences and uniquely developed capacities and patterns.”\(^2\) (Masserman’s second Principle of Biodynamics.)

If man is to operate as a unit—and he must—then somehow or other what he has learned, his conditionings, attitudes, judgments, feelings and various other physiological and psychological functions must be integrated, because all of these are influential in his response to music.

It is this matter of integration and its possible significance in the explanation of aesthetic feeling that shall chiefly be of concern in the balance of this paper. Recent neurophysiological research and resultant data have made possible new concepts concerning consciousness. More importantly, for us, they have indicated new concepts bearing on the understanding of musical emotion.

“Emotion is one of the most complex phenomena known to psychology. It is complex because it involves so much of the organ-

ism at so many levels of neural and chemical integration.”¹ Emotional response, then, involves not only what we have learned to be in our society, but a great amount of complex neurological function and a conspicuous amount of chemical activity, and all three integrated so that the individual may respond in a unitary fashion. The problem of how this integration may occur is the problem of this report.

In the last several decades, up to 1950, there had been little interest in the nervous system by educational psychologists.² This has changed in the last six years and a great deal of work is now going on having to do with neuropsychology and neurophysiology.

Previous to this, and even up to the present, it had been assumed and believed by the majority of people that the highest level of integration of man’s multiple functioning was to be found in the cortex of the cerebrum. But as early as 1938 Penfield³ through study of the various epilepsies and by experiments wrought by disease and injury to the brain, came to believe that the highest level of neuronal integration must be sought in the brain stem.

One of the chief instruments for study of the brain has been the electroencephalograph. Another important means for neurological study has been the reaction of the human brain to weak electric currents instituted by means of implanted electrodes.

Lying deep within the brain, and very ancient from an evolutionary viewpoint, is an area of the grey masses of the brain stem known as the reticular formation or reticular system, a diffuse network of neurones. This system does not include the classical sensory pathways, e.g., the auditory nerve.

It was first established in 1949 by Moruzzi, an Italian neurologist, and Magoun,⁴ an American neurologist, that when these grey masses of the lower brain were electrically stimulated, cortical electrical activity was affected. When the classical sensory pathways

were destroyed, auditory stimuli produced a state of arousing or alerting if the animal was in natural sleep or wakefulness, respectively. Such waking states in the human are characteristic-ally associated with focussing the attention, or anticipation and readiness.

Parenthetically, some embarrassment is felt about the oversimplification of this presentation. To those interested, the bibliographical items will give a much fuller and a more technical description.

Very simply, then, the reticular formation contains pathways to the cortex which are separate from the classical sensory pathways. Penfield and Jasper say that "Recent physiological and anatomical studies have brought to light a separate projection system to the sensorimotor cortex which may function to some extent independently of the specific projection system..." They say that this system for brain activation receives collateral connections from ascending afferent nerves before these nerves reach the thalamus.

Lindsley and others call this mechanism which activates the brain the ascending reticular system and suggest that it bypasses the thalamus. There is also evidence that the ascending reticular activating system tends to set the stage for the spreading and elaboration of effects in areas of the cortex.

It should be understood that this activating system is nonspecific and quite diffuse. Both Lindsley and Hebb think that this nonspecific, diffuse ascending reticular system may well underlie the energizing aspects of emotion.

And here seems to be the crux of the matter. What kind of collateral pathways or connections feed into the reticular formation which then activates the cortex? Again Lindsley answers that exteroceptive and proprioceptive pathways in passing through the lower brain stem give off collaterals into the reticular formation.

2. Lindsley, op. cit.
4. D. B. Lindsley. Ibid.
Exteroceptive pathways bring stimuli from the outside world, but proprioceptive pathways bring stimuli originating in muscles, tendons, joints and the balancing apparatus of the internal ear. Thus, these two kinds of impulses have two ways of reaching the cortex, a direct way and a diffuse way.

Penfield and Jasper\(^1\) state quite clearly that, "The continuous electrical rhythms of the brain appear to be under the separate, independent control of the brain stem reticular system." These men have demonstrated by electroencephalographic evidence that this is true. It would seem obvious, therefore, that there are many opportunities for interaction between the specific functional systems and the integrative system of the brain stem.

It may well be, then, that the ascending reticular system is making contributions towards our state of consciousness. It is diffuse and nonspecific but nevertheless it would seem to have some effect on emotional state. Does this diffuse, nonspecific activation of the cortex offer any basis for speculation as to the nature of aesthetic feeling?\(^2\)

But this is not all. We have seen that sensory stimuli from outside our bodies and from inside our bodies may be transmitted by way of the ascending system, and now evidence has been submitted by a number of experimenters that cortical stimuli produces responses in the reticular formation.\(^2, 3, 4\)

And thus it is seen that there is a flow into the reticular system not only from the sensory but from the cortical. It is here that interaction can occur. Here, it appears, arrive collateral connections bearing various kinds of stimuli, and here also arrive corticofugal impulses, impulses from the cortex. It seems possible that here they might interact, overlap and integrate. But in general the reticular formation can dictate by selective activating forces.

We quote from Penfield and Jasper:\(^5\)

It is obvious that the higher mental functions which distinguish man from lower animals ... are not possible without the cortex. ... But without the constant selective activating influences of the reticular network of the higher brain stem, the cortical mantle lies dormant.

Many studies have been reported on autonomic response to music. There is undoubtedly a significant sensory influx from the

\(^1\) W. Penfield and H. Jasper. \textit{op. cit.}
\(^5\) Penfield and Jasper. \textit{op. cit.} p. 481–82.
viscera as well as other parts. No consideration of emotion would seem to be complete without some account of hormonal or endocrine activity.

Selye¹ in his book, “The Stress of Life,” says that it is especially our endocrine glands and nervous system that help us to adjust to the constant changes that occur in and around us. “Chemical alarm signals are sent out by directly stressed tissues to the centers of coordination in the nervous system and to endocrine glands.”

Selye has taken great care to define stress as the common denominator of all adaptive reactions in the body. He has then shown how far reaching, how sensitive and how influential are endocrinological activities of our bodies, and how closely allied to the nervous system they are. He says that, “Virtually every organ and every chemical constituent of the body are involved in the general stress-reaction.” It is through the endocrine and the nervous systems that man is able to coordinate and unify.

In this present report, to summarize, it has been evident that the nature of aesthetic feeling, in our case, musical emotion or mood, has long puzzled philosophers and psychologists. It has been difficult to explain or describe, yet it is certainly a part of reality for each individual. It has, furthermore, been evident that the genesis of aesthetic feeling does not stem from the transcendental, the mystical, nor is it a supra-cultural absolute. And, therefore, the motivation for aesthetic feeling must be found in the mediation or integration of our hereditary equipment and our environment.

In addition to this, the necessity for aesthetic creativity and, the reverse of the coin, response, holds for all men; it is not a possession of one type or one class of men. It must be for all men because “behavior is motivated by physiologic need,” and it is not possible to deny that everyone has physiologic need.

Where, then, is the highest integrating center that enables man to bring his values, judgments, attitudes, past learnings, and with all of these, integrate into musical response the sensorimotor and cortical aspects of his behavior?

Much evidence was presented, all of which seemed to indicate that the highest integrating center was not in the cortex but, perhaps, in a subcortical formation, the reticular system. It is this system which receives, at least in part, sensory stimuli from inside

the body, from outside the body, and stimuli from the cortex, as well. This new concept would seem to cast some doubt on the long-held view that the cortex is the most precious part of the brain. And yet it must not be forgotten that the neurological system functions as a unit.

Along with the neurological system, attention was drawn to the endocrine, or, loosely speaking, the chemical system which also is very sensitive and active in any adaptational changes in the body. The endocrine and nervous systems were shown to work closely together, hand in hand, in cooperation in any kind of "stress."

For example, let us listen to our most favored piece of music. The various systems of our body respond and feed back diffuse, nonspecific but, nevertheless, real sensory stimuli. To this listening comes all that we have learned and been conditioned to in our culture, our values, our training, our manner of overt response in terms of our condition to respond. This in turn affects our orientation to the musical stimuli. And thus, it would seem, that, by means of the integration described, we have a receiving and, in one sense of the word, a feed-back system.

It is not at all supposed that the contents of this report do more than suggest questions. It may be, if you please, entirely speculative. To think that musical emotion is herein explained would be fatuous indeed. But it does seem that we may ask:

Is it this reticular system with its great integrative property that, in part, makes possible the peculiar, unspeakable and wordless response to music?

Does the general body state so engendered by the experience of music through the mediation of subcortical integration convey to consciousness a feeling which is very real, but because of its nature defiant of word description?

Is this why the specificity of words prohibit their substitution for music?

Is this why music sets forth forms which language can not duplicate?
The psychiatric aspect of music therapy has two focal points. There is first the consideration of the patient. A great deal has been published about music therapy with mental patients, with neurotic, psychotic and character disorders, in adults and children as well. There is no longer any doubt that music therapy is highly effective and often the method of choice; it can be used with good results where other approaches have failed or the patients could not be reached. Research and clinical experimentation will probably lead to new and more beneficial approaches within the field of music therapy; techniques will be refined, and the type of music and musical activities indicated for certain patients and disease syndromes further classified. This paper does not deal with this psychiatric aspect of music therapy, as it relates to the patient, his condition and treatment.

There is another psychiatric aspect, not too often mentioned, but of considerable importance at this stage of the development. It is the integration of music therapy within the field of psychiatry. Instead of examining the effects of music therapy on the patient, we may have to consider its effect on the psychiatrist. In many instances the music therapist finds it easier to relate herself to the patient than to the doctor. In her work she less often encounters resistance by the former than by the latter. And incidents have become sufficiently frequent to justify an examination of the nature of the difficulties and the causes for an unsatisfactory relationship.

The first obstacle which the music therapist found in her endeavors was a certain skepticism about this new branch of treatment. The last few years brought forth such an abundance of clinical reports and scientific evaluations that the question of the effectiveness of music for therapy is not often raised. Few doubt any more that music is good for patients; however, many prefer it as part of recreational activities, and reject the idea of music “therapy.” This is a new development; but it points to a crucial issue which needs to be resolved before music therapy can find its definite and secure place within psychiatry.
Objection to the term therapist has not been encountered until recently. It was first noticed at the Annual Meeting of this Association in 1954, when it was suggested that we should rather use the term "Clinical Musician." This tendency to minimize the therapeutic aspects of music has been evidenced in the attempts to discontinue the Departments of Music Therapy in institutions and relegate music to recreational activities. A musical technician could be just as effective there; a music therapist is definitely out of place within the variety of recreational programs. What is the reason for the sudden caution in permitting a therapist with a special approach to be called a "therapist?" No one ever would have thought to question the adequacy of the term "physiotherapist!"

The fact that the issue of the term therapist was first raised in regard to the music therapist, while physiotherapists, occupational and recreational therapists functioned for many years without ever causing concern with their titles, indicates clearly that music therapy is different, fundamentally, from the other adjunctive therapies. It belongs to this group, no doubt; but its function is somehow different from that of the others. It is this difference which created misgivings, aroused objections and encountered resistance. What is it that gives music therapy its special position?

This difference may perhaps become apparent when we compare the use of music in recreation with that in therapy. There is a difference, to be sure, although many administrators and many psychiatrists try to overlook or to deny it. Wherever music is used, it has some "therapeutic" effect on the patients; it can calm or excite as desired, it can integrate people into a group and make the group more cohesive. Music has been used for such purposes for ages, long before it was used for therapeutic purposes. Music therapy as such is something else again.

The music therapist enters into a more personal relationship with his patient than is customary in recreational or occupational therapy. They solicit, as a rule, more limited responses, and are not as directly and primarily operating on the emotional level. Music used in therapy has much stronger dramatic effects, and is more geared to the needs of the individual patient, be he alone or in a small group. A good example of the difference when similar approaches are used in different settings is the group; it forms an integral element in recreational therapies, yet is quite differently utilized there than in group therapy. Group dynamics have to be
known and dealt with by the recreational therapist as well as by the group therapist. Nevertheless, the group has a different effect on the patient whether he attends recreational activities or group therapy sessions.

The music therapist deals directly with the psychological and social problems of each patient, although usually not on the verbal level. However, verbal communication may often result from the nonverbal emotional interaction. The music therapist needs far more specific information from the psychiatrist about each patient, as she in turn can relate to the psychiatrist more pertinent material than would evolve from the mere observation of the patient in recreational and occupational therapy. The more intense form of therapy, occurring in music therapy, puts more responsibilities on the therapist. It would be disastrous for her to do what some psychiatrists want her to do and others criticize her for doing occasionally, namely to “retreat” from the field of therapy to the field of music as such. Here we have another evidence for a fundamental difference between music therapy and the other adjunctive therapies; no one has ever accused an occupational therapist of “retreating into occupational activities” or the recreational therapist of “retreating from therapy into recreational activity,” because these forms of “therapy” consist of just that activity, be it of occupational or recreational nature. Not so music therapy; the musical activity is secondary to a deeper therapeutic process.

It may now become clear why the term therapist becomes controversial, when the music therapist is involved, while the other form of adjunctive therapies were never questioned in their therapeutic role. No one would object to a statement that the physiotherapist provides “treatment”; but such objections would be quite vocal should a music therapist speak about “treating” her patients. What is the difference? Obviously the treatment by a physiotherapist involves mechanical procedures, while the “treatment” in music therapy would be psychotherapy. And here is the seat of the problem.

The term psychotherapy is used with great caution at the present time. New insights into motivation and psychological dynamics, emerging from the practice of psychotherapy, are applied in many professional activities. Every teacher must know something about the motivations and emotional blocks of her children. But this does not give her the right to call herself a psychotherapist; nor does her ability to have effective group discussions with her
children make her a group-therapist. But even on higher levels of qualified professional performance does the concept of psychotherapy create confusion and antagonisms. The clinical psychologist is professionally trained for psychotherapy; but some members of the medical profession object to his giving "treatment," at least without careful supervision. The whole field is sensitized by jealousies; vested interests and a multitude of misunderstandings and misconceptions. The music therapist suffers the consequence of this involved situation. She is "low man"—or woman—on the totem pole of a very well-defined hierarchy. Neither recreational nor occupational therapists are involved in this controversy since their activities keep them well out of the orbit of psychotherapy as such.

Being the object of professional jealousies is a dilemma which the music therapist shares with the members of other professional groups. In fact, she may even be more threatening since her relationships with the patient may be closer and even more effective than that between him and other staff members in the institution. At the present time we find in many hospitals a certain degree of pessimism, a sense of futility. The music therapist does not fit in such an atmosphere. She is enthusiastic, by the nature of her work, and she actually does something with and for her patients. She may even get results where others have failed. For this reason, she may be like a foreign body where she works. This precariousness of her position is even more deeply founded.

Her fate is similar to that of group psychotherapists in institutions. Group psychotherapy creates a peculiar social climate. It is impossible for a therapy group to function without providing a status of equality to each patient. The ensuing kind of relationship does not fit into an institution where individual patients are not treated with respect. One cannot have an atmosphere of democratic equality in one room and a completely contrary milieu in all the other quarters. The ensuing clash, subtle as it may be, will either lead to a change of atmosphere in the whole institution, or to the ejection of group psychotherapy from it.

Music therapy suffers a similar fate. Not only are most of its activities carried out in a group with the same effects as in group therapy, but the very nature of music creates an element of equality, of acceptance, of belonging. As long as it is used in the more remote and impersonal relationships of recreational activities, it may be tolerated; but the more intimate and intensive
concern with individual patients stands in contrast to the treatment of the other inmates, or the lack of it.

One argument which lends itself easily to a criticism of a music therapist is the question of her qualifications to deal with this highly explosive medium, namely, the patient’s emotions, which are so easily aroused by music. There can be no doubt that the present training programs for music therapists do not offer too much in the nature of psychological information applicable to individual cases. The music therapist, by the standards of her qualifications, is not supposed to be a psychotherapist, and therefore needs not to be too familiar with either the methods or the lingo associated with the practice of psychotherapy.

This state of affairs does not justify, however, an often encountered fear of the harm which a music therapist, without more training in psychotherapy, could do to her patients. Any such concern is rather surprising at a time when our patients in the mental institutions are exposed to ward personnel with far less preparation and skills. In comparison with the experiences to which the patients are usually exposed, and in consideration of the highly understaffed conditions, any person with the preparation and the attitudes of a music therapist can only be a decided asset, without much risk. Besides, the frequent anxiety about the possibility of doing harm to the patients by “weakening their ego strength” and their “defense mechanisms” is usually unfounded. The patients need not be left to their own resources; they can tolerate emotional experiences of the kind which music therapy provides.

More difficult is the absence of training in the language so often used in psychiatry. Both the verbiage and some of the psychological concepts are not easily understood and acceptable to a therapist not trained in this particular psychological orientation. And the question arises whether such training would help the therapist, with her patients as well as in her communication with the psychiatrist. The present confusion within the field of psychiatry makes it difficult to suggest a specific psychological training program for the music therapist, since she will have to depend on the orientation prevalent in the institution, if there is a dynamic orientation at all. In her training she will be limited to the approach taught at the university which she attends. The rapid changes taking place in the field today render the question about adequate psychological training even more difficult.

We can well assume that the status of the music therapist, and
with it the recognition of music therapy as a special form of treatment, will in the end be determined by her training in the use of psychodynamics and in group dynamics. Techniques of using music may not be sufficient to overcome the obstacles in establishing music therapy as a special department within the institution. The therapist will need to be more sure of her psychological foundation. She will work, naturally, under the supervision of a psychiatrist and psychologist, but she can not depend on them in her daily work with the patients.

For these reasons it is evident that careful consideration should be given to the psychological aspects in the training program of music therapists, to make it independent from the incidental orientation of the department of psychology in the various training centers, and to provide the therapist with reliable information and skill to meet the psychological needs of her patients. This training will have to consist of more than vague generalities which cannot be applied to any given case and do justice to it.

It will be necessary to find the kind of psychological training which may prove most helpful in dealing with individual patients and their problems.

Such psychological training may alter significantly the relationship between the music therapist and the psychiatrists and other supervisors and administrators. She needs to be sure of herself, of what she is doing; otherwise, she is over-sensitive and too vulnerable, yielding when she need not, and resentfully provocative under pressure and criticism. Let us keep in mind that music therapy still is in its pioneer stage. Each worker in the field is in an exposed position, alone on a frontier post, so to speak. She can be adequate to the task only if she first is confident in what she is doing, sure of her place and function, and maintaining good personal relationships, both to patients and supervisors.
SOME ASPECTS OF PREVENTIVE PSYCHIATRY IN YOUNG PEOPLE

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Psychiatry has reached a point where it now has a respectable record in the treatment of all but the most serious mental illnesses. Even among the most serious there are a considerable number that are partially cured, or at least ameliorated. Through work in clinical psychiatry we have learned a lot about how to look for areas of stress and conflict in the individual. We have been fairly successful in helping a given individual deal more successfully with the stresses that confront him. However, the area of preventive psychiatry is still a pioneering one, and in large part we are still groping. In a given person one is often able to see rather easily what has happened to the person to bring about a mental illness. There is a gap, however, between this and prevention, because what might bring about a mental illness in one person will apparently leave others unharmed.

There are countless forces within and without each individual which make for mental health or mental illness, and as yet we are unable to sift out the nature and effect of these forces so that we can predict the outcome in a given person with any certainty. For example, in the treatment of an individual we might say that most of his problems have to do with the poor relationship that exists between him and his father. However, in another instance, a person may have a poor relationship with his father and yet have assets, or encounter circumstances which enable him to mature into a strong and healthy person.

I would like to tell you of some of the more advanced research in psychiatry which we believe has a bearing on the prevention of mental illness. This research is not as yet completely substantiated, but it offers important leads toward better prevention of mental illness in the future. It is desirable also to give some clinical impressions which are shared with many psychiatrists, but which have not yet been scientifically proved.

Dr. Benjamin Pasamanick and his associates, in a series of papers, have made an important contribution regarding the influence of complications of pregnancy in the development of certain
conditions. They have found that in individuals whose pregnancy and birth was complicated, there was a higher incidence of epilepsy, cerebral palsy, mental deficiency and behavior disorders than in the normal. Since these particular conditions can be so difficult to treat successfully and are so handicapping to the individual, prevention is extremely important. Prevention in this area does not lie in the hands of the psychiatrist, but rather in the hands of the obstetrician. It would appear to be a matter of avoiding birth complications by the best obstetric techniques available, and by further research in this field to prevent the complications, if possible.

Another area which has had widespread attention, but in which the final answers are not yet available, is the area of early infancy. One has the impression that serious sickness, operations, and lack of adequate mothering in the first year of life are seen far more often in a person suffering from mental illness than in a healthy person. Sickness in infancy is not always preventable, but more and more pediatricians and psychiatrists are urging that the emotional health of the infant be taken into consideration during a sickness. For example, the separation of an infant from its mother for prolonged hospitalization is probably more traumatic to the child than is the sickness itself. The more advanced hospitals are attempting to arrange conditions so that infants have adequate mothering, either by their own mothers or substitutes, during prolonged hospitalization.

Dr. Willis Potts, who has had wide experience in major surgery with infants, has repeatedly seen the harmful effects of isolation from their mother on children who have been hospitalized. There is little doubt that an infant who receives no attention and affection will respond by failure to eat properly, failure to gain weight, and failure to show the normal course of development. Dr. J. Clark Maloney made an extensive study of the Okinawans, where he found that infants were mothered to a point beyond

that seen in our culture.\textsuperscript{1} He found that in their society mental illness and crimes of violence were rare.

Unfortunately, even in our efforts to prevent mental illness, there may be repercussions which could possibly be a cause of mental illness in their own right. What is meant by this is that many parents have been so alarmed about the fear of not rearing their children properly, and not devoting the proper attention to them that they have become insecure and indecisive. An uneasy mother, who is bombarded on all sides by books, articles, and lectures on how to rear children, is likely to be confused, to become inconsistent in her way of rearing her child, and, in turn, lose some of the naturalness of the relationship with him. She may develop so much fear of frustrating the child that the relationship becomes an unrealistic one; the child is weakened by the failure to have a strong consistent parent to rely on, and fails to learn how to accept frustration in a healthy way.

Another area in which important work has been done recently is that in learning more about the causes of sexual perversion. Dr. Adelaide Johnson and Dr. David Robinson at the Mayo Clinic have found that in cases of sexual perversion there was a marked deviation in the family circle which appeared to lead directly to the patient's symptomatic behavior.\textsuperscript{2} This ranged from actual occurrence of incest in the family to over-stimulation of the growing child by excessive fondling, or permitting the child to witness sexual activity or excessive nudity. Freud's work was widely misinterpreted by many laymen who felt that his discoveries proved that one should be unsuppressed and uninhibited. Many parents rationalized that their own unrealistic acts by telling themselves that they were being modern and free. Partly as a result of this, many children have been exposed to scenes and experiences which are unquestionably harmful and laid the groundwork for mental illness.

Some time ago Johnson and Szurek published the results of similar research, but in a different area.\textsuperscript{3} In this area, they and their associates learned that considerable antisocial behavior in children could be traced to parental attitudes. Behavior such as

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\item J. Clark Maloney with C. Biddle. "Psychiatric Observations in Okinawa Shima." \textit{Psychiatry} VIII, No. 4.
\end{enumerate}
truancy, stealing, and fire setting could be traced back to the thinly-veiled needs of the parent who, by his own attitudes, actually gave the child permission to carry out these antisocial acts.

Recently, a study was done by the late Freida Fromm-Reichmann and others on the cause of manic-depressive conditions. Among other things it was found that the person with such a condition had been in a rather unique position in the family. It seemed that many of the family's goals and ambitions were centered on this particular individual, and that he was expected to bring prestige to the family in some way. It would seem to me that this information might be particularly apropos for those of your colleagues who teach music. So often we see families who have made up their minds that their child is going to excel in some field which is particularly appealing to the parents. The child becomes a vehicle for the parents' ambition, and his own individuality is seriously thwarted. This can be particularly tragic when the child does not have the talent or the ability to be successful in this chosen field. It is certain that not all young people who find themselves in this position eventually suffer from a manic-depressive condition, but nevertheless there is little doubt that this can create a devastating situation of some sort.

One of the most important areas of mental illness, as you know, is schizophrenia. Even though volumes have been written about the cause and treatment of schizophrenia, we are still essentially ignorant in the area of prevention and cure. It appears that there are varieties of schizophrenia, and that perhaps there are multiple causes which produce the state. In spite of our ignorance, we do have some leads which would seem fruitful to follow. In a high proportion of people suffering from this condition, there are obvious parental problems. In many instances the blame has been laid to the mother for an outstandingly poor mother-child relationship. Studies at Yale University showed that in a small group of schizophrenics there was a persistent problem in the marital relationship of the parents. The nature of the problem varied somewhat, but essentially, it consisted of a serious distortion of marriage which influenced parent-child relationships and presented a confusing picture of reality to the child.

Many of our clinical impressions are not yet scientifically proved. However, these impressions are often useful in the prevention and treatment of mental illness. Many of these concepts that are widely accepted as working hypotheses in psychiatry were originated almost fifty years ago by Dr. Adolph Meyer.1 There is little question that each of us is born with different sets of capabilities and weaknesses. It seems that a high proportion of persons suffering from schizophrenia have shown certain personality characteristics for long periods of time prior to the onset of their illness. Some of these characteristics may be inherited, but they can be influenced favorably or unfavorably by parents and teachers. These characteristics can be summarized in the concept of withdrawal. The pre-schizophrenic personality often shows a social isolation, a lack of aggressiveness, and a marked tendency to fantasy. There is a trend towards living apart from others. This seems to me to be another area in which the music therapist or music teacher might have a favorable influence. Not uncommonly, the pre-schizophrenic will tend to withdraw from normal social life into a private interest of some kind. Music might be one of these interests. Here I believe we have to avoid generalization, think of each person on an individual basis, and keep an open mind in watching him develop. I must add that not all young people who like to be alone and tend to daydream are sick nor will become sick. We have to study each person individually. 

Music, like any other interest, can be a two-edged sword. For one young person it may be the means of healthy gratification and accomplishment. It may mean a stepping stone toward healthy relationships with other people. It may mean a safety valve for powerful instinctual drives with which the adolescent is struggling. It may be the means of his learning to work together with others, such as in a band. In general, it may be a means of helping him come to grips with life. On the other hand, another young person in his flight from people, may become immersed in music in an unrealistic way. For example, I know of a nineteen year old young man who was graduated from high school, but for various reasons seems to have isolated himself. He does not work, and he does not go to school. He spends the greater part of his day in his room listening to records. He is living apart from other people, and even though listening to music is undoubtedly gratifying to him, he is not really using it constructively, and is not

really living in contact with reality. A person like this is heading toward a schizophrenic break with reality, and some day may develop the delusion that music is a vehicle for sending him important personal messages.

Very often in the pre-schizophrenic young person, we see a retreat from everyday reality into quite unrealistic fantasies. These fantasies very often involve unreachable goals. The youth will sit and listen to records or go to a concert and imagine himself as a great conductor or a famous composer. However, he has lost sight of the fact that one has to learn to be a composer, and one has to practice composition even if the talent is there. In our work with students like this, one is sometimes in the position of having to disillusion the person. If this becomes necessary, one must avoid bluntness and shock if possible, since this can precipitate illness in a predisposed person. One would be inclined, rather, to try to help the student to develop his real assets and to find out what he can do in reality, before we suddenly destroy his illusions. One is often surprised at the pleasure of a youth who finds that he can do some relatively simple thing, and then, subsequently, can give up his fantastic ambitions.

It seems to me most important when dealing with young people, particularly those who seem to be heading for trouble, to consider the whole person, including his past and his future. We have come to understand his natural assets, his attitudes, his goals, and his capabilities. We have to think of him as a many-sided individual. We have to help him keep in touch with reality, even though in the adolescent this grasp of reality sometimes seems rather tenuous.

Our work in mental health in a university setting is in large part preventive. Many students are seen who are struggling with the reality problems of late adolescence and young adulthood. The transition between youth and adulthood is, in itself, a crucial milestone in life. Many difficulties are involved. The young person must resolve his conflict between dependence and independence in this period. He is usually not quite ready to face the world alone, yet feels his individuality strongly enough so that he is reluctant to rely too heavily on his parents. He is testing out his parental standards and ethics, and may be rebelling against them. At the same time, he may find himself uneasy without familiar guideposts in behavior. He is trying to control his increasingly strong sexual needs and at the same time is impatient to satisfy them.
The late adolescent, or young adult, is faced with the task of finding a place for himself in the world. He must make some sketchy choice of a career, perhaps without knowing much about it. He is faced with the sometimes formidable task of living up to his own and his parents' expectations. Much of our work is to try to help these young people deal with such problems. Many of them should not be considered mentally ill, but simply reacting to the usual stresses of this age group in the particular environment of a university. It is often remarkable how rapidly such a person will find a satisfactory solution to his problems.

Treatment of minor or acute conditions can prevent the development of more serious or chronic emotional difficulty. For example, a young person who develops a simple phobia, without treatment may find this phobia multiplying and spreading into many areas of his life. The person becomes restricted in his activities and relationships, must lower his goals, must become more dependent on others, and becomes a long-term prisoner of his neurosis. Early treatment, in all likelihood, can arrest or cure the phobia, and prevent the unfortunate consequences of a chronic neurosis.

Freud showed that everyone has some bisexual tendencies. The normal heterosexual drive may be impaired by certain vicissitudes, contributing to the development of homosexual tendencies. Although the groundwork may be laid early in life for such tendencies, the conflict often reaches its peak during adolescence. In many cases proper treatment can enable a young person to resolve his problem before it has become relatively fixed and chronic. He may thus be saved from a life of personal loneliness and social turmoil.

The college age student is an ideal person for optimal response to psychiatric treatment. He is intelligent, flexible, and is already going through a transition. Often he can be helped in a few hours to work out something that might require months of treatment for an older person.

I might mention an instance or two of problems that students have suffered from, and their outcome. The identity of the individual has to be disguised, but the situations are essentially true. One man was denied admission to officer candidate school in the Army because of physical handicap. This rejection mobilized his hostility towards figures in authority. When he entered college, he functioned well below his intellectual level. With the help of his therapist, he learned that, without fully realizing it, he felt
envious and bitter towards his instructors. He could not openly attack them, but inwardly he fought them. In effect, he would not study the instructor’s course; he would not give the instructor the satisfaction of agreeing with him; he would mentally close his eyes and ears to what was being taught. As a result, he was failing because of his own rebellious feelings. When he was able to understand fully how he felt, and why he felt that way, his unrealistic anger towards his teachers vanished, and his scholarship improved remarkably.

This kind of problem is seen frequently, and accounts for many students functioning below their capacity. In another case, an essentially healthy young girl began to suffer from claustrophobia. This kind of phobia, we have observed, often occurs in an individual who feels trapped and frustrated. It seems that she was in love with a boy who showed only a sporadic interest in her. Without realizing it, thoughts of him were constantly in the back of her mind. Simply talking about him and her feelings toward him relieved the symptoms. In this case, as in many others, we did not treat the patient long or intensively, and some of the complexities of her problem were not touched on. However, her symptoms were relieved, she was able to continue in school, and was as happy as a girl could be under the circumstances. She no longer feared mental illness and now knew what had caused her symptoms.

A great many people are quite frightened by their symptoms; when they understand what is going on within themselves and the relationship of symptoms to everyday life situations, they not only feel better but become better integrated individuals. Insight alone is not the answer in all cases, but self-knowledge is a most important stepping-stone to maturity.

Another important area in preventive psychiatry in a university is that of consulting with parents, faculty members, and administrators. Many times there is a question of whether a student needs treatment or not, or perhaps needs treatment but refuses to undertake it. In situations like this, consultation between the staff member and a member of the Mental Hygiene Clinic can be helpful. Sometimes some change in attitude toward the student or some change in his environment will solve the problem.

Finally, an important area in preventive psychiatry is that of informing the public. Even though information given to the public can be ignored or misinterpreted, many people study such information carefully and come to accept psychiatry as an aspect
of medicine that can be helpful to them or their families. Some day we hope to see people come to psychiatrists as readily as they visit their family doctors and feeling no more ashamed or cen-
sured.

I hope that by telling you some of the things we have learned tentatively about preventive psychiatry, that I have not fostered anxiety or insecurity. In case that has occurred, I would like to close with one or two points. First, it is sometimes comforting to realize that most people go through life without the occurrence of a serious mental illness. Second, that none of us in any profes-
sional field, especially one involving the complexities of human nature, know all the answers and can solve all the problems. However, if we are well intentioned, thoughtful, and interested in being of service, I am inclined to think we are justified in feeling that in the main we are being helpful. I think those of you who are participating in this pioneering field of music therapy should receive much credit for your efforts. I think there are few areas of greater importance today than the prevention and treatment of mental illness.
PART II

MUSIC THERAPY IN THE PSYCHIATRIC HOSPITAL
PRESENT TRENDS IN USING PSYCHOTHERAPY
POTENTIALS OF MUSIC ACTIVITIES

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Most of the newer trends presently noted in the uses of music in therapy are not confined to the medium of music alone, but delineate principles stressed in the use of all activity therapies. This similarity of techniques for the several disciplines is concerned with interpersonal relationships and rapport between therapist and patient rather than with ways of applying a particular skill.

Accent on similarities in approach for all activities is not a new concept, but rather it is achieving a new peak of general acceptance, if not insistence, by the medical profession and by educators in the adjuvant therapy fields. For a long time there have been doctors who have said, "Every contact and every thing that happens to a patient is, in a sense, treatment, good or bad. Therapy may come from the attitude of one ward attendant, or from some casual encounter, as well as from any one doctor." By the early 1950's this idea had crystallized into stress on standardizing approaches for all personnel caring for patients, with interdependence of scheduling and shared responsibilities.

This principle presupposes mutual understanding and respect by each discipline for the specific values and skills of the others, thereby lessening power struggle between the disciplines. From the principle of shared goal by all engaged in treatment and care of the patient, earlier called the "team approach," has come the newer phrase, the "total milieu concept."

In practice, this concept has led to structural changes of various kinds in the administration of programs. In the Middle West, there was initiated a few years ago in several states the fusion of all adjuvant therapies into one Activity Program headed by a Co-ordinator of Activities, with the total personnel classified as ATs—Activity Therapists—rather than by the several titles OTs, RTs, MTs. In California, about the same time, and in Pennsylvania, more recently, a similar fusion by a different name has been effected by co-ordinating several specialties within the administrative framework of a Recreation Department. This allows advancement from any one of the specialties to the administrative

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level of supervision approximating the co-ordinator level in an activities program. In other institutions a similar structure functions under the more clearly definitive title Rehabilitation Therapies. A common denominator in these various systems is that a therapist from any of the disciplines may become director of the total program.

It is too soon to say what effect these changes will have on professional status of the individual specialist. Certain advantages are obvious: development of broad viewpoint; accent on therapy; implications that this will increase realization of more medical guidance and regular conferences of activity therapists with medical and nursing personnel.

Opposed to these potential advantages are certain dangers. Many adjuvant therapists feel these developments to be a threat to status already gained, and that high standards of training in the specialty fields may be forfeited. This is particularly true where the supervisory control is in the recreational area, because this may mean that only diversional aspects of each specialty be emphasized, or may mean that requirement standards in the academic area be lowered. In practice, this has already occurred in California. However, this could be due to the dearth of trained therapy personnel in the music field, as well as to structural administrative changes.

Another concept which is increasingly accepted is the importance of tying the needs of the patient during hospitalization both to his life before he entered the institution, and to the potentials for his life in the future when he goes back to living in the community. Since the hospital activities program approximates so many aspects of normal leisure-time interests, and sometimes even career potentials, it represents to a hospitalized patient normal ways of living. This normalcy accent can be used toward growth through broadening horizons, toward stimulation of interest as opposed to lethargy and resistance, and toward activity as opposed to inertia. Skillful use of this continuity concept of interrelationship of past experience, present problem, and future planning can be used therapeutically to bring to the patient understanding of his particular problems, and their acceptance, with consequent readjustments in attitude. Thus, during hospitalization, he may attain a more satisfactory personal philosophy which will serve him well later.

Newer concepts within a hospital reflect newer concepts "outside." Thus, the present emphasis on broadening activity
In the Psychiatric Hospital

programs reflects the growth of the adult education program in this country, which has been a marked trend in the last decade as the work-week has decreased allowing consequent increase in leisure time.

This development is more meaningful when called "continuing education," meaning continuing, not just in the immediate postgraduate sense, but continuing throughout life. We are living in a world of challenge and opportunity in which there is an infinity of interest, more to learn, to know and to experience. To expose people, as they are now exposed through easy communication, printed material, and the ubiquitous media of radio and television to the limitless possibilities for learning is to induce them to growth, and to encourage them to reach out for more of the pleasures and fulfillments of continuing education.

The enormity of the exposure may be frightening and even overpowering to some who will refuse the challenge or have to meet it gradually. But the fact remains that there is potential benefit in the availability of so many interests from which the individual may choose, to suit his own individual tastes and preferences. By taking advantage of them he will grow in stature, become less self-centered, and less involved with anxiety and concern over his own problems. For this reason broad activity programs are particularly valuable in the care of the mentally ill.

As to the matter of preferences and tastes the patient will always find, despite the number and variety of interests, that there are many other people who have preferences and likes similar to his own. Therefore he will not be alone but will have company in his enjoyment. This will foster his "sense of belonging" and the group's solidarity. Experiences of belonging and sharing interests can be a wedge, where psychotherapy is indicated, toward self-searching and understanding of needs. Development of interest through music may serve as stimulus to other activity, as well as causing affective responses conducive to psychotherapy.

Not a new concept, but increasingly subscribed to, is the belief that music is a powerful tool for good because of its almost universal emotional appeal, its diversity of styles, and its variety of uses covering educational, diversional, and "occupational therapy" approaches. Emphasis continues to be placed on its value as a means of nonverbal communication and of self-expression, and on the nonthreatening quality of the activity when enjoyment, and not perfection of performance, is stressed. Dr. Karl Menninger, in the introduction to the Physician's Guide to the
Adjunctive Therapies used at Topeka State Hospital, Kansas, calls music "the most widely applicable clinical training tool which psychiatry has available." This seems to represent medical feeling in most of the hospitals where music is used actively in the therapy program.

In music programs, the technique of using patients as leaders in group activities and for creative planning of special music projects is growing. More lessons, with adequate practice facilities, and more small ensemble work are stressed in the larger, as well as in the newer programs. Increase in numbers of personnel and growing demand for skilled music therapists have been consistently noted. These factors all function to increase the therapy potentials of music in the hospital program.

To realize these potentials challenges the ingenuity of the therapist, because there is usually pressure to give maximum service to the whole institution in diversional and entertainment areas, as well as in the more strictly therapeutic. To fill this dual-role with economy of effort, he must acquire the technique of organization of schedules and supervision, and of evaluation of the activities available for assignments. He must know the special benefits inherent in particular activities. He must know how to structure situations so as to help specific patients with specific problems, and yet how to adjust these individual needs to contraindications which may occur where a group is involved. He must be flexible in changing the direction of activities as patients' needs change. Not only the progress of each patient and the efficacy of each activity and technique must be studied, but the music therapist must also constantly evaluate and re-evaluate himself in the role of therapist, and the music program in its changing relation to the total team effort of the hospital.

In the area of meeting the needs of patients which is increasingly under discussion in the care of the mentally ill, one must mention again concepts not new but re-emphasized in current literature and practice: that patients are people, basically not different from nonpatients but temporarily maladjusted and needing help; that it is the "whole man" who must be treated, a man with many sides and capacities of which none should be stifled; that good health requires balance between work and play, and between energy and relaxation, with enjoyment of both; and that next to, or even equal to, the importance of happiness and success in interpersonal relationships is happiness and fulfillment in the activities one undertakes.
As in the over-all thinking in the area of psychotherapy, so in music, the importance of "meeting needs of the patient" is a basic principle. The music therapist can only help distinguish underlying causes for maladjusted behavior when he understands theoretical concepts, observes objectively, and reports professionally. Thus the activity becomes one of the diagnostic tools. In therapeutic function the music therapist, by using his medium toward growth, security, and fulfillment of the individual, helps in the job of re-establishing the patient as a functioning member of society, able to return to the community; or if he must remain in the institution, able to carry on there at his best potential level of adjustment. He must help the patient accept goal levels that are attainable and pleasurable, rather than struggle with the frustrations that are inevitable when perfectionism and performance at professional level are the gauge of success. Both therapist and patient must accept such limitations philosophically and value enjoyment in the activity above perfection.

Another area of acceptance increasingly emphasized in present thinking is acceptance by the therapist of the patient’s behavior, without judgment or condemnation, so that confidence in the therapist will grow. This is a necessary prelude to growth in feelings of security, and amelioration of unhealthy attitudes and poor behavioral patterns.

In techniques of application there is increasing emphasis on the understanding that patients in different degrees and kinds of illnesses require different levels of structure and support in their activities. The more fearful patient may need to begin with highly structured activities in which formal patterns give him more security. Not only physical illness, but also disintegration of the personality, may indicate that the therapist should work on the ward, where the patient is most at home. Later, when reintegration and personality organization have been accomplished, the same patient may take pride in going to group activities in auditorium or music rooms, whereas earlier he would have been too fearful and disoriented.

The patient needs to feel complete confidence in the therapist's integrity, in his sincerity, in his dependability to continue a uniform pattern in the relationship, and in his genuine interest in the patient's welfare. Whether or not a therapist is successful in meeting patients' needs will often depend largely on his own personality and approach. The descriptive phrase used in present thinking is "use of self." While this phrase is new, the drive
toward its realization is widespread. Actually it is a concept of psychotherapy which has long been in use. In the past, the importance of this factor has been accentuated by many comments of doctors who have claimed to be more concerned with the personality of the worker than with any particular skill. It explains why, before we had the present opportunities for academic training in the field of music therapy, there were successful music therapists. With less training than others, and with less technical skill, many musicians have proven to be invaluable employees in helping patients get well, because of innate personality characteristics in which were combined sensitivity, kindness, and "common sense." The newer thinking, while acknowledging the existence of naturally therapeutic personalities, advocates conscious effort by all therapists toward growth in self-use as a necessary basis for influencing others. This "use of self" concept is given equal importance with a broad range of music skills. There is wide availability of training in both areas.

While this makes for a taxing curriculum, more and more hospitals today are requiring this standard of its music therapists. Along with these requirements is a consequent increase in status of the professionally trained music therapist. No small part of this change has come about through the activities of the National Association for Music Therapy in establishing high academic standards both in music skills and in the potentials for using music functionally.

Demand for professional job-performance is not confined to the younger therapists more recently in training. All hospital musicians are aware of the importance attached by the medical field to the understanding of therapy principles, and the dynamics of interpersonal relationships. There is neither dearth of reading material nor of guidance in these areas. It is a thread that winds through all the literature in psychiatry and much of that in psychology and the allied disciplines. It is constantly stressed in lectures, conferences, and in daily practice. There is no closed door to understanding and to growth in "use of self," which is the core of the principle. Rather, there is implication that it is up to the individual worker to keep an inquiring mind and constantly be a pupil at the "continuing education" level so that he does keep abreast of the newer trends.

Through self-searching to know ourselves better, we learn to accept our own weaknesses, and live with them, and to grow in understanding of the patient and the ways in which we may help
him. Philosophical thinking must be put on such points as the
difference between praise and flattery; between pleasantly firm,
consistent, nonpunitive discipline, and retaliation (which may
quite likely be reaction to some threat to ourselves); between
the anxiety which is an inevitable driving force but which can be
controlled to the individual's good, and the overanxiety that
paralyzes progress and is a deterrent to health. We must accept
the realization that being a good teacher, or a good performer,
or even being an inspirational person is not enough to make us
good music therapists. In short, we must know academically why
we are doing what we are doing. We must not only know that
certain phenomena may be going on in the patient but how much
of his reaction may stem from ourselves. How does it feel to be
the observer; the observed; to participate at different levels and
in different capacities? What is happening in others when we
feel vindictive? What has preceded our "self-righteous indig-
nance" when we feel abused and "put upon"? Which is cause,
and which effect? What quality in ourselves may have precipi-
tated the very happenings that now cause our own reactions?

It is not enough to know theoretically that the patient may be
feeling threatened when he shows unsuitable behavior. We have
to realize that each day, in many situations, we, too, are feeling
threats, insecurities, and anxieties, even though these may be suc-
cessfully masked and rationalized. We are bound to experience
these in our relationships with personnel as well as with the
patients whom we are trying to help. And we should often remind
ourselves, that just as patients need help and forbearance—par-
ticularly the ones who may aggravate us most—so we, also, need
help and sufferance from those whom we may unwittingly
offend. Poor behavior may be a bad way of handling anxiety,
but at least it indicates effort and to that extent it is a good sign.
What we and the patient need to look for are positive substitutes
for negative behavior so that readjustments will be constructive.

A prerequisite to therapy is that one must know another per-
son's history and understand his liabilities and capacities in order
to help him cope with his problems. In corollary to this, a second
prerequisite, stemming from the precept, "Know thyself if thou
wouldst know another," is that in order to be able to guide
another person toward more healthy attitudes and adequate be-
vavioral adjustments, one first must have consciously experienced
acceptance of limitations and adjustment to reality situations
himself. This is the essence of the "use of self" principle in therapy.
VALUES AND PROBLEMS OF PATIENT PERFORMANCES

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In attempting to establish some of the values and problems in patient performances, performance must first be defined. There are a number of definitions of performance given in the dictionary, among them: (1) the thing done, execution, completion, action, achievement; (2) a representation before spectators. We have come to associate the word more with the latter definition, possibly because so much of what we do in life is before spectators. We are always performing in life in the sense of doing, acting, achieving. But since so much of this doing, acting, and achieving is in front of other people we can see how important this secondary sense has become. We proclaim to other people what we are by our words, actions, gestures, and expressions of ideas. Even our selection of clothing and the way in which our homes and places of business are arranged can be regarded as costuming and scenery for our performances before the world.

Thus it is with patients in the hospital; they are all actors and performers whether they are sitting on the ward doing nothing or taking part in many activities. Some of them are very expert actors and some of the ones who seem to be doing least are doing the most acting. Many of them are trying to cover up what they really are, so their acting is full of subterfuge. This is negative acting or performance as opposed to positive acting or performance. One of the problems of working with patients in activities is to try to convert their negative performance into positive performance.

Looking at performance in this light, one can see the importance of the means used to convert negative doing into positive doing. For example, when patients are urged to dress in their best clothes to attend a party, a dance, or to go on a trip, they are given the opportunity through the clothing they are wearing to regard themselves on a higher level than they do ordinarily; they are dressed for the part of a respectable citizen with dignity rather than a mental patient without dignity, and for the time they are dressed that way, they can play-act at not being mental patients. The atmosphere provided for them at the party, dance, or the trip can have the same effect. In a setting or surrounding that is normal to the outside world, that is friendly and festive,
they can feel themselves becoming normal, friendly and festive; although they can not remain in this atmosphere, the impression made will have some lasting effect. The people they meet on these occasions can have a strong influence on them by regarding them as respectable citizens rather than mental patients, and treating them with the courtesy and respect they would give to normal members of society.

Consider then the patient whose performance is usually negative; events of this sort can give him a jolt, can jar him loose from his ordinary concept of self as being worthless, can throw his life into a different perspective even if only for a short while. For that time he sees himself as he might be, one who can play a part before other people, a part in which he can be proud and not ashamed. He sees himself in the light of normal living and behavior. This is an incentive in the direction of positive action.

From such a small example we can see the importance of evaluating the effect which an activity has upon the patients taking part in it. An activity may tend to further the negative state of a patient unless there are elements present to give him a different perspective of himself. In an atmosphere of indifference, dullness, drabness, or malice, a patient's behavior will probably remain as negative as before or perhaps become worse. If the patient has no chance to express himself positively, he will derive little benefit from an activity; his performance will not improve unless there is opportunity for him to function in a positive manner.

Let us take an example from a group singing activity. When a withdrawn patient is taken to a group singing activity for the first time, he will participate only to the degree to which he is able; if he can only feel that he is part of a group, that is a beginning. As time goes on and this patient begins to feel at home in the group, it is not enough to have him function only in the background. If we do not recognize him as an individual in some way, if we do not encourage him and give him an opportunity to express himself, then he will interpret our attitude as lack of interest or indifference and his feeling toward the activity will turn into drabness and dullness similar to his feeling toward life on the ward. But if he is recognized, encouraged, and is given opportunities for self-expression, then he will begin to grow and expand beyond his own limited concept of himself. In time he may begin to see himself in a way which he has always wanted, as a person who is making an acknowledged contribution to society. In this particular activity our procedure is to draw the patient
more and more away from his anonymous status in the group toward recognition of himself as an individual. One of the techniques for accomplishing this would be to select from the large group smaller groups to sing for the others and to have the patient be a member of the smaller group. As long as he is reinforced by some kind of group he may be willing to perform, whereas the thought of performing alone might still terrify him. Once he has taken the step of coming before a group he has already lost some of his fear, and the groundwork is laid for eventual performance alone.

If a patient will not perform in a small group, the entire large group can be brought up to perform before an imaginary audience, thus helping to break the barrier toward the initial step. Very few patients want to remain in their seats when they see the entire group going forward to perform. The group feeling which has already been developed in them will usually overcome their reluctance to leave their seats.

After having performed with any kind of group the next step is to reduce the size of the group until the patient stands alone as performer. This may take a longer or shorter period of time depending upon the individual. From the sextet to the quartet to the duet the patient will feel more and more recognized as an individual, and if he is able to sing harmony or add anything else that brings recognition, he has been helped along that much. Comments on the quality of his singing, appreciation of his ability in any way will help him toward the moment when he will perform by himself.

After experiencing considerable group work before others, a patient may become eager to sing a solo and cast off any negative feelings about his singing ability. It often helps to have a microphone and PA system in front of the group. It is not uncommon for a patient to step out of a group to a microphone and burst into an impromptu solo. The importance of the microphone and PA system is something which we are only beginning to recognize. A microphone has a symbolic significance to mental patients and to people in general; if there is a microphone to sing into which amplifies the sound of the voice, the individual is not so afraid to sing out. What might sound like a timid, weak, unsure voice without a microphone becomes full-bodied and strong with the microphone. The PA system is like a magnifying mirror to the patient's voice and produces something of binaural effect to his ears. Its reinforcing quality may aid the individual where
the group reinforcement leaves off. Like the ancient Greek chorus it functions as a sounding board which amplifies the expressed thoughts and feelings of the performer.

The microphone is a symbol not only of amplification, but of communication to others on a broad scale. Talking into a microphone is almost synonymous with “telling the world” or “telling off the world”, whichever the case may be. This is especially true of radio as a patient activity. A patient who does any kind of performing over the radio feels that he has joined in some way a world-wide system of communication, and that by chance people might be listening to the sound of his voice in Timbuktu.

At Downey Hospital the radio station broadcasts to only a few wards of the hospital, but whether the patients know this or not seems to make little difference in their attitude. It is the atmosphere of the radio station with its controls and equipment, its glass-windowed, soundproofed rooms which gives them a feeling of being a part of something important such as a studio of one of the great networks. The timing of the programs and the necessity of conforming to schedule also affect their sense of importance. All this plus the feeling of “telling the world” gives the patient a sense of communication with the outside world which may be completely lacking in his daily experience. On more than one occasion a patient has gotten rid of aggressive feelings toward the world in general (over the radio station at Downey) by suddenly grabbing the microphone and letting loose a flood of words. Even if he is cut off the air at once, he still feels he has gotten something out of his system and expressed himself to the world.

It is interesting to observe what takes place in group therapy sessions which are conducted in the radio station for broadcasting, and the effect on the patients taking part, as well as those listening in the radio lounge outside the studio or on the wards. Here again there is a sense of importance attached to the activity which might be lacking under other circumstances.

Another valuable mechanical aid in this work is the tape recorder. Like the microphone and PA system, the tape recorder represents amplification and communication on a wide scale to the patient, plus being a mirror which can reflect back his performance. Thus, he can sit back and be his own audience—he has thrown his performance into relief and can hear himself as others hear him. Of course, the tape recorder is devastatingly faithful in bringing out not only good qualities but imperfections
as well, but to most patients the novelty and delight of hearing themselves as others hear them far outweighs any tendency to be overcritical of their efforts.

The tape recorder may also be part of the steps taken toward individual performance by a patient. Hearing himself objectively and realizing that he sounds at least reasonably well to others, he may become more willing to perform before them. Again, a patient who does not feel up to giving a performance over the radio by himself can still profit from hearing a tape recording of his work played over the radio and can identify himself with the other listeners, thus bringing him around to a more objective viewpoint of his own ability. The tape recorder can be more of an outlet for pent-up feelings and emotions than the microphone, because a patient realizes he is not under the time pressure or in immediate relation with other people; therefore he can be more intimate and confidential, especially if he is recording for his own benefit. There was the case of one patient who presumably was recording his singing along with his own piano accompaniment, but who eventually lapsed into a kind of monologue with piano background in which he poured out intimate associations of the past. This would certainly be valuable to a psychologist, if such a patient were more or less inaccessible through other channels.

All that has been said in connection with singing and use of the voice is equally true with instruments. A patient can become lost in an instrumental group unless he is acknowledged as an individual, although the character of band arrangements and orchestrations helps to give the individual the distinction of being associated with smaller groups or choirs within the large group. However, when the same persons in the group always perform the solo parts it would be well to shift them around so that others might perform or unite on a solo part.

It is noteworthy, also, that with instrumentalists there is less involvement of the ego in the performance; the voice is like an expression of the ego itself and often seems to lay bare the inner self to the world. An instrument is an external mechanism which can translate the expression of the ego into another language; it can interpret and amplify the individual’s thoughts and feelings in a medium which allows the ego to remain somewhat concealed behind the apparatus. There are patients who, because of problems of communication with others in terms of voice, fear of saying the wrong thing, or of exploding into violent language, channel this bottled up energy into playing their instruments, and the sounds
that come from them at times are highly indicative. These patients feel that they have communicated themselves to others without exposing their real feelings through definite words and ideas.

When the performance is taken away from the rehearsal room or the radio studio into actual social events and before audiences, it is found that the concepts built up in the daily activities hold over completely in this new atmosphere. The groundwork has all been laid and there is nothing new other than the reactions of the audience to which they are peculiarly sensitive. In performing for an audience the big question to them is not so much, "How well will I do?" but "How are these people going to receive me?" Thus, there will be apprehension and nervousness before the program begins, but if there is any warmth and receptivity in the audience, then the patients will respond by warming up to their performance in a way surprising even to themselves. They have been used to rehearsing before empty rows of chairs and scattered applause, consequently the novelty of a large, interested audience reacting with bursts of applause is stimulating and fills them with enthusiasm. Individual performers who have felt uneasy about performing before an audience seem to lose all feeling of restraint, and perform with great ease once they have felt the warmth of the audience through its applause, and actually give better performances than at rehearsals. This is one of the most astonishing and rewarding things to a conductor of a patient performance, to see all the members of the group, even the withdrawn ones, putting forth every effort to give a good performance, while at rehearsals their efforts may at times have seemed half-hearted or tending to disunity.

It is sometimes forgotten that a group of mental patients would not remain a group unless there were something to hold them together. Though at rehearsals there may be a struggle between the inclinations to separate from the group or to be drawn into the group through the power of the music, at a performance the patients become completely unified in their one objective, to give a good performance. A performance before an audience represents a higher level of achievement for all members of a group. It is significant because it is the culmination toward which they have been working. The performance before an audience gives them the sense of having reached a climax in their efforts, and it is a reward and gratification for them. That is why they are willing to outdo themselves in the quality of performance. Their work takes on a meaning and purpose and they are communicat-
ing directly with an audience all that has been building up in them over the rehearsal period.

Performance before a patient audience has its advantages and disadvantages. The applause is not likely to be as warm and enthusiastic as by an outside audience, but there are personal benefits to individuals performing or listening. The patient who is performing is proud to be able to perform for his fellow-patients while the patient in the audience is impressed by his fellow-patient's ability and may think, "Well, if he can do that, maybe there's something around here I can do, because he used to be off in left field when we were in Building 124 together."

This brings up a point about individual performers and the group. No matter what degree of talent a patient may possess, there is always a way of working him into a program to his best advantage. He may sing only a few words of the songs, but he will still be a part of the chorus; perhaps he can only play a rhythm instrument, but a whole section of the music can employ the use of rhythm instruments so he will have a part to play. There is never a lack of methods for using as many patients as possible in a performance—it is only a question of fitting them in where they can function at their present level of participation.

An outside audience provides the greatest stimulation for the patient performers. If the audience creates an atmosphere of enthusiastic appreciation rather than critical coldness, the patients will unfold in the warmth of this climate and respond wholeheartedly to the applause which is like food to them. Anything that breaks down the barrier between the audience and the performers is welcome, and one of the best ways to help the audience to identify with the performers is to have them participate by joining the singing, keeping time by clapping their hands, or stamping their feet, etc. An audience that takes part in a performance by mental patients loses some of its feeling of strangeness about them; the patients become simply human beings to them, and some of the barriers which society has erected against mental patients are removed. Patient performances are one of the best means of building good relations between the hospital and the community through the power of intercommunication between performers and audience. The more informal the type of presentation before an audience, the better, because both groups are put at ease and rapport is established more readily.

At this point it is desirable to stress the importance of volunteers in work of this sort. Volunteers can help build toward a
program of participation in performance in many ways: the volunteer instructor helps the individual performer through coaching and encouragement besides giving him the necessary technical equipment; through participating in activity with the patients, volunteers can reinforce patient effort and give patients more assurance. For example, a volunteer can help a withdrawn patient in a singing group by merely sitting by his side and singing with him; through the rapport established by her friendly interest in him, she may be able to encourage him to perform where otherwise he would have been reluctant or might have refused. Again, he may be willing to perform for the group only if she is standing beside him or even touching his arm, but with her reinforcement he will do it. This is even true of performances before audiences—a patient with considerable talent may need the support of a volunteer performing with him as a singing partner or accompanist. He is anxious and eager to perform, but feels unable to face an audience on his own. A volunteer accompanist often can skilfully weave a patient of this type into a performing ensemble where the patient not only feels her support, but the support of the small group as well.

Volunteers can do much to help maintain the patients' morale before a performance and to relax afterward. A general song session around the piano before a performance can ease the tension of waiting for the program to begin; in the case of an off-station performance the volunteers can ride on the bus with the patients and encourage them to sing and enjoy themselves while traveling. The serving of refreshments after a performance is a primary function of volunteer groups, and the patients look forward to this period as the highlight of the whole occasion. In looking back over such an event the outstanding feature in their minds is the social period following the performance during which they have the opportunity to mingle with members of the audience, to meet them on their level, and to hear comments of appreciation from them for their efforts. This is their greatest reward for the work they have done.

Although various purposes are served through the function of patient performances, I believe the primary purpose should be to help the patients unfold as individuals. The therapeutic goal, working through the technique of performance, should be no different from that of any other technique: namely to meet the individual needs of the patients. What we do not always recognize is that the patients, like everyone else, have a need for displaying,
“showing off,” as it were, before other people. It is as natural as breathing for a person to want to show others what he can do.

When talent is discovered in a patient, it is not only an opportunity but also an urgency for the therapist to see that it is cultivated, for this may be the only talent the patient possesses—this may be the one thing which will help to build a bridge to normal living for him. Talent needs the warmth and sunshine of acknowledgment by other people to make it grow and blossom. Like a lighted candle it cannot be hid under a bushel or put under a bed—it has to be put on a candlestick so that it can give out its light to everyone.

What a patient will do with this talent when he leaves the hospital is not the fundamental problem. There are many avenues for the expression of musical talent other than the professional field. In most cases, the professional field should be avoided by the ex-mental patient, because of its many stresses, uncertainties, and undesirable environments. There are many social, religious, and industrial musical groups, who do a large amount of performing, in which the former mental patient can find an outlet for his musical ability. Beyond these channels there is a need for organizing groups of former patients which would sponsor and promote musical, or any other artistic talent, among themselves, not from the professional or commercial viewpoint, but merely for the joy of doing creative work and displaying it to others. By joining together and sharing aspirations they could reinforce and encourage each other in the development of their particular talents. Such an organization would fill a great need for former patients who must fit their lives into the workaday pattern of society. They are the ones who have had uncovered creative abilities while hospitalized and who now need opportunities for development. Besides the benefits this would bring to the patients, individually, it would provide another channel in which the public might find common ground with the ex-patient and thus speed up his rehabilitation. It is possible that groups of performers made up of former mental patients might serve as ambassadors of good will in the long fight to break down public prejudice against the mentally ill. By performing before audiences made up of people from all walks of life, they could help to establish and cement bonds of understanding and friendship between those who have found their place in the world of normal living and those who are struggling to find their place in it.
THE TREATMENT OF A HOSPITALIZED ADOLESCENT PATIENT BY THE METHOD OF INDIVIDUAL MUSIC THERAPY

CHRISTINE MILES

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I. INTRODUCTION

The recent survey conducted by the National Association for Music Therapy, Incorporated, pointed out that by far the largest use of music for therapeutic purposes is found in mental hospitals.¹

Cleveland State Hospital is one of the fifty-two mental hospitals carrying on an extensive music therapy program. The structure of the hospital is such that the assistant to the superintendent, the clinical director, is directly responsible for all medical and nonmedical therapies. Furthermore, it is the hospital's policy to encourage the multidisciplinary approach to the treatment of all hospitalized patients. In this atmosphere of encouragement and staff cooperation, the Department of Music Therapy was stimulated to examine its philosophy and goals.

Several approaches were made to the problem of formalizing music therapy.² This paper concerns itself with one of these approaches: the form and function of music therapy as applied in the treatment of an individual patient. It describes the theoretical framework achieved by combining the knowledge and skills of the fields of music therapy and psychology, and the results of applying this framework to the treatment of a hospitalized, psychotic adolescent girl.

II. SOME APPROACHES TO MUSIC THERAPY

As is well recognized and accepted, the use of music as a therapeutic agent has a long history.³ However, music therapy as a

¹ The writer is indebted to William L. Grover, M.D., Superintendent, and to Charles Waltner, M.D., clinical director, for their encouragement of this project.
specific profession has a much briefer existence. During this short existence, many theories and practices have evolved. These theories range from the belief in a therapeutic effect based on pure music alone to the other extreme of using music as a communicating medium much the same as one might utilize any form of interpersonal activity. For example, Gutheil says:

The therapeutic value of music depends on (a) its psychophysio logic effects, particularly those involving tension and relaxation and (b) its psychologic effects, particularly those involving the mood.¹

On the other extreme, another school of thought places its emphasis on the use of music as a way of establishing rapport along with other forms of occupational and recreational therapies. Thus, Masserman writes:

However, music, though methodologically unique and important, is only one of many avenues of approach to the patient when words alone, as is often the case, are inadequate.²

This is not to say that any one school of thought accepts only certain aspects of music while excluding all others. But a perusal of the literature reveals that different practitioners in the field emphasize different aspects of music therapy.

Thus, Podolsky writes that musical composition counteracts various emotions and that there are appropriate types of music for various psychiatric conditions.³ Another investigator, Alexander, reports on an experiment showing that music will stimulate or repose the organism depending on the type of music applied.⁴ In another direction, Friedlander, a psychoanalyst, declares that music is a good approach to psychotherapy.⁵ Music or rather music preference can be used as a diagnostic instrument according to a study by Cattell and Anderson.⁶ And all these

In the Psychiatric Hospital

people would not argue with the general statement made by Preston in an article in the Psychiatric Quarterly in which she said that music may be adapted for all patients at either the passive or active level and that all reaction types of patients gain by the application of music in one of its various forms.1

This paper is not aimed to support or deny any one particular school of thought regarding music therapy. Rather it will describe an approach which accepts the findings of all schools and creates a synthesis using as a catalyst the procedures of psychotherapy.

III. The Problem

At Cleveland State Hospital the task of formulating a structure of individual music therapy became acute when a particular patient, a 19 year old girl, hospitalized for nine months, was referred for music therapy. The ward psychiatrist considered it important to utilize the girl's interest in the piano and her ability to express herself musically. Her tendency to withdraw when placed in other therapeutic activities led to the decision to attempt to reach her through the medium of piano lessons.

This young patient had studied piano for a period of six months prior to her hospitalization. Because of her responsiveness to music and long hours spent working at the keyboard her pianistic skills were far in advance of this short period of formal training. Although quite able to read and play from the printed page, she was most fluent and relaxed when improvising her own compositions or familiar classics. This ability to play by ear was extremely important to the patient and later served as a valuable means of communication between patient and therapist.

The patient began music therapy in September, 1956. She was seen for two one-hour sessions each week. During the initial phase, the first half-hour of each session was devoted to the piano lesson; the second half-hour, to a discussion period. Although the patient readily responded to the piano lesson, she invariably confined her remarks in the discussion period to “I’d rather not say,” “I’d rather not discuss it” or “I don’t know.”

This analysis was facilitated by the environmental situation. The sessions all took place in a room with a one-way vision mirror. Each session was observed and supervised by a consultant, a psychologist, who in turn was responsible to the clinical

director of the hospital. After each session, the therapist and supervisor discussed and evaluated the experience. Furthermore, all sessions were tape-recorded for training purposes and representative sessions were transcribed for further study and evaluation.

After the first series of twenty meetings, it became evident that the dichotomy of music lesson and discussion period was not an integrated form, because it lacked an over-all theoretical framework. As a result, a synthesis of music therapy and psychotherapeutic procedures was proposed by which future sessions would be guided.† This new structure served as a framework for the next fifty therapy hours.

IV. STRUCTURE OF THE MUSIC THERAPY SESSION

A. Formal Characteristics

1. Therapist. A person interested in establishing an interpersonal relationship with another person for the purpose of helping that person to make a better adjustment in life. A person with a knowledge of musical expression and who is also able to translate this expression into the medium of instrumental or vocal technique.

2. Client. A person desiring to be helped with his emotional problems. A person with an interest in musical expression or musical experience.

3. Place. A specific place for the session.

4. Time. A specific time for the meeting.

B. Formal Procedure. The session will comprise sixty minutes.

1. Introduction. 10 minutes
   This will be a free association period. The patient will be encouraged to play whatever she wishes.

2. Analysis. 5 minutes
   The therapist will attempt to make the patient aware of the meanings of the free associations. The therapist may ask for more associations, have the patient repeat certain segments, and point out similarities in the selection of music, in manner of playing, etc.

3. Formal music lesson. 20 minutes
   This section, although being outwardly concerned with the teaching of the techniques of the piano, will have the func-

Gratitude and credit are due to Lawrence H. Tober, Ph.D., who served as consultant in psychotherapy for his part in the project.

† Acknowledgment is made to Alex Darbes, Ph.D., research consultant, whose critical analysis and suggestions laid the foundation for the revised theoretical formulation.
tion of providing a supportive assurance to the patient after the anxiety which may be provoked during the second period. The formal music lesson is an area with which the patient is familiar and in which she can rely upon the interest and skill of the teacher to give her support and a sense of achievement.

4. Interaction period. 20 minutes
In this section of time, the therapist sets the theme by providing an atmosphere of free discussion and an analysis and review of the behavior of the patient during the previous thirty-five minutes. The emphasis is upon the utilization of standard psychotherapeutic techniques.

5. Free expression period. 5 minutes
The therapist attempts to bring adequate closure to the session by again encouraging the patient to play whatever she wishes, or the therapist may join the patient in a duet.

V. RESULTS
The results of this treatment of an emotionally disturbed adolescent by means of individual music therapy will be presented in terms of the three main areas of the therapeutic structure followed by a presentation of the patient's ward behavior.

Free Association Period (Introduction and Analysis)
Shortly after individual music therapy was begun with this patient, she demonstrated a marked ability to pick up strains of music and improvise them in her own way. Because most of this self-conceived repertoire was developed and played during the precipitative and chronic phases of her illness, it seemed important to understand its meaning and significance for the patient. Table 1 presents a list of the music played during the free association period at various times throughout the fifty sessions.

Since verbal communication had broken down for this patient, music assumed the role of bridging this span in human relationships. Several times when the patient responded negatively to verbal overtures by the therapist she was encouraged to play something which expressed the way she felt at the moment. She also responded enthusiastically to suggestions that she tell the therapist stories that would fit the context of the music. As the sessions progressed the patient exhibited more freedom and spontaneity, not only in her choice of music but in her willingness to communicate with the therapist. Gradually, verbalizations
became less threatening to the patient and the free association period served as a foundation for the discussions of the interaction period.

Table 1

<table>
<thead>
<tr>
<th>Composer</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arlen</td>
<td>Somewhere Over the Rainbow</td>
</tr>
<tr>
<td>Beethoven</td>
<td>Minuet in G</td>
</tr>
<tr>
<td>Beethoven</td>
<td>Sonata Opus 13 (1st Movement Introduction)</td>
</tr>
<tr>
<td>Berlin</td>
<td>Always</td>
</tr>
<tr>
<td>Bizet</td>
<td>Habanera</td>
</tr>
<tr>
<td>Brahms</td>
<td>Hungarian Dance No. 5</td>
</tr>
<tr>
<td>Brahms</td>
<td>Lullaby</td>
</tr>
<tr>
<td>Brooks</td>
<td>Darktown Strutters’ Ball</td>
</tr>
<tr>
<td>Carroll</td>
<td>I'm Always Chasing Rainbows</td>
</tr>
<tr>
<td>Chopin</td>
<td>Funeral March (From Sonata in B-Flat Minor)</td>
</tr>
<tr>
<td>Chopin</td>
<td>Waltz in C-Sharp Minor</td>
</tr>
<tr>
<td>Chopin</td>
<td>Waltz in D-Flat</td>
</tr>
<tr>
<td>Debussy</td>
<td>Claire de Lune</td>
</tr>
<tr>
<td>Ferrao</td>
<td>April in Portugal</td>
</tr>
<tr>
<td>Friml</td>
<td>Sympathy</td>
</tr>
<tr>
<td>Grieg</td>
<td>Piano Concerto—Theme</td>
</tr>
<tr>
<td>Lecuona</td>
<td>Malaguena</td>
</tr>
<tr>
<td>Lehár</td>
<td>Merry Widow Waltz</td>
</tr>
<tr>
<td>Liszt</td>
<td>Hungarian Rhapsody No. 5</td>
</tr>
<tr>
<td>Mozart</td>
<td>Turkish Rondo</td>
</tr>
<tr>
<td>National</td>
<td>Syrian Folk Dances and Tunes</td>
</tr>
<tr>
<td>Rachmaninoff</td>
<td>Piano Concerto No. 2—Themes</td>
</tr>
<tr>
<td>Rachmaninoff</td>
<td>Prelude in C-Sharp Minor</td>
</tr>
<tr>
<td>Schubert</td>
<td>Ave Maria</td>
</tr>
<tr>
<td>Schubert</td>
<td>Unfinished Symphony—Themes</td>
</tr>
<tr>
<td>Strauss</td>
<td>Blue Danube Waltz</td>
</tr>
<tr>
<td>Strauss</td>
<td>Tales From the Vienna Woods</td>
</tr>
<tr>
<td>Tchaikovsky</td>
<td>Piano Concerto No. 1—Themes</td>
</tr>
<tr>
<td>Tchaikovsky</td>
<td>Symphony No. 6—Themes</td>
</tr>
<tr>
<td>Traditional</td>
<td>Chop Sticks</td>
</tr>
<tr>
<td>Traditional</td>
<td>Happy Birthday Song</td>
</tr>
<tr>
<td>Wagner</td>
<td>March from Tannhauser</td>
</tr>
<tr>
<td>Youmans</td>
<td>Orchids in the Moonlight</td>
</tr>
</tbody>
</table>

Formal Music Lesson

The patient responded eagerly and enthusiastically to each new music assignment. At first, the music was selected by the therapist mainly for pedagogical reasons. After the initiation of a formal structure, it seemed more feasible to select music which would have special meaning for the patient and which might stimulate more responses during the free association period. For
example, music of the Romantic Period was especially appealing to the patient and elicited a great deal of affect and bodily response. Table 2 contains a list of the music assignments presented in the approximate chronological order of study.

Table 2

<table>
<thead>
<tr>
<th>Order</th>
<th>Composer</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Bach</td>
<td>Two-Part Inventions No. 1</td>
</tr>
<tr>
<td>2.</td>
<td>Schumann</td>
<td>Melody</td>
</tr>
<tr>
<td>3.</td>
<td>Schumann</td>
<td>Humming Song</td>
</tr>
<tr>
<td>4.</td>
<td>Czerny</td>
<td>School of Velocity No. 1</td>
</tr>
<tr>
<td>5.</td>
<td>Czerny</td>
<td>School of Velocity No. 2</td>
</tr>
<tr>
<td>6.</td>
<td>Clementi</td>
<td>Sonatina C Major</td>
</tr>
<tr>
<td>7.</td>
<td>Schumann</td>
<td>Knecht Ruprecht</td>
</tr>
<tr>
<td>8.</td>
<td>Bach</td>
<td>Two-Part Inventions No. 4</td>
</tr>
<tr>
<td>9.</td>
<td>Czerny</td>
<td>School of Velocity No. 5</td>
</tr>
<tr>
<td>10.</td>
<td>Schumann</td>
<td>Hunting Song</td>
</tr>
<tr>
<td>11.</td>
<td>Czerny</td>
<td>School of Velocity No. 6</td>
</tr>
<tr>
<td>12.</td>
<td>Bach</td>
<td>Two-Part Inventions No. 8</td>
</tr>
<tr>
<td>13.</td>
<td>Schumann</td>
<td>Harvest Song</td>
</tr>
<tr>
<td>14.</td>
<td>Czerny</td>
<td>School of Velocity No. 8</td>
</tr>
<tr>
<td>15.</td>
<td>Clementi</td>
<td>Sonatina C Major</td>
</tr>
<tr>
<td>16.</td>
<td>Mendelssohn</td>
<td>Venetian Boat Song</td>
</tr>
<tr>
<td>17.</td>
<td>Haydn</td>
<td>Gypsy Rondo</td>
</tr>
<tr>
<td>18.</td>
<td>Czerny</td>
<td>School of Velocity No. 10</td>
</tr>
<tr>
<td>19.</td>
<td>Schumann</td>
<td>Mignon</td>
</tr>
<tr>
<td>20.</td>
<td>Beethoven</td>
<td>For Elise</td>
</tr>
<tr>
<td>21.</td>
<td>Czerny</td>
<td>School of Velocity No. 20</td>
</tr>
<tr>
<td>22.</td>
<td>Chopin</td>
<td>Mazurka B Flat</td>
</tr>
<tr>
<td>23.</td>
<td>Beethoven</td>
<td>Sonata Opus 13 (2nd Movement)</td>
</tr>
<tr>
<td>24.</td>
<td>Mozart</td>
<td>Sonata C Major (Complete)</td>
</tr>
<tr>
<td>25.</td>
<td>Godard</td>
<td>Waltz</td>
</tr>
<tr>
<td>26.</td>
<td>Bach</td>
<td>Two-Part Inventions No. 14</td>
</tr>
<tr>
<td>27.</td>
<td>Massenet</td>
<td>Aragonaise</td>
</tr>
<tr>
<td>28.</td>
<td>Debussy</td>
<td>Golliwogs Cakewalk</td>
</tr>
<tr>
<td>29.</td>
<td>Chopin</td>
<td>Nocturne E Flat</td>
</tr>
<tr>
<td>30.</td>
<td>Beethoven</td>
<td>Sonata Opus 27, No. 1 (1st Movement)</td>
</tr>
</tbody>
</table>

Because of this patient's responsiveness to dance rhythms and particularly those of her native culture, the therapist encouraged the patient to express herself during these individual sessions by dancing to some of the musical compositions. In addition, a tape-recorder was brought into the session and set up to record a portion of the patient's playing. The patient then danced to her own interpretations of some of her favorite compositions as she herself had played them.
It is interesting to note that the patient incorporated much of her native rhythmic beat into the playing, often producing very obvious distortions in the music. However, the patient was unaware of this contamination until it was interpreted for her by the therapist. This became less of a problem as the therapy progressed.

Generally speaking, the patient improved markedly in her ability to sustain an effort toward mastering a composition both intellectually and aesthetically. Her pianistic technique increased sufficiently to allow her to play many of the compositions which gave her the most pleasure. Moreover, she now enjoys playing for others on the ward and often acts as accompanist for singing and dancing groups among other patients.

**Interaction Period**

In the interaction periods of the last fifty hours, striking changes took place as compared with the discussion period of the first twenty hours. It will be remembered that her verbal behavior in the initial phases of therapy consisted mainly of negativism and brief "I don't know" statements. However, after the inception of the formal structure the patient responded to the permissiveness of the free association periods and gradually came to accept the interaction period as a time for the verbalizations of one's feelings and problems.

At first, her responses were guarded and were only answers to specific questions. However, as the therapy progressed, the patient came to discuss freely her past life, her life in the hospital and her hopes and dreams. In time, she also felt free to express her relationship to the therapist.

It is believed that the formal structure aided the patient in establishing a closer rapport and gave her a feeling of support and assurance.

**Ward Behavior**

The changes in the interaction period closely paralleled her behavior changes on the ward. The ward psychologist made the following comment on this patient's progress.

This 19 year old female patient was admitted to the adolescent unit in August, 1956. On admission, and for several months thereafter she remained seclusive, inert and uncooperative. She was careless about her appearance and remained aloof and withdrawn. At the present time (June, 1957) she
shows a change from her former behavior. She has ground privileges, practices the piano on the ward, has cultivated a few friends, keeps occupied and is helpful on the ward. She attends a typing class, participates in the chorus, a music listening group and a string ensemble and has been working in the commissary.

**Termination of Therapy**

The patient terminated her therapeutic relationship at the end of the month of May, 1957. This decision to terminate was made by the patient. The patient felt that she had gained maximum benefit from the relationship. It was the feeling of the therapist that this termination was premature and represented a “flight into health” on the part of the patient. However, in view of the fact that the patient was making some progress in terms of her hospital adjustment, it was decided to let the termination take place until future circumstances would warrant a reactivation of the relationship.

**VI. Summary**

In summary, this paper has presented the problem of formalizing a conceptual scheme for individual music therapy in terms of the treatment of an emotionally disturbed, hospitalized adolescent girl. It describes the development of a new structure for the therapeutic session and its application in the last fifty hours of treatment.

The patient showed considerable progress in both her therapy meetings and in her hospital functioning. She improved in terms of increased social interaction, verbalizations and musical skill.

This improvement is believed to be correlated with the adoption of the new conceptual scheme by which the procedure of each session was guided. It provided an integrated form which might be compared to the Sonata Allegro form in musical composition. There are the expositionary themes, the development of these themes, the recapitulation of the material introduced by the patient and the closure at the end of the session.

It is believed that this structure, combining as it does the use of music as a means of communication and as a stimulus to emotional expression with the integration provided by a psychotherapeutic outline represents a further step in the development of music therapy as a means of treating emotionally disturbed persons. In addition, it gives strong support to the usefulness of the
multidisciplinary approach in the solution of certain problems connected with the treatment of the emotionally ill person.

**ADDENDUM**

_A Process Recording with Analytic Commentary of a Representative Music Therapy Session_

What follows is a process recording and analytic commentary of one fairly representative music therapy session in the treatment of a hospitalized, psychotic adolescent girl made by a supervising psychologist in collaboration with the music therapist. This specific example illustrates the formal structure and function of individual music therapy. It is hoped that such a presentation will serve to clarify this new approach in the use of music therapy.

First, it should be noted that all seventy sessions with this particular person took place in a specially constructed observation room equipped with a one-way vision mirror. The room was furnished with a couch, chairs, table and a piano (upright style). Second, all sessions were observed by a supervisory psychologist. The supervisor followed the session closely and made detailed written notes of the session. Immediately following the therapeutic hour, a conference of the therapist and supervisor was conducted to discuss and evaluate the session.

The patient, nineteen years old, had been hospitalized for eighteen months in a mental institution and had been referred for music therapy.

She was first seen for some twenty hours during which time the method of the music lesson and supportive therapy was used. Following a review and an analysis of the progress of the patient, a new procedure of individual music therapy was adopted. This session represents the eighth session in the new series.

**Process Recording with Analytic Commentary of the Eighth Session of the New Series**


<table>
<thead>
<tr>
<th>Therapist—C. Miles</th>
<th>Patient—Z</th>
<th>Supervisor—A. Darbes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time in Minutes</td>
<td>Process Recording</td>
<td>Comments</td>
</tr>
<tr>
<td>0</td>
<td>(The following quotations represent abstracted highlights selected by the supervisory psychologist.)</td>
<td>(The following comments were made by the supervisory psychologist after an analysis of the session.)</td>
</tr>
<tr>
<td>Time in Minutes</td>
<td>Process Recording</td>
<td>Comments</td>
</tr>
<tr>
<td>----------------</td>
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</tr>
<tr>
<td>5</td>
<td>(Mozart Sonata in C Major is being played by patient.)</td>
<td>The first two phases of the session are theoretically devoted to free expression by the patient and subsequent clarification, restatement and possible interpretation by the therapist.</td>
</tr>
<tr>
<td>7</td>
<td>(Pt. plays rapid succession of scales.)</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>T—Did you just learn that?</td>
<td>In these first 13 minutes we see only the free expression by the patient, encouragement by the therapist and some clarification by the therapist. (You played that for me last time. Both selections are in happy keys.)</td>
</tr>
<tr>
<td>11</td>
<td>(Some questions pertaining to the background of this learning.)</td>
<td>However, there is a lack of fuller interpretation by the therapist. For example, the therapist might have followed up immediately the clues provided by the initial playing of the Mozart—the fact that the patient had played that same piece during the last session.</td>
</tr>
<tr>
<td>12</td>
<td>T—Do you know any other Mozart?</td>
<td>Substantiation of this comes very, very late in the session when the reason for this Mozart is clearly expressed by the patient.</td>
</tr>
<tr>
<td>13</td>
<td>(Pt. plays something.)</td>
<td>The therapist here simply pointed out the event and then followed it up by encouraging free association.</td>
</tr>
<tr>
<td>16</td>
<td>(T actively goes into lesson. Plays and demonstrates.)</td>
<td>The therapist does a fine job in encouraging the free association, skillfully picking up the distortion of the rhythm and mood of the music.</td>
</tr>
<tr>
<td>18</td>
<td>Pt.—I KNOW THIS THING BY HEART.</td>
<td>Still the brevity of this phase (only 13 minutes for the preliminary activity) bespeaks for a slow warm-up.</td>
</tr>
</tbody>
</table>
Time in Minutes | Process Recording | Comments
---|---|---
T—You do? You’ve been memorizing a lot lately. (What is this thing she knows by heart? Is it the love relationship?)
20 | (Pt. stops playing.) T—Why didn’t you finish it? (Pt. continues playing.) (Is this a device by the patient to test whether or not the therapist is listening?)
22 | T—Are you practicing more than usual? (T sits at piano, Pt. resting arm on chair.) T—Has your mother heard you playing? You play very well. Does she like to hear you? (Why did the therapist speak of this, if she had not unconsciously been aware of the foregoing remarks about listening?)
24 | T—Then who does listen to you? Pt.—NOBODY. MY YOUNGER SISTER, SHE’S TAKING MUSIC APPRECIATION. (Here is the theme of someone listening and appreciating her as does Pt. A in a subsequent section.)
26 | (Interruption for lesson.)
27 | T sits at piano.
29 | Pt. returns to piano.
30 | T—Look at these things closely. They resolve themselves. Find out why you’re doing these things. You’ll change.... There’s always an answer to these problems. Go slowly when you have a problem. Go back. Look for it and when you find it you can solve it.
also the little section devoted to the question of who really listens to the patient when she is practicing. The therapist then finishes with a two-pronged statement that concerns music lessons and life.
There are several points here that one might discuss. Perhaps the topic of memorization. Why does the patient memorize so much? How does she feel about it?
Second, there is the question about who listens. This is a very subtle attack on the part of the therapist and seems to follow the theme established by the initial playing of the Mozart Sonata. It is this kind of recurring theme probing that finally leads to the breakthrough in the latter part of the session. (Note that this same repetition of “who will listen” accompanies the breakthrough in the end of the session.)
The therapist might have asked about the younger sister. Is the therapist like the younger sister? It would seem that due to the physical factors of size that the patient might regard the therapist as a younger sister or peer. How does the patient regard the therapist—as a mother, sister?"
The final statement at the thirty minute mark is a useful device and could have been applied much more forcefully later on. This technique of the analogy should probably be made more explicit to the patient.
In the Psychiatric Hospital

Time in Minutes | Process Recording | Comments
--- | --- | ---
32 | (Pt. plays Nocturne by Chopin.) | This section is dominated by the idea of the music lesson. However, the therapist does not lose sight of the therapeutic aims and she manages to intersperse supportive suggestions and interactions. (Would you like a cigarette and the probing of the association of Liebestraum.)

38 | T—There are a few mistakes in the bass. The accompaniment is part of the chord. It's the foundation over which we hear this melody. You can sing along with the melody. Try doing this. (Pt. always rests her foot or arm on chair while T is sitting. Sign of dependence, affection, transference. T should notice this. Last session Pt. sat on half of chair with therapist.) | One point that might be emphasized is that the therapist should pay more attention to the motoric behavior of the patient. For example, the way that the patient sits on the chair, the fact that whenever the therapist sits down to play, the Pt. rests a part of her body on the chair.

43 | (Plays the melody once. T and Pt. play together. Pt. sits. T stands. T sings.) | Care should probably be taken here not to make too much of an issue of her motoric functioning. It might be enough to make the patient aware of this. This is in line with the idea that the patient should be taught that everything has significance, that she is continually expressing herself whether through words, music, motion or movement.

44 | T—Take your time. Don't rush ahead. Just relax and enjoy the music. Why don't you work on this for next week? You've played this before—if you keep brushing over the same mistakes, the piece doesn't get any easier. | In the latter part of this section the therapist very insightfully picks up one of the clues that tie together the patient's selection of the three pieces, the Chopin Nocturne, Liebestraum by Liszt and the third movement of the Beethoven Pathetique Sonata.

47 | T—Would you like a cigarette? (T sits down. Pt. picks up a strain from the 3rd movement of the Beethoven Pathetique. She plays it very slowly and romantically.) | |

48 | (Pt.—SOUNDS LIKE CHOPIN OR MAYBE LIEBESTRAUM.) | |

T—What made you think of Liebestraum?
Pt.—SOUNDS LIKE IT.
T—in some ways it does. How does it go? E flat and C. Somewhat the same. One is major, the other minor.
50 (Pt. returns to music, plays Liebestraum.)
T—Did you know that all three pieces begin with this sound? (T plays intervals of major and minor 6ths.) Notice how the Chopin Nocturne begins with a major 6th, the Liebestraum with a major 6th and then the Beethoven with a minor 6th. That particular interval appeals to you.

In this section we see the result of the slow build up of the previous 50 minutes. The patient becomes more expressive and allows her emotions to come to the surface. The patient talks more, moves her body with animated gestures, tries to get the therapist to feel the same way that she does, dumps ashes on the therapist and in general, gives way to her impulses.

52 (Pt. starts to play and begins to express herself with gestures and movements of body.) (Pt. abruptly switches to the 1st movement of the Beethoven Pathetique Sonata. She plays the opening chords with a great deal of bravura.) (Pt. snickers.)

T—Let’s try it once, counting the rhythm together. (T sits down and plays the first movement of the Beethoven Pathetique.) (Pt. jerks body in time to rhythm in muscular empathy. Pt. accidentally dumps some ashes on T. Excuses herself.)

Pt.—OH, THAT’S MARVELOUS, DON’T YOU LIKE IT? T—It’s very exciting, dramatic and very strong. Pt. (snickers) IT’S JUST GOT IT—LIKE THE BEGINNING OF A PLAY.

The behavior of the patient which the therapist could not observe while the therapist was playing the piano suggests that a mirror should be placed on the piano so that the therapist could observe the patient’s movements. As the therapist was playing, the patient responded with strong vigorous bodily movements to the rhythm.

56 (Patient plays again.)

T—You respond to the introduction because it’s like a play, isn’t it. And you have the leading role at the piano. 
Pt.—I THINK I’LL LEARN THE INTRODUCTION AND I WON’T KNOW THE REST OF IT. (Pt. sits down at the piano.)

And in this last section we have the stormy finale. The patient throws all her caution to the wind, expresses her feelings, lets the
In the Psychiatric Hospital

Time in Minutes | Process Recording | Comments
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Have you ever watched him play this?<br>Pt.—NO.<br>T—By stopping here you are poised in the air—waiting. The second movement. You’ve done it before?<br>Did you do it without a teacher?<br>

60 (Pt. begins to play.)<br>T—You are very expressive when you play today.<br>Pt.—DON’T YOU GET IT—OHHHHHHRRRR (and she plays the introduction again. She writhes in anticipation.)<br>T—How does it make you feel?<br>Pt.—I DON’T KNOW.<br>T—Same feeling with the other pieces?<br>Pt.—I DON’T THINK SO.<br>T—Play it once more.<br>

62 T—Did you have the same feeling that time?<br>Pt.—NO.<br>T—It lessens after playing doesn’t it?<br>Pt.—I DON’T KNOW WHY ESPECIALLY.<br>T—That’s a strong piece. Feels as if you could conquer the keyboard.<br>(Pt. laughs out loud at this.)<br>T—Isn’t that true?<br>Pt.—YES.<br>Pt.—WHO WOULD I PLAY IT FOR?<br>

64 T—Why did you ask that? Is there somebody special? Or is its own reward to you that is important?<br>Pt.—MY FRIEND, J.A. SHE SAYS “PLAY THAT, Z...” SHE NEVER TOOK MUSIC AND SHE SAID “PLAY THAT Z...”

65 T—Is that why you played it for me today?<br>Pt.—I DON’T KNOW.
T—It was the first thing you played for me today. Is there something you'd like to play for me?
Pt.—WHAT WOULD YOU LIKE TO HEAR?
T—Play anything you feel like. (Pt. plays 1st movement of Mozart C major Sonata.)

CONTENT AND SEQUENTIAL ANALYSIS OF MUSIC THERAPY SESSION
December 3, 1956 Patient Z. Therapist—C. Miles.

Dominant Theme—Transference.
1. Casting of therapist in the role of the lover.
2. Patient has need to be appreciated and loved.
3. Patient desires to please the loved one.
4. She played the music of the Mozart Sonata for friend who expressed audible appreciation.
5. She has younger sister at home who appreciates her.

Specific chronology of appropriate events of the session.
A. Pt. played the Mozart Sonata at the beginning of the session.
B. Pt. disappointed in that the T. did not respond immediately to this. Goes abruptly into the formal music lesson. The lesson itself is a way of getting the therapist involved.
C. Pt. says “I know this by heart.” Or through my heart—my heart tells me.
D. Pt. stops playing to test whether or not the therapist is listening.
E. Pt. says my sister listens to me.
F. Pt. rests arm on chair trying to establish contact with therapist.
G. Pt. free associates three compositions, all of which begin with an interval of a major or minor 6th. The Chopin Nocturne reminds her of the Liebestraum, then the 3rd movement of the Beethoven Pathetique Sonata.
H. Pt. gets excited and achieves some release by switching to the first movement of the Beethoven Pathetique. Moves rhythmically, verbal expression of “that’s marvelous, don’t you like it.” Trying to get the therapist to express emotions.
I. Discussion of affect. Therapist makes insightful interpretation of the feeling of power on the part of the patient. Pt. laughs out aloud as statement strikes home.
J. “Who would I play for?” demands the patient, wanting the therapist to come forth.
K. The patient makes explicit that the therapist should be like her friend, J.A. Patient wants to cast the therapist in this role.
L. Pt. wants the therapist to say, or make a positive statement about what she would want the patient to play. The therapist demurs at this point.
M. Patient closes session by playing the Mozart Sonata in C major. This is a classic example of closure in that the patient repeats the initial opening theme at the conclusion of the therapy session.
OBJECTIVITY IN CLINICAL PRACTICE

INTRODUCTORY REMARKS

WAYNE W. RUPPENTHAL

Director of Psychiatric Music Therapy
Topeka State Hospital, Topeka, Kansas

Undoubtedly there are people here who can remember the days before they had seen a magazine article or a newspaper story that ascribed the beginnings of music therapy to Saul and David. There may even be people here who remember the recital of that story in the Old Testament. The quotation from the First Book of Samuel in the Sixteenth Chapter, beginning with the fourteenth verse is as follows:

Now the Spirit of the Lord departed from Saul, and an evil spirit from the Lord tormented him. And Saul's servants said to him, "Behold now, an evil spirit from God is tormenting you. Let our lord now command your servants, who are before you, to seek out a man who is skillful in playing the lyre; and when the evil spirit from God is upon you, he will play it, and you will be well." So Saul said to his servants, "Provide for me a man who can play well, and bring him to me." One of the young men answered, "Behold, I have seen a son of Jesse the Bethlehemite, who is skillful in playing, a man of valor, a man of war, prudent in speech, and a man of good presence; and the Lord is with him." Therefore Saul sent messengers to Jesse, and said, "Send me David your son, who is with the sheep." And Jesse took an ass laden with bread, and a skin of wine and a kid, and sent them by David his son to Saul. And David came to Saul, and entered his service. And Saul loved him greatly, and he became his armor-bearer. And Saul sent to Jesse, saying, "Let David remain in my service, for he has found favor in my sight." And whenever the evil spirit from God was upon Saul, David took the lyre and played it with his hand; so Saul was refreshed, and was well, and the evil spirit departed from him.

It sounds like the perfect home remedy if one reads no farther. But more clinical reporting is found in Chapter 18, verse 10:

And on the morrow an evil spirit from God rushed upon Saul, and he raved within his house, while David was playing the lyre, as he did day by day. Saul had his
spear in his hand; and Saul cast the spear, for he thought, "I will pin David to the wall." But David evaded him twice.

If that typifies the life of a music therapist in those days it is no wonder the Shiloh Association for Music Therapy was never formed. As a music therapist, David was a failure. But was he a music therapist? Probably not. Perhaps he was a musician who, because he had excellent character references and was a good musical performer, was sent on a house call. He was, it must be admitted, reasonably successful as a career man, but he had to go well beyond the playing of the lyre to accomplish what he did, and it is feared that the patient was lost in the shuffle.

The point, of course, is that being a music therapist is more than being a musician; that being a music therapist must start with being a musician, but starting with being a musician does not guarantee finishing as a music therapist.

The music therapist is much more objective about his patients than David was about Saul. He must strive constantly to evaluate his own feelings about each of his patients and follow the course of action that is therapeutic for the patient rather than the one that satisfies his own needs.

It would be easy for a therapist to be so pleased by the technique that an obsessive-compulsive patient was building through hours and hours of piano practice, that he would lose sight of the therapeutic goal of reducing the compulsion through learning to play for fun. And it might be easy to assume that the next patient for whom piano lessons were prescribed should have the same "play for fun" treatment, when what he desperately needed was for someone to reinforce his weakened controls by insisting that he play his piano lesson until it was perfected.

How many times is a patient placed on a stage to perform musically for staff and other patients in order to demonstrate the musical accomplishment of the therapist with that patient, rather than because it was known to be a valid step in his treatment. How many patients are playing in orchestras because the therapists, as musicians, are gratified by conducting a group that is musically "good", and the therapists have a "need" for a large string section.

How many times does the likeable patient who plays well occupy the lion's share of the therapist's time, while the attention-starved patient sits in the corner feeling certain that he is as unlovable as he looks, and looking as unlovable as he feels.
For the music therapist, objectivity in clinical practice involves the recognition of fixed, rigid, stereotyped responses that a patient employs in his interactions with others. He must understand how these responses are inappropriate, how they are perpetuated by the subjective responses they elicit from others, and he must interrupt the cycle by responding objectively.

Perhaps a short, hypothetical example will serve to illustrate.

A young male patient is assigned to a male therapist for piano lessons. The patient is insolent, verbally attacks the therapist's character, and berates his musical ability. If the therapist is unable to be objective, he will react by becoming angry and defensive. If he is able to be objective, he will tolerate the verbal attack through the knowledge that there is no reason for the patient to attack him in this manner. The behavior is not appropriate to the reality of the relationship and must be a patterned response that is connected to someone who was important to the patient in his past life.

The patient's case history relates that he had an alcoholic father who was brutal to his family. The patient was expelled from high school for striking a teacher who kept him after school. In the six years between high school and hospitalization he has had eleven different jobs, each of them terminated because of arguments with his boss. It appears that the patient's relationship with his father may have become a stereotyped response to all figures of authority in his life. He appears to defend himself against his fear of these people by attempting to strike first. When these people respond in an emotional way with anger and retaliatory measures, the cycle is again reinforced. Here is confirmation of the stereotype reaction; here is proof that all figures of authority are cruel and dangerous as his father was cruel and dangerous.

There is good reason to believe that the tolerance shown by the therapist for the inappropriate hostility may have been the first step in showing the patient that a figure of authority does not have to be feared; that the two of them can come to a positive, healthy relationship, one that will develop during a musical association. Perhaps the cycle has been broken.

It is realized that this example is oversimplified almost to the point of absurdity. The illness of such a patient would have many complicated aspects. The music therapist and many others in contact with the patient would be tested in many ways before the treatment would be completed.
Before the music therapists are introduced who are going to relate some actual case material, another quotation comes to mind, this time from James Thurber's *Further Fables For Our Times.*1 The story relates a disturbance in communication resulting in a total loss of objectivity and concerns

a weaver who watched in wide-eyed wonder a silkworm spinning its cocoon in a white mulberry tree. 'Where do you get that stuff?' asked the admiring weaver. 'Do you want to make something out of it?' inquired the silkworm, eagerly. Then the weaver and the silkworm went their separate ways, for each thought the other had insulted him. We live, man and worm, in a time when almost everything can mean almost anything, for this is the age of gobbledygook, doubletalk, and gudda.

Moral: A word to the wise is not sufficient if it doesn't make any sense.

The Menninger Clinic in Topeka is a 113-bed, active treatment psychiatric hospital with an international reputation. I am proud to present at this time a music therapist from the Menninger Clinic. His name is Forrest Slaughter, and his paper is titled "A Transition from Individual to Group Music Therapy".

A TRANSITION FROM INDIVIDUAL TO GROUP MUSIC THERAPY

FORREST SLAUGHTER

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Many people think of the word, "objectivity," in relation to the attitude of the laboratory scientist who dissects and isolates physical matter for the purpose of observation in glass tubes or through a microscope. There is a tendency to think of "objectivity" as a certain detachment or nonparticipation by the person in the facts presented to him by a situation or by a phenomenon he may be observing. This, of course, is true in relation to the physical sciences where it is much easier to control all variables.

The therapist in the clinical situation treats people by deliberately establishing therapeutic, interpersonal relationships; he is subjectively involved in responding to the peculiar attitudes and behavior of patients. Here the word "objectivity" takes on a slightly different meaning. First, the therapeutic, interpersonal relationships contain variables not easy to measure and control. Secondly, there is no mechanical instrument through which he can observe the patient in a nonsubjective, detached way. This places the therapist in the role of a participating observer.

Any discussion of the importance of objectivity in clinical practice must consider two important factors: (1) the personality of the therapist; and (2) his ability with his modality, in the case of the music therapist, his musicality.

Some believe that one factor is more important than the other, i.e., personality first; musicality second, or vice versa. Others believe they are of equal importance. Still others prefer to withhold their decisions and suggest the development of a test that would measure the difference, if any exists.

To consider the personality factor first, what are some of the basic characteristics that would facilitate establishing and maintaining a therapeutic relationship with a patient? From our present knowledge and experience, these may roughly be classified into the following categories:

1. Warmth
2. Intuition
3. Sensitivity
4. Flexibility
5. Empathy
6. Awareness and control of one’s own personal strivings and experiences

These categories are not meant to be rigid or all-inclusive, nor do they imply that an individual’s lack or deficiency in any one or two of them would necessarily hinder or interfere with the establishment of a therapeutic relationship. It is impossible for any one person to possess all of the positive personality traits to the exclusion of the negative ones. The categories do serve, however, as a model against which a therapist may continuously measure himself for self-evaluation and observation, a necessity in working with patients objectively.

The second factor to consider about the music therapist is the contribution his musicality makes in the therapeutic approach to the patient. It is certain that the therapist’s preparation and ability should be of such a nature that he can feel a sufficient amount of security in his control and command of the various techniques and materials necessary for proper musical guidance, instruction and participation. His musical ability should enable him to use music wisely as a bridge of communication between himself and the patient, and to provide therapeutic relationships and experiences necessary for the patient within a musical setting. He must be able to respond appropriately to various musical and non-musical stimuli and situations.

Many clinical authorities believe that mental illness is the result of unresolved, interpersonal relationships with significant people in early life. The patient tends to repeat these relationships with others throughout his life. When the patient enters the clinical environment, he is provided with new and different kinds of experiences in the hope that he will give up his old patterns of responses for more favorable and less destructive patterns. In order to contribute toward the treatment aim, the therapist must be able to relate himself to the patient, not in terms of the therapist’s own life’s experiences, but in terms of the emotional needs of the patient.

One of the most difficult problems confronting many music therapists is how, when, and where to treat patients along a continuum from individual to group participation. The doctor usually decides the questions of how, when, and where to treat the patient; however, this is decided after one or several conferences
between the doctor and the therapist to consider the patient's readiness to move, what type of musical activity is most suitable for him, and the best way to make the transition. Occasionally, the doctor leaves these decisions to the music therapist.

At The Menninger Foundation, we have attempted to cope with the problem by establishing various kinds and sizes of musical groups from duets and trios to a large band and orchestra which at times includes twenty or more people. For example, when a patient has been scheduled for individual clarinet lessons, the one to one relationship is carried on until it is felt that he can be moved into the clarinet and woodwind section or group which is subsequently integrated into the band. These various groups permit the moving of a patient from a one to one relationship with the therapist to relationships with a few, and finally to relationships with many. Some of our patients, however, depending on their needs, degree of illness, and musical ability, may be placed directly in one of the several groups without beginning on an individual basis. On the other hand, there are some who start and remain on an individual basis for most, if not all of their total treatment period.

The following case, involving the transition of a patient from individual to group music therapy, will illustrate how the patient attempted to elicit responses from the therapist that would have been detrimental to his treatment. Further, it will illustrate how the therapist, through a process of self-examination, was able to respond in a manner conducive toward maintaining an objective relationship with the patient.

The patient, in his early twenties, came from a middle class family. His father was a fairly successful rancher. The patient was intelligent but always felt, and was considered by others, quite shy. He had many interests of which music was one. His illness began after a very frightening experience, and afterward he had trouble controlling himself. His social life became constricted. He was unable to make decisions for himself because he feared they would be wrong and he would be blamed for them. He wanted others to make his decisions for him, and yet he was dissatisfied and uncomfortable if they did. Whatever the situation, he felt himself in a trap. After the initial interviews and observation periods, it was decided that he needed to rediscover his pre-breakdown adjustments. He needed to use again the patterns that made him the good musician he was prior to the onset of his illness.
After a conference of his doctor with the music therapist, it was decided that the patient should be given individual lessons twice a week. The first sessions were uneventful and progressed appropriately with the patient being able to accept the one to one relationship. Occasionally, during the individual sessions, the patient would attempt to minimize or play down his musical ability to the extent of accusing the therapist of being insincere in his compliments. Although the therapist attempted to assure him that this was not true, the patient still appeared to doubt the therapist’s sincerity and would launch into an explanation of why his tone, finger- ing, or some other aspect of playing kept him from performing as he should. This explanation usually led to his stating sadly that he did not know whether he should continue playing or not.

Actually, the patient was an accomplished instrumentalist with broad, professional experience in both classical and jazz music. When he weighed the question of continuing such a career and began to enumerate his physical complaints, the therapist attempted to convey that he understood how the patient felt in not being able to make such a decision, but encouraged him to attend to the music lessons. Later, as the individual sessions progressed, the patient expressed interest in ensemble work. After various discussions between the therapist and patient, patient and doctor, therapist and doctor, it was decided that playing in the ensemble must be the patient’s decision. The patient decided to enter this small group and he played a prominent part in it, since he was somewhat more proficient on his instrument than the others. After several sessions, the group decided to give a performance before the other patients in the hospital. During one of the meetings in which plans were mapped for the performance, the patient misunderstood a remark that had passed between the therapist and another member in the group. The patient became upset, loud, and abusive toward the therapist. All attempts by the therapist to control this action were met with hostile accusations. Attempts by others of the group to explain to the patient how they understood the remark went for nought. He ignored them, and continued to blast away at the therapist. Finally, the therapist firmly ordered the patient to stop this behavior or leave the group. This brought more hostile abuses and a threat to quit the ensemble. The therapist remained quiet, as did the other ensemble members, until the patient finished. By this time the hour was up for the session. The other members left the
room, but the patient continued to pace the floor, casting angry glances at the therapist who said he would be looking forward to seeing the patient at the next session. The patient attempted to speak, could not, cleared his throat, turned away from the therapist, and walked from the room hastily. He was present and contributing to the group at the following session.

On one other occasion, after the ensemble had been incorporated into the concert band, plans were made and completed for one of the band concerts. The patient had cooperated in preparing for the event, even to the extent of assisting the therapist with the program, and other patients with perfecting their individual parts. A few days before this concert, he approached the therapist and stated that he did not know whether he would play in the concert or not. After listening to the patient's explanations, the therapist encouraged him to discuss this question with his doctor. Later, the patient repeated that he did not know whether he would play, and emphasized not playing. Again the therapist referred him to his doctor. Finally, the patient discussed his problem with his doctor who in turn did not make the decision for him but referred him back to the therapist. In the meantime, the therapist and the doctor had met for a conference and it was decided that neither would decide for him but would encourage him to make the decision. The patient finally made his decision not to play the day before the concert.

In the case described, the over-all treatment aim was to re-establish behavior patterns used by the patient before his illness; helping him to make his own decisions was part of this plan.

Having been advised by the doctor about the patient's needs, the music therapist had the problem of providing new and different experiences for the patient in music. At first, because of the patient's musical ability, the therapist felt he should encourage him to continue his professional career in music. However, this might appear to be making the patient's decision for him, so when the patient tried to discuss this problem, the therapist expressed his understanding about the difficulty of the decision and directed the patient's attention back to the music lesson.

The first sign of progress in the treatment came when the patient expressed interest in doing ensemble work. The doctor and the therapist left the decision to the patient, and he decided to do it. His ability to make his own decision was considered a big step forward in his recovery. In the ensemble he got along
well until his explosion against the therapist in one of the meetings. At this point the therapist became quite angry and felt like throwing the patient out. However, the therapist realized that his anger was being provoked so that he would respond in the same hostile fashion toward the patient. Therefore, it seemingly came as a great surprise to the patient when the therapist remained silent and, after the others had gone, quietly said he would be looking forward to seeing the patient at the next session. The patient stopped suddenly, looked at the therapist in amazement, then left the room in haste. He did appear for the next session.

The patient was later able to move into the larger group, the band, where he was cooperative and controlled his behavior well. When he announced a few days before the band's annual concert that he did not know whether he would play or not, the therapist wanted to encourage him to play, but instead he advised him to talk it over with his doctor. Even after the patient did this, he was still undecided, and the therapist found himself becoming angry and wanting to force a decision. He realized that he was angry because he felt let down, so he referred the patient back to his doctor. Meanwhile, the doctor and the therapist had conferred and decided again that the patient should make his own decision. When he decided not to play, he had moved another step forward in his recovery by making his own decision and surmounting his fear of being wrong and being blamed for it. His behavior had been provocative, and at times he was near to eliciting the responses he expected. That he did not elicit such responses required not only close guidance of the therapist by the doctor, but also constant vigilance on the part of the therapist to keep the aim of the therapy in mind and not be dominated by his own feelings.

It seems that the crux of objectivity in clinical practice lies in the possession of certain personality characteristics by the therapist. Furthermore, the therapist's ability to evaluate himself and his feelings in light of the needs and demands of the patient, and not in terms of his own personal strivings, will be the measure of his therapeutic approach to the patient. In addition, the therapist's ability must be of such a nature that he feels a sufficient amount of security in his use of music as a bridge of communication between himself and the patient. It must enable him to provide therapeutic relationships and experiences in a musical setting.
PART III

MUSIC THERAPY FOR
EXCEPTIONAL CHILDREN
MUSIC AS A TOOL IN PSYCHOTHERAPY FOR CHILDREN

INTRODUCTORY REMARKS

ESTHER GOETZ GILLILAND

Chicago Musical College of Roosevelt University

The increasing incidence of childhood aberration presents a problem of national concern. A recent study by the Child Welfare League of America reported a half million emotionally disturbed children in need of treatment. Distressing accounts of juvenile delinquency in privileged as well as underprivileged families and neighborhoods are at least producing one good result: realization of public responsibility for prevention as well as treatment.

Professional groups are devoting more time and attention to these problems. Numerous papers and discussions have been presented recently in Chicago by the American Orthopsychiatric Association, the American Psychiatric Association, and the American Society of Group Psychotherapy and Psychodrama. The Committee on Human Development of the University of Chicago presented Dr. Lois Barclay Murphy of the Menninger Foundation at its Eighth Annual Symposium, February 16, 1957, speaking on “Cultural Sequences, Expectancies and Patterns in Relation to Childhood Stress.”

It is not our purpose at this time to recount all of the contributing causes of stress in children, nor to discuss the great need for adult treatment, guidance in improving home conditions, and the cultural environment as a means of prevention. Certainly an understanding of contributing causes is necessary in planning remedial measures. Through attendance at these professional conferences mentioned above, one major problem of special significance to our association becomes evident, namely, the difficulty of reaching extremely disturbed children through the accepted techniques that are used successfully on older patients. While many authorities seem aware of the usefulness of music and movement as a means of communication, self-expression, creativity, and play, far too few psychotherapists are considering the deeper significances possible in using a child’s responses to

musical stimuli as a means of diagnostic interpretation as well as projective techniques. This subverbal medium has possibilities that deserve and promise much greater development.

Those who have observed the efficacy of music in psychotherapy for children are now searching for psychological guidance to determine what types of projective techniques are most effectual, and how to adjust these techniques to the child's interests and needs, as determined by the psychotherapist. We have a most potent tool—how far shall we go? Who takes over from where? The ideal situation, of course, is the treatment team, or co-therapists.

Music can be combined effectively with play techniques with miniature toys, and with activity games. Through play, the child not only experiments with reality in the physical, social and emotional world, but also externalizes his inner emotional life. Surplus energy is discharged through movement. Freud credited gratification of the pleasure principle to these activities. Froebel has emphasized the educational and socializing factors in games. Doll play reveals personal emotional problems as well as family and social relationships. Graphic art is used as a measure of intelligence as well as an expression of inner life. Plastic art is useful in dealing with body image problems. In dramatic play (psychodrama), the child can work out his inner conflicts in an external world. Combining music and dance with any or all of these activities can make them much more effective and meaningful.

Music and dance are recognized as essential in all school programs, and the principles of Dalcroze Eurhythmics are especially useful in developing the whole child. But in order to justify itself as therapy, music activities must not only be recreational and educational, but must extend beyond pleasure and physio-intellectual development. How can the music therapist best serve the child who has greater than average problems and needs?

Dr. Loretta Bender, senior psychiatrist in charge of Children's Service of the Psychiatric Division of Bellevue Hospital in New York City, says,

There is a group of children passing from childhood into the latency stage who are making the transfer badly due to either constitutional inferiority, hyperkinesis, deprivation of any maternal care and affection,' or other neurotic factors which tend to keep them infantile. They are thus unwilling
to accept the schoolroom situation, to make any new attachments, or to start to develop those emotional and social functions which characterize the latency stage.

These children are usually first appealed to in the music class. The rhythm band is of special value. The fascination of the instruments, the noise making, the aggressive activity of beating or pounding the instruments, and the contagious rhythm, win the children over. They are thus beguiled into a type of training under a sympathetic "mother" which gives them a pattern for activities and a sense of accomplishment and satisfaction. Furthermore they are forced to accept the group or social situation. Only after success in the rhythm band do many of the more difficult children enter into the singing of songs, and gradually carry over what they have experienced in the music class into the schoolroom and other activities.

Music therapy is one of the most valuable means of training the hyperkinetic child whose main problem is one of direction, attention, concentration, motivation, attaining a goal, and patterning impulses, all of which are disorganized in the hyperkinetic child. . . .

The rhythm band is not assigned to certain children but every child who comes to the hospital learns to play not one instrument, but all of them. They play rhythm accompaniments to such pieces as the "Barcarolle" from Tales of Hoffman; the Blue Danube Waltz; Mozart's "Minuet" from Don Giovanni; Beethoven's Rondo; a simplification of Haydn's Clock Symphony, and the "Andante" from Haydn's Surprise Symphony. All are much reduced, of course, and perhaps Mozart or Haydn would not recognize them, but the kernel of feeling for good music is planted, the ear is developed, and the response is always gratifying.

It has long been known, of course, that the defective child responds to music both actively and passively when he cannot respond to any other activity. . . . The shy, withdrawn, depressed, homesick and inferior-feeling child finds a chance to take part in group activities in the music room which fascinate and beguile him and give him a new sense of satisfaction. Folk songs are taught, together with folk lore that proves of interest. . . . For the self-conscious, growing child with awkward motility and strong feelings of inferiority the music class combined with rhythmic games or dancing, have their obvious value.1

All of this is common knowledge to most of our members, of course, but time has been taken to quote this internationally recognized authority on child psychiatry in order to entice you to study in its entirety her splendid book on Child Psychiatric Techniques with its copious references. Only by understanding why our techniques are important can we continue to progress and to extend our services.

The two other members of our panel have had signal success in using creative musical experiences according to Dr. Bender's principles. It is certain that their methods and experiences will be very helpful to all who are concerned with exceptional children. First of all, they are successful mothers in the real sense of the word; secondly, they have had years of experience in group work before they became interested in therapy; and thirdly, they have a deep understanding of the problems and needs of their patients, and are creative enough to adapt their techniques to meet the needs of any situation.

Mrs. Mildred Dickinson has studied dancing all her life with the greatest of teachers, including the Dalcroze method. She has had a fine career as a professional dancer with Pavley and Oukrainsky and Doris Humphreys. Now, besides teaching dancing to over 1,000 children per month in the Chicago suburbs, she finds time to serve as volunteer dance therapist in the children's ward of Elgin State Hospital. She is in constant demand as a speaker and demonstrator before professional groups, and you will soon understand why. And besides all of these activities, she never misses an opportunity to explore every avenue of approach and to attend classes to improve herself and her work.

Mrs. Georgia Greven is employed as Music Therapist at the Child Guidance Centers in Chicago, and at the Uptown Aid for Mentally Retarded Children. She also does private and group work with child psychotic and pre-psychotic patients under the supervision of three psychiatrists in private practice. Her music therapy career began as a volunteer at Manteno State Hospital.
MUSIC AS A TOOL IN PSYCHOTHERAPY FOR CHILDREN

MILDRED DICKINSON
Volunteer Dance Therapist
Elgin State Hospital

Since this is a meeting of the National Association for Music Therapy, I want to begin by saying that without music therapy, there would be no dance therapy, for whether we work with piano, records, singing voices or drums—it's music.

As a definition of dance, the following is quoted from the opening sentence of the chapter on Creative Dance in Bender's book, Child Psychiatric Techniques.¹

Dance is the expression of human fantasy and emotion using as its medium the motility of the body passing through space and time. This process of formulation of movement concerns itself not only with the form and action of the joints and muscles, but also with the subjective concept of the body, and with the body as seen and interpreted by an observer.

There is an article of interest in the Dance Observer called "Modern Dance as Mental Therapy,"² which described a beginning class at Bellevue Hospital in New York, conducted by Franziska Boas. It began, "They didn't want to dance. Small boy patients in the Psychiatric Division pounded and kicked on the locked door trying to get out. The psychiatrist persuaded, the dance therapist kept up a rhythmic beat on the drum, but the boys would have none of it. 'We want to go home,' they shouted, stamping around the room. But feet fell into step with the dance rhythm and the dance therapy class was on."

My own first session at Elgin State Hospital was something like this. I had spent a couple of afternoons with the children in their school room, playing the piano for informal group singing, and getting to know them a little individually. We have from ten to twenty children between the ages of seven and fifteen, the number changing as some are moved to other institutions, new ones committed, and occasionally someone goes home. They are a mixed group, colored and white, always more boys, and are classified as emotionally disturbed, with behavior disorders, and a minority of psychotics.

That first day nine, noisy, disorderly boys were brought to me by their schoolteacher; they had been told they were going to dance, and it was easy to see that none of them thought much of the idea. Much loud talking punctuated by four-letter words came from one; another threw himself on the floor with his face to the wall; a third sat down and stared vacantly at the others, while another picked his nose with one hand and masturbated with the other.

These children had only experienced square dancing and what they called jitterbug, so the first question was, “Where are the girls?” When I said, “No girls today, just you boys,” they began to tumble each other around and make trouble generally.

Then I brought from the adjoining room three of my Chinese drums, one large one about 20” in diameter, and two of smaller sizes, sat down in the middle of the floor, took off my shoes, and began to play a sharp staccato rhythm on the three drums, making a lot of noise and arousing their attention immediately. They all wanted to play the drums, but I said they were there to dance first, and then each one might have a chance at the drums. When I said, “Take off your shoes and socks,” there was a roar of refusal, but finally the teacher helped me persuade them. I told the big boy who seemed to be assuming the role of leader that we would do a sort of Follow The Leader, and asked him to be first. After demonstrating how you can move with many parts of your body at different levels, in different directions in space, (all this in split seconds because I did not dare lose their attention) I immediately began to play the drums again, and after a fashion they all joined in the exercise. The one who showed real interest was a tall colored boy. This is not surprising, because in my experience almost without exception, the colored boys and girls pick up anything rhythmic almost instantly, whether it is singing or dancing or playing instruments.

We did only one other thing that first day. Feeling that their interest had to be captured in a spectacular way, we learned to fall. I explained how handy it was to know how to fall in any direction, forward, sideways or backward, without hurting themselves, and proceeded to demonstrate. By this time they would let me talk to them, and were able to be quiet enough to be shown the principle of contraction and release of the jointed areas of the body, which together with reaches or extensions in the right direction would enable them to lower the body to the floor in a sequence of movement, which, when speeded up, resulted in a
fall. The noisiest, worst behaved boy in the group, with a perfectly co-ordinated physical body, executed a perfect fall the first time he tried it. Immediately he jumped to his feet, backed up against the wall, and shouted, "I got a tommy-gun, all you guys are going to fall down dead," as he went "ack-ack-acking" around the room. This was not too happy a development, though it was a fine example of the close relationship between movement and idea, which would be led with other movements into pleasanter fields.

With the teacher's help, we stopped the underworld demonstration by having everyone lie down on the floor, being as still as possible for a minute in order to hear the small sounds that are audible in a quiet room; then they were to tell me what they heard. I did not try to convey the idea of relaxation that first day; I merely wanted to set the precedent of a small quiet period in each session. Then each boy had a chance to try out the drums, taking turns alphabetically by name, and the session ended.

The group arrived more quietly for the second session, but the first questions were: "Do we have to take off our shoes again?" and "Where are the drums?" The answer was "No drums today. We will work with our bodies to percussive sounds on the piano, music with a strong beat, written especially for people to move to. But before we begin to dance, it's a good idea to loosen up our bodies mechanically, bending all the movable parts from head to feet, stretching the muscles, in other words 'warming up'. A violinist will carefully tune his instrument before beginning to play; we warm up our bodies, or tune them, since the body is our instrument for dance." Standing in a circle we moved our head, shoulders, arms and hands, upper body, hips and knees, ankles and feet.

Then one at a time, following me in a diagonal course across the room, they began the simplest form of locomotion, walking. With big free open strides, heads up, arms swinging naturally, they walked forward, backward, sideways, and in circles. Next came the same exercise using running steps, then we used a running-record with periodic rests or stops. Everyone now had had practice in running in four ways, so we all got on the floor at the same time, moving in any direction fancy dictated, but observing two rules: avoid collisions, and everyone must freeze in the position they found themselves when the music stopped. Of course this was kind of a musical game, but one they liked well enough to play according to rules. To my surprise, very few bumps occurred, since they seemed to enjoy developing skill in
sidestepping or retreating from any figure in their way. When we stopped, one boy said, "I know what to call this, ordered confusion." And for many weeks they asked to repeat this exercise, calling it by name.

By now everyone was hot and perspiring, glad to lie down for the quiet period, and we began to use the word relaxation, and to demonstrate it by picking up an arm or leg, letting it flop back onto the floor with no resistance, rolling the head loosely from side to side, or testing the back by lifting it slightly while upper and lower parts of the body remain sagging on the floor. Strangely enough, this part of the period became the high spot of their cooperation, each child was content to wait quietly in a completely relaxed way on the floor until the teacher came to him, and for a minute or two, gave him her undivided attention. Even the most unruly of the big boys, several of whom in the beginning would not always join in the body mechanics, would get down on the floor at that time and quietly wait to be tested. To demonstrate the difference between relaxation and tension, the children stiffened their bodies like boards, so they could be lifted in one piece and moved to a different position on the floor.

Before going any further, I want to tell you about the albums of records Freda Miller of New York has made for use in this kind of work. She has completed four; the album we use a great deal is the fourth album, which contains tempos for walking, running, skipping, turning, jumping, swinging, waltzing, and marching, as well as five "moving the way you feel" studies for free movement improvisation. These studies are titled "Angry," "Sad," "Funny," "Mysterious" and "Lively." After the children became used to the simple natural movements of running, skipping, etc., it was easy to begin listening to these descriptive mood pieces first, and then to move extemporaneously to them.

It is impossible because of time limitation to take you step by step through our growth in understanding dance movement that first year. A very significant thing is that the children came to look forward to the dance period so much that certain of their caretakers began to punish them for misdemeanors on the ward by depriving them of dance class. This, I think, is a mistake, because if there is any time when these mixed-up youngsters can get away from their complicated selves into a free affirmative kind of action, that time should no more be denied than the air.

1. Record Album "Music for Rhythms and Dance". By Freda Miller, 237 E. 81st Street, New York City.
they breath or the water they drink. These things are necessities of life.

As the children became more familiar with free movement, we began to work to some Negro Spirituals. The songs were used as a framework to contain dance movement that was only slightly directed with the lyrics supplying the ideas. They began to listen, not only for rhythm, but the changing level of pitch and dynamics. One of their favorites is "De Ol' Ark's a-Moverin". They worked out a group movement to the two-line chorus:

Oh, de ol' Ark's a-moverin', a-moverin'
De ol' Ark's a-moverin', An I se gwine home!

By this time girls had been included in the group, so they took the two-line verse:

See dat sister dressed so fine?
She ain't got religion on -a her min'! (Chorus—All.)

One half the boys:

See dat brudder dressed so gay?
They's gwine a-come fo' to carry him away! (Chorus—All.)

and the other half of the boys:

Ol' Marse Gabriel blowin' his horn;
I se gwine a-he'p him, jes' as sho's Yo' born! (Chorus).

We spend some time improvising accompaniment for our dancing. We have a rhythm band using authentic instruments, and while we begin by just beating out the rhythm haphazardly, we soon start to talk about the structure of music, note-values, phrasing, melodic line, etc. Those children using big drums or gongs learn to take the whole note values; lighter drums and hand cymbals, half notes; rattles and mambo sticks, quarter notes; and triangles and finger cymbals, eighth notes. Using Dalcroze Eurythmics we dance these note values, half the group moving and half accompanying.

A sense of phrasing is achieved by taking eight steps on half-toe, reaching toward the ceiling with our hands straight up, say-ing, Hi Hi Hi Hi, in the highest pitched tone possible; then eight wide skipping steps with arms stretched out at the side, saying, Ha Ha Ha Ha, in a middle tone; then eight low crouching steps, uttering, Ho Ho Ho Ho, followed by a fall to the floor from which the standing position is regained during a silent count of eight.

Another activity which they like is making living statues, each child taking two measures of music to reach a given spot. The only direction given is that he must be connected in some way with the person who has gone before. Sometimes I supply the theme or idea we will work for, and sometimes the children do. Here is one example that stands out as a poignant thing. I brought a picture of Lorado Taft's beautiful group at the foot of the Midway in Chicago called *Father Time*, in which fifteen or twenty sculptured figures, good, bad, big, little, strong and weak types of people pass before the massive central figure of *Time*. The children got the idea immediately, and some fine strongly phrased Brahms helped them to put a certain dignity into their efforts. It was interesting to see who chose what roles. As in life, some took strong parts; weaker ones followed; but there were some very revealing choices made. In the few minutes it took to present the idea, there was not much time to figure out what kind of person you were going to be, so what came out was on a spontaneous level of thinking.

One day I brought to class some primitive statues from Hawaii; they were squat, ugly-looking figures representing the gods of rain, war, fertility, etc. We made dances about them, working out drum and gong accompaniment.

Perceptive awareness, memory and imagination are all tools put to use by the creative forces in art. We know the infinite capacity of the child for storing impressions; if only images of crowded rooms, ugly voice, and unfriendly people exist, we must add beautiful images of sight and sound.

Nature, animal and bird life offer never-ending varieties of subject matter for use in creative dance. There are sun, moon and stars in the orderly working of the universe; rivers, lakes, and oceans; mountains and the moving clouds; the branching veins of a leaf, or the delicate spiral markings of a shell; weather, storms, lightning, heat, cold, wind; the movement of small creatures, insects, ants, beetles, caterpillars; birds, large and small, eagles, ostriches, peacocks, roosters, crows, blue jays and robins. One of our most famous American Indian dances is the beautiful "Eagle Dance," still to be seen in our Southwest.

Then there are the folk dances, so rich in music. Available now are many wonderful records from Israel. Their simple line dances are easy to learn and fun to do. The directions say, "For as many

as will," a fine inclusive phrase, and a good kind of group close-
ness is generated in a group dance that does not require partners.

We also dance to the spoken word, to poetry, and to short
verses chosen for their ready adaptability to movement, such as:

A flickering and a flash!
A flickering and a flash!
A great blazing blast of heat
And everything turned to ash.

or
Trees in their blowing,
Trees in their blowing,
Stars in their circling,
Tremble with song.¹

Before closing, I want to tell you about one fifteen year old
boy, strong, good-looking, who was rough, domineering and
antagonistic toward all the other children, his teacher, and me.

He was present at dance sessions, but he only took part occa-
sionally, always objecting to removing his shoes. When he did
participate, he did everything well, except that he was obsessed
by the idea of war and guns, talked about Hitler constantly, and
sometimes interrupting a class action by stalking through it with
a high German goose-step, shouting, "Hoch," repeatedly in a loud
tone. Once in a while he would sneer at the others saying, "Kid
stuff," "Why don't you make a dance like this?" going off into a
series of wild gyrations until he would lose his balance. One day
after he had done this several times, I spoke to him as the others
were leaving, and said, "I truly believe you could make a dance
of violence. Your movements are so strong and well co-ordinated
that in the proper form, they would tell a convincing story. Would
you like to try it if I can find the proper music? I'll bring some
special records next time, and arrange for you to stay a few min-
utes after the others go, and we'll work on it." He finally chose
the "Khachaturian Sabre Dance" as the music, and literally
threw himself into destructive, violent action so completely that it was
like a bursting dam. Because he had a born sense of dramatic
phrasing and pause, as well as good rhythm, (after I pointed out
the need for change of pace, and a clear beginning, climax and
finale) he came out with a very convincing dance of violence.

We agreed to allow his psychologist to see it, and it developed
that the second time he did it, it was toned down considerably.

¹ Bertha Stevens, Child and Universe. Printing House of William Edwin
Rudge, Mt. Vernon, N.Y.
Ten days later I gave a demonstration with the children for the entire hospital staff, since the doctors knew about dance therapy, but had never seen it in action, and when he was asked if he would like to do his dance at that time, he said, "No." However, on the day of the demonstration, just after the relaxation period, he said "I guess I'll do my dance if you want me to." So he did, but the dance had dwindled, and the original fire was gone. He had been able to work out some of his antagonisms and violent feelings through a legitimate channel. His flair for composition repeated itself in quieter ways. In a later session, when we talked about horses, cowboys, corrals and western life in general, he created a dance for the whole group with a good plan and more than adequate movement to what is commonly known as "Hi Ho Silver" to the radio audience, originally the last theme of the "William Tell Overture".

Until now, the trained dancer has gone into theater or education, and now dance therapy offers a third vocation. Those qualities that make modern dance what it is, also make the teacher of modern dance fitted to work with disturbed people. Alertness to personalities, patience and human sympathy are needed more than the ability to distinguish between a catatonic and a hebephrenic patient. Training is becoming available for the young dancer who wants to teach in mental institutions. Teacher's College, Columbia University, has special courses to prepare students for work on rehabilitation teams.

Much interest in this new field was evidenced this summer when I spoke to a group of college students majoring in modern dance at Perry Mansfield School of Theater in Steamboat Springs, Colorado. And I predict that before too long, every music therapist will make use of dance therapy, because the two are so closely related.

To sum up, again I quote from Loretta Bender:

The teaching of modern creative dance offers a great many facets for the projection of physical and psychological problems. The process of mastering the elements and techniques of dance, parallels closely the processes followed by a pianist in psychoanalysis. The formulation of emotions and fantasies in dance improvisations may clarify subconscious material and bring it to the surface of consciousness. Careful study of dance movement can become a valuable diagnostic instrument particularly for children who constantly accompany their dance activity with verbalizations expressing their fantasies.¹

Basic to successful psychotherapy with children is the establishment of greater harmony between the inner or phantasy life of the child and the external reality which he must face and with which he must deal in a socially approved and constructive manner. Those of us who work with emotionally disturbed children know that it is far easier to observe the manifestations of a disturbed personality than it is to understand "why" a child needs to act in the way he does.

The inability or often the unwillingness of the child to tell us what he thinks or feels, dreams or fears, shuts us out of his private world. He may have learned from bitter experience that people cannot be trusted; that it is safer and wiser to keep his private business to himself. Moreover his language skill may not have developed adequately. Indeed, much of the material the psychiatrist and therapist would like to know in order to help him weld his inner life to reality, may be locked within his unconscious. How can we find out what happened to him? How has he been treated by the world and especially by his family? What kind of picture did he get from father and mother as to the role and meaning of being "man or woman"? What were the dynamics of the relationship between brothers and sisters? What were the causes, beginnings, and meanings of his fears and anxieties? How does he compensate? How are these patterns carried over to today? If these and many more questions can be answered, therapy can be centered on a solid basis. We can understand him better as a human being and our understanding gives us more insight for some of the things he does. We must understand his "life style" in terms of his highly individual awareness; his manner of selection and choice; his way of dealing with situations, objects and people, including himself; for we know that this picture of himself and of the world will be largely determined by how he has been treated by his family and other adults.

How can we use music as a projective method to bridge the discrepancy between his inner world (phantasy life) and the external reality? How can we get him to express spontaneously some of the key situations of both present and past? Music,
because of its powers to contact, establish rapport, socialize, stimulate imagery and association, serve as nonverbal communication, can function as a catalyst with other art forms, and thereby, music can provide us with a medium so broad that the child can tell us many things which lie deeply within him. Indeed, this combination of music and other art forms is so nonthreatening that the child is usually unaware of what he is revealing of his inner life. Since his communication, basically, has been on a nonverbal level, he need not feel that he has betrayed himself or that he has been disloyal to those close to his life; nor does he need to mobilize his defenses and hostilities against the therapist. This technique of music combined with other art forms has been used in groups, large and small, and also in private work.

I should like to tell you how this approach has been applied at the five separate Chicago Community Child Guidance Centers. The children are referred by teachers, principals, social workers, or ministers. Many parents hear by word-of-mouth of the work done by the Centers and come to be counseled. The professional staff at each center consists of a psychiatrist or psychologist, a psychiatric social worker, and a playroom director (the music therapist). This staff works closely as a team. The social worker interviews each family and schedules them for counseling. She keeps records and arranges for two families to be counseled at each session. Each session consists of from two to ten families. All the children are placed in the play room, supervised and observed by the playroom director. At the same time the parents meet with and are counseled by the psychiatrist. After a brief interview with the children (apart from the parents), the psychiatrist and the parents hear a report from the playroom director.

The function of the playroom director is:
1. Observation: full reports must be made on each child (whose family is counseled) as to the way he deals with objects, situations, and people.
2. Re-education: we try to put into effect or activate recommendations made by the psychiatrist.

Our groups in the playroom range in size from six to thirty. The age span is from two to thirteen years of age. The group dynamics are ever changing with the age differential, the turnover, and with the large variety of cases handled. Furthermore there is a great contrast between a center located in a North Shore suburb and one located in a negro settlement house.

In the playroom we are interested in seeing what the child does
without being directed. There are all kinds of games, books, crafts, balls, music equipment, etc. The structuring of our playroom grew out of what appeared to be a “felt need” of the children. The room is divided into two areas. The large area is used for active games, dancing, roughhousing, and general social activities. The second area, which the children call the “music corner,” is small and as far away and apart from the first area as is possible. Here are table, chairs, phonograph, rhythm instruments, and all kinds of art materials. The children come in and out, and use this area as a kind of refuge or haven. As the phonograph music tends to blot out the tremendous activity of the social area, they appear to find some relief and security in this corner. The activities in this “music corner” include:

1. Doll Play—The dolls are soft, pliable, and they include papa, mama, and children dolls of all sizes. We are interested in what dolls the child selects to tell and act out his story. In the majority of cases the choice of dolls are a medium sized father, an enormous mother, an extremely small baby doll in diapers, and a child doll who towers in stature over all the other dolls. Since the child is both dramatist and producer, he controls everything the figures say and do. Usually in doll play, as also in drawing and clay work, the child accompanies his drama with a running narrative which expresses his conflicts and anxieties.

2. Drawing and Clay Work—We play a piece of music and ask the child to draw or model the story it tells. As in doll play, the child’s remarks during his creation are as pertinent and revealing as the product itself. The pictures and models give us valuable insight into how he looks upon his life at home, at school, etc.

3. Musical Story—Sitting at the table we may listen to a musical story as a group; children’s classics and folk music serve us well in this. The children’s reactions to the story, how they retell it, and perhaps dramatize it are other clues.

4. Music: Descriptive or Absolute—The therapist asks the children to listen for any story they might hear in the music and later to re-tell it.

5. Pictures—With music as a background the therapist holds up reproductions of pictures and asks for the story. The children listen to the music and look at the pictures at the same time. Often they appear to be in a reverie. Some favorite artists are: Rousseau, Monet, Manet, Van Gogh,
Gauguin, early Cezanne, Breugel, Renoir, Goya, and El Greco.

6. Dancing—Mrs. Dickinson discussed this medium.

7. Rhythm Instruments—The big rhythm band is used in the large social area. In the music corner we use bongo drums, castanets, maracas and tamborines; we also sing. There we improvise, make musical portraits, and describe moods.

8. Group discussion—After all of these activities mentioned, we usually have some group expression and discussion. Almost always the children linger at the table and seem reluctant to find the session at an end.

We have tried these projects many times with and without music. While we have no definite proof, it appears that when music is used the child’s communication pertains more closely to his inner life. When there was no music motivation, the child’s expression seemed more concerned with the outside, everyday, practical world.

The value of this music motivated program can be:

1. The child is given an opportunity to express some of his deepest feeling and conflicts within a form which is admired by others from whom he wants approval. He can find release and relief from his accumulated emotional tensions in this process.

2. Socializing factors are present in these activities. As he takes part, he observes other children doing the same and he may even admire or disapprove some of their contributions.

3. His expressions serve as a means of gaining closer insight into his unconscious life, for the material he gives us may contain some of the key answers to his emotional, social, and intellectual problems; thereby giving the psychiatrist and therapist the possibility of structuring his re-education and resocialization program more effectively.
REACHING THE BRAIN DAMAGED CHILD THROUGH MUSIC

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Brain damaged children can be reached thru music, but specific uses of music must be determined individually for each child. With these facts in mind, a program has been worked out at Home Study School whereby the social and emotional significance of music can be utilized in small groups, at the same time serving the individual child. Listening together gives a feeling of belonging, and encourages body activities without requiring any verbal participation. In this way music is basic in reaching our objective, which is to help any physically or mentally handicapped child to become a happily adjusted, socially acceptable personality to the maximum of his individual potentials.

Music implies order, and order is one thing lacking in the thinking of the brain damaged child. It is the one thing he needs the most, but the thing that he fights the hardest. In listening to and working through music, he is accepting order without resistance—the only way he will accept it. Even though help is aimed toward the individual child through music, he is being linked with the others, and thus, individual distinction is eliminated. He is made to feel a sense of belonging to and of being accepted by his classmates. Because there is no feeling of hostility on the part of the child or the group when they are working together, each one is able to do, and be recognized for what he does, thus establishing a feeling of satisfaction in social acceptance.

It is recognized that there are individual needs to be met, and even though several children are exposed to the same program, there will be an individual feeling of satisfaction. Each will take from the music that which meets his particular need, but all will have one problem in common, the lack of harmony within themselves. Until they can be in harmony with themselves, they cannot be in harmony with their associates. In working with small groups it is possible to study the individual problem of each child and give it special attention, thus helping to develop harmony.

In the following case study some of the approaches used and
some of the methods employed in helping a child to overcome his major problems will be described.

The first case concerns an eight year old boy referred to me by a community agency. He came from a middle class family of average mentality. The parents were of mixed nationality, and both were very reluctant to accept the child’s deficiency. There were no other children in the family, and the father wished to keep the child solely under the supervision of his parental relatives. At times the paternal grandfather was the child’s only companion, since both parents worked. The boy had showed articulatory inability at an early age, but this was discounted with the excuse that he was late in learning to talk. Because of this very apparent handicap, the neighborhood children would ridicule him whenever he was allowed to be among them, causing great anger on the part of both child and parents. When it was time for him to enter school, physical and mental tests revealed his inability to cooperate with anyone and refusal to respond to any of the performance tests. Therefore, he was declared to be a mentally retarded child and refused entrance to the public schools. The cause given for his behavior was traumatic dementia. He was recommended to Home Study School and enrolled as a pupil in the fall, and thus our study of the child began.

Although nothing had been said about auditory disorders, we were conscious of difficulty in that area. Feeling as we do, that regardless of the obstacle to be hurdled, a complete study of the child’s personality must be the first step, we began by exposing him to as many musical selections as possible in order to find his musical preference, and in this way it was possible to uncover his real problems. The word “uncover” is used because many times it has been found that “acquired” inhibitions do cover up the real child and are used as a defense by retarded children. Work was carried on slowly and assuredly until the fact had been firmly established that his first major problem was deafness, not in all ranges but in the middle tones. The higher vibrations brought a bright look and a desire to express himself boldly.

His second problem was hyperactivity, which was brought on by cultural deprivation and an inward stress. Having found the music he enjoyed, he was restrained and required to sit still and listen for short intervals. Then he was given a chance to perform to the music. During these periods of restraint he was made to feel that we were helping him. He was allowed to slip out of
the "loops" himself, perform his activity, return when finished, and slip the "aids" back on his ankles and around his waist. He soon recognized a pleasure in being "aided" in sitting still and learning to listen and watch. It was not long before the aids could be taken away, as he learned that self-control was rewarded by self-expression. He enjoyed his music participation period, and we found that we had a happy, cooperative, and creative personality in what was once a rebellious, unhappy child. He gained self-confidence and encouragement in discovering that he could perform with his group and be socially accepted by them. The tasks to be performed were aimed to reach well within his ability to understand and interpret; thus, he always had the satisfaction of achievement and never a sense of failure. This type of encouragement was a crutch for him.

The progress in music had established a pattern of success, but it was not carrying through, as yet, into other areas of development. One very difficult adjustment was his playground behavior. He gave way to violent outbursts of temper when barred from having his own way, or upon being asked to share with others. Complete isolation was the only way that harmony could be restored to his rebellion. When possible, this isolation area was in the music room where he had experienced pleasure and success. It was a long, slow climb, but steady progress was achieved. At the end of three years he was admitted to the deaf classes in public school where he displayed a fourth grade performance ability. His emotional problem flared up occasionally, but he was able to be kept with his class.

The second case is that of a six year old boy whose developmental history was reported to be moderately slow. There was history of petit mal, motor awkwardness, perseveration, and a hesitancy in any audible speech. Hearing was normal. He is best described as extremely hyperactive, anxious and distractable, with many frustrations including negativeness, aggressiveness, and stubbornness. Temper tantrums were frequent, and he was an upsetting influence in the group.

We were not concerned in this case with the music appreciation or with the responses that the mood of the music he heard would create. We were concerned with functional music in which the elements of music such as rhythm, melody, and harmony could be used independently. We worked to strengthen voluntary inhibition of motor acts and to offer the child a series of successful experiences. The problem of his erratic and driven
behavior was paramount, and so discipline found in music was most beneficial in his training. He realized encouragement, and through melodies that were simple, he acquired a planned behavior response. The demands made of him were simple; he was told to use the tone block in beating out "Hickory, Dickory, Dock . . . Tick Tock", while other individuals in his group took the following phrases until the end when he again beat out the last phrase. He learned to stop at the appropriate time and achieved a complete success.

Gradually the patterns of movement became more complex, and he learned to shift his body movements. By now he was expressing purposeful activity, rather than disorganization as in the beginning. He had joined a music group of four or five children, each of whom required a similar structure and active program. Surprisingly he began functioning on a higher level of social responsibility than at any previous time. From the first desperate attempts at maintaining contact long enough to form a circle by joining hands, he progressed to facing a partner for a simple dance. This circle idea was carried to the blackboard, where he was able to draw complete circles to music with chalk; this would have been absolutely impossible when he started school. Simple songs were learned, and he would follow the song through, pronouncing each word correctly, but refusing to speak in his class work.

Language growth was developing although he was unable to articulate a word correctly. He made simple gestures, did more complicated pantomimes, and a great deal of plain grunting. All the time, he was gaining confidence and learning to look and listen. Most of the training was directed toward getting him to concentrate on one item at a time; to think of one activity at a time; to listen to one sound at a time.

Steadily, an improvement in articulating became evident, not because he was concentrating on the articulation of a single word, but because his thinking, listening, and speaking habits were improving. He became more and more aware of the sound of words and the grouping of words into phrases. Thus began the first organized attempt to teach him to read.

Many of his academic experiences had been unproductive because of his behavior problems. By constant encouragement and by using attainable levels as his goals, his self-discipline was developed. His many successful experiences in areas which had formerly been extremely frustrating provided him with
hope and better relaxation. Even in his number response he was first made to feel the rhythmical beat of three or four, and to follow through by counting to rhythmic marks made on the board to music. Thus this coordinated program of music, occupational therapy, speech, and reading enabled him to grasp and apply his basic concepts. As growth developed in this boy's performance ability, his social pattern improved. His home life took on a more amiable attitude, and when he was transferred from Home Study School to a school in another city, it was felt that he had formed many constructive habits both in work and play that were sufficiently deep-seated to carry him through his new adjustment. We were not disappointed.

In conclusion, it can be said that it is our belief that music is directly applicable to all phases of learning, and such effects of music are especially important when they do not end with the music class, but are carried over to the children's attitudes in the classroom and toward their companions. It is a worthwhile goal toward which to work. And it proves that a child must first achieve harmony with himself before he can be in harmony with his associates.
MUSIC AS A THERAPEUTIC EXPERIENCE
FOR THE EMOTIONALLY DISTURBED CHILD

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In what way can music provide a rewarding emotional therapeutic experience for a disturbed child? This is a question every music therapist working with children must ask from time to time. Making effective use of music as nonthreatening, nonverbal communication, and establishing a relationship using "self" as a therapeutic tool are principles the music therapist utilizes. There is another: structuring music sessions to provide a means of conditioning affective responses.

The literature cites many examples of the use of music as therapy for exceptional children. Techniques have been described, and demonstrations have been given to add to understanding of the therapeutic effect of various approaches in different kinds of music sessions as part of the rehabilitation program.

In an attempt to provide therapeutic music experiences for the emotionally disturbed child, the writer has previously experimented with the use of music as a projective technique. Stories told to music frequently revealed faulty attitudes, and social and emotional patterns of response that indicated developmental defects. For example, Johnny told the following story: "Bill had a bad, bad fight at school with Eddie because Eddie broke Bill's kite, and Bill blacked Eddie's eyes cause that's what you do if somebody breaks your things." This story was typical of Bill's behavior, and strongly indicated a weak area in his adjustive learning, since the only way Bill could cope with difficulties was by fighting.

It has been found, also, that in spontaneous music therapy sessions, or in structured music lessons, early signs of personality defects, or maladjustments and faulty perceptions may be observed. Sometimes these can be resolved or redirected before their repetition causes them to be firmly fixed.

Observation of a child can provide valuable information if the teacher knows what she sees. The behavior and the actions of the child provide opportunities for insight into his motivations. To understand a child properly, one must
realize that his every act is purposive, and expresses his attitudes, his goals, and his expectations.1

A child reveals himself in many ways during a music lesson. If it is a group session, he reveals his social adaptability. How he responds to music, how he accepts criticism and praise, how the older child observes the rules of music such as phrasing, fingering, marks of interpretation, etc., are meaningful. They are indicative of the following: his perception of self and the teacher as a figure of authority and as a person; the degree of his resistance or acceptance to rules and order; his tolerance to stress; his capacity for perseverance until a task is completed; his pattern of emotional responses.

Emotions are responses to environmental influences and at the same time signs of what goes on in the responding person. The meaning and understanding of any sort of emotional behavior is determined fundamentally by the setting in which it occurs, the manner in which a person is involved or feels that he is involved, his previous experiences with similar situations, his previous reactions to similar situations, phylogenetically determined avenues of response, social conventions, and individual peculiarities.2

Children's emotional reactions can manifest themselves to the observer 1) through the type of overt behavior; 2) through visceral participation; 3) experimentally, through the method of play investigation.3

Emotional reactions in music sessions, or stimulus-situations, are complex and often difficult to interpret. Music in some form is a natural means of expression, an emotional outlet for a child, and is associated with many of his experiences. Interpretations of behavior and verbal expressions noted in music sessions have indicated that if music and a strong emotional feeling were present, simultaneously, later repetitions of the music often seemed to recall the original affective state but with lessened intensity of feeling-tone. Interpretations are worthwhile only if every aspect of the child's emotional, social, mental and physical development are considered.

The following music sessions were planned to attempt to condition emotional responses to music just as rhythmic responses to music are learned.

For example: as in most music classes for young children, the

3. Ibid.
pupils had learned that the Dominant 7th chord meant to sit up straight and the Tonic triad meant to stand in front of their chairs. Certain short compositions meant to form a circle, swing their arms, clap or return to their chairs. They did not need to be told to march, run, hop, or skip. They had become conditioned to do these activities when certain pieces were played. The group could give an entire assembly program without any verbal instructions, yet not know in advance what order of procedure the activities would follow.

One day two children started fighting with the boy who had been the aggressor, and who had been doing most of the striking. The therapist decided to try to create an association between fighting and music played during the fight. She immediately played a short original composition they had never heard before and repeated it twice even though the disturbance continued. Again, without any verbal comment, the teacher started playing the piece which meant to form a circle, and the entire group, including the two boys, joined in. On several occasions the teacher repeated the music played during the fight, and it invariably caused restlessness, loud talking, or caused one child to hit another. It seemed to be associated with the experience when it was first heard. The same music played for another group did not produce the response observed in the first group. The piece was in E Flat Major, in sextuple rhythm with a melody and arpeggio accompaniment, played mezzo-forte in moderate tempo.

In a private session with an older child the therapist played an original piece called "Fear," then the two discussed fears. "Fear" was alternated with similar music in four successive sessions. This child talked more about things he was afraid of after this same piece, "Fear," was played than he did after the other music was played.

Following the same procedure, in a private session with a twelve year old girl, the therapist played an original piece called "Anger," then the two discussed anger. The child mentioned many more things that made her angry, and discussed her feeling of anger in later sessions when "Anger" was repeated, than she did when other music was played.

Inadequate personality arises from the establishment of unfortunate habits of adjustment. Conspicuous among defective habits of personality and deserving of a systematic description are those which may be termed developmental defects. These are either habits that were inadequate at some
stage in the childhood of the individual, but which should have been outgrown and discarded, or else habits that normally might have been expected to appear in the course of the individual's growth and training, but which have not been acquired.¹

Most important among developmental defects are those which relate to the emotional development of the individual. Perhaps even more serious than the developmental defects relating to emotion are those which concern the integration of the individual. It has long been noted that maladjusted persons are uneven in their behavior, that they do not co-ordinate their motives and their habits effectively. They are erratic, unreliable, defective in their perception of situations and in their discriminations between courses of action. These traits, which may be termed faults of integration, are learned behavior.²

The following example illustrates how a lack of integration or faulty patterns of behavior were observable in piano lessons. Ten year old Alice, diagnosed by a psychiatrist as emotionally disturbed, was persistently willful in her refusal to finger correctly; consequently her performance was poor. Neither Alice nor her teacher derived any real satisfaction from her playing, with resultant feelings of frustration for both.

In trying to analyse her behavior, it was felt that she was trying to demonstrate her power in addition to trying to punish or retaliate. "All disturbing behavior of the child is directed toward one of four possible goals. They represent his ideas about his relationship to others in the group. He tries to: (1) gain attention; (2) demonstrate his power; (3) punish or get even; (4) demonstrate his inadequacy."³

The resistance of Alice to following rules and to submitting to order seemed to be indicative of her rejection of authority figures, and her inner rebellion at having to conform. Faulty fingering, which was never consistently erroneous, but a spur of the moment choice of fingering, was not the basic problem to attack in attempting to teach her to play the piano. Rather, it was a problem of understanding her individual determinants of perception in the light of her overt behavior, and thus enabling the child to examine her own behavior. Her performance was expressive of ambivalent feelings toward really wanting to play the piano, yet also wanting

². Ibid. pp. 363, 364.
to hurt her mother (to whom Alice's music was of extreme importance) by not playing well or making much advancement.

In music therapy sessions Alice was encouraged to talk about her feeling for music, fingering, and things pertaining to music. Then she was encouraged to talk about her feelings when she was told to do something, and how she interpreted “being bossed,” as she expressed it. The therapist always listened sympathetically, did not cross-question, did not censure or punish, and pointed out the difference between making mistakes and being a failure. Alice slowly learned to sublimate her authority conflicts and to put hostility and resentment into words and music instead of acts. She learned to accept her inadequacies and face failure without being too threatened and gained some insight about her feelings and behavior. Freed from some of her intense inner conflict, she was able to accept authority and criticism on a different basis. She had difficulty in overcoming bad habits of fingering but was able to work cooperatively with the teacher, and eventually learned to play rather well.

As Frenkel-Brunswik says: “Obviously it is the combination of social and behavioral with motivational realities which determines the perception of self and of others.”

According to Lois Barclay Murphy: “If we are to understand children at these deeper levels, we need methods which will take us directly to the feelings of the young child with as little artificiality or indirection as possible.”

Every method, every procedure and technique that can enable a child to express his feelings of self, environment and the people in it, is worthy of consideration. Music is very much a part of every child’s life, and its important role in the developmental process should not be overlooked.

In the early years of childhood the concept of self—the “ego-ideal”—is formed. Personality and behavior are developed and molded by the experiences and the manner in which the child perceives these experiences. Music is included in many of these experiences.

It is felt that what Gesell claims about laughter is equally true about music: “Children would not indulge in so much spontaneous

and (apparently to us) meaningless laughter if it did not have a wholesome effect upon their behavior and mental growth."\(^1\)

Are the evolutionary roots of making music to be found in the innate needs of the infant, inherent in the process of growth, and later significant in the dynamics of his development and maturation? Also one might well ask—does a child sing, hum, chant, or dance in an unconscious effort to find a stabilizing means of reducing tension in order to gain equilibrium? Klein says:

"The concept of "equilibrium" is useful only if we wholeheartedly recognize that the kind of balance and the means for reaching it are different for different people. Perhaps it would be better to substitute the word "solution" for "equilibrium" meaning the more or less "steady state" which an individual reaches in the face of a task, a problem, or a stimulus as he resolves it in his own way. What determines the form of the steady state as much as anything are the favored and stabilized means of tension-reduction which people settle upon.\(^2\)"

In observing a child's behavior and attempting to understand his emotional reactions, his attitudes, and his approach to learning in a piano lesson or music session, it is very plain to see that each child approaches the music period in the light of his own individuality and must be taught with respect for that individuality. If the therapist can gain some insight into the child's motivations and can understand how he perceives and interprets the music period, then goals can be set that will be beneficial to the child's emotional well-being, will influence his perceptions, and contribute to his mental health. Experiences in the music period can be provided that will be associated with a healthy affective response. Perhaps these, in turn, can influence his later reactions to similar situations and probably influence subconsciously his response to music. Thus, music may later reactivate the original affective response. Does this give a clue as to why music can frequently cause a change of mood?

When music sessions can be structured to provide a means of conditioning or redirecting affective responses, and when music can be used as a means of recalling the original affective state, it serves as an abreaction and provides a real therapeutic experience for the emotionally disturbed child.

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RESPONSE OF A BOY TO MUSIC THERAPY
IN A HOSPITAL AND TRAINING CENTER

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The responses to music therapy are as many and as varied as there are children and situations from which these responses may arise. For the purpose of this report, one case of a severely retarded, emotionally disturbed boy will be discussed.

The State Hospital and Training Center at Parsons has for its objective: "to examine, treat, educate, train and rehabilitate the persons admitted and retained so as to make such persons more comfortable, happy, and better fitted to care for and support themselves." One of the aims of the music therapy department is to aid in the most effective way possible, the psychiatric treatment and rehabilitation of each child. This is achieved through many processes which fuse in as consistent a treatment program as is possible for each child.

One of the present areas of concentration at Parsons is with those children whose abilities are questionable, whose assets are minimal, and for whom little has been found to have been accomplished in the past years. These children are on the borderline between those who are considered completely custodial and those who are able to function and benefit from some type of treatment and training program. These children need individual attention and, because of their limited assets, more detailed evaluation of their history and background. (A detailed inventory of their assets is now in the making, from which may be derived strong points to aid in the treatment of the children.) Because the assets of these children are so limited, every small detail, every difference from the normal is considered important. For with these children, the problem will be that of developing any particular talent or skill that an individual might have. This approach has been reported as successful in European countries and is an object of much study at Parsons.

Let us review for a few moments the case of Raymond T., a severely retarded and emotionally unstable boy aged 20, who periodically shows the following symptoms of psychosislike behavior. Upon entering his cottage a year ago, one usually found him rather sloppily dressed, his collection of gadgets

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fastened to his clothes with pins, and with whatever else of his possessions that he could fit into his pockets or tie around him. He sat in a corner by himself either smoking his corncob pipe or playing his harmonica. He loved to play the harmonica and entertained himself for hours at a time in this way. He would smoke or play the harmonica almost continuously and would become angry if this activity were interfered with in any way. He had continued to be one of the biggest problems on the ward because he could not stand anyone crossing him for any reason. If the other students bothered him while he was smoking or playing, he became angry and threw a tantrum; this included picking up the nearest objects (including chairs) and throwing them. Sometimes when he was disturbed, he would grab his shirt or some other article of clothing and put it in his mouth trying to chew and swallow it. He soiled himself continuously, ate with his hands, and threw food. He would not talk with the students and took no interest in activities except those noted above. The cottage aides had trouble whenever they tried to get him into other activities.

Raymond has been able to follow directions fairly well, but his rate of learning was considered poor and he needed much more training to do any job adequately. He had been tried in the school program but was unable to function at all. As nearly as can be determined, the latest test results indicate his IQ to be 37, with a mental age of 4 to 5 years.

In summary, Raymond is a severely mentally retarded and emotionally unstable boy. He is an orally fixated individual whose oral dependency needs probably have never been adequately met. The demanding nature of his behavior, as shown by temper tantrums when his wants are not immediately supplied, is evidence of primitive functioning. His eating with his hands and putting articles in his mouth are similar to activities of a young baby. His oral needs are sublimated to a small degree by his preoccupation with playing harmonica, singing, and smoking. His periodic soiling of himself may be thought of as infantile acts of aggression.

The treatment goals for this boy have been limited. It was considered that much would be achieved for Raymond if he could be brought to the stage of improved eating habits, not soil ing himself, and of not resorting to temper tantrums when his wants were not immediately satisfied. Because of his musical interest he was referred to music therapy with the objective of
encouraging his interest in music, and to get him to use it to sublimate his strong oral needs and aggressive behavior.

Raymond was scheduled for two half-hour periods a week as a temporary arrangement a year ago. This plan proved so successful that it is being continued, but with three sessions a week.

At first Raymond needed an attendant and seemed very much unaware of what was going on, or why he should be "made to do these things," as he called the activities which were the same as those with which he occupied himself on the cottage for so much of the time. He would come to the music room fully equipped, with all his gadgets pinned and tied on, then pick up any additional portable items he saw fit to add to his collection. He usually arrived in a very belligerent mood and spoke very gruffly to the therapist about his unhappy state. After his initial outburst which served for many weeks as his regular greeting of the day, he would speak no more during the session but would move gradually in the direction of the piano. There he would sit and play a conglomeration of tones on his harmonica, just running up and down the full range, or he would play single notes in as explosive a manner as possible. Once he started this, it was next to impossible to move him until he was ready.

In these beginning sessions it took from fifteen minutes to half an hour after the therapist had terminated the session to get him to stop what he was doing and return to the cottage. Gradually he would leave after less and less persuasion, but only if assured of being able to continue the same activity at a later time. At the end of a year's time he has come to the place where he will come and go on schedule without becoming disturbed.

During the first months he played his harmonica to the accompaniment of the therapist at piano. One day he decided that he wanted to play the piano and, without saying a word, just sat down and stared at it until the therapist asked if he would like to try to play. Then, very timidly and babylike, he touched his hands to the keys, but drew them away quickly as if not sure he should be doing this. This act, along with constant encouragement and reassurance from the therapist, continued for several sessions with Raymond, in an unstructured way, digging into the keys more each time. Then Raymond began to converse with the therapist, just answering questions at first, then gradually relating some of his likes and dislikes in very explosive and detached speech. He was asked to express these ideas at the piano and it
was then that Raymond began to show himself. He began talking about how he wished he could play “like you and like my mother.”

Though he knew the difference between the therapist and his mother, he associated events to both, such as their piano ability, making statements such as “you’re pretty like my mother,” “my mother knows this piece, will you play it,” etc. Rather than the therapist playing, she asked Raymond to show how his mother played, which he did rather effectively. He played in the key of C in a hit and miss manner, the melody of his favorite song, “Red Wing,” using a C chord, left-hand accompaniment throughout. This, like his speech, was performed in percussive manner. After he finished this many times repeated song, he said, “See, this is the way my mother plays—wish’d I could play like her. Will you teach me to play like Mom?” We finally had a goal that was within his scope of intelligence and understanding, even though the results were thought to be questionable.

Since then Raymond has worked very hard to “learn to play good”. With help he discovered many other songs which he liked “almost” as much as “Red Wing”. Mostly these were folk songs and hymns. He was able to find the correct melody notes after hearing them two or three times, then hunting for them till the sound was what he thought it should be. This hit and miss, trial and error method has worked effectively for Raymond. He has a good ear and fairly accurate tonal and rhythmic memory. Because he attacked the piano so aggressively, he missed more than he might have, had he been more calm and relaxed. However, with time this problem has been easing itself and he is becoming more accurate on the first attempts in proportion to his manner of approach. On days when he has been especially disturbed he has played a song with the same notes wrong each time. On days when he was less disturbed he played the same piece correctly.

After this method of finding melodies was well established and the reciprocal and complimentary roles of the therapist were no longer threatening to him, Raymond’s high and low peaks gradually became less extreme and he went through entire sessions in a calm manner. Then an attempt was made to try to improve his harmonic accompaniments. With everything still in the key of C, pieces were chosen that required only two chords. The G chord was now played for him until he heard it clearly enough to try to find it for himself. Then he used both the C and G chords but in
no proper harmonic sequence. He would bang out the root positions of the two chords alternately in time to the melody rather than according to any harmonic influence from the melody. This became very dissatisfying to him and after three or four sessions of this he began exploring the piano for new chords. This developed into a very discordant time of trying to play root position chords for each note in a melody, which was all right with him as long as the melody went slowly enough for him to find corresponding chords. But when he tried to keep the rhythm moving also, he was lost and knew it, and finally asked for help. This was a big step for Raymond, recognizing his position and the fact that if he looked for help he would find his chords more easily. So, with the help of the therapist, the C and G chords attained new recognition, and gradually Raymond played them in their proper places. Now he was beginning to smile and actually spoke in a calm, quiet manner, with explosive speech appearing less and less.

During the summer months his sessions were discontinued and he again became a problem on the cottage until he returned to music in the fall. He lost no time picking up where he had left off and has progressed slowly but surely ever since. At present this boy is capable of picking out and chording with I, IV and V chords, any melody that is familiar to him. He still plays every piece in the key of C but when picking out new melodies he plays with very few errors. He has discovered that most of his melodies begin on the first, third or fifth key note and he usually finds the right note without stumbling.

This boy takes from the therapist only what he wants. When the therapist interrupts him to make a suggestion he will follow if he so chooses or, rather than exhibit the previous tantrum behavior, completely ignore the suggestion made. This is significant for two reasons: (1) that this behavior is closer to being acceptable, and (2) that Raymond is able to discriminate and choose more constructive events that are pleasing to him. Progress is made here by the fact that these things that are becoming more pleasing to Raymond are more in keeping with what is desirable in his environment. He is becoming able to control his outbursts and substitute more acceptable behavior to express the same aggressive feelings. He is also becoming able to accept or reject suggestions in a manner that is less aggressive and more calm. For instance, several times the therapist has attempted to show Raymond how to play a broken chord rather than a block
chord. As yet he has not even seemed interested in trying such a thing, and has acted as if the suggestion were not made at all. But when the therapist introduced the IV chord, using it in one of his favorite pieces, the boy, liking the sound of the chord, picked it up and played the same piece using the chord correctly after only a few attempts. From then on he has incorporated this chord in all of the pieces he has played, using all three chords correctly. He is now trying to play “Silent Night” using chords in the right hand as well as the left. He has some difficulty but eventually he will play the entire piece using chords in both hands.

Whenever Raymond tries to play a new melody, it is interesting to note that he attempts to play the correct tempo. As many people do in a learning situation, he does not slow down the tempo, but attempts to get what he can in the allotted time, and keeps repeating the piece in this fashion until he has it in his possession. Because he is concentrating more on the music than at first, he has less hit and miss incidents and more calm and relaxed performances. Also, his speech is quiet and more controlled. His main interest now is with the piano but he continues to play the harmonica at times. The pieces he plays include popular, folk and sacred tunes. Occasionally, when trying to work out a new tune he will ask the therapist for help. He is able to tell when he has not played a part correctly and immediately seeks to correct it. This kind of performance is much different from that of the boy who came to music therapy a year ago, and is an example of what can be accomplished with a person whose liabilities are many and whose assets are minimal.

Because Raymond is a long term problem, and the treatment goals are continuing long term goals, this is not a final but rather a progress report of his development over the past year. Raymond is happy with his music; he is more willing to talk to anybody about his music; he is becoming able to use music more effectively as a substitute or sublimating device. He still smokes and stays by himself a good deal of the time, but now becomes less disturbed with the others around him. He has gained recognition on the cottage and among the other students for his musical ability. His music is now listened to with appreciation and enjoyment by those around him. His repertoire is large enough that he can play for an hour at a time, and very pleasingly. If he progresses at this rate for about two more years, he will have resolved his emotional problems sufficiently to be a happy and
well enough integrated person who may some day function in a boarding home or nursing home situation.

Realistically, music is not in itself a magic power causing these results, but with the interpersonal relationships that go to make up a therapy situation it has great strength. In this case music therapy has not worked any final miracles but has aided in the stabilizing of a very disturbed individual. There are cases where a music therapy situation is most disturbing to a child, usually because of some associative elements, but for the most part music therapy works well and helps most cases at Parsons.
PART IV

MUSIC THERAPY
MUSIC EDUCATION
SPECIAL EDUCATION
GOALS OF MUSIC EDUCATION

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The music educator has added in a remarkable proportion to the total education of the student if he has helped the student to attain attitudes, knowledge and special skills so that the student may be accepted as a worthy member of society and can contribute in some way to his community. But to secure this, a number of approaches must be used. The social sciences and the allied musical subjects such as theory, musicology, music appreciation, music therapy, applied-performance, and music education are co-ordinated into the general philosophy and teaching technique of the music educator. This is also evident in music therapy. The music therapist is involved with additional specialized work which may be added to the above mentioned subjects. It is apparent that the work of the educator and therapist in music is closely related. Therefore, many of the goals in music education would apply to the goals in music therapy. However, the music educator is involved with the teaching of music to the mass. The bulk of emphasis is aimed toward a norm that each child should reach. But he is also conscious of students who deviate from this norm; for instance, the musically talented and the mentally retarded child. The norm will be primarily considered in this presentation. It is desirable to relate some of these goals of the music educator and the pertinent elements that are taken from the various musical subjects and social sciences that assist his teaching philosophy and technique.

The music educator attempts:

1. To promote the growth of confidence and poise which is attained in a musical classroom or group. The activity of performing individually or in a group subjects a student to the experience of expressing himself before and with others. Public presentations aid in breaking down timidness and inferior and inexpressive complexes.

2. To co-ordinate the mind and body so that the student may be able to attain emotional release and expression through musical playing and singing. This is an essential need because without good co-ordination little or no satisfying performing experience and expression can be fulfilled.
3. To encourage and teach compatibility within a group. The opportunity of working together in harmony toward a common goal which may be a public performance or another type of musical project is an important growth process. The attitude of co-operation, and of realizing and adjusting to the knowledge and skills of others in group work is a great step toward the total educative social process.

4. To teach and develop self-discipline—the discipline of listening, understanding and obeying instructions properly; the discipline of manifestation of patience and evaluation of one’s work and the work of a group; the discipline of developing flexibility of thoughts. This enables the student to strengthen his mental control and assists him in meeting problems and situations successfully, individually, and in group work. He carries this learning experience from his classroom to events outside of school.

5. To attain the goal of personal accomplishment in each student—of self-realization by playing or singing in a pleasing way. Successful performance contributes a great deal to the confidence and spiritual achievement of the individual.

These are some of the objectives from musical situations in the total education of the student and all are directed toward the development of human values. The greater the achievement in human values and the realization of human needs, the greater is the success in teaching.

However, there are conflicts in the basic philosophy of some music educators as there are conflicts in the philosophy in other areas of education. Many music educators have the conception that their ultimate goal should be performing ensembles and organizations. This is an admirable quality and should always be an essential goal. However, we should check constantly to see whether we are teaching and guiding the student in the proper educative manner as well as encouraging artistic performances. Music is the medium through which music educators help in the total education of the student. The education of the student should be paramount. I say “should be” instead of “is” because this is still an issue that is sometimes lost in the philosophy of some music educators. But new teaching methods as presented in recent text books, and new and varied types of materials with this consciousness of child development have permeated the present day teaching approaches to a surprisingly great extent.
Besides possessing a good philosophy, a teacher must possess techniques of teaching to attain these goals. We all know that one may learn and not be educated. Muscular and mental habits acquired by drill need not contribute toward meaningful and useful experiences which in turn enrich the attitudes, knowledge and skills of the student. A mechanical process of acquiring knowledge does not necessarily contain a meaningful experience. In this mechanical process, facts are soon forgotten and growth with its adherence of ideas is suppressed. Knowledge is absorbed to a greater extent if it is supported by meaningful experiences of personal awareness, expression and accomplishment. If the learner expresses himself musically, is in a pleasant musical environment, is guided by these good educative goals, his chances of cultivating the desire to be musical and to retain musical understanding and appreciation is high. Good musical experiences help to integrate a child's educative experiences for they contain the growth processes expressed by the social sciences in the way of acquiring knowledge and attitudes. Successful musical performance, with the aid of the elements of the allied musical subjects, tends to promote co-ordination, discipline, skills, emotional releases and spiritual values. Thus it is seen that music fulfills necessary human experiences vividly and directly.

When the student is properly taught, the learning process is best secured by the development and growth of his values and needs through meaningful and expressive musical experiences that come from within. These are some of the goals and the methods by which the music educator attempts to attain these goals.
Any child's participation in a musical activity, if properly guided, can be for him both a motivating factor and a refining influence in the development of his whole person. At least some one of his countless needs can be met in the innumerable variety of musical activities that are possible for him. Should he be handicapped, mentally or physically, his peculiar needs can still be satisfied through guided musical experience, because the subjectivity of musical experience gives free play to his own individuality in his musical response.

This is the basis on which music educators act when they include musical participation in the school program as a positive influence on the physical, mental, social, moral, and spiritual growth of the child. This is also the basis on which music therapists proceed when they encourage and direct musical participation toward the development of these same powers — more particularly, where a mental or physical handicap has caused the development to deviate from the normal.

Whereas the music educator is normally associated with the typical classroom situation, the music therapist makes his contacts with children at a children's hospital, or at a children's convalescent cottage, or at a special school for handicapped children. The educator or therapist, each within his own sphere of activity, uses music for educational or therapeutic purposes. The present-day trend to give preference to the education of the handicapped, or "exceptional" child in the regular day school rather than in an institutional setting points up the need for relating these two uses of music.

In some schools the particular problems of the handicapped are met in the cooperative type of class in which basic subjects are taken in special groups according to the similarities of the handicaps, and in which the activities that are social in nature, such as music, assembly, and recreation, are taken with the normal children. In some other schools, an integrated program is followed, in which the handicapped children participate in regular classroom activities with the other pupils. Here, the special needs of the handicapped are served by visiting teachers, such
as medical, educational, social, and psychological specialists. In both the cooperative and integrated methods of teaching handicapped children, the musical activities of all the children are conducted in common.

In this setting an attempt has to be made to meet the individual needs of both the normal and the exceptional child within the framework of a single musical situation. Although this is challenging to the teacher, the group aspect of many musical activities does make it possible. An example of this might be the use of an activity to promote the socialization and/or resocialization of a group of children with various deviations from acceptable social behavior.

The activity might be one of the following: group singing, instrumental playing, circle dancing, folk dancing with partners, or duet and trio playing and singing. Since these are group activities on various levels of social interaction, one would be selected to meet the group's average social need. As the children progress to activities requiring a greater degree of cooperation, they acquire better habits of social responsibility. This process of socialization develops naturally in the ordinary child and is regarded as normal educational growth.

The same musical activity might be acceptable to the aggressive child merely because it is nonverbal and nonconspicuous in its demands. This child has a particular need for the order in the music as expressed in the form of the composition, or for the cooperation essential to its proper performance. If he responds, his experience is considered not only educational but also therapeutic because it has helped to lessen the extent of his social maladjustment or social "illness."

Similarly, the retiring, or withdrawn child may be enticed into the same group situation because the pleasure of the musical experience serves as an immediate reward. However, in both instances of social readjustment, continued attempts must be made to determine and to correct the underlying cause of the disturbed relationship to others lest the result be only an apparent resocialization or "pseudo-cure."

It is also possible to meet the needs of both the normal and the exceptional child in the same music session if attention is directed to more than one aspect of musical participation. For example, the value of rote singing by a group of primary-grade children can be enhanced by the addition of appropriate pantomime or rhythmic gestures. If there are cerebral palsied children in the
group, the action song or finger play will be selected for its relation to everyday life situations. The entire group will then be motivated toward coordinated physical activity but, more specifically, the cerebral-palsied child will be stimulated to a practical, coordinated muscular response that is ordinarily unattainable by him.

At another time, a rhythm band instrument might be used to accompany the same song—or any other song, for that matter. Rhythm band instruments are not only fun for children to play, but the simplicity of their performance makes them easily adapted to the physical limitations of the cerebral palsied or of the orthopedically handicapped child. The neutral tone of the percussive instrument enables the exceptional child to use the instrument freely, expressing his own emotional pattern rhythmically without interfering with or distorting the melody of the song. Meanwhile, he is exposed to the motivating influence of the rhythm in the song and to the discipline of its musical form. Of even greater value than these benefits is the sense of belonging which he derives from his identification with the group. And for the group as a whole, his contribution can afford a genuine musical enrichment.

It is impossible to list the specific adaptations of music to individual handicaps because they are as numerous as the handicaps themselves. It is also difficult to designate an exact approach for combining the educational and therapeutic uses of music because of the distinctive character of each group. The extent to which the teacher will be able to utilize music's potentiality for satisfying the diverse needs of a varying group of children will be in direct proportion to her understanding of children and her discernment of their individual needs, her psychological insight, her musical discrimination, and finally, to her own ingenuity.

This poses a problem. The classroom teacher of today is being prepared to conduct the self-contained classroom in which all the subjects are taught by the same teacher. Considering the variety of subjects with which she has to deal, it is not likely that she will possess sufficient musical discrimination and skill to realize fully music's therapeutic value. Perhaps the day is approaching when a cooperative system of conducting the school music program will be devised for schools having this setting. The classroom teacher could then conduct those musical activities that are predominantly social and/or recreational; the music therapist would make specific adaptations of the musical activities to particular handicaps.
In some schools where there are cases of extreme handicaps, a segregative method of teaching the handicapped children might be followed. When this approach is used, the entire educational program of these handicapped children is carried on in a special classroom. Unfortunately, this method places emphasis on the social isolation of the handicapped. But even here, music can provide an appropriate activity for creating group relationships.

Application of specific activities to individual handicaps would be made in a fashion similar to that in the above illustrations. In this kind of group arrangement, care must be taken not to over-emphasize the therapeutic aspects of the activity to the detriment of its educational values. Even within a group of handicapped children there is a common denominator of normalcy that some musical experience should be able to evoke. Successful promotion of such an undertaking would probably depend upon the services of a qualified music therapist, or of a teacher trained in special education with some emphasis upon music.

In this paper, an attempt has been made to emphasize the modern trend to enroll more and more exceptional children in the regular day school. The acceptance of these children by the normal group and the consequent sense of belonging which the handicapped then enjoy, is certainly at least a partial compensation for the problems that might arise from this arrangement. One of these problems could be the challenge offered to the classroom teacher to meet the needs of the exceptional child, along with those of the so-called normal child, in a single, group, musical activity. Two examples were cited to show how this might be accomplished. The conditions stated in these examples are based on a number of years of musical experience in the regular classroom, in special group situations, and in individual, therapeutic contacts.

Since many schools now include the exceptional child in the regular classroom enrollment, and since the success of the music program in this setting depends on the merging of the broad goals of music education and of music therapy, it is imperative that both music educator and music therapist understand the exact relationship which necessarily exists between music education and music therapy.
PART V

DANCE THERAPY
DANCE THERAPY IN THE WARD MUSIC PROGRAM

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Although nothing new will be presented in this paper, since the values of dance therapy have been so ably articulated by Marian Chace, and the research in music therapy has been reported by such men as Gaston and Fultz this paper does propose to do two things: (1) to test such hypotheses as have been stated implicitly or explicitly by Marian Chace; and (2) to discuss the combination of music and dance therapy, as a unified program.

There is a personal preference for this particular approach and, as an after and theoretical thought, the two, dance and music therapy, form a functional unit. Were there sufficient time the unitary values could easily be demonstrated, but anyone conversant with the material covered in the history of the dance and/or music, which at one point both converge into a unitary mode of expression, can readily comprehend the justification for this approach, that is Music-Dance Therapy.

While music-dance therapy was applied to all types of wards at Terrell State Hospital, admission, active treatment, continued treatment, and rehabilitation wards, this paper will deal mainly with one year's experience on a male, continued treatment ward.

This continued treatment ward consisted of about ninety very regressed men of long-term hospitalizations. While some improvements had been made in the general physical appearance of the ward in the six months preceding my entrance to the ward in August, 1956, a concentrated program was initiated in September, 1956. Due to previous experience as a music therapist at Topeka State Hospital in Topeka, Kansas, I was allowed to enter this male ward as the first female employee other than nursing personnel (female nursing personnel also were relatively new on this ward).

Since the registered nurses were being supplemented with nurse technicians, products of a two-year junior college "in-service" course, a concentrated effort was made to activate a more intense ward program throughout the hospital. In the beginning the goals were met primarily by the nursing personnel because these first goals were related to the personal appearance and personal hygiene of each patient, such as bathing, toilet training,
decent clothing, and good grooming. When these goals had been met somewhat, efforts were made by the staff to develop resocialization. First, the patient had to be encouraged and taught to relate to his fellow ward patients and the ward personnel. It was on this level that music-dance therapy was introduced on a semiweekly basis.

As part of the resocialization project, the personnel was urged to develop a democratic handling of ward duties and privileges. To insure this democracy, the patients who had worked full-time on the ward for many years were gradually given “off-ward” industrial assignments. This necessitated the development of new helpers on the ward and made possible some work with the most regressed, withdrawn men formerly lost in “locked rooms”.

When the patients were emotionally and socially ready, i.e., no longer excessively afraid and now wearing clothing, the ward program expanded to include special off-ward activities such as church, parties, and all-hospital programs or dances. This last step was a big one for these long-term patients because it meant relating to persons other than familiar ward personnel and patients. It meant relating to both male and female patients.

While all the rehabilitation therapies, music-dance therapy, recreation therapy, occupational therapy, library, and industrial therapy, were emphasized after the ward personnel had improved the physical condition of the ward and the personal appearance of the patients, it appeared that the patients were more receptive to dance therapy in these initial steps of resocialization.

Dance therapy helped the patient to develop an awareness of himself and gradually he developed an awareness of others about him. No effort was made to conduct other kinds of music activities until the patients had passed through this stage of rediscovering the body and recognizing the separation of body from others about him. When a patient was secure as an entity, and functioning safely with other entities through dance therapy, then he was ready for other forms of music activities such as rhythm bands and group singing. Until he had found satisfaction through nonverbal communication of body movement to music, he was not ready for the socializing experience of a rhythm band, nor the more sophisticated experience of verbally communicating through song.

The dance sessions on this ward were modeled after dance sessions at St. Elizabeths Hospital on very similar wards. The
Dance Therapy

therapist entered the ward carrying a portable phonograph, records, and dance shoes. She was always met by a ward staff member, and as the sessions became more familiar, she received a warm welcome from the patients. By the end of the spring of 1957 she found the patients gathered around the door where she would enter, or pacing in the small dining room where the dance sessions were to be held.

At first the therapist worked unassisted, circulating up and down the very long day-hall, inviting the men to join in the dancing. Since the men were very regressed and withdrawn, the therapist worked with a small group of six or eight men for several sessions. Gradually it became clearer to the patients and nursing staff what a dance session meant. Soon the prejudices of the staff disappeared and they voluntarily joined in the dancing, urging the patients they knew to join in and to stay in the group. (All the nursing staff had received orders to participate in all rehabilitation therapy ward activities, but this therapist did not push this participation since no assistant could be a contributing member of the group unless he was willing and emotionally ready to help.)

As the ward activity program developed and became more familiar to the whole hospital, several patients, both male and female, requested an industrial assignment of assisting the music-dance therapist on this ward. These patient aides were members of the church choir, male or female chorus, and/or one of the small, select instrumental groups.

Following the initial period of making contacts with the patients, inviting them to join in the dancing, and bringing them into the area where the dancing was to occur, a circle formation was used for the entire session. While the patients were very withdrawn and seemingly incapable of assuming leadership within a group, after several months some were encouraged to initiate a movement to the music, and they were able to continue the movement while the rest of the group imitated them.

The size and shape of the circle varied considerably, because the patients were given, and they accepted, the freedom to come and go as they wished. (This policy was welcomed by the patients, but the ward personnel was more reluctant to accept it as beneficial to the group.) As the men felt more secure within the group, they would remain for longer periods of time. As in the groups at St. Elizabeths, several patients would walk through the dance group during the dance session, often breaking through
the circle. Then they would stand around the edges of the group, often doing some of the simpler movements, but never actually entering the circle as a member of it. Finally they would voluntarily join in the circle for a few brief moments at a time. One such patient made his entrance into the group by breaking through the circle, grabbing the therapist and dancing with her in regular dance position but with very primitive dance steps, then leaving the group just as abruptly only to return again to join in the circle formation.

Phonograph records were used rather than live piano music or other percussion music, thus making the music a consistent factor. Also, it freed the therapist to dance rather than to provide the music. The same records were used for many sessions without any change other than the order. This was done to provide consistency and to develop a feeling of security. The types of music used and (one) order of presentation were a slow waltz, a polka, a march, a calypso number, a South American number, and a Hawaiian number. The amount of each type of music used depended upon the response of the group in that particular session. At first, the sessions were short and only the slow waltz was repeated, or two different waltzes were played, together with three or four other types of music.

The consistent factors in the sessions were the records and the therapist, while the patients participating in the group provided the variability.

Dance therapy on these continued treatment wards consisted of very simple dance movements to the music. These movements emphasized one part of the body at a time. Usually a leg swing was presented first, or an arm swing, or a rolling movement of stretching the foot on the floor from heel to toe and back several times. These movements were initiated by the therapist if no patients initiated movement when the music began. If a patient did begin a movement, the therapist picked it up and encouraged the rest of the group to follow the movement. Whatever the dance movement, the patients were urged to listen to the music and to move to the music. The patients became very familiar with the music, and soon began the same movements to a particular piece that were used in a previous session.

Some of the goals of the dance sessions were increased self-awareness, nonverbal communication, physical relaxation, exercise, and release of emotions, both hostile feelings and tender feelings.
Because these men had been very regressed and withdrawn for many years, an attempt was made to make them physically aware of their being. This was done by moving the separate parts of the body—hands, legs, head, fingers, feet, shoulders, and hips. It appeared that a turning point from schizophrenic denial of the body to a realization of the physical body came after the patient had willingly moved his shoulders and hips to rhythmic calypso or South American music. This seemed to free the patient so that he could come out of his shell and look at those about him. (It was observed that this same release of restrictive bonds made it possible for patients on the Negro admission wards and the active treatment wards to relate easier with the opposite sex in ballroom dance sessions.)

Once the patient had become aware of himself in this manner, he could begin to learn to relate to those about him. To the more obvious rhythmic patterns of marches and polkas, such movements as clapping hands together in the circle, squeezing the hands of the persons on either side in the circle, and imitating different patient leaders in simple dance movements helped the patient to relate to other patients and staff. The turning point of this relating seemed to occur when the patient could vigorously participate in such movements as shaking a partner's shoulders, throwing his fists into the circle, stamping his feet with the others, and if capable, stretching with a partner in a push-and-pull fashion, either standing or sitting on the floor.

Once the patient had become aware of others sufficiently to relate to them within the dance circle, he soon reached out to other patients to such a degree that he would encourage others to do the movements, and often he would bring someone with him into the circle.

When there was a nucleus of patients responding well to the dance sessions, i.e., coming into the dance group with little or no urging, participating in most of the movements, showing some realization of himself as a body made up of different parts that he could feel move, and relating to others enough to join hands and participate with others in simple movements, then a rhythm band session was introduced. Again the phonograph was used with the same march, polka, and slow waltz records, because the men were familiar with them and responded more readily to them. Only rhythm sticks and shakers were used, and only very simple rhythm patterns of combinations of 2, 4, and 8 beats were attempted. While the goals of the dance sessions remained, the
main goal of the rhythm band was resocialization. A rhythm band session was held alternately with a dance session; if someone decided to dance during a rhythm band session, he was encouraged to do so if it did not disrupt the group action too much.

Following a few successful rhythm band sessions, the third ward music activity, group singing, was introduced. Although most of the patients could not or would not read, a single song sheet of lightweight cardboard printed on both sides with familiar songs was used. Even if the ultimate goal was to have the patient participate verbally by singing with the group, he was considered participating if he remained within the group during the singing session. As in the dance and rhythm band sessions, he was still allowed to go and come as he wished.

While all three music activities, dance, rhythm band, and singing, were used at the end of the year on this ward, the balance between the three depended upon the needs and responses of the members of the ward. Usually there was a dance session one day, then a rhythm band, then a group sing, and then a return to a dance session the next period. However, if the patients did not seem ready for a sing, an extra dance or rhythm band session was held. As in all therapies, the therapist conducting such a program had to be flexible, patient, and very alert to the needs of the ward patients.
HOW IS THE DANCING TEACHER EQUIPPED TO DO DANCE THERAPY?

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A survey on “Dance Research Completed, in Process and Research Needed” was published by the Research Section of the National Committee on the Dance in 1955 through the joint efforts of a few college dancers and physical educators. Virginia Moomaw of the University of Carolina was its chairman.

Six hundred and seventy-six titles are contained in this survey. A few date back to the beginning of this century, but most of them have been completed in the last 15 to 20 years. An analysis of the titles of the papers surveyed is presented in the following list.

<table>
<thead>
<tr>
<th>Category</th>
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<tr>
<td>Total</td>
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</tr>
<tr>
<td>Teaching, Teachers</td>
<td>183</td>
</tr>
<tr>
<td>Dancers, History, Theory</td>
<td>126</td>
</tr>
<tr>
<td>Choreography</td>
<td>103</td>
</tr>
<tr>
<td>Rhythm and Rhythm Analysis</td>
<td>106</td>
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<tr>
<td>Psychological Factors</td>
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<tr>
<td>Physiological Factors</td>
<td>59</td>
</tr>
<tr>
<td>Measuring and Testing</td>
<td>61</td>
</tr>
</tbody>
</table>

Under the heading, “Research Needed,” three themes are outstanding:

1. Quality of movement as an object of physiological research;
2. Defining rhythmical action with the help of physiology, experimental psychology and musicology;
3. Fundamentals of the dance: the attempt to define the common denominators in various types of dance.

A trend to correlate dance with physiology, psychology, psychiatry (the latter category being so far least mentioned) is definitely present. With it goes the developing tendency of colleges to give students majoring in dance a broader education in order to fit them into areas other than the concert stage, the theatre, or the field of education. In the process of correlating dance with certain fields of science, science is called upon to improve techniques of body training, and dance itself is to be made into a
scientific tool. All this parallels the development music has taken in the evolution of music therapy during the last decade.

Since I have worked as an accredited physical therapist and as a dancing teacher for many years, I am watching this development with great interest, but not without some concern. Unlike music, dance had almost ceased to be a vital part of our culture. It was only the general revolution that took place in all the arts after World War I that reinstated the dance as a dynamic expressive art form among the other arts. Only some 35 years have passed since this revival. During this period the dance has gradually reached a wider public in addition to the avant garde in the United States, while in Europe dancers themselves only now are beginning to understand the deeper implications of dance in their culture and in other cultures such as the Hindu in which the tradition of dance and drama has never been interrupted. Modern dance is still a rather frail and precocious child. It is believed that it should fully develop its own fundamentals and terminology before entering the field of science in order that it not yield too readily to the tendency to borrow terms from psychiatry, psychology or physiology in the attempt to make itself acceptable as a therapeutic tool.

Dance has been aptly defined several times in this book. I will add here my definition, emphasizing two aspects which I think are the ones that will be most important in therapy. Dance is a nonverbal medium of emotional expression as well as joy of action through body motion. Mary Ryder Toombs has already spoken and Marian Chace will speak further about the emotional aspect of the dance in their work with emotionally disturbed and mentally ill people. My work with the physically handicapped is essentially concerned with the action aspect; with the distortions of action by injury.

In our research work at the Institute for the Crippled and Disabled we are trying to replace wherever possible—and that means medically feasible—the conventional type of localized exercise by total movement patterns based on dance fundamentals. In this approach the dancer has to evaluate the disability in terms of dance fundamentals.

Cerebral palsy and certain other nervous disorders offer a wide field of therapeutic application. In cerebral palsy habilitation modern physical and occupational therapists already think in terms of filling gaps in the sensori-motor development of these children by various exercise and activity techniques. Modern
education stresses the importance of sensori-motor experiences in the development of thinking and feeling. Now, how would the dancer describe the abnormal motor activities of a four-year-old victim of congenital hemiplegia? First of all, there is the almost complete one-sidedness of body and limb which affects most obviously not only mechanical factors in standing and walking, but involves a whole set of kinesthetic experiences. A few of these are: tactile experience of various media and textures which modify activity of arms or legs; the various relationship of limbs and body from which important spatial concepts such as right and left and inside and outside derive; and pulling and pushing with two hands in contrast to activities involving working and supporting hands. The incompleteness of such experiences may give the impression of severe mental retardation as in the case of the boy to be described here.

He was extremely restless, his speech was unintelligible at times, and his attention span abnormally short. We observed his play in the hospital nursery school. When playing with small dolls and dolls' furniture he would place figures and objects in a completely unrelated manner—usually in a broken line. When a toy was dropped he would literally fall heavily after it. On the floor he played aimlessly with the toy and then went on to something entirely different. We found that his good hand was not able to handle any toy involving rotary motion like that of screwing a lid onto a jar or using a toy screwdriver.

Disregarding the local condition of flaccidity and contractures in his right arm, we worked passively with both arms in various patterns alternating symmetrical and asymmetrical use of the arms. All motions were done in a fluid "figure of eight" rhythm and ended in various positions and juxtapositions of head to arm or arms to body—attitudes, the dancer would call them. "Above—below", "in front of—in back of", "away—near" were thus experienced. The smooth flow, the sudden arrests, the transitions from folding to unfolding of the limbs became more and more fascinating to the child; he gradually let the therapist play this game with him for longer periods of time. Whole body patterns in which weight was borne symmetrically or asymmetrically, partially or fully by different parts of the body further enriched awareness of symmetry and asymmetry. For instance, in creeping, all four limbs carry weight in a successive, reciprocal pattern; in a partially supported handstand the weight is carried on the two hands; in a partially supported headstand the weight is
carried on the head while the limbs struggle for balance and alignment. Most important also is the big rotation through space as it is experienced in the somersault forward or backward.

The effect of such an approach could not be measured by the amount of improvement in the function of the affected limb, though there was some. The important thing was that a whole set of new activities and interests appeared spontaneously. Door knobs, handles, wheels, and pulleys became the objects of intensive experimentation. The attention span increased and the speech was less mumbled.

The big rotation through space by somersaulting has been frequently used by us as a starting point for the habilitation of the young, spastic child. The somersault forward, starting with complete folding up from the head downward, is a total movement sequence which provides many kinesthetic experiences that the spastic child usually has only to a limited degree: folding, unfolding, massive weight shift, and being carried through space. Together with rolling from side to side the somersault gives in many instances the first stimulus for wanting to get from one place to another, the germ of locomotion. The characteristic flatness and rigidity of the body of the spastic child immediately conveys the lack of three-dimensional and rotary movement patterns in trunk and limbs. The development of spatial relationships is impaired because spasticity affects all outgoing movements such as spreading and reaching into space, and the turning of the chest against the lower part of the body. Space appears to be limited to only two dimensions. This may contribute to the physical and psychological withdrawalness of these children, their exaggerated fear of falling, and their apparent failure to measure distance before they master locomotion. Many of them also display a great deal of physical and psychological stubbornness. In holding on to habits derived from their disability they cling and clutch in every sense of the word.

Conventional physical therapy, until very recently, has stressed exercising the limbs with the aim of breaking through the exaggerated stretch reflex, and the exclusive use of bilateral patterns. Research on body image and the development of upright posture is changing this approach. This concurs with the dancer’s concept of “total body shapes”. To the dancer every physiological posture is charged with a definite mood. In addition, it either may indicate readiness for action, rest from action, or be the climax of intensive action. Thus the dancer, working with a spastic child
who is in rigid extension or tension most of the time, places him into a total flexor position such as that of creeping or squatting. He is held in this position in the beginning, often in spite of his protests, until he relaxes into the position. Gradually various postures are introduced, at which some induce relaxation of hyperactive muscles and some stimulate the drive to move. Increasing awareness of body and space develops sitting and standing. Quite often when several of these basic postures are mastered, a whole set of various activities spontaneously appears without any repetitive training in the activity itself.

Awareness of the relationships of the joints, of the folding and unfolding of the limbs, of the relationship to outside space and the experiencing of the spatial shapes which the body assumes in various postures are the main themes of dance in all cultures. These themes are heightened expressions of everyday actions, sensations and emotions, and of reactions to environment and people. In connection with therapy these themes are just as important as the strength-time aspect, usually called "rhythm", which comes to the minds of most people when the dance is mentioned.

In summarizing the examples of dance therapy with the handicapped I want to re-emphasize two points of equal importance:

1. Competent medical evaluation of the patient and his disability is necessary in order that the therapist clearly understands the nature of the functional loss in each individual case. Only then can proper selection of dance techniques be made. Doctor and therapist must communicate in terms of physical therapy.

2. Specific selection of dance techniques cannot be made with a sparse knowledge of various dance techniques; a bit of ballet here, a bit of folk dance and modern dance there. Selection evolves from a total creative dance experience supported by a knowledge of certain basic laws of space-time-energy relations such as those rediscovered and elaborated by Rudolf Laban in England in what he calls "space harmony" and "effort" concepts. Dance fundamentals must develop the common denominators of dance and everyday movement if dance is to be enriched by science and be used in conjunction with other tools of science.

I have to leave unanswered the questions of where and how this will be done; and how a new generation of dancing teachers will grow up, performing and applying research in dance fundamentals
which will enable them to become useful in therapeutic fields. A need for correlation of dance and certain areas of science cannot be denied. We hope that the National Committee on the Dance will become successful in integrating leading people and college and university resources in order to work out practical solutions.
MEASURABLE AND INTANGIBLE ASPECTS
OF DANCE SESSIONS

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Every person engaged in the use of the arts in a hospital situation today is constantly under pressure to participate in structured studies for the purpose of evaluating accurately and objectively what role the art sessions play in the treatment of patients. Those who are leaders in these activities are often accused of being too vague in the use of language and other symbols, so that the terms they use have little or no meaning to the other disciplines in the same environment. Since we live in an age of dependency on standard criteria for evaluation of myriads of facts, these criticisms are valid. We are dealing with the often intangible interpersonal relationships affected by shared emotional experiences. We often evaluate what is going on through our own feelings or empathy, for which, of course, there is no possible means of validation.

Perhaps in the area of painting, where the product of an individual remains visible indefinitely, some scale for the evaluation of the more gross responses and the overt changes in a participant of painting sessions can be devised and may have some validity. Too often, however, the art therapist falls into the trap of using such scales for diagnosis alone, or resorts to a shift to verbalization by the patient rather than using the art product for his evaluation and interpretation. When such evaluations are published, the reader is confused as to what was an interpretation of a verbal exchange between the patient and the art therapist and what really went on in the nonverbal area of the art communication.

A considerable amount of attention is being given to the nonverbal forms of communication, often with very little understanding of the difficulty in the translation of these happenings into verbal terms. More is lost in this translation than in the translation of word symbols from one verbal language to another. An example of this might be that of a man in one of the groups recently being studied at Saint Elizabeths Hospital who gives an outward appearance of stolid and almost sullen passivity. For six sessions this man had remained very withdrawn, although he
had participated in the group rhythmic movements. During this period he had not spoken nor made either a friendly or a hostile gesture toward anyone. The group began working on strong movements which were often aggressive, in order that they might feel positive body action rather than limp half gestures. The man previously described was asked to drive out his fists in an aggressive action toward the dance therapist, who was doing the same action toward him. It was necessary for him to walk considerable distance to reach her. This he did, without hesitation, and when he was in front of her, he reached out his arms in a tender manner, (again a descriptive phrase unacceptable to standardized scales) placed his hands under her arms and stood for a moment relaxed in front of her before he returned to his place in the circle of people in the session. In spite of the refusal to respond to her request the dance therapist experienced no rejection, but rather a dependent reaching out from him combined with a comforting gesture.

Following this incident, the patient took a more positive role during the remainder of the dance session, and at the beginning of the following one was ready with a handshake and a smile as he entered the room. On any logical scale for evaluation of group interaction he would have received a plus for showing initiative in moving across the room to the leader, but a minus for refusing a given activity. There seems to be no known scale for evaluating in a positive way what apparently went on in the emotions of this man during his action with the dance leader. Nevertheless, this is the sort of response that seems to be important to patients in dance sessions and seemed to be some sort of a beginning again for this man. He used his voice during the following session and has continued to use speech at intervals ever since.

I have recently completed a study with the Psychology Department of Saint Elizabeths Hospital. The actual evaluation of changes in the patients’ awareness of themselves and others has been determined by projective drawing tests which were given to each participant prior to the beginning of the series of dance sessions and again at the completion of these sessions. A control group matched for Goodenough score, age range, and other data were also given these tests, but participated in no activities. All of the patients, both in the dance sessions and in the control group, had been hospitalized with the diagnosis of schizophrenia for a period of from five to twenty years, and had been refusing any therapy or participation in any activity for a considerable
period of time. We were interested in whether there would be any measurable changes in the projective drawing tests of the patients participating in the dance at the end of twenty-one sessions, and whether these changes would be greater and of a different sort than those in the drawings of the patients in the control group.

Two objective observers were used to tabulate, at five-minute intervals, the degree of movement of all participants of the dance group which seemed to be related to the music or the specific activity, and a second scale to show the breadth and energy of movements made by individual patients. As a subjective observer, I attempted to evaluate the degree of participation of each patient as a member together with his initiative within the group. If accurate, this scale would show awareness of others by the individual members, and, also, their integration into the group. I used, as a base, the apparent mood of a given patient at the beginning of each session as shown by his body action. The scale was divided into five points for rating the degree of participation in the group activity and the patient's more obvious reactions to other members of the group in relation to his mood at the beginning. The results of these scales were shown on a graph for each individual patient and have been correlated with the other scales, even though they were evaluated by a subjective observer.

I have resisted submitting to a structured study for a long time, even though curious as to whether some of the factors which I believe are tangible evidence of change in some patients, may have some correlation with those things which are actually measurable in terms of the specific psychological tests in common use today. The realization was a happy one that the psychologists were as ready to acknowledge as I was that the leader of a dance sessions could not function as one of the objective evaluators of the dance sessions for this study. The leader must be personally involved with what is going on or there is no session in a therapeutic setting. The human relationships in this situation are the important factors both to the leader and to the patient participants. Force and frequency of movement, and to a degree, group awareness can be measured. But are they the really important things to be measured? Are any of these aspects of the dance sessions different in any way from those of any group engaged in any activity at any time?

It was found that we can measure in a satisfactory way all those factors in a dance session which are no different from sessions of
any other activity. However, the things that belong specifically to the rhythmic action and the relationships established through these have no possible base for the scale in use today.

If music, or the dance, or any of the arts are of value to patients, it is because of the intangible happenings which have no base for measurement. The outward signs of what happens to a person as he listens to music that is satisfying to him, or moves to this music with an awareness that he is doing so, can be observed in a more or less adequate way, provided the observer is alert and sensitive to the myriads of infinitesimal changes in body posture, facial expression and breadth of movement of the patient. But how does one evaluate these changes by means of a standard scale? If the face becomes relaxed and the body at ease, rather than apparently tense, does it mean that the patient is responding to the tonal sounds and rhythms of the music, or does it mean that there has been a recall of some previous happening due to the music? Even if it were possible to measure the degree of relaxation in the body of a patient, at any given moment, that in itself is not what makes hearing the music important. The emotions which are experienced within the patient are the important things. Where would one start as a base? So many variables are present in even one simple response. Is the patient particularly susceptible to harmonious tones; is he familiar with the music; has he a knowledge of instrument playing and thus identifies with the musician; is he susceptible to suggestion? These are only a few of the variables to be considered, quite aside from his relationship with the musician. When dance movement is added to the hearing of musical tones, even more areas for possible misinterpretations are added to those already mentioned, and one is in a quagmire of variables which are impossible to account for or to eliminate. Is it more valuable, both to the leader and to the individual patients, to keep a record of what went on in any given session on an observation level, or is it more important to measure the number of times a person moved, or the force in actions that can be observed by means of established scales?

Mrs. X often moves passively through a dance session, accepting the movements initiated by the leader, or other members of the group. Often, however, during the session, she smiles to herself and then her movements have a quality of originality and sensitivity. They are too varied to be followed by anyone else, and they will occasionally lead her to dance away from the group.
with an appearance of enjoyment, but with no apparent awareness of the group activity. After so doing, Mrs. X will sit by herself for a few minutes and then return to the group activity. These periods of sitting by herself decreased materially during the course of the project. The first session she sat alone the full hour with her back to the activity, but during the latter part of the series of sessions the majority of her time was spent with the group, and she left the activity only at infrequent intervals.

Which tells more about the enjoyment she is experiencing in music and movement—the description of her behavior, or the graph made from the standard scales showing her progress from isolation to partial participation in the group? How do you measure the satisfaction she is experiencing as she does her own movements alone and apparently unaware of the group? Her movements were not large and energetic; she left the group, and she frequently sat quietly when activity was being tabulated. Consequently on each scale she would be evaluated in the lower level of participation. Yet, as the leader of the dance sessions, I feel that she enjoyed the sessions as much as, and perhaps more than any of the other members. There are no statistics to confirm this—rather the reverse, but when consideration is given as to what dance means to people on an emotional level, the leader can sympathize with her and recognize that she has had an enjoyable experience at each session.

An extreme example of another patient who gained little if anything from the sessions as measured by our scales was Miss Y, who remained almost totally quiet throughout the twenty-one sessions, although she stayed in the group formation. The majority of the time she did not even participate in movements which were being done around her. But at intervals, when especially selected, she attempted to lead an activity even though she used very small and inadequate movements. When she was able to do this her face became radiant and alive. Again, on the scales she is almost at the bottom of the list. But who can say what those rhythmic actions mean to her when she is able to move, however inadequately. How can you rate a smile; how can you rate the reaching out of hands to a trusted person for a few minutes at a time?

It is right that attempts should be made to evaluate benefits to patients from participation in music and dance sessions. If it were not that such participation is beneficial in some way, these programs would have no place in a hospital setting. The question
is whether the descriptive method is not really more adequate for true evaluation than the present day "so-called" scientific scales of measurement. Not only do they show only the most obvious changes and happenings, but also, they are tabulated by people. This of itself brings in a subjective viewpoint, however objective the observers may try to be. Are these evaluations really more scientific than the observations of the person who is responding to a patient’s movements on a feeling level?

While we are involved in listening to music, or playing it, or using our bodies in response to it, we are involved in a feeling experience. If this is so difficult to translate into verbal terms in any way, how can one hope to translate this experience into meaningful symbols for the purpose of statistical information? It is easy to know how many people participated in a session, for how long, and with how much increase in motor activity. It can be known whether these facts coincide with possible changes in a projective drawing test. But what then? Does this tell anything of the shared experience of the group members, the enjoyment, the growth of awareness of the music, or the friendships begun and their meaning?

Are we, as artists and musicians, lending ourselves to projects for evaluation which tell less of the true meaning of these sessions to the patient than the ones we are now using? It is true that the DAP tests in this specific project showed phenomenal change for the majority of patients in the dance sessions. Although all thirty-five patients, both men and women, had been hospitalized for periods of time ranging from five to twenty years, only five did not show a change of one to twenty-one points in the two tests. One of these refused to attend, and two others were able to come only occasionally. On the contrary, the members of the control group either showed no change or showed less awareness of the body image on the second test, again with the exception of two who improved. However, this has been obvious from the total picture of improvement without the tests and without the laborious mechanisms involved in tabulating the objective observations. They indicate no more than small facets of the total picture of social improvement.

Until there are ways of measuring the so-called intangibles, which are so very tangible if one does not require a base for measurement, perhaps it would be wiser to continue making evaluations on a clinical level. These thoughts are not offered as conclusions, but rather as questions arising from personal experience.
PART VI
RESEARCH IN MUSIC THERAPY
THE INFLUENCE OF MUSIC ON GERIATRIC PATIENTS

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INTRODUCTION

The three papers which follow report work done in the Geriatric Section of Osawatomie State Hospital, Osawatomie, Kansas. When the invitation came from the hospital, Mr. Griffin, Mr. Cotter and Mr. Kurz, then completing the academic part of their master's degree, arranged to spend several days a week with the geriatric patients. Each accepted responsibility for two aspects of the study.

Each paper is an abstract of part of a master's thesis. The three young men assisted each other as necessary. Because of the brevity of presentation requested, only the salient results will be reported at this time. The complete reports will be found in their respective theses.

A. REDUCTION OF INCONTINENCY

B. INTEREST AND MUSICAL RESPONSE

JACK GRIFFIN

Many cultures attribute authority, security, honor, and a sense of immortality to the older generation. Our own culture appears to place a heavy emphasis on youthfulness, physical agility, and the behavioral constellation surrounding reproduction. With advances in medicine and technology the aged are becoming more numerous in hospital populations, and incontinency is a prominently disconcerting aspect of the geriatric ward.

Numerous causes of incontinency have been suggested and an equal number of treatment methods recommended. Psychiatrically
oriented investigators have discovered hostility, aggressive tendencies, and attention-seeking as factors related to incontinency.

One hypothesis formulated for the present pilot study was that geriatric patients, as members of music activities groups, would display observable changes in their incontinency habits.

Nine male and twenty-one female patients from the geriatric ward of a state hospital were chosen by the psychiatrist in charge of geriatrics as subjects for the study. They were considered to be representative of the patient population generally found on the geriatric ward. The patients were all over sixty-five years of age, and each had been diagnosed as one of the following: chronic brain syndrome associated with cerebral arteriosclerosis with either psychotic reaction or behavior reaction, chronic brain syndrome associated with senile brain disease with either psychotic reaction or behavior reaction, schizophrenic (paranoid type), or manic depressive (manic type). The subjects, although all were patients on the geriatric ward, were of both "true geriatric patient" and aged psychotic types.

Each subject was a member of one of three groups. Severity of regression was the prime determinant for membership in the respective groups. Group One was considered to be most regressed while Group Three was considered to be least regressed. Members of each group were given the opportunity to participate in group singing, rhythmic activities, and to play rhythmic instruments. The group sessions, conducted semiweekly for an interim of eleven and a half weeks, were under the direction of three investigators. Some patients were ambulatory, but many of them were confined to wheelchairs. The musical selections employed were copyrighted during the years from 1909 to 1930. Some recorded music was used, however most of the music was "live", and was produced by piano, autoharp, guitar, and smaller rhythmic instruments.

Hospital aides and nurses, working each of the three daily shifts, rated each of the patients on a weekly, five-day check sheet. Individual incontinency ratings were recorded on the basis of whether or not patient status was observed as being better than usual, the same as usual, or worse than usual. Both observation and statistical treatment revealed that there was a trend toward less incontinency during the latter phases of the study than during the early phases of the study. Incontinency was significantly less conspicuous on the days when the music activities groups met.
Interest in environment and the extent of directed and co-ordinated activity may be considered criteria for evaluating reality orientation of patients.

Subjects, members of the music activities groups, were also rated as to the extent of their participation in the music activities. Ratings, assigned the subjects during the music activity periods, were based on the complexity and duration of each subject's participation. Lack of overt response, or the presence of postural change, hand tapping, foot tapping, head bobbing, torso sway, singing or humming, participation in games, and dancing were the individual elements observed and taken into consideration in assigning the ratings constructed on a five-point rating scale. Many subjects in Group One were physically incapable of displaying all of these types of behavior, but all patients in Group Three were considered to be physically capable of displaying such reactions.

Both observation and statistical treatment revealed that geriatric patients, while members of music activities groups, displayed more interest and participation in music activities during the latter phases of the study than they did during the initial phases. Degree of regression and interest in musical activities (as manifested by participation) tend to show a correlation in a negative direction.
A. PHYSICAL AND VERBAL ACTIVITY

B. EATING HABITS OF FEMALE GERIATRIC "TRAY" PATIENTS

VANCE COTIER

It was hypothesized that a gain in self-esteem might be brought about in the patient if there were an appropriate change in his physical and verbal behavior. Appropriate physical and verbal activity would also tend to indicate better contact with reality. Briefly, physical and verbal behavior were considered appropriate when the patient actively took part in any of the musical activities, held realistic verbal conversation with other patients or the observers, and performed any physical act which observers thought appropriate. It was also believed that the use of musical activities might aid in reducing acts of physical and verbal aggressiveness in the geriatric patient.

In order to secure more objective evidence of changes in behavior of the patients, a check sheet was constructed to enable the observer to tabulate acts of appropriate verbal and physical behavior; acts of physical and verbal aggressiveness; and physical and/or verbal hallucinatory responses.

A comparison was then made between the first five observations at the beginning of the study and the last five observations at the end of the study in order to determine whether or not there were differences in the physical and verbal activities of the patients.

Both observation and statistical treatment showed significant changes in the physical and verbal activities of the patients as a group. It was found that there was a significant increase in appropriate physical and verbal acts, and there was a significant decrease in physical and verbal hallucinatory responses. There was no change in the amount of verbal aggressiveness, but a slight trend was noted toward less physical aggressiveness.

Through the use of music, this study also attempted to improve behavior in the dining room of a group of female geriatric "tray" patients. It was hypothesized that music might aid in establishing better eating habits for the geriatric patient.

Ten female "tray" patients who were not participants in the music activities groups were subjects for this study in which eating habits were observed while recorded background music was played. The subjects were observed twice weekly while eating
their evening meal. Twenty experimental periods were conducted with each period consisting of approximately 30 minutes. Both mildly stimulative and mildly sedative music of a familiar and popular nature were tape recorded and then reproduced.

The observer marked an appropriate check sheet which made it possible to evaluate the eating habits of each of the ten patients. A five-point rating scale was used. A 1 rating was assigned the patient who was spoon-fed. This patient depended upon someone else to place food in his mouth. The patient considered to have poor eating habits was assigned a 2 rating. This included lapping food, fingering and playing with food, and throwing food. He may have displayed any one or a combination of these eating habits. A 3 rating designated the patient with average eating habits. The patient may have played with the food but attempted to use the eating utensil; occasional urging might have been needed. A 4 rating was assigned the patient considered to have good eating habits. He employed the eating utensil, may have had accidents occasionally, but needed no urging. The patient considered to have very good eating habits was assigned a 5 rating. This patient successfully manipulated eating utensils and exhibited table manners comparable to socially prescribed standards. A base line of individual eating habits with no background music was established during the initial phases of the study.

A comparison was made between patients' eating habits observed during the first four periods and those observed during the last four periods. A slight improvement was noted which approached, but did not reach statistical significance.

At the conclusion of the experiment, the aides were questioned as to their feelings about the use of music during the dining period. They expressed a definite liking for the music and a desire for the music program to continue. During the evenings when the experiment was not conducted, it was noted that several patients asked for the music.

The following conclusions were reached:
1. Properly selected music might aid in improving eating habits among female geriatric “tray” patients.
2. Music does tend to provide a happier and more congenial atmosphere in the dining room of these patients. The aides as well as several patients enjoyed the presence of the music during the dining period.
3. Mildly stimulative music alternated with mildly sedative
music seemed to produce an acceptable type of musical stimuli for dining purposes. Modern arrangements of recorded songs of a popular nature appear to be satisfactory for dining music.
A. PERSONAL APPEARANCE

B. REDUCTION OF NOISE LEVEL IN A FEMALE DAY HALL

CHARLES KURZ

The "Personal Appearance" division of the study proposed to investigate the function of music as a means toward the partial restoration of self-esteem in the geriatric patient. It was hypothesized that gain in self-esteem would be made evident through neater personal appearance of the patient.

The procedure employed was similar to that mentioned previously, i.e., the patients involved in the music activity periods participated as subjects while daily changes in personal appearance were noted by the experimenters, evaluated according to a five-point rating scale, and recorded on a check sheet. The rating scale assigned one point for disrobing; two points, partially disrobing; three points, clothed but unkempt; four points, fairly well-groomed; and five points, well-groomed.

The ratings from the five initial periods, plus the base line ratings as established by the psychiatrist in charge, were compared with the ratings of the final five periods and subjected to statistical treatment.

For the group as a whole the results were statistically significant. Of the 23 patients checked, 16 improved, 6 exhibited no apparent change, and 1 appeared more poorly groomed. The data indicated a tendency for the least regressed patients to exhibit a more positive change in personal appearance.

The last segment of the geriatric study involved the problem of the high noise level, generated by the patients, found in many geriatric day halls. It was hypothesized that selected background music might serve, either directly or as a tool, in helping to create a warmer and more pleasant atmosphere in the milieu of the geriatric patient, thereby decreasing the noise level in day halls. In addition, the music might also serve as a worthwhile contribution to the morale of the hospital staff.

The experiment was conducted semiweekly for seven weeks in the Osawatomie State Hospital female geriatric ward. The ward population averaged fifty patients during each two-hour, afternoon experimental period. Selected recorded instrumental music, arranged according to the "Iso" principle and alternated with brief periods of no music, was played the first hour on alternate
days, and the second hour on the remaining days. Sound level recordings were taken every twenty minutes through a nondirectional crystal microphone, amplifier, and voltmeter. Preceding the six weeks of music, sound level recordings were taken for two, two-hour periods to determine the day hall base sound level. The data thus collected was subjected to statistical treatment to ascertain the effect of music on the sound level.

The average sound level of the day hall during periods of recorded music showed an over-all decrease of 30 percent, and an average decrease of 10 percent per patient. The average day hall sound level, during periods of no music that followed the music program, showed an over-all decrease of 50 percent and an average decrease of 27.50 percent per patient. This indicates, at least partially, the carryover effect of the quieting potential of the music. The average day hall sound level, during periods of no music, that preceded the music program was essentially identical to the base day hall sound level, which indicated that the quieting effect of music, in this particular case, does not continue for as much as forty-eight hours.

Remarks of patients were frequent and nearly always favorable to the music program.

Check sheets were utilized to obtain the hospital staff's evaluation of the music program. Fifty percent of the staff members contacted indicated the patients' attitudes to be more positive when recorded music was present, while the remainder observed no apparent change; 66 percent indicated increased patient cooperation and manageability; 100 percent expressed a favorable opinion towards the effects of the music program upon the patients, and further indicated that personal pleasure and enjoyment had been obtained. All the hospital personnel expressed a desire for the music program to be continued, or a similar program substituted.

In conclusion, it seems that there is a definite tendency for appropriate, recorded instrumental music to serve, either directly or as a tool, in reducing the sound level of a female geriatric day hall, and further, music seems to induce a more favorable atmosphere for both staff and patient.
THE EFFECT OF BACKGROUND MUSIC ON FREQUENCY OF INTERACTION IN GROUP PSYCHOTHERAPY

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Music has often accompanied man's social relationships because it is a source of enjoyment and may serve as a common ground of interest for group members. Because music is a nonverbal, emotion-arousing stimulus, it is possible that it can facilitate the release of pent-up emotions in members of psychotherapy groups.

The purpose of the study was to determine whether background music would increase the frequency of interactions and pause lengths in group psychotherapy sessions.

PROCEDURE

Two psychotherapy groups of seven members each were selected as subjects for the experiment, the groups being matched as closely as possible. The group members were chosen from the Topeka State Hospital patient population by the psychotherapist who was a staff member.

Each group was observed through a one-way glass once a week for a period of thirteen weeks. Meetings were held in a Group Room in the Music Therapy Department. A control observer also met with the groups, acting as a silent member to record the proceedings of the meetings. Two ten-minute segments of verbal interaction were recorded for each therapy hour. A verbal interaction was scored if one patient spoke to another. A new score was added if the interaction continued over one minute, if it was broken by a pause over two seconds, or if it was interrupted by a verbal interaction of another group member. Interactions were registered on a recording machine designed for the experiment by Wayne Ruppenthal.

A base line score was established for each group after six experimental periods. For this time, no music was played for either group. Then the group which had the lower interaction score was selected as the experimental group. For this group, mildly sedative background music was played during the seven remaining meetings. The recordings used were semiclassical and popular melodies. Music was tape-recorded and was played
at a fairly constant intensity, just above the auditory threshold so that it would not distract the group proceedings.

**Results**

Data were collected for the frequency of interactions, number of long pauses, and number of patient absences for both the experimental and control groups. Analyses of these data revealed that there was a significant increase in interactions (at the .05 level) within the experimental group for the period in which the music had been played, while there was not a significant increase within the control group. There were no reliable differences in number of long pauses or absences for either of the groups.

Most of the members of the experimental group felt that the background music was a pleasant addition to the meetings. One patient commented that the presence of the music made the periods of silence more tolerable. An important by-product of the study was that the therapist requested that background music be continued for the experimental group at the termination of the experiment.

**Conclusions**

The results of this study support the theory that suitable background music is a means of increasing verbal interactions in group psychotherapy. The inclusion of music in the therapeutic situation provides a pleasant nonintrusive stimulus upon which group members can focus their attentions periodically. The selection of music should be flexible enough to be compatible with the needs and moods of the group members.

It is likely that the music would have been more effective in modifying pause lengths if a higher loudness level had been maintained. Perhaps then the music would have served as an available “shelter” where the patients could have retreated when the group situation became too threatening. Such a retreat would be more acceptable to the group than leaving the therapy room, and certainly more reality bound than withdrawing entirely in one’s self.
THE APPLICATION OF RHYTHMIC MUSIC STIMULI TO LONG-TERM SCHIZOPHRENIC PATIENTS

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The Albany Veterans Hospital is a 1005-bed general hospital with over a third of its beds allocated to the Psychiatry Service. The majority of these beds are utilized for long-term mental patients. The Psychiatry Service has set itself a task which is concerned with a prime problem of modern psychopathology, the rehabilitation of schizophrenic "chronic" mental patients. Toward this end we have engaged in an experimental comprehensive treatment program. Not only have we accepted the newer psychiatric and psychologic treatments in conjunction with the more usual methods of modern psychiatry and psychology, but we have actively sought for new avenues of approach. Among the latter are the special skills of the music specialist, who has made available to us a variety of musical, rhythmic group activities for mental patients.

In conducting treatment with a variety of schizophrenic patients, it has become apparent that the rehabilitation goal must be realistic. For most of these patients, particularly the regressed and older ones, the goal is better ward adjustment, or grounds privileges, or participation in hospital functions, or increased social communication, or simply deceleration of the mounting deterioration of the intellectual functions and the personality. Early in the course of our group psychotherapy it became apparent that any form of activity which could stimulate participation by these regressed patients would yield a finger-hold upon an otherwise untenable surface. The activity had necessarily to be simple but interesting, and a stimulus to continued participation within the activity. Since rhythm instruments have been used with groups of children at mental age of 4 or below, this type of activity was selected for trial with our patients. Many of the

latter functioned at an intellectual level equivalent to a mental age of 5 or 4, or even less.

Two rhythm groups of long-term schizophrenic patients have been meeting since that first beginning. Other groups have been organized as necessary, and there have been as many as five groups in progress. An experimental group of patients, participants in the special comprehensive treatment program, had the benefit of rhythm group activity. Objective quantitative evaluation of the program demonstrated marked improvement in consequence of this and other forms of rehabilitation treatment such as occupational therapy, hydrotherapy, group psychotherapy, and electroshock. In contrast to these developments, a control group which did not have the benefit of such intensive and various treatments remained unchanged during the six-month interval that the trial program was in progress.

In all ensuing clinical ward programs we have utilized musical rhythm, to induce patient participation in social group endeavor. The evidence is strong that mentally "normal" persons do respond behaviourally and physiologically to music and its rhythm group provides to the regressed and primitivized patient opportunity for creative self-expression and the exercise of initiative. The frame of reference is necessarily the patient himself, creativity being judged from the standpoint of his competence and from his perspective. The rhythmic medium provides such creative, self-expressive opportunities within a wide gradient of ability.

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rhythms. Does the long-term schizophrenic patient manifest an objectively measurable response to such rhythm? If it could be demonstrated that the activity and the physiological functioning of the schizophrenic did respond to musical rhythms, then these stimuli might constitute a valid method for the modification of the behavior of the schizophrenic patient.

The two measures chosen for the present study were pulse rate and general motor activity.

Pulse Rate

The cardiovascular system in mentally normal persons does respond to musical stimuli. Many of the studies in this field have been clinical in nature; hence they were necessarily weak in experimental design, adequacy of controls, or size of sample. One important and well-planned experiment by Ellis and Brighouse did not yield consistent nor significant mean change in the heart rate of a group of 36 college students who listened to selected recorded music during 4-minute intervals. The heart rate of some subjects did rise, but the significance of this change was not statistically tested. On the other hand Gilliland and Moore in their comparison of recorded classical music with jazz music, concluded that jazz did increase the heart rate significantly above that of classical music.

4. The research described herewith is resumed from a more complete report entitled "The influence of rhythmic drumbeat stimuli upon the pulse rate and general activity of long-term schizophrenics," published in J. Ment. Sci., 103 (1957) 172–188.
These various results were obtained from mentally normal subjects. The cardiovascular effects of musical stimuli upon the mentally disordered or the schizophrenic patient have not yet been submitted to controlled experimentation. The variable, unpredictable nature of the schizophrenic response to stress and to sensory stimuli of all types, is well known. The present report describes an investigation into the effect of drumbeats upon the pulse rate of chronic schizophrenic patients.

**Problem 1**

(a) Does music in the form of rhythmic, percussive drumbeats delivered to a group of long-term, hospitalized, deteriorated male schizophrenic patients significantly affect their pulse rates when compared to the ordinary changes which occur during a control period without such beats (designated as “Silence”)?

(b) Do different rhythmical rates of drumbeat stimulation (different basic frequencies of beat) exert a differential effect upon the pulse rates of these patients?

**General Motor Activity**

A second portion of this investigation pertains to the motor response of long-term schizophrenic patients to musical stimuli. A variety of techniques has been employed to define the effect of musical stimuli upon the neuromuscular response of mentally normal persons. Various aspects of the neuromuscular apparatus have been submitted to study by assorted methods,\(^1\), \(^2\), \(^3\) and some work has been reported with braindamaged but nonpsychotic subjects.\(^4\), \(^5\), \(^6\)

There is a dearth of studies pertaining to the motor response of mentally disordered or psychiatric patients to music stimuli. Altshuler and Shebesta,\(^7\) in a pioneer investigation of the effect of music upon the motor output of several excited psychotic patients during hydrotherapy, tentatively concluded that music could

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produce favorable psychological effects upon psychotic patients by altering their general motor output. Skelly and Haslerud\(^1\) more recently studied the effect of music upon the general activity of apathetic schizophrenics. Their subject population consisted of 39 females, aged 19 to 56 and showing “blunted emotionality, lack of feeling, and impassivity,” but with no intellectual deterioration. All had been admitted to the hospital within the past year and were characterized by chronic inactivity. The general activity of these patients during assignment to an occupational therapy room, with and without accompanying music, was rated on a 7-point scale. The authors reported a significant increase in general activity when lively recorded music was played.

**Problem 2**

(a) Does music in the form of rhythmic, percussive drumbeats delivered to long-term, deteriorated schizophrenic patients, significantly alter their level of general activity when compared to a control period without such rhythmic drumbeats?

(b) Do different rates of rhythmic stimuli, i.e., different frequencies of rhythmic pulsation, exert a differential effect upon these patients’ level of general activity?

**Procedures**

**Subjects**

These consisted of 23 ambulatory schizophrenic patients from two wards which housed long-term mental patients. All were World War I, white, male veterans; the median age was 60 years, and they had been hospitalized for an average of 29 years.

**Stimuli**

The three experimental stimulus rhythms each consisted of a bongo drum solo by a professional drummer.\(^2\) Each one of the three was made at a different basic rhythm beat, timed by a clocking system. The basic frequencies or beats selected were designated as follows: (a) Rhythm A at 54 per minute, representing a low pulse frequency with great enough deviation from the normal pulse rate to be perceptibly slower but still within the

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2. Grateful acknowledgment is made to the Hospitalized Veterans Service of the Musicians Emergency Fund, Inc., New York, for providing the drum soloist and technical assistance required to prepare the stimulus rhythms of this experiment.
range of average pulse variability; (b) Rhythm B at 90 per minute, representing a pulse rate great enough to be perceptibly higher than the common pulse rate of 72 per minute, but still within the range of average pulse variability; and (c) Rhythm C at 72 per minute representing the common pulse rate. The bongo drum solos consisted of varied patterns within the stated frequencies and were therefore definable as music. They avoided the monotonous, unvarying, amusical sounds of simple metronomic beats per minute. A fourth condition, the control condition, was termed “Silence”; it designated the absence of rhythmic musical stimuli. The stimulus rhythms were recorded upon magnetic tapes; the rhythm appropriate to each experimental condition, A or B or C, was supplied from the tape play-back through the ward’s loudspeaker system. All volume settings were maintained at constant readings.

The experimental and control conditions (A, B, C and Silence) were present in a randomized sequence, 20 minutes in the morning and in the afternoon for five serial days.

Another and final experimental condition was introduced for theoretical purposes. This was the experimental condition “Combined Rhythms (A,B,C)”. It did not represent an experimental session or sessions as such. It was the mean of all the readings taken individually under Rhythm A and B and C respectively. This “Combined Rhythms” condition permitted statistical tests to be made between the effects of Silence and of Rhythm regardless of the specific tempos (within the limits of the beat frequencies of this experiment).

Procedure

All patients participating in the study were brought into a large ward day room mid-morning and early afternoon of each day that the experiment was in progress. The other, nonparticipating patients were removed from the ward during these sessions. At each of these experimental periods the patients were permitted to take their ease and assume the position most comfortable to them before the pre-session or base-line experimental readings were recorded by the observers. Upon the conclusion of each experimental session the necessary post-session readings were noted, and the patients were then returned to their usual activities for the day.

Each patient served as his own control. The control observations, pre- and post-, were also made during the sessions of
Silence (absence of rhythmic drumbeat stimuli) in accordance with the experimental design. The same experimental situation was maintained for the condition of Silence as for the three conditions of rhythm.

Observational Methods

The measurements were made by a battery of nine observers including nurses, nursing assistants, a social worker, a psychiatrist, and two psychologists. Each observer recorded the pulse rate reading and motoric activity reading from a minimum of two or a maximum of three specifically designated patients (total N = 23), throughout the course of the experiment. This permitted him to utilize a constant frame of reference for the notations of motor behavior and activity changes in each of his specifically designated patients.

The ratings of activity level, and change in activity level, were made on a specially prepared Activity Rating Scale. A fresh scale was utilized for each subject at every session.

Methodological Comments

For the purpose of this study, motor activity was defined to include all forms of activity (or lack of same) whether verbal, locomotive, or manipulative. Macroscopic muscular movement was the criterion. The purpose of the behavior, i.e., its meaningfulness or its congruence with reality, was not at issue in this connection. The observers were instructed that "activity pertains to any form of motor behavior including change in position, walking, running, striking, talking, shouting, or other movements or gestures."

Results

Pulse Rates

(a) There was a decided mean drop in pulse rate during the control condition of Silence. No such significant drop occurred under any of the experimental Rhythm conditions. In the case of experimental Rhythm A there was even a small although statistically nonsignificant rise in pulse rate.

In summary of results, the conditions of Rhythm prevented the pulse rate from slowing down to that level which did occur under the control condition of Silence. Comparing the three respective experimental rhythmic conditions among themselves, there was no significant evidence of differential effects exerted upon pulse rate shift by these variations in beat frequency. It was true that
the mean pulse rate did rise somewhat under frequency A while it dropped somewhat under B and under C, but statistical analysis gave no evidence that any factor other than chance was involved in this differential trend.

**General Motor Activity**

(a) There was a significant mean increment in the general level of activity during the Rhythm sessions. In decided contrast to this, the general level of activity remained essentially unchanged during the control Silence sessions.

Each of the experimental Rhythms was significantly more potent than Silence in its influence upon the level of general activity of these chronic schizophrenic patients. Since the respective Rhythms showed no significant differences when compared to each other, there was no reason to believe that any one Rhythm was more effective than the others in altering the general level of the patients' activity. Rhythmic frequency of beat, i.e., slow versus fast within the definition and limits of this experiment, did not influence the degree of change in activity level.

(b) Several inferences seem warranted from close analysis of the data on motor activity. Even under ordinary control or Silence conditions, there is a surprising degree of change in the motor activity of quiet schizophrenics over the course of brief time spans (20-minute spans). Some show increase in their activity, others decrease. This constitutes a state of dynamic equilibrium in the sense that the number of patients increasing and decreasing in activity are equal in extent. They are in balance and therefore do not significantly change the algebraic group mean activity level. Rhythms, however, do significantly upset this equilibrium by driving the mean group movement emphatically forward into increased motor activity. Finally, within the limits of this experimental design and procedure there was no reason to believe that the patients' increasing familiarization with the Rhythms affected their responsiveness of pulse rate or of general motor activity. Special statistical tests were made to test this, but the null hypothesis was upheld.

**Correlations**

A rank order correlation was computed between the mean changes in pulse rate and in motor activity under the several conditions of this experiment. The rank order correlation between pulse-rate change and activity change was +.68, P = .05. Under
those experimental conditions which raised the activity level there was also a tendency for the pulse rate to rise, and vice versa. A causal relationship between motor activity and pulse-rate change need not necessarily be postulated to account for this relationship. It is alternatively possible that both variable reflect an underlying holistic response to the Rhythmic stimuli, a responsiveness which is reflected by a variety of physiological indices including the pulse rate and the neuromuscular activity.

**DISCUSSION**

The findings are recapitulated as follows: (a) the main pulse rate dropped significantly during Silence but not during Rhythm; (b) there was a significant mean increment in activity during all experimental Rhythms but not during the control Silence; (c) the activity state of these chronic schizophrenics under ordinary resting conditions—Silence—constituted a state of dynamic equilibrium rather than total passivity; (d) rhythm exerted force upon this equilibrium, driving it forward toward increased activity; (e) familiarization with the rhythms had no effect upon changes in pulse rate or activity level; and (f) the degree and direction of pulse-rate change was correlative with the degree and direction of activity change, computed for groups.

Problems 1a and 2a, posed earlier, are now answered in the affirmative. Musical rhythm does significantly affect pulse rate and activity level, in contrast to the resting control state (Silence).

Problems 1b and 2b conversely are answered in the negative. There are no significant differential effects among the several rhythmic beat frequencies. The faster rhythms (B at 90/minute and C at 72/minute) are no more nor less effective than the slower rhythm (A at 54/minute) in affecting the pulse rate and activity level.

The results indicate unequivocally that patterned, rhythmic drumbeats do stimulate an organismic response in chronic, deteriorated schizophrenics who have been hospitalized for many years. Their neuromusculature responds strongly, and their cardiac rate is maintained at a higher-than-average level (for them). These objective data are entirely consistent with the findings of Skelly and Haslerud.¹ They demonstrate that older, long-term schizophrenics can be stimulated to behavioral and cardiac response by musical rhythm: their many years of hospitalization and their deteriorated status notwithstanding.

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¹ C. G. Skelly and G. M. Haslerud. *op. cit.* p. 188–192.
The present study was concerned with motor and cardiac response as such, not with the creative quality or directed focusing of the response. A challenging problem flows directly from the findings of this investigation. Can the neuromuscular response of these schizophrenics be directed into creative, productive channels? Are we able to focus the energy increment of these patients, an increment which is released through the medium of musical rhythms, into a direction which is productive and which leads toward therapeutic success (increased behavioral adjustment)?

This report delineates experimentation with but two physiological measures. Numerous other measures are available, and many have already been utilized in music research with normals. Among these are plethysmographic recordings, EEG, spiromgrams, and electromyography. An extension of these to the study of schizophrenic responsiveness to music could prove fruitful beyond expectation. The physiological effect of musical rhythm upon schizophrenics demands further exploration.
OBSERVATIONS ON THE RESISTANCE OF SOME PATIENTS TO MUSIC THERAPY

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INTRODUCTION

It has been observed that certain male neuropsychiatric patients do not wish to participate in music therapy listening groups. Their responses varied from the patient who said he hated music and considered it to be a "sissified" form of expression and therefore beneath his attention, to the patient who responded negatively to going anywhere or doing anything, commonly noted among schizophrenic patients who were more nearly on the catatonic level. However, there were patients who did not fall into either of these categories of resistance but who still gave some excuse for not wanting to attend music listening sessions. These excuses ranged from the patient who maintained that he derived no benefit from music sessions, to the patient who said that the "noises, shrieking," and various other forms of expression attributed to vocalists and instrumentalists were to him upsetting, disturbing and tremor provoking.

The types of resistance to music varied just as the personalities of the patients. It was felt that this resistance did not merely include opposition to listening, but also included unconscious resistance, in the analytic sense, in the form of repressing forces involved in the laying bare of the unconscious. It has been stated that music reaches the acutely psychotic patient when no other method appears to succeed. Should a patient necessarily exhibit satisfaction in order to derive a therapeutic benefit from a music activity? Is it not possible that a patient who exhibits a dislike for a music listening session receives profit therapeutically from the session?

Statement of the Problem

It was the purpose of this study to determine (1) what type of music generally evokes resistance from most patients; (2) whether a "captive" patient audience would show resistance to a music listening session they were required to attend, regardless of their feelings about the music; (3) whether it is therapeutically
Definition of Terms Used

Resistance: The reluctance of the subject to give up habitual patterns of thinking, feeling, and acting to take on less neurotic and newer modes of adaptation.

Related Literature

There seems to be little literature dealing with the problem of resistance in patient music-listening groups. However, there is some literature that is closely related to this problem. Choisy\(^1\) states that the patient shows resistance “against himself,” not against the analyst. Further elaboration of resistance and its manifestations in therapeutic groups of psychotic patients may be found in a study by Rosen.\(^2\) Pertaining to listening to music, Szuman and Lissa\(^3\) state the supposition that listening is not only passive submission to acoustic incentives but active cooperation of the listener, emphasizing the influence of social factors. Geiger\(^4\) found that about twice as many people listened to a radio program of fine music when it was labelled “popular” as did when it was labelled “classical.” It would seem that some persons in audiences are frightened away by the terminology of classical music. This would seem to be a matter of semantics.

In an experiment concerning the efficacy of two methods of teaching music appreciation, Keston\(^5\) found that teaching music appreciation with explanatory comments is superior to exposure to “classical” music without comment. Esman\(^6\) says that in France, “hot jazz” appeals most to those who have regarded themselves as outside the accepted cultural framework, such as “intellectuals,” adolescents, and Negroes. Margolis\(^7\) also found

that jazz has attracted social elements in protest; the nature of jazz symbolizing and satisfying the adolescent's ambivalent conflict.

**Method and Procedure**

The patients in this study included open and closed ward male groups from two Veterans Administration neuropsychiatric hospitals observed at two different periods of time. The diagnoses of the patients from both hospitals ranged from neuroses to acute psychoses. Their attendance at each music therapy listening session was required as a part of the general therapeutic program of each hospital. The total number of group music sessions studied from both hospitals was slightly over thirty. These sessions met for one hour during the week. The number of patients in the groups varied between twenty and fifty.

The group music programs consisted of both "live" and recorded music performances. The performers ran the gamut from individual instrumentalists and vocalists to symphonic groups. The "live" performers included volunteers, music teachers, professional musicians, music students, music therapy trainees, and music therapists. The types of music performed consisted of folk songs, sacred, country and western, popular, semi-classical, and classical. The length of the musical selections was limited to approximately five minutes due to the (assumed) comparatively short attention-span of some of the patients. This also allowed for demonstrations and discussions between each number played. These discussion periods varied with the questions and interests shown by the patients. In these intervals, interesting data regarding the composers and performers were presented. In addition, instruments such as the harp, bassoon, celeste and saxophone were demonstrated, and the history of their development added further to the discussions. The sessions also included films pertaining to music, talks about music in different countries, and other material that, covertly, would offer educational value.

The patients' reactions to the music and discussions were obtained by observing their behavior during each session and by their verbal responses at the end of each session. Observations were made by the psychiatrist, nurses, ward personnel and music therapists.

**Results and Interpretations**

The observed behavior varied from that of patients who slept through the sessions, to that of patients who wandered restlessly
back and forth between the drinking fountain and the toilets. There were some patients who appeared to be completely indifferent to the entire proceedings. There were others, however, who evinced a keen interest in the music and discussions. Among these, the sociopaths entered into the conversation with compliments and apparent enjoyment, using the occasion to manipulate in their own behalf the performers and therapists alike. Among some of the schizophrenics who seemed to have shown little interest, there were those who showed appreciation and expressed themselves with approbation. At times this was not only disconcerting, but almost a shock to those who ordinarily had these patients under their supervision, since these patients usually had shown little interest in their environment.

In some of the earlier group music sessions the patients were noisy and restless whenever the numbers were uninteresting and the discussions too long. It was found that some patients tended to project their own feelings into all the musical selections played during a music session, regardless of the melodic, harmonic, or rhythmic structure of the music. For instance, one patient stated that "Pomp and Circumstance," "The Bee," and "None but the Lonely Heart" were all sad and solemn. Patients were unequivocally frank in their remarks about liking or disliking the programs. Some stated that they felt uncomfortable when listening to music in the group sessions. This was felt to be an expression of anxiety aroused by the attention required in concentrating on the musical selections, for it was observed that such patients seemed to be unaffected by music when heard over radio and television to which they were not required to listen. This also is in keeping with some patients' feeling that they must make an attempt to cooperate, however unwillingly, since many regard the hospital in the category of a prison. Many of the patients showed genuine interest in the group music listening sessions, complimenting the artists on their performances, and seemed to appreciate the efforts that were made in their behalf.

There did not seem to be any specific type of music that evoked resistance from most patients. It was interesting to note that for the most part the group accepted "classical" music with quiet attention and with a relaxed attitude. This was especially interesting in light of the fact that many of the patients had never been introduced previously to this kind of music because of their cultural patterns and environmental backgrounds. In fact, it was felt that a great deal more resistance would be met during "clas-
Research

"classical" performances than was the case, for emotional outbursts are common among disturbed patients. Although it was impossible to measure the results of this study objectively, it was felt that the observations of the personnel involved, based on the patients' responses and observed behavior are of interest and worthwhile reporting.

Summary and Conclusions

It has been observed that some male patients in neuropsychiatric hospitals show resistance to group music listening sessions. This is not always expressed as dislike, but often as some form of rationalization. Two similar male groups of neuropsychiatric patients were required to attend such sessions for an hour once a week. The number of group sessions was slightly over thirty. The number of patients in each group varied between twenty and fifty. The program range was varied and diverse with "live" and recorded individuals and groups playing music which varied from country and western to classical music. On the basis of the results derived from this study, the following answers to the questions asked in the problem may be made:

1. There does not seem to be any specific type of music that generally evokes resistance from most patients.

2. In the initial phases, resistance was met from many patients by requests to be elsewhere, to finish work in other departments, etc., but as the music listening sessions continued these disapprovals evaporated.

3. Although required to attend sessions, patients as a group derived benefit whether or not they wished to be present. The presentation of music for its educational value, just as all therapy eventually is "educational," makes it go hand in hand with other treatment.

Resistance is a definite factor with which we must deal, regardless of whether it appears in the relationship between an analyst and his patient, or whether it is shown by patients in a group to whom are presented music as a form of therapy.
AN EXPLORATORY STUDY OF SINGING AS A MUSIC THERAPY OPERATION FOR THE REHABILITATION OF KORSAKOW PATIENTS

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INTRODUCTION

A few months ago, Dr. Naomi Raskin, chief pathologist at the Boston State Hospital, requested the cooperation of the Music Therapy Department in an attempt to rehabilitate a 57-year old Irishman suffering with Korsakow psychosis. She had noticed that he experienced a severe memory loss, especially for recent and immediate events, but that he could reproduce completely, or nearly completely, Irish ballads which seemed to have been learned in youth.

The patient had been a chronic alcoholic for several years. On admission to the hospital, he showed several types of memory disorder. One of these, a falsification of memory, presented curious mixtures of past experiences with present events. There also appeared another process, a number of confabulations, contradictory in character, in which he seemed to try to explain gaps in his recall by presenting a very reasonable fabrication, only to forget what he had invented in it, so that the next moment he would substitute another different story for the first. He seemed to think that the second World War had not yet ended, and that Franklin D. Roosevelt was still president. Such confusion of time, space, and relationships resulted in distortion of his perceived environment which he tried to hold stable and make definite by minimizing his circumstances in a sort of mild euphoric good humor with little concern for his present plight. In response to inquiries about where he was, what day it was, his name, etc., he would say either some nonsensical answer or make a resigned “I don’t know that, Miss”. He was almost completely disoriented in time. “What day is this?” “Thursday” (correct). “And what day was yesterday?” “Monday.”

Most accounts of the Korsakow syndrome indicate that this psychosis is more organic than toxic in its etiology. Many cases
are reported showing permanent changes in the central nervous system with deterioration in cell structure in the brain. Dr. Raskin, however, declared that many of her autopsies on Korsakow patients revealed no such organic lesions or cell deterioration. Of course, this would not rule out the possible chemical influence on cell function which might not manifest itself structurally at all.

Anatomically and physiologically, there exists a very interesting separation of verbal, speech functions, and music-making functions in the brain. Because the main objective with this patient was to test the ability of the brain to contribute toward musical function rather than oral function, it was peculiarly appropriate for the music therapist. Goldstein did not subscribe to the theory of localization in different areas of these functions. Today, it is well established that these physiological differences of locus exist. The area of motor speech (Area 44 of Broca) lies above and behind the area controlling music-making (Area 45). (The numbers refer to the classification scheme of Brodman.) With respect to the recognition of speech, (Areas 41 and 42) two comparatively small areas identified as Wernicke's area, are located more centrally and in and near the central fissure, and are in the temporal lobe. The music recognition area localized in Area 38, is well forward, making up the tip of the temporal lobe.

From the viewpoint of function, neurologists seem to hold fairly uniformly that there exists dominance in one or the other of the cerebral hemispheres. Especially is this important for our present study, since if lesions and/or deterioration might be assumed to have occurred in the speech recognition areas, it would not be reasonable to think that such disorder would exist equally on both sides. The same would hold with respect to musical recognition, as well as to the two motor areas of speech-making and music-making.

In regard to the speech-making areas, one side "dominates the other side to a considerable degree, so that injury to the major side can cause an almost complete motor aphasia while a lesion on the minor side may have no detectable consequences." Now, this picture seems to change in regard to the sensory system by which speech sounds are recognized.

Neurologists have usually considered that the area referred to in the preceding paragraph (Wernicke’s area), is partly concerned with auditory memories and association. Some are even more specific. They believe Wernicke’s area is the area for recognizing the meaning of speech sounds. In this function, as in all language functions, the major side is very much superior to the minor side, so that a lesion on the major side causes practically complete loss of ability to understand spoken speech (word deafness).¹

This suggests to us that for language functions the existence of this dominance of one side of the brain over the other provides the physiologic substrate explaining loss of speech-making functions and speech-recognition. But, the same condition, physiologically, does not seem to prevail with respect to the music-recognition areas. In the case of this sensory area, Morgan and Stellar continue by pointing out that the brain is so organized that it has its memories for speech in one place and those for music in another. Yet many neurologists believe their evidence indicates that the area assigned the duty of recognizing music is area 38, which makes up the tip of the temporal lobe. There is supposed to be a little dominance of one side over the other but not very much. For that reason, losses of musical memory (amusia) are rather rare.²

We may gather from this that losses of musical memory should be less likely than in the case of speech.

The problem of localization of memory functions is viewed differently by different neurologists. Thus Henschen,³ for example, believes in strict localization of functions, while Goldstein,⁴ on the other hand disagrees and holds to the view that there is little localization. Whether one adopts the view held by Goldstein, Hebb,⁵ and others, a view that seems to suggest that the capacity for rehabilitation of function, in this case memory function, depends upon the amount of intact mass of the particular area of the brain with which one is concerned, or whether one speculates

1. Morgan and Stellar. Ibid.
2. Morgan and Stellar. Ibid.
on the authority of Henschen, Nielson, and others that vicarious functioning gradually takes over the operations of a different incapacitated mass does not need to limit us. In either case, explain it as you may, we want to know whether developing the patient's ability to reconstruct songs with which he has had no prior contact covaries with his recovery of other forms of memory function and attendant signs of improved contact with reality.

**Experimental Procedure**

It was decided to bring the patient into an office equipped only with two chairs and a flat-topped desk. Sitting opposite the therapist, the patient was first requested to sing anything he wished to. After one minute of singing ad libitum, a period of two minutes was assigned to testing his recall from the previous learning of songs acquired from us quite recently. In a third period of singing the old material he was fairly well able to reproduce from songs he learned in youth. A two-minute rest period then occurred allowing the patient to smoke, go out of the room, stretch, etc. Then a period was instituted amounting to from one to nine minutes of intensive teaching of the new material followed by a five-minute test period to see how much of intact sequence he could reproduce without prompting by the therapist. Each of the four-phrase songs was repeated five times, and notes kept on the time involved in each recall of a phrase. Every effort was made to keep the patient vigorously occupied throughout the period which never lasted more than thirty-five minutes. Special notes were kept on blocking events, words, music, associations, and remarks were written opposite each of the several periods referred to above as the interview proceeded. As far as was possible the interview was held at the same hour each day. These meetings were kept every day of the week except Saturday and Sunday, and on one or two occasions when the female therapist was sick. The procedure continued for ninety-two days. The patient is still being seen irregularly, but the formal study was dropped at the end of that time.

Certain signs appeared as the contacts progressed which mark the progress of the patient from one level to another. During the first twenty-three meetings, the patient's general bearing showed the mild euphoric good humor referred to above, with no resistance to suggestions except to laugh self-consciously if he could

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not remember a passage. During this time, he was unable to recognize the therapist as someone he knew or had seen the day before, much less to call his name. When the female therapist conducted the interviews he called her “Miss” or “Nurse”. He thought the male therapist was someone he had met in a tavern in South Boston. Another characteristic response during this period was a marked tendency to make up stories on the spur of the moment, as if to keep the conversation jolly, animated, and continuous. It was also noteworthy that during this period the early testing period failed to produce any change in his reconstructions of new material. In his production of old Irish ballads, certain events seemed to mark a blockage at which he regularly failed to be able to continue the song. In singing, for instance, “The Daughters of Erin” this would happen consistently after a number of lines which ended with the words, “as pure as the heather that grows on the mountain ...” This song was the first one he sang of his own accord in the opening free-period. The second ballad (usually following the above) began with “He was only a private soldier” and continued a sentimental story of the soldier’s homesickness and ultimate demise. His memory seemed to get snarled on the line, “He had left a feeble mother and a father who was old and grey and a dear little cot.”

The patient entered a second stage with the twenty-fourth meeting. Up till now the duration of the first test period phrases never exceeded more than five or six seconds involving less than the first two phrases of the new material. But at this meeting, new signs began to appear chiefly in his musical recognition pattern. The new material seemed to begin to “jell” and he could produce from ten to twelve seconds of intact sequences of the phrases of “Jacob’s Ladder,” when he first entered the room. He also seemed to want to sing these songs in preference to the Irish songs. A Czech hiking song, “Over the Meadow,” was introduced in addition to the imperfectly mastered “Jacob’s Ladder.” In the warm-up period preceding the first test period, he began wanting to sing popular tunes such as “Side by Side.” During the first two periods, he was given no prompting as to the words of the song, but the therapist tried playing the tune on the piano. His comment on entering was: “Yes, I know you; I told you I’d think of some songs but never remembered until now when I saw you.” The patient did very well on this occasion with “Over the Meadow” in the first test period. He was given no words, just listened to the
music and constructed the correct lyrics himself, and sang the song perfectly the first time. Afterwards he did make some mistakes. He said that he did recognize the tune as it was being played. This was quite different from the response he gave to “Jacob’s Ladder,” which he could not seem to recall now without extensive prompting. The patient said on several of these occasions in this second group that he thought his memory was coming back. This only seemed to precede the deeper manifestations of anxiety which appeared later.

At the Doctor’s suggestion a few questions were asked of him with the following results: (1) “Where are you?” (reply) “Hospital somewhere.” (2) “What is the name of this hospital?” (reply) “I don’t know.” (3) “What kind of a hospital is this?” (reply) “State Hospital.” He stated again that he lived at (gave a Boston address), and he felt that he was beginning to remember things, but he continued to be disoriented as to dates and current events. Said that Roosevelt was president and that this was 1936. On the next day, a check was made as to his correct address and it was found to be 449 instead of 491. When this was mentioned to him, he said, “Yes, that is it, you’re right!”

Beginning with the sixty-seventh meeting, certain trends which had already been developing previously began to emerge more clearly. First, a noticeable change was taking place in his general attitude. He was irascible instead of euphoric. He got into a fight with another patient and lashed out at the attendant. With these seeming hostile reactions there was an undercurrent of hopelessness and anxiety which indicated an increasing awareness of his plight, his locale, his surroundings. Second, he could not do much with “Jacob’s Ladder” in test periods, and it was finally dropped from his routine examination. He could reproduce “Over the Meadow” and “Side by Side” at will, and as he walked from the ward to the music room he would improvise his own wishes into lyrics which he sang to the therapist to the tunes of the several songs he had learned. But in his distress, he was often uncooperative and eventually, we were no longer able to continue the formal observations.

Observations and Suggestions

So much of the foregoing is of such a complex nature and involves so many different functions that we must say that much clarification and research is needed before one can generalize his
observations, or do more than speculate about the possible explanations for the Korsakow's chief characteristic, his severe loss of memory.

It is plain that in the case described above, the musical activity of this patient contributed to his becoming more aware of his surroundings and his state. Certain musical events became undesirable to him, while others appealed to him. Along with his development, as he "dried out", there was noticeable deepening of his anxiety, and greater facility in recalling new material. It seems justifiable to state that his perception of the limited area of his environment associated with these daily musical experiences had gradually become stabilized and definite to him. Along with increased control of musical recognition there was an improvement in speech recognition, but an increasing difficulty in getting along with others around him.

The rehabilitation value of this development would hardly guarantee his return to the level of occupation and personal relatedness in the community from which he had come. Perhaps this one individual might, under supervision, be able to carry on some routine task in which remembering simple aspects of the task might be reliably predicted. In this way he might earn a limited amount of money.

**SUMMARY OF FINDINGS**

A carefully controlled procedure having been established on a daily schedule, a 57-year old male patient with Korsakow's psychosis was enabled in less than one hundred treatments to recall complete musical numbers which were not known to him prior to the experimental study. Along with improvement in musical command, better orientation occurred for dates, places, and personnel. These two forms of improved contact with reality were accompanied by signs of anxiety and defective interpersonal relationships.

**CONCLUSION AND RECOMMENDATION**

We may say that the results of the introduction of this music therapy "singing operation" are far from discouraging, if not somewhat encouraging. It is urgently recommended that a number of patients be found in several different hospitals in different parts of the country, and that uniform procedures be designed and tested, and that the results be noted and tabulated, perhaps through the good offices of the NAMT Research Committee. It is
hoped that such a process will be governed by a refined experimental design so that, eventually, statistical probabilities may be calculated and published, once they are established.
This paper reports the results of a study carried out in Toronto, Canada, to determine whether children affected with muscular dystrophy would be able to take part in musical activities and whether they would benefit from these activities. The project was under the auspices of the Canadian Muscular Dystrophy Association, and was conducted at the Home for Incurable Children, a hospital school, and Lyndhurst Rehabilitation Lodge, from November 1956 to June 1957.

Progressive Muscular Dystrophy is a term used to designate a serious crippling disease. The study of muscular dystrophy is of recent development, and even today attracts comparatively few research workers. This disease attacks the voluntary muscles which then waste away, and eventually it renders the patient completely helpless. It invades the body without pain and without warning. Between 60 and 70 per cent of its victims are children, who seldom live beyond adolescence. There is no known cure at the present time nor is there any kind of effective treatment that will halt or retard the progress of the disease.

Dr. Milhoret from the New York Cornell Hospital, has emphasized that the physical handicaps in muscular dystrophy do not interfere with intellectual function. However, dystrophic patients may appear slower in their responses. They seem to have weaker reasoning capacities because they do not get as much experience as the normal individual. Personality tests indicate that most muscular dystrophy children are quiet and emotionally immature. Although they often appear happy on the surface, closer observation reveals deep feelings of hopelessness, despair and dread of the future. In addition, their isolation, helplessness and deep sense of uselessness and incompetence make it all the more vital that they be given opportunities to become involved in activities which might give them a sense of accomplishment. Working in a group is particularly important to muscular dystrophy children because it enables them to learn to contribute to their own
community, to assume responsibility by doing minor tasks and to develop skills through working together.

The unavoidable facts that degeneration takes place faster than rehabilitation, and that the life-span of the muscular dystrophy child is short and progressively more inactive, have resulted in defeatist attitudes on the part of educators and the community toward their rehabilitation. Perhaps this has been responsible for the apparent neglect of these children, who, after all, have hopes, aspirations and inner resources which can be developed.

During my work with handicapped children in the past five years, it became quite evident that those suffering from muscular dystrophy were the most forgotten group. I felt that an educational and recreational music program especially tailored for them might be feasible, and therefore approached the Canadian Association for sponsorship.

My aims in this experiment were:
1. To encourage the child to express himself through music and to provide him with mental stimulation
2. To reduce the child’s isolation and to give him a sense of group participation and a feeling of achievement (which is difficult for children who lead such confined and dependent lives)
3. To help the child develop his latent potentialities and to broaden his creative experiences
4. To promote function wherever possible in the hope of counteracting atrophy from disuse

The initial group consisted of four children from the Home for Incurable Children, ranging in ages from 11 to 16. These children were in the advanced stages of the disease and showed marked wasting and weakness. After two months, they were joined by six boys and three girls who were living at home with their parents. The second group was from 5 to 12 years of age. Only two of the children were ambulatory; the remaining eleven were severely handicapped and in wheel chairs, with one girl having a body and neck brace for additional support.

These children were of normal intelligence, however, most of them suffered from under-achievement. All except two attended school, but only three were at the proper academic level for their age group, presumably because they were forced by illness to miss much of their schooling.

The class met for two hours every Saturday afternoon. The difficult problem of transporting the children was solved with the
help of volunteer drivers who collected the children in special station wagons and taxis from their homes throughout Toronto. After being unloaded the children were wheeled into a huge gymnasium in Lyndhurst Lodge.

At first the children were shy and withdrawn. I did not urge them to participate, feeling that they would, in time, gain confidence and realize that the tasks set before them were not beyond their ability. The first few afternoons were spent in discussions on the evolution of music from ancient times, and how early instruments were made by primitive peoples. By the third session, eight of the children were ready to take part in our musical explorations.

Even without music it is natural for children to skip, walk and jump with rhythmic motions in games and spontaneous activities. Since physical bodily movement is the starting place for the expression of musical feeling, it was felt that rhythm play should be the initial step in our group work. These muscular dystrophy children, hampered by their multiple physical disabilities, were unable to express their natural musical feelings. It was necessary to show them how they could respond rhythmically before they could experience a sense of release through music.

To help them use their imaginations and move their limbs to rhythm, I chose the form of the music story. This was always done with a piano and various instruments such as auto harps, glockenspiels, drums and recorders, while an assistant led the class in the motion patterns. All of the children could participate because it was sufficiently interesting for the older ones and not too difficult for the younger ones to follow. Because many of the group were boys, these stories took the form of adventures to far off countries. For example, we would take a safari through Africa. Through mime with a music accompaniment, we went through the motions of waking up and preparing for a ride to hunt a lion. We mounted our horses (the children beating their hands on their thighs or chairs for hoofbeats), we went over bridges, through swamps, skirted around snakes we saw on the way and finally dismounted—for there ahead of us crouched a huge lion. After killing it with a single shot, we galloped home to feasting and music.

This simple example illustrates the therapeutic use to which these stories were put. The stimulus of the imagination, aided by well-defined rhythms, made response to these organized exercises spontaneous and enthusiastic.
Because of the low muscular endurance of these children, it was necessary to arrange a program which alternated between active and quiet participation. Their energies must always be carefully husbanded, and this kind of scheduling helps sustain their interest. To get the needed variation in the program, we evolved the practical work which, though it overlapped into other fields of art, was related to our music-making in different ways. For instance, during our discussion on primitive instruments, the children themselves suggested that they make drums on which they could beat out the rhythm patterns. And so, drum making became our first related project. This was undertaken as a co-operative effort, each child doing whatever part he was able to perform.

After this project started, the class was divided into different groups. One section made drums and eventually included such activities as cutting out cardboard figures for puppet work, painting puppet theatres, or working on mosaics. Another group had some instruction on simple instruments—recorders were used for jaw muscles—auto-harps and xylophones for forearm muscles. They also worked on rhythm patterns using speech, body-slapping, echo-clapping, and echo-singing. Sometimes they did choral readings from “Hiawatha” or played music bingo. The last was extremely useful when the children were less energetic.

Meanwhile the younger children were wheeled into position around the piano and learned action songs, did some rhythm band work or took part in dramatic play. In this, the children no longer were Susie, Billy and Andy confined to wheelchairs, but Peter Rabbit eating carrots, or a big angry giant, or perhaps a very proud streetcar conductor. These characterizations formed the basis for little operettas enabling the children to use their imaginations. The small ones especially enjoyed what we called hand-dancing. For this we used a modified type of handpuppet made from paper serviettes with faces crayoned on by the children and secured by rubber bands around their wrists.

Each group switched from one activity to another when necessary. Junior assistants were always ready to wheel a child from one group to the next if he tired before the others. Despite this permissive atmosphere, there was no difficulty in maintaining discipline, after the first few sessions. The flexibility of the program was an asset to discipline and morale because the children apparently enjoyed the freedom to choose their activities. We also found that those who worked with their hands, despite the
absorption in their own tasks, often listened to and commented on the music activity in the background.

One undertaking which was within the scope of these children was a shadow puppet theatre for which the story of Peter and the Wolf was eminently suitable. The puppets of Peter, the grandfather, the wolf and other animals were made from light weight cardboard with balloon sticks for support. The screen was made from stage cotton with the scenery painted by hand. Even the most severely disabled were able to manipulate the puppets without difficulty. A desire to hear recorded orchestral music evolved from the venture. For the puppetry, a shortened version with narration was used. However, the children were soon eager to hear a recording of the original work. From this we progressed to the inclusion of music appreciation in the classes.

At this point I should mention another project, which, though not connected directly with the muscular dystrophy program, was an achievement of lasting value for five of these dystrophic children. In June, 1957, with the aid of the Occupational, Physio and Speech Therapy Departments of the Home for Incurable Children, I produced the first Canadian wheel-chair show which was held before a large public audience. This was conceived as a full-scale therapy project. It had a cast of 43 handicapped children, and included a Ballet on Wheels, done to Prokofiev's Cinderella, a puppet show of Hansel and Gretel, and an hour long Wheel-Chair Operetta.

The children received a standing ovation and the show was later televised throughout Canada. Significantly, muscular dystrophy children took leading roles in this production because we wished to demonstrate that no matter how handicapped a muscular dystrophy child may be, he still has potentialities which can be realized, and a medium can be found through which each child can achieve his own level of success.

I want to emphasize the danger that lies in beginning a music program for handicapped children on too sophisticated a level. To develop musical interest and understanding in these children, to release their creative powers in this field of expression, one must begin on their level. Only by helping them to make music and to carry out an interesting program of related activities can success be realized.

**CONCLUSION AND SUMMARY**

It is difficult to evaluate the extent to which this project helped the children physically. There is a tendency on the part of those
who come in contact with muscular dystrophy children to try to do everything for them, thus robbing them of opportunity and incentive to use their limbs and perhaps, thereby, increasing their sense of incompetence and dependence even further. In this program every effort was made to get the children to do things for themselves. Just possibly the movements involved might be an influence in counteracting disuse atrophy.

Regarding the psychological effects, both individual and collective attitudes were quite evidently changed. At the beginning of the project the children were passive and withdrawn, social interaction and communication were limited. Afterwards: six children, who were frightened and reluctant to attempt an active role in the group, were absorbed into the program; two children, who were not able to accept authority or discipline, finally achieved a better social adjustment with their classmates and with the therapist; two boys, who were less incapacitated and who openly ridiculed those less fortunate than themselves, became active members of the whole group and began to show concern and consideration for the others.

Having acquired motivation, it became progressively easier for the children to shift from a passive attitude to one of interested and eager participation. Thereafter, discipline came from the group itself. Because the program aroused their interest and curiosity, communication with the therapist and with each other was stimulated. All observers, therapy and nursing staff of Home for Incurable Children, and one social worker, felt that the interpersonal relationships within the group showed marked improvement. Perhaps the best indication of the effect of the program lies in a statement made by one of the adult polio patients at Lyndhurst, “I can’t understand what kind of magic goes on down there. The kids go into the gym as quiet little ladies and gents; they come out a few hours later as noisy, laughing brats.”

In my opinion, music can have a definite therapeutic value for the muscular dystrophy child. We must, however, bear in mind that the inevitable result of this disease is complete bed-confinement. At that stage the children scarcely have the ability to function. Therefore it is all the more important that during the time that they still have limited mobility we begin to build up some resources from which they can later derive comfort and satisfaction.

For these children, music with its ever-varying appeal to the imagination can provide the imagery and emotional release that
they will need when the power of motion is completely gone. I believe that they need music more, not less, than other children, and that the seed planted in music classes is one that will bear a harvest in the last stages of their lives.
THE EFFECT OF MUSIC ON MUSCLE TONUS

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INTRODUCTION

"The entire output of our thinking machine consists of nothing but patterns of motor coordination . . ." because " . . . all brain excitation has ultimately one end, to aid in the regulation of motor coordination. Its patterning throughout is determined on this principle." So writes R. W. Sperry. Furthermore, he believes, greater success will be attained in discovering neural correlates of consciousness when efforts are directed on this basis rather than any other. This may, at first, appear heretical to those oriented in dynamic psychiatry, but it would seem to be a logical conclusion if the phantom of dualistic thinking concerning mind and body has been truly eradicated from their thinking. Be that as it may, this thought serves to underline the philosophy upon which this study is based.

Physical rest is mandatory for treatment of almost every illness. Many books have been and are being written which attempt to show one how to relax within our increasingly complex and accelerated society. Illnesses having tension as a major symptom are more frequently noted in the clinic and the hospital. The production, sale, and use of sedative drugs is on the rise, to the alarm of many health officials. All this is common knowledge and observation, and indicates the importance and necessity for studying the problem of tension and ways of controlling or alleviating it.

May music serve such purposes? By observation, we infer that it may. Music used for functional occasions, such as ceremonies, dancing, sports, religious gatherings, and so on, exhibits similarities from culture to culture both in its general tonal construction and the observed effects on the participants. We have come to apply the words sedative and stimulative to various kinds of music. If these observations be correct, they should be amenable to more controlled investigation. Such was the intent of this study; generally, to determine by direct measurement the effect

1. This paper is an abstract of a Ph.D. dissertation in process of completion at the University of Kansas, Lawrence.
of music in evoking changes in the muscle tension or tonus of music listeners.

**Related Literature**

In relating some of the background information for this study, investigations of the uses of music will be omitted, since it is assumed the reader will either be familiar with the findings or will have had access to other reviews in previous Books of Proceedings.

That sound stimuli may have effects on human motor pathways in more direct ways than through the cortical sensory mechanism may be seen by referring to Diagram No. 1, page 205. This diagram is a schematic composite of information gathered from many sources.\(^1\) In some cases specific neural pathways, especially their connections, have not been definitely established but have been inferred by the evidence available to the various writers. It is significant to note that sound stimuli may be routed directly to motor effectors before it reaches the level of conscious sound. Very pertinent to this study is the following: probable afferent pathways originating in the cochlea can be traced to the dentate nucleus which exercises an inhibiting and a facilitating influence upon motor activity. When the dentate nucleus discharges at a low frequency, inhibition of motor activity takes place while facilitation is produced by a high rate of discharge.\(^2\)

The nervous system transmits intensity variations of a stimulus by changes in the frequency of discharge of the neurons concerned; the greater the intensity of the stimulus the more rapid the discharge rate. Combining this with the fact that one of the main differences between stimulative and sedative music is that of intensity and intensity pulses (rhythm), one arrives at a possible neurological correlation for the affectivity of music.

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1. Includes the following sources:

   
   
   
   
   

Psychologists call set the postural attitude assumed in the preparation for and the carrying out of an activity. This set is necessary for the efficient accomplishment of any task and is evident in the overt posture of the individual concerned. This posture, of course, is the result of muscle tension or tonus within the individual.

Such writers as Dunbar, Freeman, Reich, Kempf, Gesell, Freud, Allport, Jacobson and Cobb have stressed the importance of postural tension in psychology and psychiatry, its meaning as a direct reflection of the emotional state of a patient, and its use in diagnosis and treatment. Freeman states that instead of being merely handmaidens and servants to the brain, the muscles are seen as important regulators and determiners of its function. . . . The balance of evidence favors the view that the nervous system acts as a total integrated unit rather than a mere aggregation of isolated pathways.

Jacobson concludes that complete relaxation of peripheral parts results in the diminution or complete absence of mental activities and emotional states.

With this brief background, the problem of the study may be more specifically stated:

1. Can music stimuli, chosen according to the characteristics now generally labeled sedative and stimulative, evoke changes in the muscle tension or tonus of persons listening to the music?

10. Freeman, op. cit.
2. Are there any differences in response between musicians and nonmusicians, between males and females?

3. Since graphic records of the electrical activity within certain muscles of the listeners will be obtained, are there any patterns of activity peculiar to either sedative or stimulative music stimuli?

**Equipment, Subjects and Procedure**

A Grass Instrument Company electroencephalograph, set to record muscle action potentials, was used for recording indications of variation in the muscle tonus or tension of the subjects. The process of recording the electrical activity of muscles is called electromyography. Thus, for the remainder of this paper, the electroencephalograph will be referred to as the electromyograph. A fine quality record player, amplifier and speaker system were used for presenting the music stimuli which were a rather large number of records sampling the popular, classical, semi-classical and primitive categories of music literature. All the records were instrumental music and were chosen for sedative and stimulative characteristics. The testing studio, in a section of the University of Kansas Memorial Hospital, consisted of two rooms. One room was electrically shielded and acoustically treated. It had the speaker system built into one corner and contained a chair for the subjects. The other room contained the electromyograph, the record player and amplifier. An observation window opened between the two rooms.

The design of the study called for college age subjects in the following categories: four male musicians, four female musicians, four male nonmusicians, four female nonmusicians, or sixteen persons whose responses were to be recorded during three different testing periods. Twelve male musicians, twelve female musicians, twelve male nonmusicians, twelve female nonmusicians, or forty-eight who were to be tested only once. Through circumstances beyond control, the total number of subjects in some of the categories was not obtained. However, seventy-five individual testing periods of forty-five minutes each were held, resulting in approximately 12,000 feet of electromyographs.

The procedures for conducting electromyographic studies as outlined by Davis¹ were followed within the capabilities of the

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equipment used. Nearly five years of pre-testing with several hundred subjects preceded this study. The hospital technician operated the electromyograph while the investigator presented the recorded music at controlled intensities appropriate to the musical selection.

The subjects were tested individually and in the same fashion. They were seated on a straight chair with their hands in their laps; sponge type, surface electrodes were placed on the extensor and flexor muscles of the right forearm. The electromyograph was turned on to record the subject's existing tension level. When a subject's response indicated a high degree of tension, sedative music was played, and contrariwise, if the degree of tension was low, stimulative music was played. As the subject's tension level varied up or down a significant amount as observed by the investigator, the music was changed in an attempt to move it the other way. The subject had been requested to remain in the same position and to refrain from making overt movements. If he needed to stretch or change position, the procedure was interrupted to allow him to do so and appropriate notation was made on his chart.

No attempt was made to use a planned sequence of music for all subjects nor for any subject studied three times. The intent was merely to evoke changes in a subject's tension level by means of music stimuli controlled at the volition of the investigator.

Before this study was begun, certain deficiencies were known to exist. Since the electromyograph was a clinical instrument used by the hospital, certain limitations and precautions too involved to pursue here were placed upon its use. Testing periods had to be geared to the hospital schedule. Recordings from more muscle groups should have been taken simultaneously, but time was a limiting factor. The use of an electronic integrator for changing the tension recordings into more analyzable form would have been highly desirable.

TENTATIVE RESULTS, CONCLUSIONS AND DISCUSSION

Since the data gathering portion of this study has just recently been completed, the analysis of the data is still in process. However, several tentative conclusions can be drawn, subject to future modifications or extensions. These conclusions are based only upon the impressions gained during the course of gathering the data and a cursory examination of all the data after the gathering had been completed.
Music stimuli does evoke changes in the muscle tonus of listeners, and the evoked effects of increased or decreased tonus correspond closely with what is implied by the terms stimulative and sedative music. This holds true when considering the responses of all subjects as a group; individual responses do not always give such correspondence. In some instances, a subject’s tonus level was below the threshold recordable by the electromyograph, so no changes were recorded. At other times, after sedative music had been used, the tension level dropped below this threshold and could not be raised again. Sedative music reduced the tension level in nearly one hundred percent of the times it was used. Stimulative music, however, was less effective in increasing tension levels. This, possibly, resulted from instructing the subjects to refrain from overt movement. A subject may have become more tense in some other part of his body and may have forced voluntary relaxation of his right arm. This points to the necessity of further study using more muscle groups.

Changes in tonus were more effectively produced in nonmusicians than in musicians, and in female subjects more than in males. These phenomena possibly have educational and cultural implications in need of investigation.

With one exception, for all subjects, the electromyographic patterns were similar in shape for both the sedative and stimulative music, a very complex and asynchronous pattern with the stimulative music effecting an increase in amplitude and frequency of the spiked pattern. The exception occurred several times during which stimulative music had been played. The pattern changed from an asynchronous to a synchronized, repetitive pattern resembling rather closely the graph of a complex tone, with a fundamental contour superimposed with overtones. However, in each instance, the stimulative music used had its own distinct characteristics, a regular, repetitive rhythm with strong dynamic accents.

One other result seems worthy of mention at this time. One subject had a muscle twitch in his right arm. It was evident in his electromyogram. During stimulative music, the twitch increased in both frequency and amplitude, and decreased in both aspects during sedative music. However, when an African drum record was played, the twitch disappeared approximately five seconds after the record started and remained suppressed until the end. Then it returned. This phenomenon presents another problem for future study.
[Following the reading of this paper, sample electromyographs were projected on a screen with an opaque projector. A portion of one subject’s record was made to move across the screen while the music which corresponded to the record was played on a tape recorder.]

Diagram No. 1
Schematic of Probable Auditory Pathways
A STUDY TO DETERMINE POTENTIAL MUSIC THERAPY NEEDS IN A FEDERAL CORRECTIONAL INSTITUTION

DONALD E. MICHEL

Assistant Professor and Director of Music Therapy Program
Florida State University, Tallahassee, Florida

INTRODUCTION

At the Federal Correctional Institution, Tallahassee, Florida, Chaplain Worth Conn indicated an interest in expanding the rehabilitation activities for inmates with the use of music. In order to determine the present uses of music in the institution and the potential needs for music therapy activities there, this study was undertaken by a group of students in the class, "Problems and Procedures in Music Therapy," in the School of Music at Florida State University, under the direction of the writer. A few music activities were already in operation under the chaplain's auspices, such as a choir and a weekly fellowship hour where there was community singing. During the past three years, university students had been employed on a part-time basis to assist in these activities, and performing groups from the university and the community periodically presented programs for the inmates. In addition, an intramural public address system was being utilized to provide radio and record programs in the dormitory areas of the institution, with inmates assuming responsibility for its operation.

The Federal Correctional Institution represents one of only a few such institutions in the federal penal system. In these institutions the slowly changing concepts of penology find expression in the provision of corrective and rehabilitative programs. Accordingly, this institution seemed to present an ideal situation in which the potential uses of music therapy might be explored. When the chaplain agreed to cooperate in surveying such potential uses, and secured institutional administrative approval to do so, this study was undertaken.

In reporting the findings, the students who carried out the study wrote their reports individually and utilized various approaches in their introductions. These included historical background of the changing philosophy of penology and references to the few articles available on the uses of music in penal

institutions, especially those reported at former NAMT conferences by Benedict.1,2 Because of limitations of time and space, these references are not cited herein. (A bibliography is provided with this paper, however.)

PROBLEM

The problem of the study was stated in the form of specific questions to be considered, as follows:
1. What music is being used at the present time, and how is it being used?
2. How does the present program fit the criteria of a music therapy program?
3. What are the needs for music in such an institution?
4. Can music therapy contribute to the rehabilitation program of such an institution; if so, how?

METHOD

The method of this study was the survey. Background information on the institution itself and its present program was provided by the chaplain and the warden. A questionnaire was devised to be distributed to inmates, (who filled them out anonymously) seeking to determine interest, and levels of interest in music activities, present and future. Visits to the institution by the students to inspect physical facilities and observe inmate participation in music as well as in other activities was a part of the method used in this survey.

RESULTS AND INTERPRETATIONS

The results are presented in six tables (see following pages) which describe: (1) the institution and inmates, including types and prevalence of offenses which had resulted in the convictions of the inmates; (2) sample radio and music programs used on the institution public address system; (3) musical facilities and equipment including available instruments at the institution; and (4, 5, and 6), the results of the questionnaire. In addition, a narrative description of the educational, vocational training, exist-

ing music activities, and other correctional programs of the institution is provided in the original reports.

Summarizing, the results indicate that there now exist only minimal music activities, which for the most part must be considered recreational-diversional in function. Only a 30 plus percent return was accomplished on the questionnaire distributed to inmates, and many of the returns had to be considered invalid or at least highly suspect, because of the nature of the responses (some were facetious). Nevertheless, the questionnaire response showed that, unquestionably, there were a considerably larger number of inmates with musical background, and many more inmates with a genuine interest in music, than were then participating in music activities. In addition, reactions to the present music available, including the programs on the public address system, revealed a number of factors which should be helpful in future planning and programming. One item, for example, was the generally unfavorable reaction to the loudspeakers in the dormitories. After the study was completed, the speakers were replaced with individual earphone headsets in the dormitories so that inmates might choose to listen to programs or not, without disturbing others. One rather intangible result of the study reported by the chaplain has been an increased awareness of music activities and interest in music among the inmates.

CONCLUSIONS

Limited to the scope of this study, the following answers to questions posed in the statement of the problem can be made:

1. A small supply of music designed to satisfy the tastes of the majority of the inmates is provided at F.C.I. Most musical activity is passive (listening) with only a small percentage of the inmates participating in active musical situations.

2. The present program of music at F.C.I. only partially fulfills the aims of a music therapy program, and does so only in an incidental way.

3. Due to the questionable validity of some of the inmate responses to the questionnaire, it is difficult to state precisely what the needs are for music at F.C.I. It may be assumed, however, that the inmates have more interest in musical activities than is shown by the number who are actively participating now.

4. Considering the effectiveness of music in other institutional programs, it may be assumed that music therapy could con-
tribute to a rehabilitation program in a penal institution where there is a policy of attempting to socialize the individual and to change his attitudes from loyalty to criminal society to loyalty to noncriminal society. This conceivably could be accomplished through the planned use of music in group listening situations, and through the establishment of therapeutic relationships (group and individual) in music activities under the guidance of a trained music therapist.

SUGGESTIONS AND CRITICISMS

The most obvious criticism of this study is that the data obtained from the questionnaire is inconclusive. Further observation of inmates in activities rather than interviews with the staff personnel might provide a better picture. Interviews with the inmates also might provide a more complete picture of the needs and wishes of inmates than the data obtained in this study. Further study should investigate more thoroughly the needs and interests of the inmates, and small experiments might be done to test the degree of rehabilitative usefulness of various musical situations.

In summary, this survey has shown the need for further study of the needs and possible usefulness of music therapy techniques in penal institutions such as the Federal Correctional Institution at Tallahassee, and seems to indicate a positive need for development of music therapy activities at this particular institution.
Table 1

DESCRIPTION OF INSTITUTION AND INMATES

<table>
<thead>
<tr>
<th>Average Age</th>
<th>33.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>18–85</td>
</tr>
<tr>
<td>Average Length of Sentence</td>
<td>18 mos.</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>10 mos.</td>
</tr>
</tbody>
</table>

Most Prevalent Reasons for Incomplete Sentence

<table>
<thead>
<tr>
<th>Reason</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfer Good Behavior</td>
<td>234</td>
</tr>
<tr>
<td>Transfer Regular Parole</td>
<td>90</td>
</tr>
</tbody>
</table>

Average Rate of Turnover

<table>
<thead>
<tr>
<th>Method</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>100/mo.</td>
<td></td>
</tr>
</tbody>
</table>

Average Educational Grade Level

<table>
<thead>
<tr>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.6</td>
</tr>
</tbody>
</table>

Description of Offenses

<table>
<thead>
<tr>
<th>Type of Offense</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Revenue Liquor Law</td>
<td>234</td>
</tr>
<tr>
<td>National Motor Vehicle Theft Act</td>
<td>90</td>
</tr>
<tr>
<td>Interstate Violation</td>
<td>41</td>
</tr>
<tr>
<td>Forgery</td>
<td>33</td>
</tr>
<tr>
<td>Postal Law Violation</td>
<td>29</td>
</tr>
<tr>
<td>Narcotics</td>
<td>17</td>
</tr>
<tr>
<td>Theft of Government Property</td>
<td>16</td>
</tr>
<tr>
<td>Desertion</td>
<td>16</td>
</tr>
<tr>
<td>Larceny</td>
<td>14</td>
</tr>
<tr>
<td>Income Tax Violation</td>
<td>10</td>
</tr>
<tr>
<td>Murder</td>
<td>10</td>
</tr>
<tr>
<td>White Slavery</td>
<td>9</td>
</tr>
<tr>
<td>Selective Service Act</td>
<td>9</td>
</tr>
<tr>
<td>False Statements and Claims</td>
<td>9</td>
</tr>
<tr>
<td>Assault</td>
<td>9</td>
</tr>
<tr>
<td>Robbery</td>
<td>8</td>
</tr>
<tr>
<td>Embezzlement</td>
<td>7</td>
</tr>
<tr>
<td>Impersonation</td>
<td>6</td>
</tr>
<tr>
<td>Accept Wagers without Paying Tax</td>
<td>5</td>
</tr>
<tr>
<td>Rape</td>
<td>4</td>
</tr>
<tr>
<td>Immigration Laws</td>
<td>4</td>
</tr>
<tr>
<td>Extortion</td>
<td>4</td>
</tr>
<tr>
<td>Offenses on Government Reservation</td>
<td>3</td>
</tr>
<tr>
<td>Fraud</td>
<td>3</td>
</tr>
<tr>
<td>Indecency with Children</td>
<td>3</td>
</tr>
<tr>
<td>Theft on Government Reservation</td>
<td>2</td>
</tr>
<tr>
<td>Bank Robbery</td>
<td>2</td>
</tr>
<tr>
<td>Selling Government Property</td>
<td>2</td>
</tr>
<tr>
<td>Counterfeiting</td>
<td>2</td>
</tr>
<tr>
<td>Stowaway</td>
<td>2</td>
</tr>
<tr>
<td>National Stolen Property Act</td>
<td>2</td>
</tr>
<tr>
<td>Disobey Officer</td>
<td>2</td>
</tr>
<tr>
<td>Sodomy</td>
<td>2</td>
</tr>
<tr>
<td>Assault Postal Employee</td>
<td>1</td>
</tr>
<tr>
<td>Conspiracy to Destroy Vessel</td>
<td>1</td>
</tr>
<tr>
<td>Transporting Firearms after Conviction</td>
<td>1</td>
</tr>
<tr>
<td>Assault to Rape</td>
<td>1</td>
</tr>
<tr>
<td>Housebreaking</td>
<td>1</td>
</tr>
<tr>
<td>Burglary</td>
<td>1</td>
</tr>
<tr>
<td>Smuggle Aliens</td>
<td>1</td>
</tr>
<tr>
<td>Damage U.S. Property</td>
<td>1</td>
</tr>
<tr>
<td>Foreign Shipment Violations</td>
<td>1</td>
</tr>
</tbody>
</table>
Table 1 (continued)

<table>
<thead>
<tr>
<th>Type of Offense</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delinquency—Juvenile</td>
<td></td>
</tr>
<tr>
<td>Accept Bribe</td>
<td>1</td>
</tr>
<tr>
<td>Illegally Wearing Uniform</td>
<td>1</td>
</tr>
</tbody>
</table>

Enrollment in Vocational Training Program        | 64         |
Average Attendance at Music Appreciation Class  | 12         |
Average Attendance at Chapel Choir               | 25         |
Average Attendance at Music Sight-Reading Class  | 18         |
Total Inmate Population                          | 625        |

1 As of Midnight, June 30, 1956, for previous year.
2 Standard Achievement Level Test
3 Entering population of 621, out of total of 625 (five holdovers).

Table 2

SAMPLE RADIO AND MUSIC PROGRAMS (FOR TWO TYPICAL DAYS)
USED ON THE INSTITUTION PUBLIC ADDRESS SYSTEM

<table>
<thead>
<tr>
<th>Time</th>
<th>Thursday Source</th>
<th>Thursday Program</th>
<th>Friday Source</th>
<th>Friday Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>6:45-9:30</td>
<td>WTAL</td>
<td>Sam Zack Show</td>
<td>WTAL</td>
<td>Sam Zack Show</td>
</tr>
<tr>
<td>9:30-11:00</td>
<td></td>
<td>OFF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:00-12:00</td>
<td>WMEN</td>
<td>Sweet &amp; Swing</td>
<td>WMEN</td>
<td>Sweet &amp; Swing</td>
</tr>
<tr>
<td>12:00-12:15</td>
<td>WTNT</td>
<td>News</td>
<td>WTNT</td>
<td>News</td>
</tr>
<tr>
<td>12:15-12:30</td>
<td>WTNT</td>
<td>Luncheon Melodies</td>
<td>WTNT</td>
<td>Luncheon Melodies</td>
</tr>
<tr>
<td>12:30-3:30</td>
<td></td>
<td>OFF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3:30-5:45</td>
<td>WMEN</td>
<td>Music &amp; News</td>
<td>WMEN</td>
<td>Music &amp; News</td>
</tr>
<tr>
<td>5:45-6:30</td>
<td>WTNT</td>
<td>Sport Parade</td>
<td>WTNT</td>
<td>Sport Parade</td>
</tr>
<tr>
<td>6:30-7:30</td>
<td>FCI</td>
<td>Spanish Records</td>
<td>FCI</td>
<td>Spanish Records</td>
</tr>
<tr>
<td>7:30-8:00</td>
<td>FCI</td>
<td>Hillbilly Records</td>
<td>FCI</td>
<td>Hillbilly Records</td>
</tr>
<tr>
<td>8:00-8:30</td>
<td>WTNT</td>
<td>Official Detective</td>
<td>WTNT</td>
<td>Counterspy</td>
</tr>
<tr>
<td>8:30-9:00</td>
<td>WTAL</td>
<td>Music</td>
<td>WTAL</td>
<td>Music</td>
</tr>
<tr>
<td>9:00-10:00</td>
<td>WTNT</td>
<td>Martian Galaxies</td>
<td>WTNT</td>
<td>Martian Galaxies</td>
</tr>
<tr>
<td>10:00-10:30</td>
<td>WLAC</td>
<td>Randy Records</td>
<td>WLAC</td>
<td>Randy Records</td>
</tr>
<tr>
<td>10:30-11:00</td>
<td></td>
<td>OFF</td>
<td>WLAC</td>
<td>OFF</td>
</tr>
<tr>
<td>11:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 3
MUSICAL FACILITIES AND EQUIPMENT AT F.C.I.
(As of May, 1957)

<table>
<thead>
<tr>
<th>Facility</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loudspeaker System</td>
<td>Extending throughout institution, including cell blocks and dormitories.</td>
</tr>
<tr>
<td>Library of Records</td>
<td>For use on loudspeaker system.</td>
</tr>
<tr>
<td>Music Appreciation Class</td>
<td>Met twice weekly.</td>
</tr>
<tr>
<td>Education Department</td>
<td>Record Library</td>
</tr>
<tr>
<td>Chapel Choir</td>
<td></td>
</tr>
<tr>
<td>Music Sight-Reading Class</td>
<td>Met once a week.</td>
</tr>
<tr>
<td>Auditorium and Small</td>
<td>Stage</td>
</tr>
<tr>
<td>Musical Instruments</td>
<td>Piano, Field Organ, and various orchestral instruments in varying condition.</td>
</tr>
</tbody>
</table>

Table 4
MUSICAL BACKGROUND OF INMATES AT F.C.I.*

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
<th>No Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sung in choral groups</td>
<td>61</td>
<td>74</td>
<td>88</td>
</tr>
<tr>
<td>Played a musical instrument</td>
<td>59</td>
<td>128</td>
<td>34</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Instrument</th>
<th>1-5 years</th>
<th>5-10 years</th>
<th>Over 10 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accordion</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Banjo</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Clarinet</td>
<td>4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Drums</td>
<td>6</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Guitar</td>
<td>3</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>Harmonica</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Harp</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Oboe</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Organ</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Piano</td>
<td>2</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Saxophone</td>
<td>5</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>String Bass</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Trumpet</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Violin</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>All stringed instruments</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>All reed instruments</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
</tbody>
</table>

* Responses of 221 inmates
Table 5

<table>
<thead>
<tr>
<th>Preferences and Dislikes for Current Musical Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Like</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td>Music over loudspeaker</td>
</tr>
<tr>
<td>TV programs</td>
</tr>
<tr>
<td>Chapel Choir</td>
</tr>
<tr>
<td>Music appreciation class</td>
</tr>
<tr>
<td>Music sight-reading class</td>
</tr>
<tr>
<td>Visiting entertainers</td>
</tr>
</tbody>
</table>

Other sources:
- Gospel Quartet | 1 |
- Modern jazz | 16 |
- Variety show | 1 |
- Radio | 6 |
- Hillbilly programs | 11 |

Table 6

Musical Interests of the Inmates

<table>
<thead>
<tr>
<th>Interest in the study of a musical instrument</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guitar</td>
</tr>
<tr>
<td>Piano</td>
</tr>
<tr>
<td>Saxophone</td>
</tr>
<tr>
<td>Drums</td>
</tr>
<tr>
<td>Clarinet</td>
</tr>
<tr>
<td>Cornet</td>
</tr>
<tr>
<td>String Bass</td>
</tr>
<tr>
<td>Violin</td>
</tr>
<tr>
<td>Trombone</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interest in musical activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hillbilly Band</td>
</tr>
<tr>
<td>Listening to records</td>
</tr>
<tr>
<td>Dance Band</td>
</tr>
<tr>
<td>Band</td>
</tr>
</tbody>
</table>
SELECTED REFERENCES


PART VII

"QUESTION BOX SESSION"
SUMMARY OF "QUESTION BOX" SESSION

DONALD E. MICHEL

Director, Music Therapy Program
Florida State University
Tallahassee, Fla.

Panel: Ernest Grisham, VA Hospital, Murfreesboro, Tennessee; Ann W. Howe, South Carolina State Hospital, Columbia, S. C.; Patsy Shinn, De Paul Hospital, New Orleans, Louisiana; Geneva Scheihing, Texas Women's University, Denton, Texas; Philip McCarty, State Hospital No. 1, Fulton, Missouri. Mr. Michel, Chairman.

The purpose of providing this session was to allow conferees an opportunity to bring up and discuss with the panelists pertinent questions regarding music therapy practices in general, questions arising out of conference programs held earlier in the day, questions from student music therapists in attendance, and general questions raised by the panel chairman for specific answer by the panelists.

Prior to the conference, the panel chairman had sent to each panelist a list of seven general questions, requesting that the panelist submit his answers for possible discussion at the conference. While only two of the panelists submitted answers in writing, all participated in the discussions during the conference session. Since some of these questions were of the type asked by conferees present at the session, they are listed below. Answers provided in writing by the two panelists follows:

1. What do you consider the most important single thing you have learned in your practice as a music therapist?

   MISS HOWE: An understanding 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 under the guidance of the psychiatrist and in the context of which principles of music therapy are applied.

   MISS SHINN: The necessity of empathy—the ability to feel with the patient objectively (rather than subjectively.)

2. How much background information on a patient do you consider essential for you to have to be able to work effectively with the patient?
MISS SHINN: As much as possible. To do the most effective work with the patient there should be a knowledge of his illness, his particular needs and the treatment goals for him in other therapies.

MISS HOWE: Tentative diagnosis and outstanding symptoms.

3. What kind of background information on a patient do you think is most helpful when beginning work with him? Case notes? Age? Musical background? (etc.)

MISS HOWE: Some knowledge, at least, of hereditary, constitutional and environmental factors involved in the illness. The social, educational and musical background of the patient.

MISS SHINN: I especially like to know of the patient’s stage of treatment (whether starting EST, tranquilizers, etc., or close to termination of such therapies), the patient’s initial adjustment to his unit, his probable duration in the hospital, his individual needs, e.g., does his confidence in himself need bolstering, does he need to be “squelched,” or does he mainly need to be kept occupied?

4. How do you determine the musical approach you will use with a patient who has little or no previous musical background? What do you use most frequently?

MISS SHINN: Usually through direct conversation with most patients, a great deal about general interests, cultural and educational background, etc., can be learned. Most often I base a musical approach on what I have learned of the patient through conversation and other means, and would ask a patient with no previous musical background, but who has had a fairly high education, e.g., college, to join a music appreciation group, while I would not ask a patient to such an activity when either educational or musical background was negligible.

MISS HOWE: This depends on the locality, the nationality, the education and social background of the patient. As a rule, hymns and folk songs, national airs and familiar current tunes have been useful in my locality.

5. What do you consider to be your most satisfying activity in your music therapy program?

MISS HOWE: The patient planning committee of our Music Therapy Club which meets weekly to discuss ways and means of promoting and encouraging equitable relationships between patients and the hospital staff in the
establishing of a therapeutic environment in the hospital treatment program.

**Miss Shinn:** I feel that group singing is the most satisfying activity in our program, particularly if it follows a more physically strenuous activity such as dancing.

6. What do you think will be the most important future development in the field of music therapy?

**Miss Shinn:** Wider use of music in hospitals of all types.

**Miss Howe:** The continued development of medical research and collaboration in an integrated program, involving music therapists, psychiatrists, psychologists, and related professions.

7. Where do you feel that the music therapy department functions best in a hospital organizational plan?

**Miss Howe:** Music therapy functions best in the hospital organizational plan where there is better administrative regulation and medical coordination of all hospital musical activities.

**Miss Shinn:** Having worked in only one hospital, I can give only the administrative setup of that hospital. Music therapy is independent of other therapies such as occupational therapy and recreational therapy, and the music therapy head is responsible to the hospital administrator and the clinical director. This seems to work out very well for us.

In conclusion, it may be said that a question box panel of this kind probably fulfills a need at any conference, and in some ways may perform an important function in allowing more or less free expression of ideas among conferees and panelists. At other conferences, similar sessions may be called "buzz-sessions" or by other such titles, but they seem to be a permanent part of most conference programs.
PART VIII

ASSOCIATION GROWTH;
REPORTS FROM
REGIONAL CHAPTERS
EXPANDING OUR HORIZONS THROUGH REGIONAL CHAPTERS

WILHELMINA K. HARBERT

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

What is meant when we say "Expanding our horizons through regional chapters"? We mean becoming more active in developing work in our own sections of the country, thus vitalizing the whole national structure which is represented here today.

In early September, when review was made of our membership cards, it was noted that within eight years NAMT has grown both in individual memberships and in the number of areas represented. It now has over 600 members, representing forty-two states, Canada, Mexico, Hawaii, England, and South Africa. It is felt that one of the most significant, recent gains is the number of active and associate members from other countries, all of whom are dedicated to one common goal.

At the present time the United States is divided into eight regional sections: Mid-Atlantic, New England, Great Lakes, Southeastern, Midwestern, Southwestern, Northwestern, and Southern California. At best, only forty-two states are represented in regionals, and probably we should aim for the inclusion of all the other states in these eight sections. As membership chairman, the question occurs, "Where should we place the active and associate workers from England, Canada, Hawaii, Mexico, and South Africa?" If we are to expand our horizons internationally as well as nationally, then careful plans must be made for inclusion in our existing regionals of these workers from outside the United States.

It has been heartening to receive reports from regional presidents on their specific programs, indicating their general goals, describing their interesting programs in action, and reviewing their over-all accomplishments. Since you are about to hear individual reports from each regional chapter, may I emphasize the general purposes of the regionals as they function today and suggest some of the ways in which we might expand our horizons through them.

The regional chapters are the strong arms of the national structure and, therefore, should be dedicated to the high purposes of the National Association for Music Therapy, namely:
Advancement of research
Distribution of helpful information
Establishment of qualifications and standards of training for therapists
Perfection of techniques of music programming which aid medical treatment most effectively.

The purpose of this report is to discuss how our regional chapters may become more effective as part of the total program of NAMT. Ten points which seem worthy of consideration have been listed.

1. We should work for better communications between members, guests at our programs, the public, and the national organization.

2. We should include on regional programs more than one area of activity in which music is used therapeutically.

3. We should use more speakers from other therapies, thus becoming better informed on the present interdisciplinary movement.

4. We should encourage regional membership only where there seems to be a genuine interest, adequate qualifications, and membership in the National Association.

5. We should make good use of the National Bulletin as the mouthpiece for the regionals, thus distributing helpful information and keeping in closer contact with NAMT.

6. We should improve the quality of the academic part of our programs through the services of outstanding leaders in the fields of medicine, psychology, and special education.

7. We should encourage research among regional members, and we should include reports on current studies in all of our meetings.

8. We should present appropriate demonstrations of techniques which are found to be effective in the use of music as a therapy.

9. We should develop stronger interpersonal relationships between regional chapters.

10. We should become strong, articulate parts of the total structure.

For a few moments I would like to restate and enlarge on these ten points.
1. We should work for better communications between members, guests at our programs, the public, and the national organization.

Communication, which according to Dr. Dreikurs is one of the strong factors in the dynamics of music therapy, is often the point at which regionals fail to function effectively. Life moves too fast and our duties overwhelm us. Thus the development of good communication which is an all year around process becomes merely a duty just before a regional or national meeting. This happens to all. At regional meetings those who "know each other", who work together, or who sit on the same platform as fellow speakers communicate only briefly. Some of the words of a key speaker may sift out through a reporter to the public, but too often real communication of underlying purposes, problems, and activities will not take place. Therefore, in our regionals there exists a real task, namely, to see that every member of the respective chapters becomes a communicator for music therapy in the best sense of the word—not once or twice a year, but throughout the year.

2. We should include on regional programs more than one area of activity in which music is used therapeutically.

Although it is quite normal for the first emphasis to be placed on the use of music in hospitals, now so many other areas are found in which music is an effective agent in rehabilitation that it is a duty to expand horizons in regional programs to include as many of these as possible. As some of the recent programs from various regionals are examined, it is gratifying to find that in this matter progress is in the right direction. For example, more emphasis is being placed today on work with children who have special needs and for whom music as a therapy is indicated. Reports and demonstrations show considerable growth in this way, and the years ahead give promise of significant developments. Therefore, when we come together for regional meetings, there must be a readiness to share more experiences and develop better research along these lines.

3. We should use more speakers from other therapies, becoming better informed on the present interdisciplinary movement.

Music therapists cannot live within their own ivory towers and properly receive the "vibrations" which seek to mingle with ours. There is much to be given, and much to be received. None can
work alone and grow healthy. Music of itself is a creative sharing experience. It is not only a duty but a privilege to work with, and not against, other therapies; to learn what they have to offer in the process of rehabilitation of the ill; and to move ahead with them for the best interests of those who need therapeutic treatment. The present interdisciplinary movement may seem new but is familiar to those who have worked in interclinic situations. There is rich promise in this movement for the future. But now, as more awareness of this newer trend develops, regional meetings should avail themselves of every opportunity to share with other therapies and learn how to move on together in a better and more unified front.

4. **We should encourage regional membership only where there seems to be genuine interest, adequate qualifications, and membership in the National Association.**

In this eighth year of development there are only about six hundred members, but the majority of these seem to be well qualified for membership. It is not just quantity, but rather quality of membership that is sought. Members are welcomed who exhibit willingness to cooperate with each other, and who are dedicated to the improvement of methods and techniques in whatever phase of work they find themselves. This means, however, careful screening of candidates for membership; insistence that national membership comes first, with regional second; and evidence that the prospective members will contribute to the growth and development of the total program. If you are a student of music therapy in a college or university, contact your nearest regional, join the national organization, and then become as active as possible in your local program.

What are some of the different types of membership? **Associate membership** offers exceptional opportunities to volunteers. **Active membership** means exactly what the word implies, and yet opens the door to educators, physicians and psychologists engaged in teaching, administering or using music as a therapy. **Contributing membership** is for those who are so deeply devoted to the growth of the program that they may wish to help by giving more money to support various projects sponsored by NAMT. **Sustaining membership** gives organizations opportunities at regional and national levels to do what the verb implies, sustain our program.

There may be those people who are not only interested in therapy, but are able to become **life** members of NAMT. NAMT
has ten life members, and would like to double that number this year. An increase in life memberships would help to lay firmer foundations for the national program. Also, there may be individuals, or organizations, or foundations who could give $500.00 or more for research or special studies.

The importance of memberships has been emphasized because this is a very important part of our work. It is the hope of the national officers that you will go back to your regionals and begin to expand your horizons by the addition of many new, qualified, and devoted members of NAMT.

5. *We should make good use of the National Bulletin as the mouthpiece for the regionals, thus distributing helpful information and keeping in closer contact with NAMT.*

In this way can be distributed helpful information, and closer contact kept with the National Office. There are many members of our regional chapters who are inclined to feel that their individual contributions to the Bulletin are not particularly important. This is a false concept. Much more good material is needed from all sections of the country and from abroad to keep us informed of current practices, experimental studies, and new efforts in research in the use of music as an adjustive tool in rehabilitation.

6. *We should improve the quality of the academic part of our programs through the services of outstanding leaders in the fields of medicine, psychology, and special education.*

For some of our regional chapters it is extremely difficult to find speakers who can give their time and effort, and pay their own expenses to participate in meetings. The financial problem must be met in order to help provide for more outstanding speakers. It would be helpful if those could be found who could afford to underwrite expenses such as these and thus provide for more scholarly offerings at regional meetings.

7. *We should encourage research among regional members, and we should include reports on current studies in all of our meetings.*

A glance at this conference program will reveal the attention given to research and experimental studies, but there are many other studies not presented at annual national conferences. One reason may be that scientific terminology often stops the music worker from organizing observational data in proper form. It is necessary, however, that all therapists who are documenting
material and doing experimental research work closely with the national committee, lest something of vital importance be lost.

8. We should present appropriate demonstrations of techniques which are found to be effective in the use of music as a therapy.

Very often we talk too much about what we are doing, and forget that those whom we would interest in music therapy should be given frequent opportunities to see what actually happens when different techniques are applied. Regional meetings offer the right situations for such demonstrations. Both audio-visual and live demonstrations should be used to show the lay public, as well as the music workers, how music functions as a therapy in varied situations.

9. We should develop stronger interpersonal relationships between regional chapters.

Distance between chapters seems to preclude this goal. Also some members may be inclined to think that their own region is the only one with problems and that others are not concerned. It is certain that if there were better public relations and an exchange of ideas between regionals, there would be much more effectiveness in our annual national conferences. Thus national growth would materialize through stronger regional unity.

10. We should become strong, articulate parts of the total structure.

If the eight regional chapters develop more effective interpersonal relationships, if they exchange ideas and share experiences with each other throughout the year, and if they keep their national officers informed of problems, programs, and progress, then they will become articulate members of the National Association for Music Therapy, making their own unique contributions to the total structure, as well as increasing immeasurably their effectiveness in their own areas of activity.

To summarize, in order to expand our horizons through regional chapters, we need to improve communications, to present more effective local programs, to develop stronger interpersonal relationships, and to maintain closer and more productive contact with the national organization. If, in the regionals these goals can be achieved, memberships will grow in quantity as well as quality; members will make greater strides in the scientific study of music as a therapy, and the total organization will come closer to national acceptance and certification.
The Mid-Atlantic Chapter has eighty-five members from seven states and the District of Columbia, whose activities are centered in therapeutic efforts for mental patients, in correctional institutions, and in many other handicapped groups. The chapter meets three times each year; the annual meeting is held in April at which time the election of officers is accomplished.

Meetings have been held in Veterans Administration hospitals for the study of the splendid programs in these institutions, in state hospitals where fine work is in progress, and in colleges and other educational facilities where training programs in music therapy have been reviewed.

Plans are being prepared for a semi-monthly newsletter, for state meetings held in conjunction with the State Departments of Health and Welfare, and for a membership drive.

Thirteen members of the Regional Chapter attended the eighth annual national conference in 1957.

Dues in the Regional Chapter are two dollars yearly, with membership in the National Association prerequisite to local membership.

The Great Lakes Regional Chapter has had a highly productive year. Membership has grown markedly. At the time of this report there are fifty-two members in good standing. Thirty-nine are Active, nine are Associate and four are Student Members. Nineteen of these fifty-two have joined since the Regional Conference in April, 1957. Each person accepted for membership in the chapter must first be a member in good standing in NAMT. The Second Vice-President and Membership Chairman, Doris Robison, has done outstanding work and has been most diligent in her follow-up of every prospect for membership. With each set of application blanks she sends a personal letter.

There are some problems concerning membership. Many members of the national organization do not belong to the regional group. Another difficulty is that of the defaulted member.
In April, 1957, a regional conference was held at Michigan State University. The day's program was planned from answers to a questionnaire sent to all chapter members. The complete schedule of events can be seen in the January, 1958, issue of the NAMT Bulletin.

Two features indicated the broadening of the horizons of the profession of music therapy. One considered the community settlement house and the role which music plays in the lives of the people it serves. Richard Kauffman, Director of Extension Programs for Settlement Houses in Cleveland, Ohio, pointed up the possibilities of music therapy in his field.

The keynote speaker, Juvenile Judge Paul W. Alexander, Lucas County Court of Domestic Relations, Toledo, Ohio, was probably the first jurist to appear on the program of a music therapy conference.

Both national and regional business is slowed down all too often because of problems in communications. The Great Lakes Chapter is trying to keep in close touch with its members. The officers manage frequent contact with one another. The most important channel of communication will be a little publication, known at present as "The Great Lakes Newsletter." This paper is now in the planning stage. Pat Otto, the first regional president, is chief editor. In order to ease the burden of this project, the president has appointed a member from each of six states as a state editor. It has been suggested that a student editor be appointed to gather news from student members in the region.

The names and fine work of some of the officers have been mentioned. Recognition of service is due also to Annamarie Pannier, Treasurer, and to Martha Dee Morrison, Recording Secretary, and to members of the Executive Committee.

REPORT FROM
NEW ENGLAND REGIONAL CHAPTER

Arthur Flagler Fultz, President

The New England Regional Chapter has been the object of a number of unfortunate circumstances. Its regional activity achieved seven annual conferences of unusual quality and merit, and its chartering ushered in what presaged an era of even greater distinction. But, some very human events began to take toll. Such things as death, marriage, abandonment, internal
conflict, and plain fatigue occurred in quick succession leaving a mere handful of wistful looking music therapy enthusiasts.

It would appear that a surer way to build interest in music therapy in New England would have to be adopted, so a Music Therapy Club at the New England Conservatory of Music was started, composed of the students in the Department of Music Therapy. With this club as a solid and very active nucleus, it is hoped that the dormant Regional Chapter will be revived. The NEC Music Therapy Club holds weekly meetings to which people from all over New England are invited. The organization has a constitution, elects officers, and carries on many activities, such as holding discussions of clinical experiences in affiliations with hospitals, presenting movies on mental health, giving public demonstrations of music therapy standard operations, and sponsoring a Saturday Concert Series at the Boston State Hospital. It is hoped this will enlarge to the status of a Regional Chapter of NAMT that will again afford New England a proper view of the work of music therapy.

**REPORT FROM SOUTHEASTERN REGIONAL CHAPTER**

Donald E. Michel, President

The Southeastern chapter of NAMT is in its fifth year of existence. It includes the states of Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, and Tennessee. While music therapy may seem to have developed somewhat more slowly in this region than in others, our enthusiasm cannot be surpassed. The outlook for the future, immediate and long-range, is bright and we can only be optimistic when considering the potential growth of our profession in the next few years.

At present, active programs in music therapy are in existence at the following places: VA Hospital, Murfreesboro, Tennessee (Ernest Grisham, Director); VA Hospital, Salisbury, N.C. (James S. Gregory, Director); S.C. State Hospital, Columbia, S.C. (Ann Howe, Director); Central State Hospital, Pineville, La. (Carol Marsh, Director); DePaul Hospital, New Orleans, La. (Patsy Shinn, Director); State Training School, Gainesville, Fla. (Lee Crook, Director of Recreation and Music); and most recently, Georgia State Hospital, Milledgeville, Ga. (Melvin George, Coordinator of Religious and Recreational Activities).
In the field of music therapy for exceptional children, two individuals have achieved considerable recognition in this region. Mrs. Augustus Roan of Atlanta, Ga., has been working with handicapped children for a number of years, and Mrs. Evelyn T. Gates of Macon, Ga., has been working through special education programs in the public schools. In addition, Dr. Erwin Schneider of the University of Tennessee, has become a recognized authority in music therapy for the braindamaged child.

The development of degree programs in music therapy at two major institutions in this region undoubtedly has provided a source of leadership as well as a future source of trained therapists to meet the increasing demand. Florida State University began its degree programs in 1954 and has established internship affiliations with the VA Hospital, Salisbury, N.C., the VA Hospital, Murfreesboro, Tenn., the Menninger Foundation, Topeka, Kansas, and Essex County Overbrook Hospital, Cedar Grove, New Jersey. Loyola University, New Orleans, La., inaugurated a degree program this fall, and has affiliated with DePaul Hospital for internships in New Orleans.

The Southeastern regional chapter now claims approximately thirty members and anticipates a share of the growth in membership being experienced throughout the country. Four annual conferences have been held, the last one being in March, 1957 on the campus at Florida State University, and a fifth is planned for March, 1958 at the State Hospital, Columbia, S.C., with Ann Howe as program chairman. We feel that the regional organization is becoming increasingly effective in carrying out the purposes of NAMT, especially through such annual meetings.

Signposts which seem to indicate the potential for development of music therapy in this region are seen in a general trend toward improvement of state mental hospitals and in a growing awareness of the need for better rehabilitation programs in many other fields. In Florida, for example, the state hospital system is undergoing a gradual improvement program with new hospitals being built and professional staffs being increased. There is much promise of a corresponding expansion of treatment programs which will include a significant place for music therapy. The state special education program also is growing rapidly and considerable interest in music therapy already has been evidenced. The penal system of the state is being overhauled and we feel that this, too, offers a potential for future development of rehabilitation programs which will include music therapy.
Association Growth

Other Southeastern states are showing signs of improvement in hospital and rehabilitation fields. Louisiana now has a state scholarship program for adjunctive therapists, including music therapists, and a private benefactor in New Orleans is providing scholarship money for training music therapists from that area and has helped to inaugurate music therapy programs in several New Orleans hospitals. We anticipate particularly exciting progress in this section of the Southeastern region.

Along with the general upsurge of interest and activity in mental health and other treatment programs it appears that music therapy can look forward to a continuation of progress and expansion in its application in the Southeast. The Southeastern chapter of NAMT expects to play a significant part in this movement and cordially invites all interested persons to affiliate.

REPORT FROM MIDWESTERN REGIONAL CHAPTER

Philip N. McCarty, President

The Midwestern Regional Chapter was established July 17, 1953, at Topeka, Kansas, with twenty members. The chartered regional chapter consisted of the states of Kansas, Missouri, Oklahoma, Arkansas, North Dakota, South Dakota, Colorado and Nebraska. Two years were spent organizing and building membership. A constitution was submitted and accepted in May of 1955.

The purpose of the regional chapter was set forth in the constitution as follows:

The purpose of the Midwestern Regional Chapter of the NAMT shall be the consolidation of music therapy interests and efforts in this region, and the strengthening of the national organization.

Extended membership drives have been underway during the past two years with very positive results. The heaviest concentration of active members in the region is in Kansas and Missouri. At the meeting in April, 1957, six states were represented; forty members and about twenty guests were present.

At the 1955 meeting of Midwestern Regional, a request was made for formation of a local chapter of Music Therapists at Topeka, Kansas. This request was granted, and a local chapter known as the Topeka Association for Music Therapy was formed; at present there are nineteen active members. This chapter holds
four meetings per year and has produced some very interesting and worthwhile programs. These programs and activities of the Topeka Chapter have been extremely useful toward helping orient and train students from the University of Kansas, and students from other schools who are accomplishing clinical training at the several Topeka hospitals. In November, 1956, a sub-group, Music Therapy Club, was formed on the campus at the University of Kansas. Members of this club are music therapy majors at the University of Kansas.

The Midwestern Regional Chapter does not have a regular publication. The Topeka Chapter publishes a quarterly newsletter which includes much of the regional news.

The last meeting of Midwestern was held on April 12, 1957, at Osawatomie State Hospital, Osawatomie, Kansas. The program placed major emphasis on the practical problems facing music therapists.

The next meeting is scheduled in the spring, 1958, at State Hospital Number One, Fulton, Missouri, and will be the first regional meeting held out of the State of Kansas. Considerable effort is being made toward contacting new members, and it is hoped that the attendance can be doubled.

REPORT FROM
NORTHWESTERN REGIONAL CHAPTER
Vernon De Sylva, President

The Northwestern Regional Chapter has completed a year of minimum activity as an organization, but steady productive work has been shown by individual members.

One disturbing factor has been the lowering of educational requirements by the California State Personnel Board for the Civil Service Examination for hospital therapists. It is hoped that the certification of schools and registration of therapists by NAMT will provide a solution to this problem.

During the year one meeting was held in San Jose, California, in September, 1957. Special attention was allotted to areas where there might be possibilities of expanding music as a therapy. There is a definite trend toward the use of music as a therapy in special education. This offers many opportunities for experimentation and research. It also means the gradual merging of educational and therapeutic objectives, especially in the uses of music with exceptional children.
It is hoped that in the year 1958–1959 there will be growth in this region, and that it will be possible to unite with the southern branch to become more effective throughout the entire west coast area.

**REPORT FROM**

**SOUTHERN CALIFORNIA REGIONAL CHAPTER**

Lois Benedict, *Executive Committee*

During the report year the Southern California Regional Chapter has held several meetings all of which have been highlighted by excellent speeches by leaders in the fields of medicine and psychology. Members of the chapter have been active in various areas devoted to the use of music as a therapy. The work has been in hospitals, rest homes, and correctional institutions.

Through several talks by outstanding members of our chapter high interest in music therapy as a career has been stimulated among college students.

Although the membership of the chapter is small numerically, there is every indication that effective work is being done, and that the year ahead will see some significant developments in contributions to current literature and research in the field of music therapy.

**REPORT FROM**

**SOUTHWESTERN REGIONAL CHAPTER**

Dorothy Brin Crocker, *President*

The second meeting of the Southwestern Regional Chapter was held March 24, 1957, at Texas Woman's University in Denton, Texas.

Officers re-elected were: Dorothy Brin Crocker, President; J. Wilgus Eberly, First Vice-President; Roderick Gordon, Second Vice-President; George Bragg, Treasurer; and Joan Moreman, Secretary.

In spite of the increasing interest in music therapy in Texas and New Mexico, there is still a great deal of pioneering necessary in order to develop this chapter. Distance is a real problem; however, it is believed that work and enthusiasm of the members will overcome this obstacle. It is hoped that it will be possible to build a chapter that will reflect the high standards of the National Association.
APPENDIX
SUMMARY OF BUSINESS SESSION RECORDS OF
THE EIGHTH ANNUAL CONFERENCE OF NAMT, INC.

DOROTHY BRIN CROCKER
President, NAMT, 1957–58

Two general business sessions and two meetings of the executive committee were held during the Eighth Annual Conference of the National Association for Music Therapy, Inc. The minutes of these meetings are on file in the office of the Recording Secretary, and the important business transacted at these meetings is summarized here.

The first general business meeting was held at 9:00 a.m., Thursday, October 10, 1957, at Kellogg Center of Michigan State University, East Lansing, Michigan. Dr. Roy Underwood presided. (His presidential address appears elsewhere in this volume.)

In the absence of Phyllis King Noble, Martha Loven was appointed as Recording Secretary pro tem. The Treasurer’s report was read and accepted; committee reports were received. The Membership Chairman reported a current total membership of 668. This included members in several localities out of the United States.

The Chairman of the Education Committee reported that several thousand brochures, *Music Therapy as a Career*, had been sent out in answer to requests.

The Chairman of the Public Relations Committee reported that the brochure, *Music Therapy, What and Why*, had to be reprinted to meet the demand for it.

The report of the Nominating Committee was presented at the first general business meeting, in the form of a slate of officers, including the new office of President-Elect, and prospective members-at-large of the Executive Committee. At the second general business meeting the slate of officers was elected unanimously. Three members-at-large of the Executive Committee were elected by vote of the members present from a list of seven nominees. (The names of officers and committee members appear in this volume following this report.)

It was voted to join the World Federation of Mental Health, and the Interdisciplinary Study Group concerning the use of activities in psychiatric treatment.

The most important business action taken was the acceptance of the plan for the Registration of Music Therapists as presented
by Dr. E. Thayer Gaston, Chairman of the Certification Committee. The membership chairman gave approval also to the plan for certification of music therapy training programs. The National Association of Schools of Music will then approve music therapy training programs.
OFFICERS OF THE
NATIONAL ASSOCIATION FOR MUSIC THERAPY, 1957-58

Elected Officers

President:
DOROTHY BRIN CROCKER, Director of Music Therapy, Shady Brook Schools, Richardson, Texas; Instructor of Music Therapy, Southern Methodist University, Dallas, Texas; Chairman, Music Therapy and Psychology of Music for Southwest District of Music Teachers National Association; Member, Public Relations Committee of American Society of Group Psychotherapy and Psychodrama; Member, Committee on Music for Exceptional Children of the Music Educators National Conference.

President-Elect:
DONALD E. MICHEL, Assistant Professor and Director of the Music Therapy Program, School of Music, Florida State University, Tallahassee, Florida.

First Vice President and Program Chairman:
ROBERT F. UNKEFER, Assistant Professor, Department of Music and Department of Psychology, Michigan State University, East Lansing, Michigan.

Second Vice President and Membership Chairman:
WILHELMINA K. HARBERT, Professor of Music Education, Director of Music Therapy Clinic, College of the Pacific, Stockton, California; Chairman, Committee on Music Education for Exceptional Children, Music Educators National Conference; Advisor, Northwestern Regional, NAMT.

Recording Secretary:
MARTHA A. LOVEN, Director of Psychiatric Music Therapy, Parsons State Hospital and Training Center, Parsons, Kansas.

Treasurer:
ERNEST H. GRISHAM, Director of Music Therapy, Veterans Administration Hospital, Murfreesboro, Tennessee; Past President, Southeastern Regional Chapter, NAMT.
APPOINTED OFFICERS

Editor:

E. THAYER GASTON, Ph.D., Chairman, Department of Music Education, University of Kansas, Lawrence; Chairman, Committee on Psychology of Music, Music Teachers National Association; 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.

Editor of the BULLETIN:

ERWIN H. SCHNEIDER, Ph.D., Professor and Chairman, Music Education, University of Tennessee, Knoxville; Past President, Southeastern Chapter, NAMT; Member, Committee on Music in Higher Education, Music Educators National Conference; Member, Committee on Music and the Exceptional Child, Music Educators National Conference.

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Publisher and Acting Business Manager:

HAROLD ALLEN, The Allen Press, Lawrence, Kansas.
Appendix

MEMBERS-AT-LARGE OF THE EXECUTIVE COMMITTEE

ROY UNDERWOOD, Mus.D., Immediate Past President, NAMT; Director, Division of Fine Arts, Michigan State University, East Lansing; Past President, Music Teachers National Association.

ESTHER GOETZ GILLILAND, Lecturer in Music Therapy, Chicago Musical College of Roosevelt University; Music Therapy Counselor to Sigma Alpha Iota; Member, Committee on Music Education for Exceptional Children, Music Educators National Conference; Fellow, American Society of Group Psychotherapy and Psychodrama; Past President and Editor NAMT. (1959)

JULES H. MASSERMAN, M.D., Professor of Neurology and Psychiatry, Northwestern University Medical School, 305 E. Chicago Ave., Chicago; Co-chairman, Dean's Committee in Psychiatry and Director of Postgraduate Training, Veterans Administration; Senior Consultant in Psychiatry, U.S. Navy; Scientific Director, National Foundation for Psychiatric Research; Past President, Illinois Psychiatric Society; Fellow, American Psychiatric Association; Past President, America Association for Group Therapy; President Academy of Psychoanalysis, 1957–58; President, American Society of Biologic Psychiatry, 1957–58; Chairman of the Section on Psychotherapy of the American Psychiatric Association. Special Consultant in Psychiatry to the World Health Organization for Europe and South America. Author of Behavior and Neurosis, 1943; Principles of Dynamic Psychiatry, 1946; Progress in Psychotherapy, 1957; Practice of Dynamic Psychiatry, 1957; Science and Psychoanalysis, 1958.

REVEREND JOHN H. REINKE, S. J., Xavier University, Cincinnati, Ohio. (1960)

HELEN ROSENTHAL, Director of Music, Longview State Hospital, Cincinnati 13, Ohio. (1959)

WAYNE W. RUPPENTHAL, Director of Psychiatric Music Therapy, Topeka State Hospital, Topeka, Kansas (1959)
ERWIN H. SCHNEIDER, PH.D. (See Appointed Officers) (1958)

WILLIAM SEARS, School of Music, Ohio University, Athens Ohio. (1960)

FORREST SLAUGHTER, Music Therapist, Adjunctive Therapy Department; The Menninger Foundation, Topeka, Kansas. (1958)

ALAN WELLS, Director of Music Therapy, Downey VA Hospital, Downey, Illinois. (1960)

THE AUDITING COMMITTEE

ERWIN H. SCHNEIDER, Ph.D., Chairman (See Appointed Officers)

ROBERT BOHANNON, Nursing Assistant, Music, Veterans Administration Hospital, Murfreesboro, Tennessee.

MARGARET SEELEY, Music Therapist, Central State Hospital, 2009 Cedar Lane, Nashville, Tennessee.

THE BUDGET COMMITTEE

FORREST SLAUGHTER, Chairman (See Executive Committee.)

PHILIP McCARTY (See Appointed Officers)

PATRICIA R. OTTO, Graduate student, DePaul University; Editor, Great Lakes Regional Newsletter. Chicago, Illinois.

THE EDUCATION COMMITTEE

MYRTLE FISH THOMPSON, Chairman, Past President, NAMT; Director, Department of Music Therapy, Essex County Overbrook Hospital, Cedar Grove, New Jersey. (1958)

ESTHER GOETZ GILLILAND (See Executive Committee)

DONALD E. MICHEL (See Elected Officers)

THE CERTIFICATION COMMITTEE

E. THAYER GASTON, Ph.D., Chairman (See Appointed Officers)

MYRTLE FISH THOMPSON (See Education Committee)

WAYNE W. RUPPENTHAL (See Executive Committee)
Appendix

THE RESEARCH COMMITTEE

ARTHUR FLAGLER FULTZ, Chairman; Past President NAMT; Chairman of Research Committee, Chairman, Department of Music Therapy, New England Conservatory of Music; Director, Music Therapy Affiliate Training, Boston State Hospital; President Northeastern Regional Chapter, NAMT. Boston, Massachusetts.

RUTH I. BARNARD, M.D., Director of Professional Education, Los Angeles Psychiatric Service, Los Angeles.

MARTHA BRUNNER-ORNE, M.D.; Medical Director, Westwood Lodge, Westwood, Massachusetts; Chief Psychiatrist, New England Hospital, Boston, Massachusetts; Former Consultant in Mental Hygiene, Wellesley College, Wellesley, Massachusetts; Former Associate with Neuropsychiatric University Hospital, Vienna.

JOHN H. REINKE, S.J. (See Executive Committee)

WILLIAM W. SEARS (See Executive Committee)

THE ADVISORY COMMITTEE

IRA M. ALTSHULER, M.D.; Director, Group-Music Therapy Department, Wayne County General Hospital, Eloise, Michigan; Vice-Chief of Staff, St. Clair Psychiatric Hospital, Detroit, Michigan.

RUDOLF DREIKURS, M.D.; Director, Alfred Adler Institute, Chicago; Professor of Psychiatry, Chicago Medical School, Chicago, Illinois.

HOWARD HANSON, Mus.D., FAAR; Director, Eastman School of Music, University of Rochester, Rochester, New York; President, National Music Council.

CHARLES U. LETOURNEAU, M.D.; Editorial Director, Hospital Management Magazine; Consultant in Hospital Administration; Director of Program in Hospital Administration, Northwestern University, Chicago, Illinois.

KARL MENNINGER, M.D.; Chief of Staff, The Menninger Foundation, Topeka, Kansas.
THE EDITORIAL COMMITTEE

ESTHER GOETZ GILLILAND (See Executive Committee)

RUTH BOXBERGER, Assistant Professor of Music Therapy and Music Education, Mississippi Southern College, Hattiesburg, Mississippi.

ERWIN H. SCHNEIDER, Ph.D. (See Executive Committee)

ROBERT F. UNKEFER (See Elected Officers)

THE NOMINATING COMMITTEE

ROY UNDERWOOD, Mus.D., Chairman (See Executive Committee)

VIRGINIA CARTY, Dean, Peabody Conservatory of Music, Baltimore, Maryland.

LOUISE WHITBECK FRASER, Founder and director of Home Study School, Inc., Minneapolis, Minnesota.

JANET M. LINDECKER, Music Therapist, Family Court Center, Toledo, Ohio.

LOUISE E. WEIR, Music Supervisor, Devereux Foundation: Devereux branch school, Santa Barbara, California.

THE PUBLIC RELATIONS COMMITTEE

MARTHA LOVEN, Chairman (See Elected Officers)

LOIS BENEDICT, 1116 North Kenmore Avenue, Los Angeles 29, California.

MARIAN CHACE, Dance Therapy, St. Elizabeths Hospital, Washington, D.C.

HELEN DINKLAGE, Director, Rehabilitation Therapies, San Antonio State Hospital, Box 1840, San Antonio, Texas.

EDWINA EUSTIS, 30 East 81st Street, New York 28, New York.

RICHARD GRAY, Director of Music Therapy, Winter VA Hospital, Topeka, Kansas.
Appendix

JAMES GREGORY, Recreation Supervisor (Music, Drama, Social Recreation), c/o Special Services, VA Hospital, Salisbury, North Carolina.

GEORGIA GIVEN, Director of Uptown Aid for Retarded Children; Playroom Director; Community Child Guidance Centers, Chicago, Illinois.

DOROTHY HALL, Assistant to the Director of the Music Therapy Department, Essex County Overbrook Hospital, Cedar Grove, New Jersey.

DORIS ROBISON, Music Therapist, Chaplain Service, Illinois Masonic Hospital; Apt. 3-B, 2705 North Mildred Avenue, Chicago 14, Illinois.

GENEVA R. SCHEURING, Instructor in Music Therapy and Music Therapy Research, Department of Music, Texas Women's University, Box 3865, University Hill Station, Denton, Texas.

MARGARET SEARS, Beckley Building, South Court Street, Athens, Ohio

LEO SHATIN, Ph.D., Chief Clinical Psychologist, Albany Veterans Hospital; Associate Professor of Psychology, Albany Medical College of Union University; Psychological Consultant, Hospital Program, Musicians Emergency Fund, New York; Instructor, Russell Sage College, Albany Extension.

PATSY SHINN, Music Therapist, De Paul Hospital, P.O. Box 404, New Orleans, Louisiana.

MARY RYDER TOOMBS, Director of Music-Dance Therapy, Terrell State Hospital, Terrell, Texas.
QUALIFICATIONS FOR MEMBERSHIP

*Active membership* is open to all persons engaged in the use of music in therapy including music specialists, therapists, physicians, psychologists, administrators, and educators, and provides the right to vote, participate and hold office in the Association. Annual dues $5.00.

*Associate membership* is open to music volunteers or individuals who are not professionally engaged in the use of music in therapy but who wish to support the program of the Association. This membership does not include the right to vote or hold office. Annual dues $3.00.

*Student membership* is open to students enrolled in music therapy training courses at the college level. This membership does not include the right to vote or hold office. Annual dues $1.25.

*Contributing membership* is open to individuals who contribute $25.00 annually to the support of the Association, and shall carry privileges at whatever membership level the individual qualifies.

*Sustaining membership* is open to individuals, organizations, institutions, or business firms which contribute $50.00 annually to the support of the Association. This may include an individual membership assigned to a person designated by the donor. This person will be entitled to privileges at whatever membership level he qualifies.

*Life membership* is open to individuals upon the payment of $100.00 without further payment of annual dues and shall carry privileges at whatever level the holder qualifies.

*Patron membership* is 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 a person designated by the donor who will be entitled to privileges at whatever membership level he qualifies for one year.

*Honorary life membership* may be conferred by the Association upon any person in recognition of distinguished service in the field of music therapy without further payment of annual dues and provides privileges at level where recipient qualifies.
LIFE MEMBERS

MRS. ANTHONY M. BARONE, Martin Lane, Northfield, Illinois

MR. DUREL BLACK, Box 1440, New Orleans, Louisiana

MRS. MICHAEL BRAHMS, 2707 West Chase Avenue, Chicago 45, Illinois

MRS. ALEXANDER DICK (EDWINA EUSTIS), 30 East 81st Street, New York 28, New York

MRS. HARTWIG DIERKS, Apartment 808, 1919 South Grand Boulevard, St. Louis, Missouri

MR. CARL HAVERLIN, President, Broadcast Music, Inc., 589 Fifth Avenue, New York 17, New York

MRS. MARY HOWE, 1821 H Street N. W., Washington 6, D. C.

MRS. PHILIP R. MALLORY, Crows Nest, Fishers Island, New York

MRS. JOSEPHINE E. NUNN, 6450 Camino de la Costa, La Jolla, California

MR. ROBERT A. SCHMITT, Paul A. Schmitt Music Company, Minneapolis 3, Minnesota.

CONTRIBUTING MEMBERS

DELTA OMICRON, Mrs. Roxine Beard Petzold, President, R.F.D. No. 2, Newark Valley, New York

MRS. WILHELMINA K. HARBERT, 125 West Mendocino, Stockton, California

MR. L. H. MARTIN, National Autoharp Sales Company, 560 – 31st Street, Des Moines 12, Iowa

MR. OSCAR SCHMIDT, International, Inc., Mr. H. G. Finney, 87 Ferry Street, Jersey City 7, New Jersey

SUSTAINING MEMBERS

MU PHI EPSILON, Mrs. Van E. Fiser, 1139 North Ridgewood Drive, Wichita 17, Kansas

SIGMA ALPHA IOTA, Colleen J. Kirk, D.M.F., 1011 West Clark Street, Champaign, Illinois
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)

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**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
Appendix

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

MUSIC THERAPY 1954

The book of proceedings of the Fifth Annual Conference of NAMT, held in New York City, October 15–18, 1954, is available from The Allen Press, P.O. Box 4, Lawrence, Kansas, for $5.20 postpaid U.S.A.

PART I—Core Constructs of Music Therapy
PART II—Dynamics of Music Therapy
PART III—Music Therapy for Specific Syndromes
PART IV—Music Therapy for Exceptional Children
PART V—Volunteer Services in Music Therapy
PART VI—Ancillary Therapies and Their Relation to Music Therapy
PART VII—Progress in Music Therapy in Veterans Administration Hospitals
PART VIII—The Music Therapy Education Program
PART IX—Research in Music Therapy

MUSIC THERAPY 1955

The book of proceedings of the Sixth Annual Conference of NAMT, held in Detroit, Michigan, October 6–8, 1955, is available from The Allen Press, P.O. Box 4, Lawrence, Kansas, for $5.20 postpaid U.S.A.
PART I—Correlates of Music Therapy
PART II—Music Therapy for Exceptional Children
PART III—"Music in Action" at Wayne County General Hospital, Eloise, Michigan
PART IV—Reports of Six Regional Presidents
PART V—Music Therapy in Veterans Administration Hospitals
PART VI—Reports of Literature
PART VII—Research in Music Therapy
PART VIII—Survey, Uses of Music in Institutions
PART IX—Summary

MUSIC THERAPY 1956

The book of proceedings of the Seventh Annual Conference of NAMT, held in Topeka, Kansas, October 18–20, 1956, 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—Professional Growth of Music Therapy
Part III—Music Therapy in the Adult Psychiatric Hospital
Part IV—Music Therapy for Exceptional Children
Part V—Music Therapy for the Blind
Part VI—Music Therapy Equipment
Part VII—The Music Therapy Education Program
Part VIII—Research in Music Therapy
Part IX—Summary
Part X—Index of Preceding Volumes of this Series

BULLETIN OF THE NATIONAL ASSOCIATION FOR MUSIC THERAPY, INC.

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, Inc., P.O. Box 4, Lawrence, Kansas.
PAMPHLET—MUSIC THERAPY AS A CAREER

Prepared by the Education Committee of NAMT for distribution, this pamphlet gives opportunities for employment and outlines personal and educational qualifications. It is available from the chairman of this committee, National Association for Music Therapy, P.O. Box 4, Lawrence, Kansas.

PAMPHLET—THE WHAT AND WHY OF MUSIC THERAPY

Prepared by the Public Relations Committee of NAMT for distribution, this pamphlet contains a general description of the field of music therapy for the lay reader. Historical information is included. It is available from the chairman of this committee, National Association for Music Therapy, P.O. Box 4, Lawrence, Kansas.
Plan for Registration of Music Therapists

Who Shall Be Eligible

For the present, and for the next several years all persons actively and for the most part engaged in music therapy shall be eligible. In addition, educators who have directly to do with music therapy either administratively, pedagogically or clinically shall be eligible.

Experiential and Training Determinants

Persons not holding a college degree but who have been engaged satisfactorily in music therapy positions on salary for a period of at least three years previous to December 31, 1960, shall be eligible for registration.

Persons who have a college degree whose major study was not in music therapy, but who have been engaged satisfactorily in a music therapy position on salary for a period of at least one year previous to December 31, 1960, shall be eligible for registration.

Persons who have completed a degree course in music therapy from an institution "tentatively approved" or "fully approved" by NAMT previous to December 31, 1960, shall immediately upon graduation be eligible for registration.

Eligibility After December 31, 1960

After December 31, 1960, no one shall be eligible for registration unless he has completed a four-year degree course in music therapy from an institution "fully approved" by NAMT with the one exception noted below.

After December 31, 1960, a person graduating from a "tentatively approved" institution may become eligible only after the Certification Committee of NAMT shall have examined and found satisfactory the transcript of his academic and clinical training.

Machinery and Requirements for Registration

A form shall be devised which shall present evidence:

(1) for music therapists, without college degrees, that they have had three years of satisfactory engagement on salary in music therapy previous to December 31, 1960;

(2) for music therapists with a college degree, that they have had one year of satisfactory engagement on salary in music therapy previous to December 31, 1960;

(3) for music therapists with a degree course in music therapy, that they have completed all requirements for the degree. An official college transcript of academic courses and clinical training must be attached to the form.

(4) for educators, that they have directly to do with music therapy, administratively, pedagogically or clinically.
Appendix

NATIONAL ASSOCIATION FOR MUSIC THERAPY, INC.
COMMITTEE ON REGISTRATION
E. Thayer Gaston, Chairman
Myrtle Fish Thompson
Wayne W. Ruppenthal

Application For Registration As A Music Therapist

Name ____________________________________________________________ Age ________ Sex ________
First Middle Maiden (if any) Last

Present Address ________________________________________________________ Street and Number City or Post Office Zone State

Permanent Home Address __________________________________________ Street and Number City or Post Office Zone State

General Instructions

If you are eligible for registration, the conditions of your eligibility are described in one of the four following sections. Check the section under which you wish to become eligible. **Check one section only.** Type or print clearly all information required in that section. Secure and have in your possession all statements, letters, transcripts or other materials which may be called for in the section. Sign and date the statement at the end of this form. Prepare a check or money order—DO NOT SEND CASH—payable to **Registration in NAMT, Inc.** in the amount of $10.00 for your initial registration fee (of which $9.00 will be returned if your application is not acceptable). Then place all of this material, (1) Application Form, (2) statements, letters, transcripts or other materials called for, (3) registration fee of $10.00 in the attached, self-addressed envelope, affix stamp and mail. Send nothing in until you send everything that is called for. **YOU MUST USE THE SELF-ADDRESSED ENVELOPE.**

At no time can you be a Registered Music Therapist without being a member of NAMT.

It should be clearly understood that whether your title is **music therapist,** **recreation therapist,** **music aide,** **musician,** or whatever your title is, **ALL** who are engaged in music activities in hospitals, training schools, correctional institutions, on salary, are eligible.

Section 1 ☐

If you **do not** hold a college degree, your eligibility depends on evidence that you have been engaged satisfactorily in a music therapy position or positions, on salary, for a period of at least three years previous to December 31, 1960. If you have **not** been employed for three years, keep this form until you have **been** employed three years. At that time, fill it out as herein directed and send it in.

In the spaces below, fill in the name of the institution(s) where you have been employed, the location of each institution, the position you held, the beginning and ending date of each employment, and by a “yes” or “no” indicate whether or not you were on salary.

Attached to this form you found a perforated sheet of blanks by means of which you are to supply evidence of your employment on salary for three years. Tear off **one** blank for each institution which you have listed below, mail it to the **appropriate administrator,** have him fill it out and return it to you. The filled-in blank(s) should agree in number and content with the information you supply below.

1. Institution Location Position From To Salary?
2. 
3. 
Section II

If you hold a college degree, but it is not in music therapy, nor with a music therapy major, your eligibility depends upon evidence that you hold a college degree of some kind, and that you have been engaged satisfactorily in a music therapy position or positions for a period of at least one year previous to December 31, 1960. If you have not been employed for one year, keep this form until you have been employed one year. At that time fill it out as herein directed and send it in.

In the first space below fill in the name of the degree earned, the institution granting it, its location, and the date the degree was granted. Write to the Registrar of the institution from which you obtained your degree and ask him to provide you with an official statement that you were granted a degree, the name of the degree, and the date it was granted. The contents of this statement should agree with the information you supply immediately below.

<table>
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<tr>
<th>Degree</th>
<th>Institution</th>
<th>Location</th>
<th>Date granted</th>
</tr>
</thead>
</table>

In the spaces below, fill in the name of the institution(s) where you have been employed, the location of each institution, the beginning and ending date of each employment, and by a "yes" or "no" indicate whether or not you were on salary.

Attached to this form you found a perforated sheet of blanks by means of which you are to supply evidence of your employment on salary for one year. Tear off one blank for each institution you have listed below, mail it to the appropriate administrator, have him fill it out and return it to you. The filled-in blank(s) should agree in content and number with the information you supply immediately below.

<table>
<thead>
<tr>
<th>Institution</th>
<th>Location</th>
<th>Position</th>
<th>From</th>
<th>To</th>
<th>Salary?</th>
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Section III

If you hold a degree in music therapy or with a major in music therapy, your eligibility depends upon evidence that you hold such a degree. In the space immediately below, give your title or position, the institution of which you are a staff member, and its location.

In the second space below, check the appropriate square to indicate whether your work is administrative, clinical or pedagogical. If your transcript does not contain a record of your clinical training or internship, then secure a statement from the department head or appropriate administrator of the college or university where you earned your degree that you did complete your clinical training.

<table>
<thead>
<tr>
<th>Degree</th>
<th>Major</th>
<th>Institution</th>
<th>Location</th>
<th>Date granted</th>
</tr>
</thead>
</table>

Section IV

If you are an educator, your eligibility depends on evidence that you have directly to do with music therapy administratively, clinically or pedagogically. In the space immediately below, give your title or position, the institution of which you are a staff member, and its location.

In the second space below, check the appropriate square to indicate whether your work is administrative, clinical or pedagogical. In addition, submit with this application form a page, or pages, from an official, printed publication (catalog, schedule of classes, etc.) of your institution which will provide substantiating evidence of your function as an educator directly involved with music therapy.
**Appendix**

<table>
<thead>
<tr>
<th>Title or Position</th>
<th>Institution</th>
<th>Location</th>
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</thead>
<tbody>
<tr>
<td>Administrative</td>
<td>Clinical</td>
<td>Pedagogical</td>
</tr>
</tbody>
</table>

Are you a member in good standing of the National Association for Music Therapy?  
Yes ☐  No ☐

I do hereby declare and affirm that the information contained in this application is true and correct. I understand that after this initial registration I must register each year and must be a member of NAMT to maintain my registration.

---

Signature: ___________________________  Date: __________
Constitution and Bylaws of the National Association for Music Therapy
Revised, 1957

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, President-Elect, 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 an Editor, an Editor of the Bulletin, 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 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 Treasurer, the Editor, the Editor of the Bulletin, the chairmen 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. No member-at-large may be elected to immediately succeed himself.

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. Nine (9) members of the Executive Committee of which at least five (5) 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 nonbusiness 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.

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**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 himself would qualify.
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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.

SECTION 4. Persons who have forfeited rights of membership as active, associate, or student members because of nonpayment of dues shall be able to reinstate themselves with payment of dues of the current period plus the back-payment for one year.

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 duties of the President-Elect shall be to assist the President as requested, to study the duties of the President in order to be prepared at the suitable time to take over the responsibilities of this office.

SECTION 4. 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 Committees, 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 5. 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 6. 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 7. 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 8. 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 9. A. The Editor shall serve as Chairman of the Editorial Committee and shall be responsible for the editing and the supervision of the publication of the Book of Proceedings.

B. The Editor of the Bulletin shall serve as a member of the Editorial Committee and shall be responsible for the editing and the supervision of the publication of the Bulletin.

SECTION 10. 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 11. 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 seven standing committees: Auditing, Budget, Certification, 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, the Editor, the Editor of the Bulletin, and three appointed by the President on the recommendation of the Editor. The Editor shall serve as chairman.

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 for 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.

SECTION 6. A Public Relations Committee, with one member designated 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 Certification Committee shall consist of three members elected by the membership in convention assembled. Each member shall serve for a period of three years, and no member shall serve for more than two terms in succession. The election shall take place in such a manner that one new member shall be elected each year. The Nominations Committee shall present two names for each vacancy on the Committee. Election shall be by ballot. The Certification Committee shall annually choose its chairman for the year. Any vacancy occurring during the year shall be filled by Executive Committee appointment to serve until the next election takes place at a regular meeting.

The Certification Committee shall (1) establish standards and procedures for the certification of Music Therapists, and (2) institute formal approval of training programs. The actions of this Committee shall be subject to the approval of the Executive Committee.

SECTION 8. 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 9. 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.