MUSIC THERAPY 1959
MUSIC THERAPY 1959

NINTH BOOK OF PROCEEDINGS
OF THE
NATIONAL ASSOCIATION
FOR
MUSIC THERAPY, Inc.

Founded 1950

Volume IX

Papers from the Tenth Annual Conference
East Lansing, Michigan

EDITOR
ERWIN H. SCHNEIDER, Ph.D.

ASSOCIATE EDITORS
RUTH BOXBERGER
WILLIAM W. SEARS, Ph.D.

Lawrence, Kansas

Published by the National Association for Music Therapy, Inc.

1960
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
CONTRIBUTORS

ALTSHULER, IRA M., M.D., Director, Group-Music Therapy Department, Wayne County General Hospital, Eloise, Michigan; Chief of Staff, St. Clair Psychiatric Hospital, Detroit, Michigan; Fellow, American Psychiatric Association and National Diplomate in Psychiatry; Vice President, Detroit Philosophical Society; Member, Michigan Academy of Arts and Sciences; Honorary Member, Detroit Federation of Musicians.

BASSICH, JOSEPH B., S. J., Professor of Education, Loyola University, New Orleans, Louisiana; President, Southeastern Regional Chapter NAMT.

ALWARD, EILEEN, Consultant in Special Education, Flint Public Schools, Flint, Michigan.

BLAIR, DONALD, M.D., CH.B., D.P.M., Consulting Psychiatrist, St. Bernard’s Hospital, Southall, and St. Mary’s Hospital, London, England.

BOXBERGER, RUTH, R.M.T., Assistant Professor of Music Therapy and Music Education, Mississippi Southern College, Hattiesburg, Mississippi.

BRADFORD, GLADYS D., State Chairman, Music in Hospitals, Michigan Federation of Music Clubs.

BRASWELL, CHARLES, R.M.T., Director of Music Therapy Program, Loyola University, New Orleans, Louisiana.

BROOKING, MAIR, A.R.C.M., Music Therapist, St. Bernard’s Hospital, Southall, and Horton Hospital, Epsom, Surrey, England.

BURNS, ROBERT FRANKLIN, Graduate Student, Florida State University, Tallahasee, Florida.

CARMICHAEL, DONALD M., M.D., Director, Aftercare Clinics, New York State Department of Mental Health.

CHACE, MARIAN, Dance Therapist, Saint Elizabeth’s Hospital, Washington, D.C.

 Cotter, Vance W., Instructor of Music Therapy and Music Therapy Research, Texas Woman’s University, Denton, Texas.

CROCKER, DOROTHY BRIN, R.M.T., 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, Southwest District of Music Teachers National Association; Member, Public Relations Committee of America Society of Group Psychotherapy and Psychodrama; Member, Committee on Music for Exceptional Children, Music Educators National Conference; Member, Texas Composers Guild.

DOLLINS, CURT, Director of Music Therapy, Richmond State Hospital, Richmond, Indiana.

DREIKURS, RUDOLF, M.D., R.M.T., Director, Alfred Adler Institute, Chicago; Professor of Psychiatry, Chicago Medical School; Past President, American Society of Adlerian Psychology; Past President, American Society of Group Psychotherapy and Psychodrama.

FULTZ, ARTHUR FLAGLER, R.M.T., Chairman, Department of Music Therapy, New England Conservatory of Music, Boston; Music Therapy Consultant, Metropolitan State Hospital Children’s Unit, Waltham, Mass., and Bedford VA Hospital, Bedford, Mass.; Director of Affiliate Training in Music Therapy, Boston State Hospital, Dorchester, Mass.; Past President, NAMT; Member, Eastern Psychological Association.
Gaston, E. Thayer, Ph.D., R.M.T., 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.

Giovanni, Sister, S.S.N.D., Institute for the Deaf, Marrero, Louisiana.

Harbert, Wilhelmina K., R.M.T., Formerly Professor of Music Education and Director of Music Therapy Clinic, College of the Pacific, Stockton, California; Chairman, Committee on Music for Exceptional Children, Music Educators National Conference; Advisor, Northwestern Regional Chapter, NAMT.

Hart, Ann, Director of Music Therapy, DePaul Hospital, New Orleans, Louisiana.

Loven, Martha, Director of Music Therapy, Children's Center, Hamden, Connecticut.

Meuli, Albert L., Coordinator of Activity Therapy, Dr. Norman M. Beatty Memorial Hospital, Westville, Indiana.

Michel, Donald E., Ph.D., R.M.T., Assistant Professor and Director of the Music Therapy Program, School of Music, Florida State University, Tallahassee, Florida; President, National Association for Music Therapy.

Pedrey, Charles P., Ph.D., Director, Speech Clinic, Michigan State University, East Lansing, Michigan.

Pound, Marilyn M., Music Therapy Volunteer Worker, Hattiesburg, Mississippi.


Rule, Betty, Consultant, Elementary Music, Flint Public Schools, Flint, Michigan.

Schneider, Erwin H., Ph.D., R.M.T., Professor and Head, Department of Art and Music Education, The University of Tennessee, Knoxville, Tennessee.

Seals, William W., Ph.D., R.M.T., Lecturer in Music Therapy, Department of Music, Ohio University, Athens, Ohio.

Thompson, Myrtle F., R.M.T., Director, Department of Music and Creative Art Therapies, Essex County Overbrook Hospital, Cedar Grove, New Jersey.

Van Stone, Joan Kinnear, Music Therapist, Topeka, Kansas.

Werner, T. A., M.D., D.P.M., Consultant Psychotherapist, St. Bernard's Hospital, Southall, Middlesex, England.
EDITOR'S PREFACE

This volume presents the papers and reports given at the Tenth Annual Conference of the National Association for Music Therapy, Inc., held at Michigan State University, East Lansing, Michigan, on October 9–11, 1959.

The Editor is deeply grateful to those music therapists and their colleagues in allied fields who gave of their time and experience in preparing the papers which made this publication possible.

Those who peruse this volume will find an up-to-date account of the concepts and uses of music in the therapeutic setting; a wealth of information on specific music therapy techniques; and an emphasis on the need for continued research in this functional use of music.

Part I of the volume deals with the uses of music in mental hospitals and emphasizes the use of music and musical activities for specific purposes—particularly the value of individual music therapy, on a prescription basis, as an integral part of the treatment plan.

Part II is devoted to volunteer assistance in music therapy programs. Here is given a picture of a training program for volunteers; statements regarding professional staff responsibilities to volunteers; and a report on the opportunities for volunteer assistance in the community.

Part III presents papers on the uses of music with exceptional children—particularly those with speech and hearing disabilities. The specific problems and the techniques given in these reports should prove to be of great value to those persons working in special education and in institutions serving exceptional children.

Part IV stresses the importance of the group, and the dynamics of the group, which give meaning and value to musical experiences in music therapy and music education activities. Emphasized in this section is the need for preparation in group leadership on the part of music therapists and music educators. The group, because of its dynamics, demands practices different from those used in individual musical activities.

Part V is devoted to the use of music in geriatrics. Here is reported the many values of music, and the manner in which music and musical activities should be used with this type of
patient. The physiological, social, political, and psychological problems of aging also are discussed at some length.

Part VI is concerned with special conference reports. The development and revisions of curriculum standards and clinical training standards are discussed, as are NAMT's relationships with the American Medical Association. The latter report is of great importance since the recognition of music therapy by the Joint Committee to Study Paramedical Areas, of the American Medical Association, marks an important step forward in gaining professional recognition for music therapy.

Part VII presents research reports, and Part VIII, reports of the activities of the Regional Chapters of NAMT.

The Editor wishes to thank Dr. William Sears, Miss Ruth Boxberger, and Mrs. Joann Hipshire, for their help in the preparation of the manuscript. We are likewise grateful for the sympathetic advice, patience, and assistance of the publisher, Mr. Harold Allen.

Erwin H. Schneider, Ph.D.

Knoxville, Tennessee
May, 1960
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ANNUAL BANQUET ADDRESS
NEW DEVELOPMENTS IN THE CARE AND TREATMENT OF THE MENTALLY ILL

DONALD M. CARMICHAEL

There have been many changes for the better in the care and treatment of mental illness in the postwar years, particularly since 1954. In the United States we have seen the development of intensive and extensive use of tranquilizing drugs in both private and public mental hospitals. In New York State's mental hospitals some 45,000 patients, over half of the total population, are receiving tranquilizing drugs. Associated with drug therapy has been a more hopeful attitude among hospital staff and improvement in care and treatment generally, with consequent greater benefits to more patients. Concrete evidence of these greater benefits is the fact that patients these days are spending shorter periods in the hospital. Despite a sizable increase in admissions during the past two years, the steady decrease in inpatient population of the previous three years has continued. There has, of course, been a greater increase in placement of patients on convalescent care in the same two years.

Throughout the past two years the introduction of some recent British psychiatric practices has wrought many changes in hospital care programs aside from the changes mentioned above in the specific treatment programs. The concept of the open hospital, as developed over the past twenty years in Britain and other European countries, has been introduced into this country and is already contributing materially to remission of symptoms in a large number of patients. Among pioneers in the development of the open hospital in Britain are Macmillan, in Nottingham, England; Bell, in Melrose, Scotland; and Rees, in Croydon, England. In the last four years many psychiatrists from the United States have visited Britain and other parts of Europe in order to observe the operation of the open hospital and associated developments in the community. Your speaker was privileged to spend four weeks during June and July of this year visiting some of the outstanding psychiatric centers in England as one of a

1. The observations and opinions expressed in this paper are those of the author and do not reflect the policies of the New York State Department of Mental Hygiene.
group of eight, accompanied by Dr. Macmillan, who arranged the trip. Our group first spent a day visiting Maudsley Hospital in London, a combined mental hospital and institute of psychiatry similar to the New York State Psychiatric Institute and the Massachusetts Mental Health Center. Among the most interesting services, there are the out-patient clinic with its newly developed twenty-four-hour emergency service, the day hospital, and the night hospital. A week was spent studying the organization of the treatment program developed in Nottingham by Dr. Macmillan, perhaps the most outstanding in England; one day at an unusually fine geriatric center for psychiatric cases under the direction of Dr. Cosin in Oxford and three days in observing the psychiatric program established since 1956 by Dr. Mandelbrote in Gloucester. The group also visited the Long Grove Hospital, of about three thousand beds, which serves a central section of the City of London, and spent three days observing the program in Worthing and Chichester, under Dr. Carse. These centers, except for the Long Grove Hospital, are among the most progressive in the country.

A day was spent at Belmont Hospital to observe the "therapeutic community" under the direction of Dr. Maxwell Jones. This is a unique residential treatment program for psychopaths, with group therapy the chief treatment technique, and with all patients participating in two sessions daily. The entire community, both patients and staff—over a hundred in all, meets for an hour and a quarter after breakfast, chiefly to discuss problems of disruptive behavior which usually have occurred in the last twenty-four hours, reported by the patient chairman and patient representatives of the wards and workshops. There is wide participation by patient members of the community, and members involved must face and respond to questions and criticism, and for the most part appear to be willing to accept and act in accord with the community's advice and counsel. The staffs are there chiefly to observe and evaluate, participating only as they see fit, by questions or information, or on demand of the patient members. For the other daily group session the patient members are divided into four groups, each directed by one of the four psychiatrists, other staff members also attending.

The current trend in British psychiatry is a shift of emphasis towards providing for care and treatment of patients living at
home rather than in the mental hospital. This goal is achieved through community psychiatric out-patient clinics connected with the psychiatric division of a general hospital or mental hospital, and home treatment by psychiatrists in close association with general practitioners. New laws were enacted this year regarding the mentally ill and mentally defective, based for the most part on recommendations made by the Royal Commission, which had studied the situation over the previous three years. The chief features in these laws are aimed at putting mentally ill and mentally deficient patients, as far as possible, on the same footing as patients with other forms of illness or disability; expanding community services, including residential services for all groups of mental patients, thus shifting greater responsibility for care of the mentally ill to the local authority; and removing the former statutory limitation of treatment of "persons of unsound mind" in "designated" hospitals, so that hospital authorities will be able to arrange that any kind of hospital may receive any type of mental patient either on an informal basis or under provisions permitting compulsory admission.

In Britain there has been a steady decrease over a period of years in admissions by certification and also by signing a voluntary application (statutory voluntary). More and more patients are being admitted by an informal type of admission requiring no written application nor any legal procedure. The new laws make no provision for certification, though provisions are made for compulsory detention when this is indicated, but within a relatively short time such admissions are almost all changed to "voluntary." In Nottingham, no certified patients have been admitted for the past four or five years, most persons coming in on informal arrangements. In New York State during the past two years there has been an increase in voluntary admissions from less than ten per cent to over thirty per cent; these, however, are of the statutory type requiring a written application. Recently, in Connecticut, their present law providing for admission of voluntary patients was found by the state's attorney general to permit voluntary admission without the necessity of making a written application, providing that such patients should be discharged immediately on their own request.

During the early stages of development of the open hospital, wards were opened one at a time after much discussion between
the psychiatrists and the ward staffs, until the latter were ready to have the ward opened. Since the open hospital has gained acceptance, it was possible in Gloucester to open its two mental hospitals within a six-month period, while earlier in Nottingham, it was seven years before all the wards were opened. Within two years of application of the open hospital policy, over sixty per cent of the 89,000 patients in New York State mental hospitals are on open wards.

With the opening of the mental hospitals and encouragement of informal admissions, patients soon showed themselves to be much more responsible persons than had been believed. Thus, many needed but a short stay in the hospital and could live at home while receiving aftercare treatment. This led to development of more and better extramural psychiatric facilities in order to shorten the period of hospital care or perhaps avoid it altogether. It is increasingly obvious that every health district needs comprehensive mental health facilities providing for early diagnosis and treatment of patients while working and living at home. These should begin with local adult and children's clinics, day hospitals, and treatment at their homes by psychiatrists and/or general practitioners, assisted by psychiatric social workers or nurses. For a certain number of cases requiring more intensive treatment, psychiatric inpatient services would be necessary as part of a general hospital or in a special psychiatric hospital. With such basic community services it has been possible to materially reduce admissions to mental hospitals and to shorten the period of hospitalization. For example, of the patients admitted to the Mapperly Hospital in Nottingham during 1958, fifty-five per cent were able to go home within three months, seventy per cent within six months, and ninety per cent within twelve months. In addition, there has been relief of the previous overcrowding in the psychiatric centers with such integrated facilities, and further, there is now usually a substantial number of vacant beds. This has occurred in urban areas such as Nottingham and more rural and semirural areas such as Worthing. In 1956, before the Worthing Experiment, 645 patients were admitted from the Worthing area to the district mental hospital. After the opening of the day hospital, plus the mental health clinic at the general hospital and home treatment service, this figure, in 1957, was reduced by fifty-six per cent, and in 1958 by sixty-one and seven tenths per cent.
Perhaps the most impressive feature of better mental health programs in England, unfortunately rare in the United States, is integration of the psychiatric services, clinics, hospitals, etc., with other health and welfare agencies, both public and private, rehabilitation centers, schools, and with the general medical practitioners. This integration of services developed gradually on an informal basis over a period of some years past in the better centers, and has now, with the newly amended mental health laws, been legally sanctioned. Thus we see personnel of the mental hospitals and local authority engaging in joint service in local authority, general hospital, and child guidance clinics. This, of course, is fruitful only in districts of limited geographic size with a population in keeping with the available mental health personnel. The system facilitates and expedites the care and treatment of patients, and involves cooperation between agencies under the central government such as the hospital and rehabilitation centers, as well as those under the local, city, or county government, such as the mental health service, public health facilities, welfare services such as "meals-on-wheels" service, voluntary help through their country-wide patient transport service, and locally through voluntary organizations such as the League of Friends and mental health societies.

Undoubtedly the British National Health Service Acts, in effect since 1948, facilitate integration of all mental health and complementary services. In the United States there are a number of factors hindering integration of resources involved in the mental health field. A most obvious one, and perhaps the most important, is that a large proportion of the country's psychiatrists are engaged almost exclusively in private or clinic practices and do not deal with psychotic patients. In Britain, all but a few of the psychiatrists devote their time to work in the National Health Services mental health programs, and general practitioners are more widely involved in the direct handling of mental illness, with psychiatric consultation as needed. It is important to note that there are well integrated mental health services in other European countries without "socialized" medicine, an example being Holland, which, however, does have compulsory health insurance. We in this country will have to work out in our own way the vitally needed integration of resources that can meet the demands for over-all coverage in the mental health field.
British psychiatry, as practiced in the centers visited, appears to come closer to meeting the mental health needs of the community than does our program in New York State or throughout this country as a whole. This is not to say that British treatment techniques are better than ours, or even as good, but rather that there are fewer gaps in the provision of treatment, and certainly one does not find out-patient clinics with long waiting lists. The British, apparently, are no better off proportionately than we are in regard to available personnel, though their system of practice, as described above, makes it possible for them to use their personnel to better advantage than we are as yet able to do. Another important factor accounting for the effectiveness of the care and treatment in the centers visited is the more widespread acceptance among the people of Britain of mental illness and mental deficiency as realities of life with no stigma attached. It is possible that the British programs for education of the public in matters of mental health are more effective because the British people live in an older, more settled country, with a more homogeneous population which moves about much less than we do in America.

Along with new developments already mentioned or described at some length, marked changes have occurred in the treatment program and in the roles of the psychiatrists, nurses, social workers, and activity therapists. The attitude of patients and their families towards hospital treatment has changed to the extent that they are almost like members of the treatment team or, better, have entered into partnership with the hospital personnel. This is in contrast to some former attitudes of passive acceptance, disinterest, or resistance to treatment.

Nowadays in Britain the period of hospitalization for many patients is short, being more or less limited to the acute phase of the mental illness. This is dependent on the stage of development or availability of voluntary, especially informal, admissions, the open hospital, and integrated comprehensive community (local authority) mental health services. Considering this, hospital programs need to be geared both to the shorter period of hospitalization and to preparation for the patient's return to his home, job, and community. This necessitates much more imaginative and yet more practical programs to meet the individual patient's needs, allowing him to exercise his new-found responsibility and develop initiative. Experience already gained both in
Britain and the United States under the new care and treatment programs points to a more favorable prognosis for many long-term patients. Thus, both hospital and community programs for them should be aimed at effecting their rehabilitation and return to a place in the community. We have found this to be so for a considerable number of long-term patients in a day therapy center serving our Brooklyn Aftercare Clinic.

The shift in emphasis from care and treatment in the hospital to care and treatment in the community has been gaining ground in Britain for a period of some years and, with the new laws, can now be more readily implemented. This shift would not be possible, were it not for willing acceptance of responsibility on the part of the patients' families, friends, the community generally, as represented by neighbors, and especially, public and private agencies. Equally important in the centering of treatment in the community itself is the fact that the British system of psychiatry—more so than ours as yet—both recognizes and depends to a greater degree on the patients' innate capacity for self-help, which means acknowledgment of their capacity for assuming a responsible role. This attitude is generally apparent among mental health personnel, patient care and treatment techniques being modified to encourage the patients to avail themselves of the opportunities for self-help. Treatment programs in the better centers, though effective, do not appear to be as intensive as many of ours are. It would seem that the British treatment goals are more realistic and, on the whole, more attainable, whereas our goals, especially as pertains to psychotherapy in both in-patient and out-patient services, are more idealistic and often less attainable. (Let's keep our idealism, but temper it with more realism.)

Worthy of comment is the fact that eighty per cent of the psychiatric clinics in Britain are in the out-patient departments of general hospitals, most of the clinics' psychiatrists being from the mental hospitals. Day hospital facilities in England may be in the mental hospital, or general hospital, or at a different location, though affiliated with the hospital. The Marlborough Day Hospital in London provides some night hospital service and is not connected with any other hospital. Patients are referred there from other hospitals, clinics, and by general practitioners. Psychiatric care at home (domiciliary care) and twenty-four-hour emergency service are provided by psychiatrists from a mental
hospital or day hospital, assisted by hospital social workers or mental health workers from the local authority. Halfway houses, or hostals, as the English call them, are usually connected with the mental hospitals or a voluntary mental health agency. They serve as a place of residence for patients in the transition period between the hospital and full return to the community; from the hostel they often get their first job during or after completion of treatment. Day hospitals are available for special groups such as old people and children, all of them providing a treatment program, the equivalent of psychiatric inpatient service. In Nottingham there is an occupation center which provides training for mental defectives living at home. They are brought to the center daily by the national patient transport bus. Vocational rehabilitation services, originally developed to serve the physically disabled, are available also to the mentally and intellectually disabled. Such services are under the National Ministry of Labor, a typical unit being the one in Nottingham. All such disabled persons requiring vocational services from the Nottingham area are seen by one of the consulting psychiatrists from the Mapperley Hospital before being sent to the rehabilitation unit. This consultant visits the unit at weekly intervals and enters into staff discussions about newly referred patients or the progress of previous referrals.

Although this rehabilitation center has been accepting mental patients for five or six years, the director and senior staff being most cooperative, there are at times complaints from staff of the various workshops indicating some reluctance to dealing with such patients. All patients referred to this unit are there for a period of six weeks, during which time they can brush up on their old skills or take advantage of the opportunity to try out different possible trades from among the variety offered there. After six weeks, some may be referred directly to jobs by the placement service; others may be referred to the nearby training unit for training as apprentices in various trades; while others may be referred to work centers, called Remploy factories, which are essentially sheltered workshops. For many, Remploy may be a final job placement, while others will after a time be able to get jobs in regular factories or offices.

Although the vocational rehabilitation services in this country are good, we have had less experience with mentally handicapped patients than have the British. They are thus able to provide
such services to a larger proportion of those needing it than we can at present.

While the Labor Law provides that employers of more than twenty people must have at least three per cent of the labor force taken from the handicapped, some having over ten per cent, such employees are the first to lose their jobs. Under the Labor Law all patients in the rehabilitation and training centers must be registered as handicapped persons. This places them in the position of being accepted for work primarily as handicapped persons needing a job, and prevents them from being hired on their merit as skilled workers who merely happen to have been ill.

Occupational therapy programs in the mental hospitals, on the whole, did not appear to be as far advanced as many other parts of their program. The work being done in occupational therapy centers seemed to be mostly of a diversionary character, with little or no vocational carry-over, though perhaps this is adequate in view of the short period of hospitalization of so many of the patients. Recreation programs available to the patients seemed in general to be adequate; also, there is usually a good patients' library service. Little was noticed or called to our attention regarding music, art, or educational therapy.

Social rehabilitation centers for the mentally ill and mentally defective—or rather, to use the English term, mentally disordered, which covers both—were not apparently available in the centers visited, though there are said to be over a hundred in the country. A number of them in London are connected with the Marlborough Day Hospital and the Institute of Social Psychiatry. These social clubs, supported through voluntary contributions, are open not only to patients referred from the day hospital and institute, but also to relatives of the patients at times. A psychiatrist and social therapist from the above two services are present at every club meeting. The psychiatrist is available to individual members and participates in, but does not direct, the various group sessions he attends.

The club programs are informal, the members, after a getting-acquainted interval, break up into spontaneous groups for discussion of current events or social problems, for games, music appreciation, dancing, etc. The meetings are held in quarters which may be a private home, vacant store, or meeting room in some voluntary organization. The clubs are well attended by
patients under treatment, and also by former patients who drop in occasionally.

At Beilen, a small town in a rural area of Holland, I visited a mental hospital of 100 beds, which has a fine family care program. There are 300 patients placed, two to a family, in 150 homes in the community. However, the patients do not work for the family with whom they live, as is the case in the famous family care program at Gheel, in Belgium. In Beilen most of them work for, and are paid by, the hospital, eat their meals at home with the family, and sleep there also. The village is small, and the hospital is immediately adjacent to it. They work in the hospital maintenance shops, laundry, food service, about the grounds, on the farm, and, on a subcontract basis, in assembly work such as packaging clothespins and bookbinding. A few patients work in the local dried milk plant or for other business firms.

In The Hague, seat of government for the Netherlands, with a population of 650,000, I visited an outstandingly fine sheltered workshop serving 400 patients, both male and female; 65 per cent of them are mental defectives, mostly imbeciles, and 35 per cent mentally ill, mostly schizophrenics. The pupils (out-patients), living either in family care homes or with their own families, come to work by train or bus. The workshop, operated by a private association, is supported partly by private contributions, but mostly through grants-in-aid from the city and province. Those referred to the workshops, mainly from aftercare organizations, are examined before acceptance by the psychiatrist in charge and the workshop director. The remaining staff consists of shop foremen and psychiatric nurses. The goal of the workshop is to educate the patients, if possible, so that they will be able to enter the open labor market, or to develop their capacity in order to enable them to get satisfaction from their work, increase their self-esteem, and contribute to their financial support. Their pay is based on a merit system; every three months they are rated on five items—quantity and quality of their work, interest in the work, behavior towards others, and care in handling of material and equipment. Careful daily note is made on each individual patient; evaluation of production is made by shop foremen, and by nurses with regard to the other three items.

Work done in the shops includes garment and sneaker making, and the assembly of ball-point pens and electronic equipment.
For the mental defective group especially, there is a slow-moving assembly line in which paper covers are applied to cardboard boxes.

The goal for patients is to have them perform at least one-third of the normal activities in order to be eligible for social provisions such as sickness insurance, holiday bonus, and working clothes, if necessary. About 250 pupils fulfill this condition, and the association has special arrangements for the 100 pupils whose capacities are below one-third of normal. It may take two or three years before the desired goal is achieved. For most, the workshop continues as a place for permanent employment, though about ten per cent go on to competitive labor jobs.

While in Amsterdam, I spent half a day with Dr. Querido, who is in charge of the city's Mental Hygiene Section of the Public Health Bureau, which has responsibility for adults and children. Through the emergency psychiatric service for adults, a psychiatrist is available day and night to answer any calls. If a member of the family calls, he is referred to a local doctor unless the situation appears acute, in which case a psychiatrist makes a house call. The patient may then be sent to the psychiatric ward of a general hospital, kept at home, referred to an out-patient clinic, or sent directly to a mental hospital. In Amsterdam, all patients requiring psychiatric care must first be screened by the Mental Hygiene Section. An effort is made to provide adequate treatment in home or clinic, to the extent that the proportion of patients hospitalized in relation to the population is small.

Another unique feature of the Dutch psychiatric service is the fact that mental hospitals and clinics are operated under government subsidy by volunteer organizations. This is done on a religious denominational basis—Catholic, Protestant, or Jewish—though some are nonsectarian. The cities or provinces in the country provide the funds to operate these facilities, except for the child guidance clinics which are subsidized by the national government.

During the time spent in England, I visited patients in their homes with a psychiatrist or mental health worker, in Nottingham, Gloucester, and Worthing. There is, in my mind, some question as to the necessity of psychiatrists visiting these patients as often as they do, when well-trained social workers or mental health workers might suffice in some instances, with provision for frequent consultation with the psychiatrist readily available.
In addition, it seemed somewhat questionable in the case of several patients visited whether they would not have been better off in the hospital rather than remaining in the community as long as they did, to the point of severely trying the patience and tolerance of family and neighbors. Interestingly enough, a similar comment was made by one of the psychiatric residents in Holland to a colleague of mine who visited there recently.

The general picture regarding the practice of psychiatry in England and Holland, as far as could be observed by your speaker, seems more adequate in terms of meeting the needs of a larger number of people in the centers with better-developed programs than is the case with us in this country. On the other hand, physical facilities in the way of buildings and equipment in most instances are better in this country, though improvements are being made in both the countries visited. The aspects of the British psychiatric services which are notably missing in the United States are the widespread involvement of general practitioners in direct care and treatment, and better development of home and community services, integrated with the mental hospital. Adaptation of the better basic features of programs in Europe is spreading in this country, but as yet has not reached the advanced stage that was observed in centers over there, particularly in Nottingham. There is no reason to think, however, that improvement and further development to equal the best in England will not occur here, though it will be a number of years, perhaps, before this can be achieved.
PRESIDENT'S ADDRESS
THE ELUSIVE QUALITIES OF MUSIC WHICH MIGHT BE THERAPEUTIC

DOROTHY BRIN CROCKER

Every serious musician, at some time, has thought about the mysteries of the enchantment of music. He has been intrigued and puzzled by the intricacies and many facets of its appeal and admitted that there are qualities that elude description and analysis. The search for the key to the secrets of the meaning of music has been a challenge to numerous musicologists, musicians, critics, philosophers, and serious thinkers in various related fields. The search for the key to understanding the therapeutic uses of music has been, and will continue to be, the goal of all who are interested in music as a therapy. The therapeutic qualities of music are just as elusive as the secrets of music.

Since the organization of the National Association for Music Therapy in 1950, there has been a continual re-examination and readjustment of techniques and methods in an effort to increase our understanding of the dynamics of the therapeutic use of music. This represents a kind of dissatisfaction that is good. It is a sign of healthy growth and leads to the pursuit of further knowledge and understanding. This continuous search for greater efficacy in music therapy techniques is our responsibility and the challenge should be accepted with enthusiasm and humility. Enthusiasm because the approach to frontiers of knowledge and truth is exciting and stimulating; humility because the acquisition of knowledge is but the first step and must be integrated if it is to result in wisdom and evolve into understanding.

Music therapy is not a static concept. As music therapists we have admitted that our knowledge of the influence of music on behavior, whether positive or negative, is incomplete. We know that the number of scientifically conducted research studies is small and that many will be needed in order to find the potentiality of music therapy.

Elston first asks the question, "Can the curative powers of music be controlled?" He follows by saying, "The answer will be forthcoming only after intensive and exhaustive investigation of
all the conditions which involve the use of music as a therapeutic agent. This is an attitude with which NAMT agrees.

As music therapists we are happy to be accepted as a member of the ancillary team under the direction of a physician. We recognize that our goal, as a member of the team, has been to establish a therapeutic relationship with the patients assigned to us which would contribute to the total approach used to promote better health. As we use music in various ways, during individual or group sessions, we keep in mind the principles of therapy and attempt to realize the values of the “therapeutic use of self.” Our reports to physicians or psychologists have been observations or statements pertaining to social and emotional areas, and have noted evaluations of musical performance only as related to improved integration, altered behavior, and changed attitudes.

Simultaneously we have searched for some verifications of our theories of music as a therapy and beliefs about music as an art. As Hanson, a member of the Advisory Committee, has said:

Music is a curiously subtle art with innumerable varying emotional connotations. It is made up of many ingredients, and according to the proportions of these components, it can be soothing or invigorating, enabling or vulgarizing, philosophical or orgiastic. It has powers for evil as well as for good. If we are to use it as a social or therapeutic force, the first essential is that we find out something about it.

Copland has referred to the joy of being carried forward by the flow of music:

Music’s incessant movement forward exerts a double and contradictory fascination—on the one hand it appears to be immobilizing time itself by filling out a specific temporal space, while generating at the same moment the sensation of flowing past us with all the pressure and sparkle of a great river. To stop the flow of music would be like the stopping of time itself, incredible and inconceivable.

What are those elusive qualities in music that can move some persons to the depths, bring to others a message that is uplifting or enriching, or frequently serve as a means of dissolving, re-directing or sublimating anger, and anxiety on a conscious or subconscious level as they respond to the flow of music?

There are certain aspects of the so-called "inner life"—physical or mental—which have formal properties similar to those of music—patterns of motion and rest, of tension and release, of agreement and disagreement, preparation, fulfillment, excitation, and sudden change. In discussing emotion and meaning in music Meyer has said:

Affect or emotion felt is aroused when an expectation—a tendency to respond—activated by the musical stimulus situation, is temporarily inhibited or permanently blocked. . . . In musical experience the same stimulus, the music, activates tendencies, inhibits them, and provides meaningful and relevant resolutions for them. This is of particular importance from a methodological standpoint, for it means that granted listeners who have developed reaction patterns appropriate to the work in question, the structure of the affective response to a piece of music can be studied by examining the music itself.

It is the hope that this paper will encourage music therapists to attempt to find out more about the therapeutic value of music by pointing out the importance of more careful analysis of the music used in therapy sessions. Serious study will result in knowledge that can be used advantageously. This does not mean to attempt to classify music simply as to mood, but in terms of harmonic relationships, melodic line, rhythmic patterns, style, tempo, dynamics, and deviations.

Meyer considers alterations in the expected progression, which he calls deviations, as emotional or affective stimuli. He says also that:

The greater the buildup of suspense, of tension, the greater the emotional release upon resolution. This observation

points up the fact that in aesthetic experience emotional patterns must be considered not only in terms of tension itself, but also in terms of the progression from tension to release. And the experience of suspense is aesthetically valueless unless it is followed by a release which is understandable in the given context.6

It has been interesting to note the kinds of music requested by emotionally disturbed children in individual music sessions. The periods are started with the therapist asking the question, "What kind of music do you want to have played for you today?" Requests such as loud, fast music; soft, fast music; slow, loud music; slow, soft music, heavy music; big music; or something pretty are granted by short piano improvisations in the manner requested. This is one way of teaching them to listen to a melodic line, a rhythmic pattern, harmonic progressions, movement, unexpected changes, or agreeable and satisfactory progressions.

One musical boy, age eleven, asks for loud, fast music when he has been having a difficult time with his studies and feels upset; but he requests something pretty when he is less disturbed. His idea of pretty music is a melody with accompanying chords. He likes waltzes very much. Another boy always wanted slow, soft music and preferred music in the whole tone scale to melodic music with arpeggio accompaniment or sonatina style. His request changed to slow, loud music as he became less withdrawn; and his psychiatrist said he was less anxious and better integrated. This might be partially explained by the statement:

Because chromatic and whole-tone scales and augmented and diminished triads all involve intervallic equidistance, they create uniformity and produce ambiguity. And it is no accident that such weakly shaped, ambiguous series have tended to become identified with affectivity and have so often been used to express intense emotion, apprehension, and anxiety.7

The children are encouraged to express what they like or dislike about the music and in this way the therapist gains some insight about their responses to music, and they are learning to listen somewhat critically to rhythms, melodies, and harmonies. After hearing a deceptive cadence, one child said, "I know the

music is not finished yet and I'm glad." One little girl commented about a perfect authentic cadence, "That's pretty; it sounds like the ending of a story where everyone lives happily ever after." Another girl said, "That time didn't go right; it stopped being pretty." She was referring to a disturbance in metric continuation which was an unexpected syncopation.

Occasionally there are requests for pieces with a lot of chords, a pretty melody, or a lot of rhythm. When children request music that is angry, sad, or happy, the therapist tries to feel the emotion of anger, sadness, or happiness by recalling some personal experience and attempting to let the music sound the way she feels. It is the inner music that has resulted from the recollection and immediately replaced it that is allowed to flow outward, not an inner feeling that is expressed in tone while thinking about the feeling. This is not the same as thinking of anger and trying to express anger in music or describe a situation involving anger. Langer says, "What music can actually reflect is only the morphology of feeling."8

In other sessions when symphonies or great classics are played for the children, it is to encourage them to learn to listen to the beauty in music and to enjoy it. They are forming habits of deciding what kind of music they want to hear, of trying to follow what music does, and of listening for beauty and for pleasure.

Music therapists have the responsibility of using music in situations which attempt to induce responses in patients; there must be a realization that the music simultaneously produces responses in the therapists. The interaction is comparable to a duet in which both players have a part. There can be feelings of closeness which are not assertive or demanding between therapist and patient when they are sharing musical experiences, either active or passive. There can be feelings of mutuality if there is a similarity of responses; however, since neither participant can be compelled to respond in a specific manner, there is no need for resistance or rejection. It is advantageous for a music therapist to try to evaluate his own responses to music as well as those of the patients, but these evaluations can only be expressed in terms of what is heard in the music itself, not in terms of what the music means.

The assignment of meanings is a shifting, kaleidoscopic play, probably below the threshold of consciousness, certainly outside the pale of discursive thinking. The imagination that responds to music is personal and associative and logical, tinged with affect, tinged with bodily rhythm, tinged with dream, but concerned with a wealth of formulations for its wealth of wordless knowledge, its whole knowledge of emotional and organic experience, of vital impulse, balance, conflict, the ways of living and dying and feeling. Because no assignment of meaning is conventional, none is permanent beyond the sound that passes; yet the brief association was a flash of understanding.9

It is the "flash," or feeling of understanding and the insight gained about the attitudes and feelings of the patient that make it possible for the music therapist to use "self" in developing a therapeutic relationship. The therapist tries to give to the patient (or else awaken or unlock), feelings of worth and respect, love and acceptance, approval, achievement, hope, and confidence.

The art of music without specific subject matter and little specific meaning is a balm for the human spirit, not a refuge or escape from the realities of existence, but a haven wherein one makes contact with the essence of human experience. It is an exhaustible font from which all of us can be replenished.10

9. Ibid., p. 198.
PART I

MUSIC IN MENTAL HOSPITALS
MUSIC THERAPY IN A MENTAL HOSPITAL

HENRY R. ROLLIN

Musick is a roaring-meg against melancholy, to rear and revive the languishing soul: affecting not only the ears, but the very arteries, the vital and animal spirits, it erects the mind and makes it nimble.¹

It would be difficult to find a greater advocate of the therapeutic benefits of music than Robert Burton (1577–1640). In his classic work the “Anatomy of Melancholy,” of which only a fragment is given above, he sings the praises of music as a manipulator of emotions. One is tempted to quote further: “it doth exterminate fears and furies, appease cruelty—abateth heaviness: and, to such as are watchful, it causeth quiet rest; it takes away spleen and hatred, be it instrumental, vocal, with strings, winde; it cures all irksomness and heaviness of the soul.” Literature, throughout the ages, is peppered with apt quotations describing the powers of music, but if a charter for Music Therapy were ever written one could do no better than to echo what Burton said over three centuries ago.

As to the theoretical concepts by which music exercises its powers much has already been written, and it is not proposed in this contribution to add to them. Suffice it to say, however, that the disturbance in so much mental illness is in the field of the emotions. Schizophrenics, for example, who make up such a large proportion of the mental hospital population, suffer particularly in this respect. A characteristic of the disease, emotional flattening or an inability to respond appropriately in terms of feeling to a given situation, is often manifest. Again, among victims of manic-depressive insanity or affective psychosis, there is a morbid distortion of emotions ranging from elation or pathological happiness on the one hand, to melancholia or pathological unhappiness on the other. Music, it was felt, could be employed as a means whereby these emotional upsets could be attacked, either by stimulation or sedation, and the fundamental disease progress mitigated. Let it be emphasized, however, that

at no time was it considered possible that music could replace established methods of treatment such as electro-convulsive-therapy, deep insulin therapy, leucotomy, etc. It was always considered that music, in the light of our present knowledge at any rate, must be rated as an ancillary form of treatment, or perhaps as a catalyst, facilitating other therapeutic procedures. This is not to minimize its importance, but rather to keep a sense of proportion so that extravagant objectives are not aimed at and over-optimism confined. Music therapy must still be regarded as an experimental project and modesty in its immediate aims in this, as in any other experiment, is not necessarily a handicap.

It is felt that the interests of this contribution can best be served by giving a factual account of work done in a particular hospital. Horton Hospital, Epsom, is one of five mental hospitals built on a large estate in the last decade of the 19th Century and the first two of the 20th Century. It is typical of the late Victorian style of institutional buildings—huge, solid, and ugly. Originally it was designed to accommodate 2,000 patients in vast, barn-like wards which were equally divided between night and day room accommodations. Behind their erstwhile locked doors the patients, with a somewhat arbitrary method of selection, numbering between 60 and 100, spent their whole time as an isolated community mixing little with other wards except on High Days and Holidays; for example, the weekly dance, the annual fete, and attendances at Church. The decorative schemes, if they could be graced with such a term, were drab in the extreme; chocolate brown and olive green predominated. The furniture was massive and designed much more with an eye to durability than comfort. The clothes in which the patient was dressed were miserable in the extreme—badly designed, of the coarsest, cheapest materials and, in all, calculated to degrade the unfortunate being who was made compulsorily to don them. The atmosphere, therefore, was compounded of partly that of a workhouse, partly of a prison and with only a faint trace of anything which could be deemed to improve morale. There was an ironic justification for the term "to be put away" which was used to describe admission to a mental hospital of this sort in those days. Treatment other than custodial care was virtually nonexistent, and what cures or improvements took place were the result largely of spontaneous remissions in the mental illness from which the patient suffered.
Music in Mental Hospitals

It would be apropos to mention the place of music in the hospital at that time. There was music in the form of a para-military brass band, with perhaps a string section, which played with great gusto but with little expertise for the weekly dance or special "gala" occasions. (Male nurses, or significantly enough, "attendants" as they were then called, were chosen for their proficiency as instrumentalists or their capabilities as footballers or cricketers rather than for any nursing potential they might have had.) There were, too, pianos of a sort; great lumbering "grands" in most wards of ghastly quality, rarely tuned, and used mainly as jardinieres.

Horton during both world wars was cleared of mental patients and used as a military hospital in the first and as a military-cum-civil hospital in the second. In 1948 it was reopened as a mental hospital with 150 or so chronic patients who were brought back from other hospitals to which they had been evacuated since 1939. In the same year the hospital was taken over by the National Health Service from the London County Council. The hospital, therefore, had to start again from scratch with all the obvious difficulties. However, there were advantages which on balance outweighed the disadvantages. It did mean that the enormous developments in the treatment of the mentally sick during the preceding 20 years or so could be adopted and built into the new organization which came into being. Thus the then new treatments, deep-insulin, E.C.T., pre-frontal leucotomy and the like were introduced one by one. With the hope which these procedures engendered came a revolution in the atmosphere of the hospital. As and when wards were redecorated, browns and greens gave way to brighter pastel colors. The ugly Victorian furniture was replaced by lighter and more comfortable chairs and tables. An ever increasing number of wards were "opened" so that patients had access, at will, to other parts of the hospital. Other steps, important in the aggregate, were improvements in the clothing and diet of the patients, the provision of a women's hairdressing salon and a chiropody department, a better library, social and recreational facilities, an increased number of ground and town passes, and the encouragement given to patients to spend week-ends or longer periods with relatives or friends. Furthermore, with the dawn of rationalism and humanism in the management of mental hospitals came the growing awareness of
the demoralizing effect and the affront to human dignity of enforced idleness in the mentally sick. There can be no doubt that the picture of dementia seen in some of our long-standing cases is the sum of deterioration inherent in their particular mental illness plus an "institutional psychosis" forced on the patient by a dull, unimaginative routine and by idleness. Nowadays, to combat this invidious process a policy of "total push" is pursued; that is, every effort is made to employ patients in one way or another. Nor must the employment be "work for work's sake." To be of real therapeutic value the work done, or the activity engaged in, must be intellectually or emotionally satisfying or both. And herein lies the value of music therapy.

It has taken some time to paint in the background against which the inception of music therapy at Horton took place. The time was propitious; there was a prevailing wind of optimism which blew into every corner of the psychiatric world. New ideas abounded and fortunately the enlightened Management Committee of the hospital was receptive to them. With such an idea did our music therapist come to Horton, and in October, 1955, the idea was put into practice.

There were no preconceived notions as to what the objectives should be or how the idea should be put into operation. (It should be interpolated here that there was then a "music appreciation program" in existence attended by all who cared to go, but it was felt that what must be done now should be more specific and individual.) There was no equipment except an antique piano salvaged from a ward and restored to its inferior best, and an electric gramophone. Initially, the only accommodation available was the Main Hall, built in the grand manner, large enough to house a fleet of mammoth aircraft, but with acoustics which had to be heard, or not heard, to be believed. But a start was made. To begin with, a group of male patients was selected who had had musical tuition either as professionals or as amateurs. It was felt on prima facie grounds that to reawaken an interest in an activity which at one time must have given deep satisfaction ought to be of therapeutic value. No attention was paid to the mental disease from which the patients suffered or the phase of their illness. As by far the largest single clinical group in any mental hospital is that of schizophrenia, it is not surprising that of the nine patients who comprised the first group, eight were schizophrenics and one a manic-depressive. Of the
nine, one had been a professional pianist of some standing; one had been a student at an academy of music at the time of his breakdown; another had been an amateur violinist of above average ability, and the rest had been pianists of widely differing levels of achievement.

The schedule at first was a simple one. After being assembled, gramophone records, initially selected by the therapist but later selected by the patients themselves, were played. Then the therapist played piano solos, mainly, as the program got under way, by request. Finally, each patient in turn was urged to play something—anything—at the piano. It must be remembered that not one of the patients had touched an instrument since admission to the hospital, which was for periods varying from several weeks to 20 years. The standard of performance, therefore, varied enormously from passing fair to excruciatingly bad. But virtuosity was not the objective; what was asked for and what was obtained, with a minimum or a maximum degree of cajolery and encouragement, was participation. It was heartening in these early days to see retarded and/or deteriorated patients scramble, some way at any rate, out of their psychosis and communicate by means of the music they played with their fellow men. That the communication was received was manifest in the applause of the rest of the patients for the performance, no matter how inferior it was. A group was formed spontaneously from individuals who by virtue of their mental illness tended to be solitary and asocial. It was the creation of this group, that is, an association of people with a common purpose and a common language, in this case music, which paved the way to future endeavors. Lest the one and only violinist be forgotten let it be said that he had his fiddle sent from home and that his contributions as a soloist, duettist, or in various small ensembles were, and still are, greatly appreciated.

Some time later equivalent groups of female patients selected by the same criteria were formed and with a success no less than with the male groups. By early 1956 more than 30 patients had been included who had specifically asked to be so, or requests for their inclusion had been made by relatives. From these heterogeneous groups, a few patients, male and female, had crystallized out as being specifically gifted, musically speaking, and to these, individual tuition was given.
In the summer of 1956 an important milestone was reached; a superb Steinway grand piano was acquired by an unusual example of Anglo-American cooperation. The long and benevolent arm of Madame Yolanda Mero-Irion, Executive Director of the Hospitalized Veterans Service of the Musicians Emergency Fund, Inc., in America, reached across the Atlantic and interceded on our behalf with Messrs. Steinway of London, so that the instrument was made available at a very special price which was paid by the Horton Management Committee. This was not only a symbol of success in that the Committee was sufficiently impressed with the experiment in music therapy to give its blessing in such a tangible form, but also as a boost to the morale of patients and staff alike. To play this magnificent instrument in preference to the antique model already described became a privilege, and there was competition between patients to be allowed to do so, either during music therapy sessions or during practice sessions which had by now been drawn up.

By now the number of patients handled had steadily increased, and as a further group activity, a women's choir had been formed. The standard of playing of the few patients for whom time had been found to give individual instruction had improved inordinately. Indeed, it was felt that the time was now ripe for concerts to be given by the patients for the patients. These were started in the spring of 1956. The programs were ambitious, and, considering the material with which the music therapist had to work, the fact that they were performed at all, at any level, was in itself an achievement. Some of the performances were extremely good. Perfection was not aimed for and certainly not attained; but what was achieved was a psychological triumph for performers and audience alike. The frequent rehearsals had welded the performers into a large group with the same group and individual tensions and anxieties which normal musical groups undergo in similar circumstances. The fillip to their egos once they had done their bit was all too obvious. They glowed with pride as they took their bows and again when they received their little gifts as tokens of appreciation of their efforts. Temporarily, at any rate, they had fulfilled man's fundamental need—to be needed. The mentally ill, admitted perforce to a mental hospital, are for the length of their stay failures. They have failed their social group, their families, and particularly themselves. What better index of hope for the future could there be than to stand in
Music in Mental Hospitals

the limelight, in both the literal and metaphorical sense, to receive the plaudits of their fellows. For the audience, composed of over three hundred patients, shared in the success of the concerts and reflected glory of the performers, and in so doing they too became part of the group—the music therapy group—in just the same way as a school, a university, or a whole town can project themselves into, and identify themselves with, the triumph of their team. As further evidence of this phenomenon it should be mentioned that these patients’ concerts occasion much more discussion for a much longer time than any given by outside artists, no matter how eminent.

Having established these musically orientated groups it was felt that the net could be cast wider and experimental groups started with patients to whom music, or rather rhythm, might appeal at a more primitive level. To this end, in March 1957, percussion bands were formed with, as the stock of instruments gradually increased, drums, tambourines, triangles, cymbals, bells, maracas, tambours, chime bars, trumpets and “nightingales.” The criterion for inclusion in these groups was that no other form of treatment had been able to hold their interest. Clinically, therefore, they constituted the least hopeful element in the hospital. The technique was quite simple; the piano was played with a forceful rhythm, usually incidentally by another patient, while the patients in the group were encouraged by members of the staff to shake or beat the percussion instruments which had been handed out to them. These instruments require no musical skill whatever; all that is needed is to determine and maintain the rhythm of the piano. The result is not nearly as cacophonous as might be expected in spite of, or because of, the limitations in tonal range. In fact, with a percussion band going full blast, and this is the desired result, the effect can be very stirring. The regressed schizophrenics who make up most of these groups are by the nature of their psychosis withdrawn, apathetic, and anergic, so that spontaneous participation was not expected nor achieved. However, with the coaxing and encouragement mentioned above, the majority of the patients were induced to play their part, or their instrument, at first feebly, but later with growing gusto. The success of the venture could be measured quite simply indeed by the volume of sound which emerges from the group, and in this respect a decibel recording instrument is
not needed; an arbitrary assessment can be made from the distance from the music room before the group can be heard. There can be no doubt that these percussion groups have succeeded within the limited objectives set for them. It is most reassuring to see these lost, preoccupied beings become, for the moment at any rate, animated and “have a go” with whatever instrument they happen to wield.

In July 1957, a second, important milestone was reached; the acquisition of a music room. In keeping with the other assembly halls at Horton the chapel is of giant proportions, far too large for the spiritual needs of the community, patients, and staff. With the kind cooperation of the Management Committee and the ecclesiastical authorities, permission was obtained to annex roughly a quarter as a music room and concert hall. At the moment there is only a symbolic wall separating the spiritual from the secular in the form of a series of screens most attractively painted by a patient of one of the music therapy groups. Plans are in hand for a real conversion whereby the music room will become self-contained. The plans include an artists’ room and toilet accommodation. Although the acoustics as they are now are infinitely superior to those of the Main Hall, it is thought they could be substantially improved by the building of a false ceiling which would reduce resonance.

The acquisition of a home of its own gave the music therapy project a decided fillip. New experimental schemes were set in motion and yet another group, a recorder group with mouth organ and/or banjo and autoharp plus a percussion section accompanied at the piano by a patient, was formed and has proved a great favorite. Indeed, so great were the patients’ demands for practice time, either for individual patients or small ensembles, at times other than the official music therapy sessions, that a year or so ago a second music room was fashioned from a disused general bathroom, and two reasonable upright pianos housed there. It is hoped, when funds become available, to repair and redecorate the room which, despite its present state of dilapidation, is in full use. Practice lists for both music rooms have now to be worked out in advance so that there is no clash of times or interest. Thus, the number of patients actually participating in the project has risen from twenty or thirty at the beginning to, at present, seventy or eighty, which is approximately five per cent of the total patient population.
A typical program for the two music therapy sessions held consecutively on a Monday is as follows:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:30 A.M.-10:30 A.M.</td>
<td>Mixed Percussion Group</td>
</tr>
<tr>
<td>10:45 A.M.-12 Noon</td>
<td>Listening Group and Individual Performances</td>
</tr>
<tr>
<td>12 Noon-1:00 P.M.</td>
<td>Individual Instruction</td>
</tr>
<tr>
<td>2:00 P.M.-2:40 P.M.</td>
<td>Mixed Listening and Choral Group</td>
</tr>
<tr>
<td>2:40 P.M.-3:20 P.M.</td>
<td>Mixed Recorder, Mouth Organ, Percussion, Choral Group</td>
</tr>
<tr>
<td>3:20 P.M.-4:00 P.M.</td>
<td>Female “Chronic” Group—Listening and Chorus</td>
</tr>
<tr>
<td>4:00 P.M.-5:00 P.M.</td>
<td>Instrumental Groups, Duets, Trios, etc.</td>
</tr>
</tbody>
</table>

It would be pertinent to add a note concerning the attitude of the nursing staff to the project. To begin with there was an understandable scepticism which gave way as the scheme got under way, and particularly after the most successful patients' concerts already referred to, to growing enthusiasm and increasing cooperation. Nowadays there are up to eight members of the nursing staff, male and female, present during the sessions, and their help is particularly valuable with the percussion groups where so much encouragement and coaxing is needed to ensure the patients' participation in the activity. It is noteworthy, too, that two male recruits to the nursing staff, both of whom have had musical training, came to Horton because of its music therapy program. Their help in carrying on the work, particularly with the ensembles, in the absence of the music therapist has been most valuable. Furthermore, the interest and cooperation of the Occupation Therapy Department is now wholehearted, and attendance at the groups is considered as an integral part of the training of student occupational therapists at the hospital.

As offshoots to the main program, mention should be made of some minor experimental projects, not necessarily successful but all showing the growing interest in music as a therapeutic agent and a certain spirit of adventure in putting it to use. Thus, in 1958, at the suggestion of a member of the nursing staff, music on gramophone records was played in the Insulin Therapy ward at the time when the patients were emerging from coma. During this period of half-consciousness, patients are very often restless,
irritable and confused. Music does seem to allay the restlessness in some cases, due partly to the sedative effect of the music itself but also to the establishment of contact with reality through the auditory stimulus provided. Again, in the geriatric wards, classes have been instituted which are conducted by the nursing staff whereby movement and relaxation to gramophone music are encouraged. In the same department a small pilot experiment has been instituted to see if, by the playing of gramophone records for a period at night, the use of sedatives can be reduced or even eliminated. Furthermore, a regular item in the hospital's entertainment program for the past few months has been the entertainment of senile patients in their own wards by members of the music therapy classes either as groups or as individuals.

In drawing a picture of the "total-push" program in a mental hospital it is not possible, nor is it desirable, to differentiate between what is primarily therapeutic and what is primarily entertainment. For this reason it is felt that no account of the place of music at Horton would be complete without mention of the "celebrity concerts" given by established artists for a very nominal fee which have given infinite pleasure to patients and staff alike. These concerts are given in the winter and spring at roughly monthly intervals and for the season 1958-1959, for example, included:

- January—Sonata Recital by Olive Zorian—Violin, and Raymond Leppard—Piano.
- March—Oromonte Trio.
- April—Sonata Recital by Carl Pini—Violin, and Niso Ticciati—Piano.
- May—Recital by Eric Harrison—Piano.

In the account given of the growth and development of music therapy in this hospital, no attempt has been made to assess the improvement, either individually or collectively, which has resulted. It cannot be overemphasized that at no time, in the light of our present knowledge and/or with the facilities at our disposal, was it thought that music could replace such established therapies as E. C. T., deep insulin, chlorpromazine, or psychotherapy. However, as an ancillary form of treatment there is no doubt that music plays its part, and an important part at
that. As witness to this claim it should be restated that during the four years in which music therapy has been practiced, the enthusiasm of the patients for this particular activity, either on a group or an individual basis, has progressively increased. The whole project has snowballed; the numbers handled directly have increased fourfold since its inception; there is an increasing diversity of activities during the actual classes; and experiments in the use of music outside the routine classes by members of the medical and nursing staff are in progress. It is appreciated that these claims, modest as they are, would not stand up to strict scientific enquiry, but if opportunity in the shape of further money and personnel to establish a controlled experiment were provided, then data of a more acceptable "scientific" sort might be forthcoming. Nevertheless, there are several specific cases where the improvement manifested, leading to their discharge or to their social upgrading within the hospital, was, on clinical grounds, attributable to their participation in music therapy.

CASE REPORTS

Case 1. Mrs. E. H., age twenty-three on admission as a certified patient in September, 1952. The diagnosis was schizophrenia; she was deluded and hallucinated for hearing, i.e., she believed she was being persecuted by the police, that her thoughts were being read, and that she was being plagued by "bangings and rappings." Under the influence of these phenomena her behavior was at times grossly disturbed. She was treated with deep insulin and electro-convulsions from October, 1952, until November, 1955, and although her condition underwent fluctuations it was, even at best, far from satisfactory. She was argumentative, quarrelsome, and at times violent.

She was, by virtue of her musical training in her native Bulgaria, included in the first group of female patients selected for music therapy which began in November, 1955, i.e., after physical methods of treatment had ceased. Despite the fact that, as a girl, she must have achieved a relatively high standard of performance as a pianist, she had not touched a piano for years. However, she was encouraged to play, which she did reluctantly, but on the strength of her performance she was selected for individual treatment. The early stages of her musical rehabilitation were far from easy because of the potency of her psychotic symptoms.
Gradually her dexterity returned and she applied herself with increasing zest to her practice. As she did so, there was a perceptible falling away of the strength of her delusions and hallucinations so that, at least, she was able to live with them.

She was one of the soloists in the three first patients' concerts and although she needed a great deal of support and encouragement to take her place on the platform, when she did so, she performed admirably.

In the summer of 1957, her behavior, in spite of the persistence of symptoms, had so improved that she took a job as a salesgirl in the town while continuing to live in the hospital. Finally, at the end of July, 1957, she was discharged from the hospital and has managed to maintain herself on her own in London ever since.

Case 2. Mr. G. W., age twenty-seven on admission as a voluntary patient in August, 1952. The diagnosis was schizophrenia; symptoms had been present for at least four years prior to admission and in other hospitals he had had physical methods of treatment.

He was a serious behavior problem to begin with; he was lazy, dirty, and totally unreliable. Thus, he would abscond from the hospital, go into the town, and would be returned by the police for a variety of misdemeanors which included begging, theft, and indecent exposure. Because of this total unreliability, he had to be kept in a closed ward.

He had had a sound musical education and had been a reasonably accomplished pianist. Because of this background, he was one of the original male group selected for music therapy in October, 1955, and later for individual treatment. His piano playing has improved enormously and he is now, and has been for some years, the cornerstone of the various small ensembles which have come and gone. He is an excellent accompanist and, for example, accompanied Mrs. E. H. in the concerti arranged for two pianos given at the patients' concerts.

As his interest and proficiency in his music rose so his status vis-à-vis his fellow patients rose too. Gradually, he was given more and more privileges and for some time now he has gone home regularly for week-ends. He is neat in his appearance and conducts himself with propriety.
Case 3 Mr. C. S., age seventy-two on admission as a voluntary patient in January, 1956. He is a case of chronic hypomania; he is garrulous, overactive and grandiose in manner. He had been a good amateur violinist in his native Germany but had neglected his instrument for some years. He was selected for inclusion in the early groups for music therapy and volunteered to have his fiddle brought from home. He was encouraged to practice and ultimately played in various ensembles and is a regular performer in the patients’ concerts. The symptoms he originally exhibited are still present, but his social behavior, since his interest in music was reawakened, is so improved that he now enjoys all the privileges available in the hospital.

Case 4. Mr. F. M., age fifty on admission in October, 1958. The diagnosis was chronic alcoholism. He is a professional violinist who in the past held important jobs as a leader of various light orchestras. As his alcoholism increased he slid down the social and professional scale until he became unemployable. He finally pawned his violin. When admitted he was penniless, destitute, and his morale broken.

He was placed in one of the music therapy groups. Reluctantly at first, he agreed to play on a borrowed fiddle to the group. Gradually, his confidence and proficiency improved and every facility was given him to practice outside music therapy sessions. Eventually, a loan was arranged so that he could redeem his own instrument from pawn. He was, not unnaturally, overjoyed to be reunited with it and redoubled his efforts to regain his old proficiency. In mid-December he was successfully auditioned for a job as a leader of a ship’s orchestra and left to take up his appointment two weeks later.
Music therapy in England is not yet a recognized profession as it is in America, but a good deal of music is used in rehabilitation and social work with maladjusted or mentally disordered children and adults. The work is done in hospitals, clinics, psychiatric social clubs, centers for delinquents, and in special schools. Often the people concerned are not trained musicians; nevertheless they make a most valuable contribution. Indeed, it would be true to say that the large amount of work done by teachers, social workers, therapists, psychologists, and a few doctors has been mainly responsible for the widespread interest shown in the potential value of music therapy today. In this respect the professional musicians have been, until recently, very much in the background. It is only now—as a result of this public interest—that they are coming forward in any numbers, though it is only fair to admit that there is still a feeling among musicians in general that music therapy is second best to concert performance—a tendency to imply that only those who cannot make a success in more glamorous fields are likely to be attracted into therapeutic work. This is, as you all know from personal experience, based on a complete misunderstanding of the qualities both musical and personal needed to make a good therapist. It will be one of our major tasks in the future to set a very high standard of professional competence in order to readjust the balance.

National Health Service

When one considers how music therapy may develop, there is one marked difference between conditions in America and England. That is the existence of the National Health Service, in which, generally speaking, all hospitals come under the Ministry of Health. In practice this means that any treatment which has proved its value is eventually included in this service. It follows that, although music therapy on the present small scale can be financed by private sources or charitable bodies, the work itself must be done in state hospitals. If such hospitals decide that music therapy is a sufficiently important addition to current
treatments then music therapists will be taken on the staff. At the moment there are very few such appointments, and they are only on a temporary basis—which means they come up for renewal every six to twelve months. Naturally, a great deal more evidence must be accumulated before the Ministry of Health would consider creating an entirely new national service with all the complications of pay, allowances, qualifications, pensions, and so on, which that entails. But this is what we have to work for; you will appreciate this is a much more complex matter than persuading individual hospitals to use music and musicians, apart from what is already done by Occupational Therapists.

I would like to digress a little on this matter of staff appointments which seems to me to be very important. As the staff music therapist at St. Bernard’s and Horton hospitals, I am directly responsible to the Superintendent for the affairs of my own department. I attend all appropriate staff and ward meetings and have access to case papers. During music therapy sessions all nurses on duty are under my direction, and, of course, I can call on all the facilities of the hospital for anything that is needed. When there is a concert, for instance, it makes a very great difference to be able to use the Stores Department, gardeners, carpenters, printers, electricians, etc.

It is very noticeable when one goes to a hospital where a music therapist is working as a volunteer, that little, if any, of this happens, because he has no authority and has to exist more or less through the good offices of any members of the staff who happen to believe in the possibilities of music as a therapy. Working on the same basis as other therapists in the hospital one can naturally ask more from one’s colleagues—and get it.

**STAFF RELATIONSHIPS**

The importance of staff relationships cannot be overemphasized. The effect of all therapies is, everyone agrees, extremely difficult to assess. Music, because of various factors with which we are all only too familiar, is possibly the most difficult. It can so easily remain on the level of entertainment. I am the last person to decry its value in that respect, but it is not therapy in an acceptable sense and one certainly could not justify the employment of someone called a music therapist if that is all he can achieve. Transforming entertainment into therapy is,
in my experience at least, an extremely difficult thing. It is only occasionally in a ward session that I feel it has been done and then perhaps only for a few minutes. But that is the level on which every session must be approached in order to justify asking the rest of the staff to give you their support. This they will certainly do, most generously, once they have seen for themselves that the patients are receiving some real benefit from the activity. In my opinion this is most effectively done when the nurses are part of the team. In St. Bernard's and Horton hospitals all group work is done with the help of the nurses and patient leaders, in mixed groups as well as in those for men or women only. This has been by far the most important single factor in getting general support for music therapy in both hospitals. Even so, active interest must be maintained and, if possible, increased by a variety of means such as concerts given by patients and music therapists, talks with doctors, therapists and nurses, and a continuous effort to integrate music therapy programs with other therapeutic activities. I am sure you will agree that to get the best value out of music therapy, it should be completely integrated with all the other treatments to which the patient is subjected. Naturally this implies that all members of the therapeutic team—doctors, nurses, occupational, art, and music therapists—shall understand what each is trying to do and have mutual confidence in their ability to produce results. In such conditions music therapy can, and does, make a contribution which is in some ways unique. The most important of these is probably its ability to join and hold together a group of people without the necessity for words.

Group Activities

Ward Sessions:

The wards chosen provide a cross section of the patients to be found in any mental hospital; psychotic, neurotic, and infirmary. Music therapy sessions take place once or twice a week as appropriate.

1. Psychotic Wards. With these patients we try first to gain attention, perhaps by playing or singing, and then to extend the period of concentration through rhythm groups. Finally we try to join the whole ward together in some activity, often by some form of dancing, while those patients unwilling or perhaps unable to move, keep time for the others by hand clapping or
with percussion instruments. Any patient who can is encouraged to perform alone or possibly in a small group. The main principle to be observed is that music must be grounded on simple rhythms, straightforward melody, and elementary harmony.

In singing, folk songs which take people back to childhood are the most successful. For listening, we find that well-known classical pieces like Gounod's "Ave Maria," Schubert's "Serenade," bring the best response. We use the South American rhythms and old music hall tunes for movement. No set form of dance is expected in such groups which may number up to sixty patients. We usually start by forming small circles of three or four, then gradually link these into bigger and bigger circles until the whole ward is moving spontaneously. We might then break off behind a leader who takes the line in patterns all over the ward, joining up again in one large circle to finish the session. Before leaving, everyone is asked what they thought of the session and if there are any suggestions or requests for next time. The nursing staffs on duty are also included and particular care is taken to encourage them to follow up the results, good or bad, of every session. This team work is generally agreed to be well worth the effort in terms of organization and time given by the ward staff since it improves the atmosphere, quietens even very disturbed patients, and provides something to look forward to the following week. Perhaps even more important, the music therapists who live and work away from the hospital provide a friendly link with the outside world.

A supplementary scheme is run in connection with these wards. Twelve long-term patients (possibly from ten to twenty years standing), none of whom has responded noticeably to any other treatment, are formed into special groups with two junior nurses and two patient leaders allocated to each. With a carefully controlled activity program, which includes habit training, they have two music therapy sessions each week in addition to the ward session. For this they come to a small room away from the ward. Singing, rhythm, and movement are used, but much more time is spent in making personal contact with each patient and encouraging some kind of response, however small, even if it is only to choose an instrument, move a chair, or notice the color of a dress. Special care is taken to greet each member of these groups and to shake hands when saying goodbye at the end of the session. Once a month they
are invited to a concert given in one of the infirmary wards. This is made an occasion for encouraging better social response in what is deliberately a party atmosphere with tea, sweets, and cigarettes, as well as best dresses and suits. This method does, by general consent, induce a marked improvement in many cases. The objective is limited by necessity with such patients; we hope that by these means we may help them to be a little happier in themselves or, at least, more manageable for the staff.

2. Neurotic Wards. Since neurotic patients tend to be acutely self-conscious, we find that group singing or listening is much more successful in gaining their cooperation than rhythm sessions which they are apt to consider childish, or movement which might expose them to ridicule before fellow-patients. It is very important to shield them from failure in any form since the object in such wards is to get everyone to join in and, even for a short time, to forget their troubles. We try also, by teaching simple instruments (recorder, autoharp, ukelele, chime bars, etc.) and by singing chorus and part songs, to build up self-confidence. Any actual or potential soloists are given opportunities to perform both in ward sessions around the hospital and at concerts.

The most successful songs are those from current shows and a few more serious ones like Handel’s “Where e’er you Walk” and Schubert’s “Who is Sylvia?” Anything which takes them back to school days is resented. For listening one can range through all the romantic composers, Chopin, Schumann, Brahms, Mendelssohn, Beethoven, Debussy, and give great pleasure as well as induce tears on some occasions.

When the music therapy sessions are cancelled for some reason these patients are usually disappointed and even resentful, which is at least some measure of success.

From among the patients who suffer through excessive tension, a small group is selected for relaxation. This is held once a week in the music room. After breathing and relaxation exercises the patients lie down while suitable music is played to help maintain the state of release. The music ranges widely; slow movements from sonatas by Mozart, Haydn, Beethoven, or Brahms; intermezzi are suitable but they should, if possible, be unfamiliar as it is necessary to avoid stimulating attention. At the same time the pieces must be played in such a way that
rhythmic shape and form are maintained, but the whole effect is not obtrusive. Quality of tone production is even more important here than at other times, if that is possible. Further exercises, to be continued during the week, are given at the end of each session.

This group which has only been going for three months is still experimental, but it has made a promising start.

3. Infirmary Wards. Sessions in these wards usually take place once a week. As a very large number of these patients are unlikely, for one reason or another, to leave the hospital, the emphasis is very much on entertainment. For this reason we give a concert every month in one big ward, patients and therapists together, to which other patients from all over the hospital are invited and given tea. This is organized by the Assistant Matrons who merely ask me for the time and the guest list. Extra nurses are on duty in the ward, as well as those accompanying visiting patients, and senior members of the staff always look in for awhile to see how everything is going. It is very surprising how many of these old people will take percussion instruments or get up to dance when the concert is over. They seem to be as responsive as children to rhythm.

Apart from giving quite obvious enjoyment to the patients, this is, of course, an excellent way of letting the rest of the hospital see what music, properly directed, can do for elderly people, many of whom are too ill or infirm to leave the ward.

Small Instrumental Groups:

Patients who already have some musical skill are put on the list for tuition and practice and as often as possible are formed into small groups; the composition of these naturally depending on the instruments. They are all coached for hospital concerts (about one every four months) to build up self-respect and confidence through performance, to increase concentration, and to improve social behavior.

A typical program for such a concert is likely to include a Mozart or Beethoven piano concerto, a sonata for violin and piano, perhaps a Haydn or Telemann Trio, and some piano solos, possibly a Chopin study or nocturne, part songs by Schubert, and a selection of popular songs like “Santa Lucia” or “Lili Marlene,” and always a percussion band performance by the
more withdrawn patients. This is never a set piece but is run spontaneously to demonstrate the capacity of such patients to respond to the stimulus of rhythm. These concerts are distinct from the entertainment series given by professional artists during the winter season.

**Music Therapy as an Aid to Individual Psychotherapy**

The psychiatrist discusses a selected case with me and, after giving instructions and advice on how to approach the patient, agrees on the number of sessions per week likely to be useful. These may vary from time to time according to the state of the illness, but we generally begin with two lasting about three-quarters of an hour each. The psychiatrist may ask for repressed material to be brought to the surface, resistances to be broken down, or that I should try to relax the patient and maintain a friendly, noninterfering relationship where he can rest secure without any demands being made on him. This can be successful if the music therapist has considerable experience and works under the very close direction of the psychiatrist. A report of each session is given to him and as often as possible we meet for further discussions.

Popular or classical music is selected at first according to the patient’s taste, but this is varied later on as occasion demands. I always explain to the patient how we think music may help and also—this is extremely important in view of the emotional relationships which may develop—that the psychiatrist is the head of the team and any difficulties arising in the music session which are insoluble there will be dealt with by him later.

Team work is in fact the basis of such treatment. You will appreciate how necessary it is in this specialized work to have absolute confidence between members of the team in order that the psychiatrist may use any situation to the best advantage. I should like to say here how very fortunate I have been in the doctors I have been privileged to serve in this way.

People often ask what music is used to gain these effects. This is dangerous ground because I find continually, as we all must, that one composition will have different effects not only on several people but also on the same person on different days.

The most I would like to say is that I find classical music much more effective than the popular kind and that pieces fall
not so much into division by composers but rather into broad categories such as peaceful, exciting, imaginative. I find that the way a piece is played is far more important than what it is. Also, of course, live playing in these circumstances is usually far more powerful than records.

Patients receiving this treatment frequently continue for some time as out-patients, going alternately to the psychiatrist and me or perhaps to one immediately after the other. I should add that all patients attending music therapy of any description are selected by the doctors in charge.

**TRAINING SCHEME**

We started an experimental two year training scheme on April 22, this year, the first six months of which has just been completed at St. Bernard's Hospital. The students will spend the next six months at Horton Hospital and the final year visiting other hospitals. The scheme is financed by the Association for Music Therapy in Hospitals, an English organization originally sponsored by the Hospitalized Veterans Service of the Musicians' Emergency Fund of New York City. All applicants must be professional musicians of some experience. They are interviewed first on the grounds of musical qualifications. Suitable applicants are then referred to the Psychiatric Interviewing Board.

We decided that the main emphasis must be on practical work with a series of twenty-five lectures as a background. These were given by five senior doctors, the Clinical Psychologist, and a senior P.S.W. The lectures were approached with a view to sorting out the students' current difficulties as well as giving elementary instruction.

The Matron, Assistant Matrons, the Ward Sisters and Nurses, and the Principal of the Nurses Training School gave their enthusiastic support. Weekly discussion groups were held with these members of the hospital staff in the school. During these sessions the effect of music therapy on the patients, their group and individual reactions, were discussed thoroughly. Every student was, in addition, allotted one patient in each ward in whom he or she was expected to take a special interest.

The Occupational Therapy staff were very helpful in rearranging their timetables and making constructive suggestions.
In the ten wards and four special groups selected in connection with training the main categories of mental illness were covered.

During the first three months the students worked as a group under me. Subsequently they graduated to working in pairs and, in addition, gradually did a certain amount of work alone, with the necessary amount of supervision. Throughout the course I held a discussion, attended by all the students, at the end of each day. Each one also attended a private interview with me once a fortnight during which time any ideas or personal difficulties could be aired.

Training took place on Tuesdays and Thursdays each week. We decided that our students, being musicians, should continue to pursue their professional careers as teachers and performers for two reasons. First, the work itself is concentrated and exhausting. In order to maintain high standards one needs the stimulus of outside musical activities, particularly from the standpoint of performance. Second, we feel the fact that a music therapist is continually moving between the hospital and the outside world adds immeasurably to his usefulness as a therapist, on the understanding that perhaps the best thing he can do is to find the person inside the patient and keep tight hold. In this context very special emphasis is laid on the necessity for good manners. I am sure all of us have seen only too often the unhappy consequences of any lack of respect towards patients on the part of the staff. It is hoped that our training scheme may play some small part, particularly with mixed groups and mixed staff, in the fight against this destructive attitude which is a problem in many mental hospitals. Students were discouraged from using too many psychiatric terms, which they could only half understand, and also from taking notes at lectures which were intended only to give them the necessary background information.

For the future? As things stand now I feel that music therapy is likely to be most useful as part of a well-integrated team effort, one tool among many which may help to alleviate distress
THE GOAL-DIRECTED HOSPITAL MUSIC PROGRAM

CHARLES BRASWELL

INTRODUCTION

Since the founding of the National Association for Music Therapy in 1950, the official publications of this organization have contained articles concerning a wide variety of subjects. However, one important subject has not been thoroughly explored, and this concerns the actual practice of music therapy in institutions. Other adjunctive disciplines, particularly recreational therapy and occupational therapy, have published extensive outlines on the use of their media in various types of hospitals. Actual procedures have been listed and discussed; programs for patients have been given; problems in clinical practice have been reported and suggested solutions to these problems offered as an aid to other workers in the field. This gap in the music therapy literature is unfortunate. Material dealing with hospital techniques and procedures would serve several purposes.

1. Music therapists engaged in professional practice could compare their programs, techniques, and procedures with those given in the published material.

2. The beginning hospital musician should be able to utilize the published material as a supplement to the techniques learned in clinical training.

3. Through exchange of ideas, the practice of music therapy could become increasingly standardized on a national level.

4. Music therapists teaching in educational institutions would find this material useful in the classroom; and through this expansion in classroom teaching, students would be better prepared for clinical practice.

5. The publishing of material on hospital techniques should stimulate constructive criticism from hospital musicians in other areas; particularly from those who work in different types of institutions. A situation such as this could lead to a refinement in techniques.

More reasons could be given to support the need for more literature on this subject, but those given above should emphasize the urgency of the situation.
One of the statements above mentioned the educator and the classroom situation. Perhaps it would be wise to discuss some of the problems of the music therapy students in our universities. Usually the student is expected to learn about hospital techniques from certain classes at the university and during the clinical training period. However, it seems that with the present state of knowledge in this field that this situation is not ideal. The educator responsible for conducting classes must depend almost entirely upon personal experience gained during his clinical training period and later professional experience.

The student encounters many of the same problems experienced by the educator. The student’s subsequent professional growth will probably be determined by the type of clinical training program conducted by his university and the participating hospital. It is an accepted fact that treatment procedures and even treatment concepts differ markedly among hospitals. Good examples of this administrative difference can be found in the organization of the music departments in veterans, state, and private hospitals. If the student trains in one type of institution and begins his professional career in another, real problems are likely to develop.

As stated before, perhaps the best solution to these problems would be an increase in the literature on music therapy techniques. The educator would then have means of extending his knowledge on this subject, and the student could become acquainted with additional procedures through classes at the undergraduate and graduate levels.

**The Goal-Directed Hospital Music Program**

This paper is not concerned with the development of any particular technique or practice, nor is it concerned with any one of the special areas of the hospital. It is, instead, a rather generalized statement concerning the over-all practice of music therapy. It is hoped that this material can be of some assistance to the therapist, regardless of the area in which he works.

In the past, musicians working in hospitals and institutions have been somewhat on the defensive about music therapy. One of the most difficult questions to answer with any degree of clarity and brevity is: “What is music therapy?” It would seem to be a relatively simple matter for a professional person
to explain the function and procedures of hospital music, but often this is not the case.

When prospective students come to the university with which this writer is affiliated to inquire about the hospital music program, they are asked, in the best nondirective tradition, to explain their ideas on music therapy. The answers usually fall into one or both of the following categories: (1) the panacean idea, or the belief that music is played for a group of patients, and through some curious type of alchemy the patients are suddenly cured; or, (2) the belief that the music program is designed to keep the patient busy and prevent him from thinking about his problems.

The fault for these misconceptions can be partially explained by the realization that music therapy is a new profession and that the public has not realized the scope and purpose of its activities. However, this is only partly true. Occupational therapy and recreational therapy have been in existence as organized professions for longer periods of time, yet similar misconceptions are encountered by these groups. Perhaps the major fault lies in the fact that many of our hospital musicians do conduct programs that are designed primarily to keep the patient busy and entertained.

This brings up a basic question that has plagued every adjunctive specialty at one time or another. Stated in relation to our profession, the question is: "What is therapy in music therapy?"

This immediately brings up semantic professional problems, because many meanings are attached to the term "therapy." Often the term is considered to have the same meaning as "psychotherapy." However, the practice of this structured procedure is usually limited to psychiatrists and psychologists. If, then, hospital musicians do not practice psychotherapy, even in the term's broadest sense, how can the name, music therapy, be justified? Admittedly, many hospital programs operating under this name do not deserve the title, even in its limited connotation.

Perhaps the answer to this problem lies not so much in procedure as in approach. In other words, possibly the basic music therapy program should not be radically altered, but the existing program should be reviewed and the procedures analyzed according to a new rationale. This rationale is quite simple, conceptually, and consists in the formulating of the hospital music program according to conscious, realistic, and workable goals.
Restated, this means that every music therapy activity, group or individual, should be structured in such a way that during the activity some predetermined therapeutic goal, or group of goals, will either be accomplished or partially accomplished.

In setting up the goal-directed program, a certain amount of self-analysis and professional honesty will necessarily have to accompany the efforts, and certain rationalizations, prevalent in hospital music departments for years, will have to be discarded. For example, a term often found on music therapy prescription blanks is “encourage sublimation.” In the goal-directed program this curious term could safely be omitted without loss of status. Undoubtedly the process of sublimation does occur with some degree of frequency during music activities; however, it is rather unlikely that the therapist can induce this phenomenon, or accurately report the startling fact of its occurrence. It would be interesting to know how many psychiatrists would understand a statement such as this in relation to the music department, and even more interesting to know the number of hospital musicians who would understand the techniques to be employed if one of their patients received a prescription of this type.

It seems important to mention one fact as a preliminary to the discussion of goal-directed activities, and this is that the concept of goal-direction will have more application in group activities than in individual sessions. This is because the goals in relation to individual patients will probably be determined by the medical staff of the hospital and not by the therapist. Ordinarily when patients are referred for individual sessions, the therapist will receive a prescription form listing the patient’s diagnosis, prognosis, and treatment aims. Also, the therapist will become acquainted with other material contained in the hospital records.

A situation, entirely hypothetical, will be structured for a music activity on a regressed, continued treatment ward. The patients on this ward are female; the age ranges are from eighteen to fifty-three years; average length of hospitalization is six years; and the patients live on a locked ward in a locked building. The therapist might analyze this situation in one of two ways: (1) the patients need music therapy; the activity set up will be one which will receive the fullest cooperation from all the patients on the wards; or (2) the patients need assistance
in specific areas; what music activities can be initiated to fulfill these needs? Of course, the second statement is the correct one.

On a ward of this type, resocialization is ordinarily not indicated, because the majority of these patients will not return to the outside community. However, socialization and adjustment to ward routine are goals worthy of initiation. Another factor on this type of ward is the problem of regression. If patients on continued treatment wards are allowed to sit on the ward all day without an adequate adjunctive program, regression often occurs and patients usually require progressively greater amounts of care from the nursing staff.

Thus far, we have indicated three factors on this hypothetical ward that should be worthy of the hospital musician's attention. Undoubtedly, many more factors could be mentioned, but in the interests of verbal economy this discussion will be limited to these three.

The hospital musician has now consciously defined three goals to be accomplished. They are: (1) socialization, (2) adjustment to ward routine, and (3) a retardation of the regressive process, if possible. In order to work effectively, the musician must secure cooperation from the professional staff working on the ward. This might have been quite difficult if the therapist had not formulated specific goals. The nursing staff would probably have offered only passive acceptance. However, since the therapist now has a specific program to offer, with specific goals to be accomplished, he should receive active, intelligent cooperation.

It should now be possible to explore the methods to be used by the music therapist in the realization of these goals. A session in music appreciation would probably accomplish nothing except a certain amount of verbal or behavioral resistance. However, a simple program of physical movement with musical accompaniment would at least be a start in the right direction. To begin, a simple piece of music in 2/4 or 4/4 meter could be used. The therapist, aided by nursing personnel, could start walking through the ward in time to the music, inviting patients to join the line. As soon as the patients are moving, they could be manipulated into other activities. Simple circle dances, consisting of right, left, and center movements called by the therapist, could be initiated. The grand march, with the patients...
marching in groups of two or three, is usually effective. Body movements from the basic circle position are good forms of exercise. Admittedly, the first program might meet some resistance, but with the aid of the ward personnel, later programs could be very beneficial.

It should be interesting to assess the accomplishments of the hospital musician to date. The first goal of socialization has been partially accomplished, because the patients managed to perform certain movements with musical accompaniment, *as a group*. The second goal of adjustment to ward routine will probably never be completely realized, but some progress has been made because the patients now have a new activity to think about and look forward to as a relief from the monotony of the ward routine. The third goal, the retardation of regression, of course, has not been realized; but, again, some progress has been made. If an activity of this kind could be continued on a regular basis, some physical and psychological improvement could be the result.

In discussing this activity on the regressed ward, it is entirely possible that the therapist might have initiated such a program without the formalized structuring of goals. However, it is strongly believed that the same force of purpose and motivation would not have been achieved. Also, the same degree of cooperation from ward personnel might have been lacking.

There are other reasons for the initiation of a goal-directed program:

1. The hospital musician can be at least partially relieved from his defensive attitude, because he now has some concept of what he is trying to accomplish and why.

2. If the planned goals are realistic and capable of fulfillment, the therapist will achieve a certain amount of gratification from noting the progress in his patients.

3. As mentioned before, the therapist will be more likely to achieve cooperation from the professional staff of the hospital. Also, this cooperation is more likely to be of the intelligent rather than the supportive type.

4. It is believed that *only* under this type of planning is it possible to write adequate and helpful progress reports on a ward or large-group activity.
5. The over-all hospital music program should improve noticeably, with increasing benefits to the patients.

6. If the therapist realistically attempts to perform the correct type of planning and assesses his personal performance in relation to the goals accomplished, the therapist should grow progressively in professional stature with each new experience.

In conclusion, it was stated that the hospital musician is often on the defensive about music therapy. These questions are asked: (1) "Why do we have music therapy in hospitals?" (2) "What is therapy in music therapy?" (3) "Is the hospital musician justified in using the term music therapy?"

The answers advanced in this discussion suggest that with the initiation of a goal-directed music program the hospital musician has less need for a defensive attitude; that the "whys" of music therapy are partly answered, and that the term "music therapy" is not only acceptable, but that it is strongly indicated.
PART II

VOLUNTEER SERVICES
IN MUSIC THERAPY
Since the NAMT Conference last year in Cincinnati, the list of hospitals in which our volunteers serve has grown from seven to eleven. The Pontiac and Kalamazoo State Hospitals, the Grand Rapids Veterans Hospital, and Wayne County General Hospital have been added to our roster.

Volunteers to staff these hospitals have increased in number to well over a hundred. Most of them have a fine educational background in music, but they need professional advice when using their talents in a hospital setting; this is especially true when they are working in a hospital where there is no music therapist to direct their efforts. The latter is true in most of the hospitals in Michigan.

The interest of busy men and women volunteers cannot be held long unless it is channeled to do the most good. Every volunteer deserves the best tools that can be provided for him. He has a right to feel confident and comfortable in the work.

Little information can be found in state and public libraries to aid a volunteer in this particular field. Urgent requests have been received from all parts of the state for more instruction of professional calibre. Out of this great need the idea of our Extension School was born.

Dr. Roy Underwood and Mr. Robert Unkefer of the Michigan State University Music Department, Mrs. Gilbert Burrell, who was at that time the president of the Michigan Federation of Music Clubs, and myself, held a conference to determine the best course of action. The final decision and planning was left to Mr. Unkefer and me.

It was decided to present a two-day pilot school at the Traverse City State Hospital in May. This was unique in that it was sponsored by our Federation of Music Clubs in cooperation with the Department of Music and Continuing Education Service of Michigan State University.

Prior to the actual School we held a planning session at the Traverse City State Hospital with the Clinical Director, the Director of Volunteer Services of the hospital, and the Hospital
Chairmen of our two clubs who serve in that area. Because so many of them live at a distance of fifty miles or more, it was decided to conduct the School during the afternoon of May 18, and the morning of May 19. The purpose was "to aid the Volunteer Worker in Music Therapy in bringing improved care and treatment to the mentally ill, the mentally retarded, and the physically handicapped."

The staff was composed of Dr. Arthur Dundin, Clinical Director, Traverse City State Hospital; Robert Unkefer, Assistant Professor of Music and Psychology, Michigan State University; and Mrs. Paul Freeland, a volunteer from the Lansing Music Club. Assisting in the project were Ohmer Curtiss, Director of Volunteer Services, Traverse City State Hospital; Milton J. Hagelberg, Regional Director, Continuing Education Service, Michigan State University; Mrs. Gilbert Burrell, President, Michigan Federation of Music Clubs; and myself as the State Chairman of Music in Hospitals.

The attendance was a few more than twenty, which was good for this sparsely settled area. In compiling the results of their evaluation sheets, two ideas emerged; one, that this should be an annual affair, and two, that actually working with a group of hospitalized patients would be more helpful. There was no adverse criticism, quite the opposite. Many referred to our conference program as "stimulating" and "thought provoking."

Since the results of this pilot school proved favorable, the decision was made to repeat it in four or five more areas of our state in the fall and winter.

During the summer the groundwork was laid for another school to take place at the Northville State Hospital early in September. This was streamlined to a one-day session, 9 to 4:30, and for the benefit of our volunteers serving in the Ann Arbor and Dearborn Veteran Administration Hospitals, the Northville and Pontiac State Hospitals, and the Wayne County General Hospital.

For this School and the ensuing ones planned for this year the Michigan Federation of Music Clubs and the Music Department of Michigan State University assumed co-sponsorship.

There is now a permanent staff of three people for each school, Mr. Unkefer, Mrs. Freeland, and myself. The rest of our staff is obtained from the area in which we present the School. This is arranged at the pre-planning session where the conference will take place. There we ascertain from the local
area Hospital Chairman the questions uppermost in the minds of the volunteers. These determine the direction which our School will take and the kind of additional staff needed that we may plan our program to fill the needs.

In each area we select a qualified physician to present, in laymen's terms, the functions of the activities in psychiatric treatment. Dr. Dundin did this effectively in Traverse City; in Northville, we were fortunate to secure Dr. Jacob Miller, Staff Psychiatrist at the Northville State Hospital; in Grand Rapids, Mr. Theodore Monsma, Psychologist at Pinerest Sanitorium, fulfilled this function on our staff. Our staff also includes Miss Kay Ewer, Music Therapist at Mary Free Bed Children's Hospital and Orthopedic Center; she speaks on Music Therapy for the Physically Handicapped.

From our pilot school in Traverse City we learned that we need to stress motivation of volunteer workers, asking them to evaluate themselves and re-examine their own motives. For this reason, we have added to our agenda a talk on the goals of volunteer workers and a historical background of how the Federation became active in this area of service.

We consider Mrs. Freeland's position on our staff of prime importance. She graduated from Michigan State University with a degree in Public School Music, and has had additional work in psychology. She has held the position of County Supervisor of Music in Saginaw County. Having served as a volunteer at the Battle Creek Veteran Administration Hospital since 1954, she has much to offer from both a professional and a practical viewpoint. Mrs. Freeland as a volunteer, can point out to present and future workers what can be done; this has a strong psychological appeal.

Having presented the background, let me summarize a typical school day. Immediately following the Registration and Coffee Hour, Mr. Unkefer, as Presiding Staff Member, opens the meeting. We allow about fifteen minutes for the formalities, greetings from the Superintendent of the Hospital, our State President, Mrs. Ralph Curtis, and other dignitaries who may be present. This is followed by a session on "Goals of Volunteer Workers." There is an hour for the lecture from the staff doctor, with time for questions and discussion following. In these discussions the physician is able to relate the volunteer's problems to particular
patients in graphic terms. The morning is usually concluded by Mr. Unkefer’s lecture on the “Use of Music and the Role of the Music Therapist in Treatment.” We try to arrange with the hospital that we may all dine together and continue our discussions informally through the luncheon hour.

The afternoon’s agenda is focused on many things: creative music activities, a short session concerned with individual music lessons, techniques in the conducting of ward singing, music games, demonstration of simple folk dances, and an analysis and evaluation of music activities.

Because the volunteers who attended our pilot school were firmly convinced that they could have learned a great deal more had they been able to observe work with actual patients, this arrangement was provided in our Northville School. There Mr. Unkefer worked with a small group of both men and women patients. In the short time that he worked with the group, which was totally strange to him, he was able to demonstrate that they could be brought to a higher level of performance.

The Northville School was attended by fifty volunteers and proved stimulating to both staff and workers. The following are some quotes from their evaluation sheets. In answer to the question, “What part of the School did you find most interesting?” (1) “The practical demonstrations and exchange of ideas.” (2) “The simple and clear presentations, down to earth.” (3) “Patient demonstration and actual techniques shown.” The majority of answers to this question stated, “the demonstration with the patients and getting them to participate.” In answer to the question, “What part of the School did they find the most useful?” typical answers were: (1) “New ideas to stimulate activities and interest.” (2) “The specific and realistic approach to the therapist’s role.” (3) “The demonstration of teaching a class of patients.” (4) “The information in the staff members’ lectures.” (5) “Discussion groups, pertinent facts about actual cases.” (6) “How to deal with the patients and acquaint them with reality in music.” In answer to the questions of what part was least interesting and least useful we had little response. To the question, “How can future Schools be improved?” the answers were largely to the effect that they wished we had more time than one day for a School, more time for discussions following
lectures, and more time for music activities; all boiling down to two words, "more time."

With the growing interest and awareness on the part of our volunteers, the need for direction is all too clear. From this report it is evident that our Extension School is in the embryo stage, suffering many growing pains. Yet we hope that in a small way it will help to equip our volunteers with some of the knowledge, the understanding, and the skills they need to do their job well.
OPPORTUNITIES FOR MUSIC THERAPY IN THE COMMUNITY

Marilyn M. Pound

What role can a volunteer play in bringing about an effective program of Music Therapy in his community? How does one begin? What is the purpose of the volunteer to be?

Through the services of volunteer workers the therapeutic values of musical activities can reach a larger group of those in need of these activities than is otherwise possible. In those situations fortunate enough to have a trained therapist at hand, the benefits of this individual become increasingly more cumulative in direct proportion to the number of volunteers available to assist her, or be assisted by her. Here, the role of the volunteer is simplified, because all she has to do is carry out a program of activities directed by the therapist. In those communities where, due to financial considerations, lack of understanding of music therapy, or other reasons, a registered therapist is not available, the volunteer can provide some measure of therapeutic help by setting up a simple outline of the needs of the community and acting upon it. In both situations the volunteers are the difference between a dynamic, far-reaching therapy program, or restricted localized programs spotted throughout the country. The volunteer also provides a contact with reality which confined groups do not receive from doctors, nurses, or institutional therapists.

The therapy program, in turn, provides the volunteer worker with the satisfaction of helping those who are ill, confined, or handicapped, through the use of her knowledge, skill and interest in music. This does not presuppose knowledge or skill as a music therapist (although it is assumed the volunteer possesses some degree of interest in the therapeutic development of music). On the contrary, it is important that the volunteer realize from the outset she is not a therapist but an important worker in the implementation of a therapy program.

It is possible, of course, for the volunteer to become a good "practical" therapist through experience (comparable perhaps to the practical nurse in the hospital), but it should still not be possible for her to identify herself as a qualified therapist.
A volunteer suffers from lack of background and requires the aegis of qualified supervision. Unresponsible treatment has no place in working with the physical and mental health of human beings.

A volunteer program can begin with one or more persons who recognize the need for musical activities of a therapeutic nature in their community as they see them, seek the advice of responsible therapists and/or medical men, evaluate the resources available, then institute those phases of a program they feel will provide the greatest good in continuing activities. These activities can run the gamut from providing emotionally disturbed children with private lessons to organizing rhythm or kitchen bands with the "golden age" groups.

Perhaps the greatest challenge for the volunteer is found in the smaller communities and towns. Large cities, although they may still make good use of a volunteer corps, can usually afford persons trained in setting up a broad program. Smaller places must rely on interest, a good-judgment, resourcefulness, and willingness to seek advice on the part of the volunteer.

Possibly the most difficult but most easily implemented situation in which the volunteer therapist may work is the offering of private lessons. The term "volunteer," by the way, is used here only in the sense that the teacher offers to accept a student who has a therapeutic need. The private teacher should be paid for these lessons. The lack of proper training to cope with the personal involvement inherent in the private lesson situation requires that the volunteer constantly guard against allowing herself to view the relationship as anything other than teacher-student. One must bear in mind she is but part of the total therapy program, functioning primarily in giving the patient an opportunity to satisfy the need for an emotional outlet.

An effective setup for offering this type of aid can be for the private teachers to work with the local medical association—either individually or through the local teacher organizations. The medical society can be advised of the willingness of some music teachers to teach those students recommended by the doctors to be in need of an emotional outlet. These teachers need not be qualified music therapists. They must, however, work under the supervision of the doctors with whom the responsibility for the patient is vested. Further, they should be
able to recognize their own inabilities to work with certain types of personalities and report this to the doctor when confronted with such a conflict.

There are problems other than that of personal involvement with the student which the teacher must face. If the teacher is working with an emotionally upset person she must remain entirely anonymous to this person. True, the smaller the community the more difficult it is to maintain this relationship. However, details such as name, phone number, address, etc., can be kept secret. The volunteer or unqualified therapist should not attempt to take on a student who is both handicapped and emotionally disturbed. The problems attendant are too great for the untrained volunteer to surmount satisfactorily.

The volunteer must realize, too, in any phase of his activity that he is not to strive for perfection in music as an art. The purpose of her service is to give people something that satisfies a need. Direction from the doctors and understanding on the part of the teacher can create a very satisfactory phase of a music therapy program.

The emotionally disturbed child is not the only one who can benefit from learning to play an instrument. There are mothers who find themselves at a loss after their children are in school, fathers who need to relieve the tension and boredom of their work, and retired people who are finding too much time on their hands and need to have a challenge of some sort.

Another area in which the volunteer might find opportunities for service are in the homes for the aged, medical hospitals, and convalescent homes. Simplicity in the volunteer activities is to be stressed throughout the entire program. A regular schedule incorporating group singing, the playing of records, and the providing of programs by local music groups can make a successful program. Since it is not the primary purpose of the volunteer to train these groups musically, one should be willing, of course, to play or sing music the people like and understand.

In some communities, a small school for retarded children may be found. Such schools, although not financially able to hire a full-time therapist, can profit greatly from the assistance volunteers are in a position to provide. Communities in the immediate area of a college which offers a course of study in music therapy
are fortunate, because there exists the possibility of setting up a program of music therapy in the school under the supervision, or at least the advisement of the therapy department.

Our older citizens have grown in number during the past decade to where they now represent a large segment of the population. These people need group musical activities such as the “kitchen bands” which enjoy such popularity across the country. The rhythm band is a good activity for this group, providing the instruments and music are designed for adults. To use materials suited for elementary school can provoke a feeling of being coddled and cause lack of interest on the part of the adults. If the volunteer performs no other function than that of organizing and leading the activities, she has served a useful purpose. People of this age have a tendency to be uncooperative with their peers and turn more readily to an outsider for leadership.

Other groups with whom one may work are church organizations for older women and men who can no longer get around conveniently and need the companionship of their friends. The church provides the meeting place for these people and the volunteer provides musical activities, most likely, group singing. The volunteer can also provide transportation to and from the church.

If there is an orphanage in the area, volunteers can provide musical treats such as being taken to hear concerts and any other “extras” that may supplement the music provided by the institution. The collecting of musical instruments to be given to homes or orphanages comes under the volunteer program.

Active volunteers can be found by making the need known to local music clubs and musicians. The volunteer program also needs “inactive” volunteers. They provide financial support. They are the ones who are willing to give the money necessary for purchasing materials and paying other expenses. As with any other civic service endeavor, the “inactive” group can consist of individuals, civic clubs, or other local organizations. The therapy program can be publicized through the newspapers and other news dispensing media. Radio and TV stations, for example, provide time for public service programming as required by the Federal Communications Commission Code.
The volunteer worker, then, can find worthwhile, rewarding, sometimes gainful employment of her time as an important component of the music therapy movement. Her requisites are: an interest in the therapeutic uses to which music can be put; the musical background and skill necessary to perform the functions her phase of the program will provide; and a recognition of her limitations as a music therapist. Her program of activities can begin as soon as her interest and available time grow to the point of spurring her to action.
STAFF RESPONSIBILITIES IN THE EFFECTIVE PARTICIPATION OF VOLUNTEER ASSISTANTS¹

EDWINA EUSTIS, MARIANA BING, AND ALBERT L. MEULI

INTRODUCTION: Miss Eustis

It would be impossible within the time allotted to deal exhaustively with our subject, so we shall confine the area of discussion to consideration of volunteers assisting with music programs in an institutional setting and suggest factors which we, from our own experience, deem most important.

Let me emphasize, as a former active volunteer in this field, that this training session appears to mark a coming of age for volunteers in music therapy. Our growing pains, which have been at times very severe, are not yet over. However, we have always been grateful that the National Association for Music Therapy permitted us to be included in its ranks from the very start, and that the Veterans Administration and many other hospital staffs accepted our assistance with less specific training and perhaps somewhat hazy standards of procedure than are required today.

The time has now come when we are being asked to state what we as volunteers expect from the hospitals, what our chief difficulties are in dealing with the staffs. To this area of the subject our comments will be directed. As a prelude to the comments of the speakers, I believe it would be wise to clarify two points: (1) That a volunteer is an unsalaried, part-time worker who, in nearly all cases, is sincerely willing to work, to learn, and to take direction. (2) That the terms “volunteer” and “layman” are not synonymous, any more than are the terms “salaried hospital worker” and “professional.” There are many volunteers who are professionals in their own fields and laymen in the hospital setting. Similarly, there are many salaried hospital workers who can be considered professional only in the hospital setting. Acceptance of these two points is basic to an understanding of our subject.

1. A transcript of the Training Session held at the Tenth Annual Conference.
In approaching our subject, I am reminded of the Dean of a Graduate School who, in his opening session with students, cautioned them that, try as they might, they would find it difficult to win the struggle of keeping to the schedule. If early to class, some would think them anxious; if late, resistive; and if on time, compulsive.

So it may seem to many full-time, paid staff in institutions and agencies who are engaged in establishing and initiating methods and techniques that will insure the effective, efficient, and satisfying participation of their part-time volunteer assistants, especially in this day of growing emphasis on citizen participation in health and welfare programs. If the staff person moves too fast toward setting up a volunteer program, he is very apt to bump into trouble. He may well expect to find his fellow workers not yet ready, and perhaps not even sure they want "outsiders" cluttering up their neat professional patterns of operation. There literally may not be room to take care of the extra coats, hats, cars, and the myriad other little extras that go along with the good manners of interpersonal relationships. Even the patients may not be conditioned to what, at first, may appear to be an intrusion into their safe little world. If these things are so, the climate is not right, as some people would put it, and climates were never created in a hurry, especially in the hospital of today, involving as it does so many different disciplines and functions.

On the other hand, if the worker moves too slowly, it can be equally difficult. In the setting from which I came most recently, flourishing volunteer programs were under way in at least four other institutions of the city when I arrived two years ago; and during the preceding year, dramatic steps had been taken to "throw away the locks" of this old State institution, to open the doors for the people who paid the bills to see for themselves what went on inside the iron fence that for so many years had separated the community of the institution and the community of the surrounding area. Already these communities had come a long way from the era of isolation from each other, independence of each other, and strangeness to each other, to an inter-relatedness between what went on in each and every segment of the total community, an interdependency between
the human beings who made up these various segments, and
an intermingling and interaction that was daily taking place
between these human beings. Accordingly, it was only to be
expected that the potential volunteer workers of the surrounding
areas would be literally "champing at the bit" to help out in
this institution where there was every reason to believe the
needs for their assistance were very acute, needs they were
already filling elsewhere in hospitals far better staffed and
equipped than this one.

Hence, the resistive worker who moves too slowly may well
have just as much difficulty as the anxious worker who moves
too rapidly. As for the compulsive worker, the one who knows
intuitively and professionally exactly when to initiate and then
to proceed in the development of what will eventually prove
to be a sound volunteer program, he is indeed a rare creature
in this world of so many variables and complexities in structure
and relationships.

But be that as it may, I am sure you will agree that the place
to start in any such development is with the WHY—the aim,
the basic purpose of any volunteer program in any institution
wherein you people are apt to be found working as music
therapists today. To me, the purpose of such a program is, very
simply, to supplement the efforts of employed staff and other
resources already available to the institution in meeting the
needs of its beneficiaries in ways that are appropriate for volun-
teers to serve. There can be but one WHY for volunteers in
a hospital, and that is to help meet the needs of the patients.
Until the staff of the hospital feels that volunteers can help
them help the patients, it may be risky to try to bring volun-
teers into the institution except as the most casual visitors.

Given this purpose, this aim, we may then turn to its means
of execution. A most significant volume on this subject is the
recent publication of the American Psychiatric Association, The
Volunteer and the Psychiatric Patient.2 This book was produced
as a report of a 1958 conference involving a diversified group
of some sixty people from throughout the country chosen because
of their experience with and interest in volunteer services to

2. Daniel Blain, and others. The Volunteer and the Psychiatric Patient:
124 pp.
psychiatric patients. Made possible by a grant from the National Institute of Mental Health of the United States Public Health Service, this meeting was cooperatively sponsored, planned, and conducted by the American Psychiatric Association with the American Hospital Association, the American National Red Cross, the National Association for Mental Health, and the Veterans Administration. For a full year prior to the conference, four groups concerned themselves with a comprehensive study of four areas of the subject, namely: current status and objectives; administrative responsibilities and personnel policies; the recruitment, selection, placement, training and recognition of volunteer workers; and expanding opportunities for the future utilization of these workers. Of the 1640 different organizations invited to contribute to this survey, 1140 responded, with 525 of these reporting some sort of volunteer program under way. Designed for the use of professional staff who need the invaluable services of volunteers as well as for the volunteers themselves and the organizations they represent, this highly readable report is the most comprehensive document of its kind to date.

The second chapter of this report, "The Volunteer at Work—Running a Volunteer Program," seems particularly pertinent to our subject. Acknowledging that there are no pat systems, no magic formulas, to assure success with these programs, the reporters nevertheless conclude, "But it is clear that to use volunteer services successfully—just as to use paid staff services successfully—it is necessary to develop sound administration and appropriate personnel policies." In regard to the basic purpose of a volunteer program and the climate within which such a program can be expected to develop wisely and well, the report has this to say:

To get a volunteer program, you will have, of course, to want one. You will have to feel, with the leadership of the majority of professions concerned, that it is desirable to bring volunteers into a psychiatric hospital to help your patients get well... When the staff of a psychiatric institution, from top administrators right down to the ward personnel, believes in the value of volunteer services, it is much easier to start a volunteer program. If the staff, enthusiastically aware of the program's potentialities, is ready
Volunteer Services

to accept and support it, the proper climate or atmosphere for starting it will exist.

Certain more specific guides and basic functions in initiating, developing and maintaining a sound, effective program of volunteer services are outlined in the Indiana Mental Health Volunteers Handbook and Guide, published by the Division of Mental Health of the State of Indiana. In a portion of this booklet dealing with how the program operates at the institution level are listed the following steps:

1. Establish a framework for the program—as primarily the task of the top administrator of the institution in setting forth the basic purpose of the program and assigning staff to be responsible for its operation.

2. Define specific needs for volunteer assistance—as the responsibility of staff in charge of the programs in which volunteer personnel and/or voluntary donations are to be utilized.

3. Interpret needs to potential resources for meeting them—the job of the Director of Volunteer Services where there is one, in making these needs known to people in the community who are or may become interested in helping to meet them.

4. Recruit the volunteers and the materials needed—generally the concern of interested groups and individuals in the community whom staff should always stand ready to assist even beyond providing them the complete information regarding existing needs that they must have to recruit successfully.

5. Train all volunteers concerned with the program—a joint responsibility of the organizations the volunteers represent and the administrative and supervisory staff of the institution wherein they are to serve.

6. Supervise volunteer personnel and the use of material donations—their immediate guidance and direction is the job of the staff in the departments where they are supplementing established programs, but with all staff playing an important role in helping volunteer services attain maximum effectiveness.

7. Recognize all volunteer efforts—as a function that should permeate every phase of the development of such a program, by dignifying the volunteer job to be done as well as by showing respect for the person who does this job and the manner in which it is done.
In closing, I would like to return to The Volunteer and the Psychiatric Patient for brief mention of a few of the "principles for progress" contained in this report. These basic principles are:

1. That it is best for the proper climate to exist in an institution before a volunteer program is begun.
2. That a volunteer program is a give and take proposition entailing administrative responsibilities best discharged through a written plan firmly establishing what services are to be used where and by whom.
3. That the volunteer, as a member of a staff therapeutic team, must be recruited and must work foremost to meet patient needs; and that these needs are best met when the volunteer is fitted into the organized structure of the institution.
4. That sound personnel practices are as necessary for the volunteer as for other staff members.
5. That the volunteer must be carefully oriented, trained, and supervised according to the job he is doing.
6. That the closer a community's relation with its psychiatric institutions, the better for both.

That basic materials for the guidance of all concerned with the effective participation of volunteers in hospital programs are now becoming readily available in published form, is a most encouraging development from which we may all benefit during the months and years ahead.

COMMENTS: MR. MEULI

The comments I wish to make relate to several questions raised by Miss Bing concerning the WHY of a volunteer program, the climate in setting up a volunteer program, and some of the steps used to organize a program of volunteer services. I shall also explain why I feel it is necessary that such a program be a give and take proposition on the part of both staff and volunteers. I have divided my comments into four basic areas—Administrative Cost, Administrative Plan, Problems in Volunteer Services, and Staff Responsibility.

1. Administrative Cost. It is very easy to overlook the cost of a volunteer program. Though the returns on cash invested in such a program are not always measurable, its quality usually depends on the amount put into it. The three kinds of cost to be considered in planning a volunteer program are:
a. External Cost: the time spent by staff in recruiting, making speeches, explaining the program, becoming a part of the community.

b. Internal Cost: the cost of orientation and supervision of volunteers and staff.

c. Increase in Administrative Overhead: The cost of food, mailing materials, coat rooms, and office equipment, must be considered. Are the volunteers going to be required to wear uniforms? Are volunteers to be issued keys to wards and other secure areas? Are volunteers going to be handling patients' funds in selected cases? What shall be the policy regarding the volunteers accepting gifts? What compensation is available in the event that volunteers are injured in line of duty? These are a few of the considerations that the hospital administration will have to recognize in order to implement a good volunteer program.

2. Administrative Plan. It is imperative that hospitals be well organized if they are going to seek the services of volunteer workers. This also would apply to the organization of the music therapy department. The department must be well organized and efficiently operated if one is to give the volunteer the needed supervision and if one is to utilize the volunteers' time and talents most effectively. Good volunteers want to be guided and want to know exactly where they fit into the overall scheme of things. Written policies and program plans are most important for successful and effective participation of volunteer assistants.

3. Problems in Volunteer Services. Many problems arise in establishing a volunteer services program which must be met realistically. Under the category of administrative problems, you may have absenteeism, rapid turnover, scheduling around various vacations, and children in the home of the volunteers. Getting volunteers to adhere adequately to hospital rules and regulations and establishing in them a feeling for hospital ethics also may present administrative problems.

Another difficult area may center around personality problems. You may find volunteers unsuited to work with specific types of patients. Volunteers who are extremely domineering and overly aggressive may, at times, present definite problems in staff relationships. It should be kept in mind that although the volunteer may be a "professional" in a specific skill, he can still
be very much of a layman in the music therapy program. It therefore behooves the supervisor of the music therapy department to convey these facts to his staff so that they will not be threatened by volunteers who are highly accomplished in a specific music skill. At the same time, I should like to caution that though it is imperative that the volunteer be given guidance initially, he should eventually be allowed to function on his own, to the fullest extent of which he is capable, with only general supervision provided by the paid staff.

4. Staff Responsibility. Assuming that it is up to the staff to set the climate for a volunteer program, I should like to discuss with you several key responsibilities of staff that I deem essential in this respect.

a. The assignment of a volunteer is a very important part of setting the climate for the program. First, you must ask yourself several basic questions. Is there a real need for the volunteer's service in your department, is it a realistic service, a part of good patient treatment, or is it busy work? Is there a job description, either written or clearly establish in your own mind, for what the volunteer is being asked to do? Is the volunteer's interest, his skill, his unique ability adaptable to this particular service or department and designed to meet patients' needs? Does the department know exactly how many hours it will need him and whether this is in the mornings, afternoons, evenings? Volunteer services geared to meet first the needs of the patients and then the needs of the hospital are the services most successfully performed.

b. The orientation of the staff is another very important responsibility. The head of the music therapy department must adequately orient his staff prior to setting up a volunteer program. Here again there are several basic questions to answer. Do your employees understand the volunteer program and its contributions to good patient care? Do they realize that you would want volunteers even if you had all the paid staff needed because of that something volunteers bring to the patients beyond what paid staff is able to give? Do they really know that you are trying to supplement their jobs, not to supplant their positions?

c. Another responsibility of the staff is the provision of continuous staff guidance and recognition to insure continuity in the volunteer program. As mentioned earlier,
there should be initially very close supervision of the volunteer; but later the volunteer should have freedom of operation within the basic framework of department policies.

d. Closely related to the provision of continuous guidance is the staff responsibility for in-service training of volunteers. May I again inject here a note of caution, do not attempt to make of the volunteer a carbon copy of the therapist. It should not be the intent of in-service training to make of the volunteer a "professional" in the sense of a paid full-time staff member because then we would be losing many of the very important qualities which the volunteer brings to the hospital as a member and link with the community. However, volunteers, as they take on increased responsibility, should know more about mental illness, more about the specific types of illness being treated in the hospital they are serving, more about procedure and policy changes within that hospital. They should be welcomed into staff meetings, both administrative and clinical, if they are truly to be accepted as nonpaid employees.

e. The last staff responsibility that I shall mention has to do with participation in community affairs as fullfledged citizens of that community. Music therapists should have knowledge of recruitment sources in the community. They should also know about the various recruitment methods and techniques. This knowledge in no way should interfere with the role of the Director of Volunteer Services, inasmuch as the therapist merely supplements his efforts to recruit volunteers and material donations for the department. However, it is very important to realize that, if we are going to expect volunteers to come into our hospital community, the staff in turn is going to have to become a part of the community adjacent to and surrounding our hospital community.

CONCLUDING REMARKS: MISS EUSTIS

In concluding this session, I would like to read you some material that came to my attention recently which embodies, I believe, the principal emphases of our discussion. This piece is entitled *A Bill of Rights and A Code of Responsibility for Volunteers* and was written originally for presentation at the Oregon State Conference of Social Work in April, 1957, by Mrs. Richard L. Sloss, an administrative volunteer in the Pacific Area office of the American National Red Cross. Some of you may
have already seen this material in reprinted form in the February 1, 1958, issue of Hospitals, Journal of the American Hospital Association. It reads as follows:

Every volunteer has:

1. The right to be treated as a co-worker—not just free help, not as a prima donna.

2. The right to a suitable assignment—with consideration for personal performance, temperament, life experience, education, and employment background.

3. The right to know as much about the hospital as possible—its policies, its people, its programs.

4. The right to training for the job—thoughtfully planned and effectively presented training.

5. The right to continuous education on the job—as a follow-up to initial training, information about new developments, training for greater responsibility.

6. The right to sound guidance and direction—by someone who is experienced, patient, well-informed, and thoughtful; and who has the time to invest in giving guidance.

7. The right to a place to work—an orderly, designated place, conducive to work, and worthy of the job to be done.

8. The right to promotion and a variety of experiences—through advancement to assignments of more responsibility, through transfer from one activity to another, through special assignments.

9. The right to be heard—to have a part in planning, to feel free to make suggestions, to have respect shown for an honest opinion.

10. The right to recognition—in the form of promotion and awards, through day-by-day expressions of appreciation, and by being treated as a bona fide co-worker.

Correspondingly, each of us who are volunteers accept obligations to:

BE SURE: Look into your heart and know that you really want to help other people.

BE CONVINCED: Don’t offer your services unless you believe in the value of what you are doing.

BE LOYAL: Offer suggestions, but don’t “knock.”

ACCEPT THE RULES: Don’t criticize what you don’t understand. There may be a good reason.
SPEAK UP: Ask about things you don't understand. Don't coddle your doubts and frustrations until they drive you away or turn you into a problem worker.

BE WILLING TO LEARN: Training is essential to any job well done.

KEEP ON LEARNING: Know all you can about your hospital and your job.

WELCOME SUPERVISION: You will do a better job and enjoy it more if you are doing what is expected of you.

BE DEPENDABLE: Your word is your bond. Do what you have agreed to do. Don't make promises you can't keep.

BE A TEAM PLAYER: Find a place for yourself ON THE TEAM. The lone operator is pretty much out of place in today's complex community.
PART III
MUSIC THERAPY FOR
EXCEPTIONAL CHILDREN
MUSIC THERAPY AND SPEECH CORRECTION

CHARLES P. PEDREY

It should be conceded at the outset of this discussion that music therapy may be a valuable adjunct to speech correction with the child who has cerebral palsy, with the child who is emotionally disturbed, with the child who is brain damaged (whatever that may mean), with the mentally retarded child, with the child who is hard of hearing, or with the aphasic patient.

The above admissions are being made by one who is admittedly naïve about the scope of music therapy and its tested application to speech correction. However, since it is an almost universally accepted assertion that music is a universal language, and that certain kinds of music may have a relaxing influence upon the listener, it may be admitted that music therapy may be used to advantage in helping the cerebral palsied person to relax. This relaxation may, in turn, make it easier for this child to better produce the sounds which the speech correctionist is trying to teach him. These things may be admitted and they may even be true. There appears to be little experimental evidence, however, that there is much (if any) carry-over from learning to relax under the stimulus of music and learning to relax in the various social situations that the cerebral palsied individual finds himself, and in which he must, nevertheless, speak.

Music therapy may be used to calm the emotionally disturbed child so that his response to the speech correctionist may be more conducive to learning than the response of an agitated person might be. But we must ask ourselves, “What are the lasting qualities of such stimulation? Do we really know, as a result of experimental studies, how much of a calming effect music has on the child, and for how long after the stimulus is removed he will remain calm and undisturbed?”

It is perhaps possible that music therapy may be used to stir up, emotionally and physically, the mentally retarded child and thereby prepare the child to respond to the stimuli presented by the speech therapist. But is music therapy any more effective in stirring up the child than is, let us say, play therapy
with its accompanying physical activity? And we have experi-
mental evidence that play therapy can be successfully employed
to induce the growth of a practical and functional vocabulary. We
have no such experimental evidence that music therapy
can help us to this end.

When we work with the hard-of-hearing child we have clinical
evidence that the use of music helps the child to learn to dis-
criminate one sound from another. Since the ability to discrim-
nate between sounds is essential to the learning of speech, we
like to exploit this avenue of approach to the fullest. Whether
or not this use of music by the speech therapist fits into the
music therapist's concept of the role of music therapy, is suspect.

It has been asserted by music therapists that their technique
is highly successful with aphasic patients. We know that people
with aphasia can often sing a song, remembering all the words,
although they may be unable to utter a single word in volitional
speech or be unable to answer when asked to name an object.
It is equally true that some people with aphasia can repeat a
long-ago learned prayer or the multiplication tables they learned
in grammar school. Further, aphasic patients are often able to
say the right words when they are under great emotional strain.
There is no experimental evidence to show that the use of music
therapy with aphasic patients results in more rapid recovery of
spontaneous, propositional speech than does the application of
conventional speech therapy without the use of music therapy.

So much then for what we, as speech correctionists, can do
with music in the treatment of certain kinds of speech defects,
and more specifically, certain kinds of speech defectives.

But, now, let us look at the largest group of speech defective
cases with which the speech correctionist works, and where it
is difficult to see how music therapy could be used: the public
school children who make up the bulk of his case load, the
children with articulatory difficulties uncomplicated by physical
or mental abnormalities.

Easily eighty-five per cent of speech defective children may be
classified as defective in articulation. These children exhibit no
observable physical malformation or malfunction of the articula-
tory mechanism (jaw, tongue, lips, soft palate), nor any dis-
cernibly significant mental deficiency or maladjustment. These
are children who just failed to learn to make some sounds cor-
rectly. The children may merely have a lisp, or they cannot
properly make the "I" sound, or they substitute the "w" for the "r" sound, or they omit some sound altogether. So far as we may determine, the reason for their faulty learning may have been: lack of motivation; improper motivation or stimulation; poor home, community, or school speech standards. In short, these are normally healthy children, both mentally and physically.

Just how could music therapy be used to speed up the re-learning process of these children? The speech correctionist sees these children usually twice a week, for periods of about twenty or thirty minutes, in small groups of from three to eight children. Because of requirements as to size of case load, the speech correctionist may be forced to visit as many as eight schools each week. He may work with children from the kindergarten through high school.

You may say that this is, of course, a minor objection; and you would probably be right. It would seem to me that the really serious objection is that it is extremely doubtful that the speech correctionist knows (or could be properly taught in a course or two) enough music therapy to understand and appreciate its proper use. Or, perhaps, it should be put in a different way: our schools and professional organizations do not believe that we can properly train a speech correctionist by exposing him to a course or two in the theory and etiology of speech defects, and the methodology of speech correction. By the same token it is doubtful if your organization believes that a music therapist is adequately trained after a course or two of music therapy and/or methods.

Incidentally, that classification of speech defectives commonly referred to as stutterers has been purposely left out of this discussion because it is difficult to see how music therapy could help this group. It is true that (to use a Proctor and Gamble cliché) ninety-nine and forty-four hundredths per cent of these people do not stutter when they sing. It is equally true that we have never found a stutterer who claims to have helped himself (or been helped by someone else) to control his stuttering by the use of music.

So that puts us right back where we started: that music therapy may be useful for some kinds of speech therapy with some kinds of speech defective cases; and that there is little experimental evidence that music therapy enhances the rehabilitation of the speech defective.
It would seem, then, that before we can make a case for the use of music therapy in conjunction with speech therapy, we (speech correctionists as well as music therapists) need research in the matter, rather than "I think . . ."
MUSIC THERAPY TECHNIQUES IN THE DEVELOPMENT OF SPEECH

WILHELMINA K. HARBERT

We who use music as a therapeutic tool find it an effective means of communication between therapist and client. It is often described as the nonverbal factor in our treatment which makes speech unnecessary. However, the ability to use spoken language to communicate thoughts, desires, and needs to others is the goal toward which we strive and which we hope to see attained by the children.

Music as sound does not become a threat to those who, for one reason or another, cannot or will not speak. Consequently, it is our task as music therapists to use the most functional techniques and procedures possible in helping those with speech problems, and to provide a suitable climate for more intensive work in speech and psychotherapy.

For several years it has been the writer's privilege to use music as a diversional and therapeutic tool with children who stutter, cerebral palsied children with speech problems, deaf and hard-of-hearing children, aphasics, cases of disordered speech due to physical trauma, and many children with delayed speech due to emotional problems.

For the stutterers, group work with the singing of familiar songs with steady rhythmic patterns, chanting to soft background music, and the use of choral speaking has been found effective. The emphasis has been on group work, thus reducing the possible threat to the individual.

If the physical involvements have not been too great, we have worked individually with the cerebral palsied children. Special emphasis has been placed on the development of good breathing habits, voice "training," and playing instruments adapted to the particular limitations of each child. With the more involved cases, especially those of the athetoid type, we have stressed listening to relaxing music and have gradually built up competencies in the use of the singing and speaking voice. Group work has been found to be more beneficial than individual work in these cases.
A seven-year-old boy, classified as an aphasic with complete loss of speech, was referred to the music therapy clinic a few years ago by the speech therapy department. First, it was essential for Pat to gain confidence in both the therapist and the children before he could even join the circle. Through creative rhythms he gained body release and a lessening of certain observable tensions. One day during a dramatization in which Pat joined the other children in their “make believe” search for gold (to the tune of Grieg’s “Hall of the Mountain King”), the therapist suddenly and rather bruskly said to Pat, “How much gold do I get from you?” Before he had time to think he shouted, “Two bits.” This was the beginning of his return to oral communication. For several weeks following this incident, Pat was given drawing paper and soft chalk and encouraged to express himself graphically.

He drew ships, bombs falling in the water, homes at curious angles, and always the father and mother figures, with the brother represented somewhere in the drawings. By the end of the seventh week, he was able and ready to tell in short, broken phrases the story of his most “exciting” picture, “a house burning down, the father, mother, and brother cannot get out. It is all burning down.” The following week the picture was much brighter in color, and the house more consistent in form. Outside the door was a small black figure which he called a “witch.” “That’s my mother,” said Pat.

During the following months with work and cooperation from both parents, observable progress was made with Pat in the home. School adjustments were recorded, daily speech became more normal, and, at this time, he is functioning in the public school at the junior high level.

In Music Therapy 1953, I reported on music techniques as applied in a case of disordered speech of an adult. The patient was referred by the family physician and the psychiatrist. The diagnosis provided for the music worker was: paralysis of the throat muscles due to thrombosis, right cerebellar artery; hemiparesis of pharyngeal extrinsic muscles, vocal chords intact. During a year of work with this patient, exercises were used in accordance with standard vocal procedures. Frequent reports were made to the physicians in charge, and all recommendations were carefully followed by the therapist. At the present time,
the patient, now forty-two years of age, conducts his own business, speaks quite clearly, and remains stable in spite of many family crises. This year he appeared on a television program with your speaker. He conversed well, sang rather "hoarsely," and indicated a poise and confidence in himself which was quite gratifying to observe.

The most recent case with which we have worked in our music therapy clinic is that of a six-year-old boy, referred to us by the speech clinic. J. K. is one of a family of three children, one older and one younger. He is the son of a physician, and has a medical history of diabetes incipitus. The birth was by Caesarean section, with a record of a "severe case" of chicken pox at the age of six months. There is some evidence of poor coordination in the boy's walk, but other than that he appears to be quite normal, except for the lack of speech. Both the parents and the head of the speech clinic felt that with the use of music J. might possibly become more socially aware of other children and eventually begin to develop speech. The Leiter International Performance Scale was used as a testing device for J.; the first one was administered in the fall of 1957, and the second one on October 1, 1959. The I.Q. for the first test was 62 and for the second, was 72. During the past six months J. has been "promoted" from the Point 2 to the Point 1 class in the public schools, and now he communicates verbally in single words, short phrases, and sometimes quite normal sentences.

In working with J. in the music therapy clinic, we have found the following activities most helpful: (1) the body rhythms, (2) group singing, (3) outdoor play and swimming with children and workers, (4) creative self-expression through drawing, and (5) continued speech stimulation in "one-to-one" relationships within the clinic setting.
MUSIC AS AN AID IN TEACHING THE DEAF

SISTER GIOVANNI

In a wide sense, therapy is a means of improving the physical and mental state of a person. In using music in its various forms with deaf children, we have had some degree of success in the improvement of the whole child. Music in the lives of deaf children is by no means used as a means of producing composers or concert artists, but as an aid to better speech, more fluent language, and for the enjoyment, relaxation, and pleasure it brings with it.

The entire school experience of the deaf child is affected by music; it lends variety and interest to lessons which by nature must be repetitious. Music also creates an atmosphere of relaxation so necessary in teaching a deaf child; day-dreaming is replaced by alertness and attention by using amplified music.

Recorded music offers a means of building up a tolerance for sound, preparing the child eventually to use an individual hearing aid. It is a preliminary to audiometric testing. During the sensory period the young deaf child is sensitive to sound, and it is during this time that the little listener's attention span can be gradually lengthened by the use of recorded music especially made for him.

CHORAL RECITATION

Incredible as it may seem to those who do not know this, the deaf child does enjoy "singing." In the use of songs as choral recitation, a number of phases are touched upon. First among them is the practice of exact speech. By this, we mean crisp consonants such as S, T, K and P; good resonance through the production of M and N; and finally clear "vowels." These can be repeated many times as they are put in a pleasant type of drill, namely singing. Songs are also very beneficial in increasing the child's rate of utterance in speech. Listening and keeping up with the words in a recorded song helps him considerably. Not all types of recordings or songs can be used, as the rate of song may be too fast. If a group is singing the song, it becomes too complicated for the child, and he finds it impossible to
eliminate the irrelevant and to listen only for the fundamental sounds. A strong solo voice can be used to the best advantage. When teaching a song to the child, he should listen carefully for the words he can understand. Usually, at first, there are no words he can understand and repeat. The words are then written for him, and he memorizes them; he listens again and follows the written words. Over a period of time, he learns to listen for the words and can associate what he hears with what he sees on paper. Finally, he reads, listens, and says the words of the song according to the rhythmic pattern of the music.

**Tonettes**

In speaking as in singing, breath control is fundamental for good production. Because of his handicap, the deaf child does not have this control of breath. Sometimes he uses too much or too little, and the voice gives evidence of this. In the preparatory room, there are various exercises and games used to help this condition. With one group of older children, tonettes are being used, and they have been a help in developing good breath control. Since breath control exercises are important and must be repeated often, the use of the tonette provides a pleasurable and relaxing means of acquiring better breath control.

**Accordion**

Instruments such as the accordion and the piano do not require hearing for accuracy of tone, so they would be within the scope of the deaf child's ability to learn and enjoy. A number of our children take a weekly music lesson and have acquired some degree of skill in playing. The accordion lends itself to group participation which gives the children an opportunity to learn the give and take of teamwork. There is also a certain amount of character training involved as the child realizes that he must practice from day to day in order to keep up with the group. He must learn to keep on though it requires a great deal of effort on his part. Coordination of movement and thought are also developed as the child learns to play the bass and treble clef of the various selections. His memory for retaining visual impressions is strengthened; his span of attention increased.
Piano

In learning to play the piano, the child becomes acquainted with the concepts of slow and fast, loud and soft, and high and low sounds. All of these are important as they are needed in acquiring a perception of volume, pitch, and resonance in speech. The child’s voice may be too loud, too soft, or too high. From his own production on the piano and the vibrations it produces, he gains a better concept of the full impact of these terms in relationship to his own voice production. Through the use of the piano by the teacher, the concept of accent in words can be taught. Proper accent placement in words is paramount in understanding speech. For the deaf child, this is an important phase in his speech training and also in the use of the dictionary when learning new words on his own.

Dancing

This discussion would not be complete without including another phase of music, and that is dancing. Here again, we have no intentions of producing professional ballerinas but we use it to teach any number of things. Primarily, we use it to improve balance; for physical development, muscular coordination and control; and to stimulate the child to express in rhythmic movements the emotions and experiences normally released through speech. Dancing is enjoyable; it tends to make one forget self; it contributes not only to the physical well-being of a person, but also to the mental well-being. The rhythm of music is conveyed by the pace of the dancers, running or strolling, leaping or striding. It teaches grace, poise, patience, and charm more easily than the printed page and will remain with them always. All of these we hope to teach through the dance.

Symphony

Music hath charms even for the deaf child. Not long ago, a group of our children attended a symphony concert and enjoyed it very much. They look forward to this occasion from year to year. It is surprising how many lessons can be learned from attending such a program. They learn the social graces required in a group, to follow the program, and to interpret the feelings of the music through the movements of the conductor and other members of the orchestra.
PART IV
MUSIC THERAPY AND MUSIC EDUCATION
Musical experiences are usually not solitary, but occur in a group setting. We can well say that music and the group belong together. As music links people and creates a group feeling, so the group seeks expression through music. The stronger the group is integrated, the more it makes use of music, as in religious and political activities.

This relationship between music and the group deserves closer scrutiny. It is too much taken for granted, so that the underlying dynamics are often overlooked. They certainly are not sufficiently considered in the teaching of music and perhaps even in the use of music for therapeutic purposes.

Let us first consider the function of the group. The human being is fundamentally a social being, a *zoon politicon*, as Aristotle called man. Human existence is almost unthinkable in complete isolation. Even if man survives alone, he loses all human characteristics. What makes us human is our social relatedness. All human qualities are expressions of movement toward others, responses to and interactions with others. In all our activities and forms of existence, we are interdependent; almost all our problems are social problems.

The integration with others may vary in intensity, from a loose relationship in a crowd to the intense mob formation in which the individual loses his personal identity almost completely and submerges into the character and configuration of a highly motivated group. Between these two extremes of a crowd, where the individual is only vaguely aware of the people around him to the utter disregard of his own likes and standards by accepting those of the mob, are all the shades and gradations of distance and integration within a social setting.

Where does music fit into this picture? First of all, music is communication, one of the many forms of nonverbal communication. But its means of communication lend themselves less to the dialogue between two, than to an appeal to and the stimulation of many. Verbal communication is primarily one of ideas and thoughts. Emotions may only be evoked as a by-product;
if they become strong, the meaning of the words may be completely lost in a different meaning of emotional attitudes which may neglect or even contradict the logical content of the spoken word.

The two basic elements of music which produce its characteristic form of communication are the emotional quality which any specific piece of music conveys, and the rhythm which permeates a sense of order. In other words, anyone who listens to music receptively will be inevitably affected by a definite mood and order which he shares with all those around him who are also receptive to this kind of music and understand its language. In addition, music can be so overpowering that it may even succeed in drawing those under its spell who originally are not receptive, either to this particular kind of music with its specific emotions, or to the idea of becoming integrated with others at all, at least at the moment. It is this faculty of music which makes music the ideal instrument of group integration, whenever this is desired for any purpose. Music has the power of uniting all in its reach in a common experience, in shared emotions. It can intensify already existing or potential emotions, and, therefore, can stimulate drive, action, individual devotion, and submersion. Since its communication is nonverbal, it does not evoke or permit a possible resistance to words to which one may object. The willingness to listen is increased by the appeal of beauty, melody, and rhythm. Since one can fall under its spell, it has an insidious influence and draws even the hesitant bystander into a group, which he may have opposed or, at least, to which he may have been indifferent had it not been for its musical seduction. This can best be seen in incidents where a completely indifferent bystander who watches a parade or mass meeting cannot help but feel strangely affected and attracted by the music which expresses the group's ideas and intentions.

This is the reason why groups need music and why music needs groups. As the goals of the group need music to evoke fellowship and enthusiasm, so the group enhances the effects of music. It is one thing to listen alone to a recording, another to sit in an orchestra hall. Even a few friends around intensify the pleasure of listening to a record. A strong feedback mechanism makes each participant a source and an object of emotional stimulation. This is one of the reasons why chamber music
players do not like to play by themselves, except during practice; they want and need an audience. And those who are acquainted with this style of music are perfectly willing to sit and to listen to the players, even though their artistic competence may be far below the level which the listener would be willing to endure in a concert or recording.

These general predilections of a group setting for musical activities should be kept in mind when music is used with students in music education, or with patients in music therapy. Music therapists are more inclined, thus far, to recognize the benefit of the group approach, while teachers, by and large, prefer to deal with individual students and usually accept class teaching only for economic reasons. Many teachers prefer individual instruction to classroom teaching for several reasons, such as greater effectiveness, higher level of instruction, etc.; however, their wrong preference may be due to their unawareness of the increasing significance of groups in our times, and to their lack of familiarity with the techniques which are effective with groups. Our education, in general, is still based on the presupposition that each teacher instructs individual children, may they come for individual instruction or sit together in a classroom. This is not true; teaching in a class or giving individual lessons demand different approaches.

The main reason for the increased significance of groups is to be found in the democratic evolution which makes individual authority an anachronism. Democracy is more than the designation of a political system. It implies a change in social relationships, a shift from the traditional relationship of superiors and inferiors in which the dominant imposes his will on the submissive to a relationship of equals where common efforts have to be based on voluntary agreement. Teaching and learning are such common efforts toward a common goal; therefore, it requires voluntary cooperation. In such a situation, the authority of the teacher is no longer sufficient to promote compliance; to stimulate growth; to insure the willingness to study, to practice and to apply oneself.

As the authority of the adults, parents and teachers, diminishes, the group of peers gains increasing significance. Many students are more interested in gaining and maintaining the
approval of their peers than that of their teachers. Many difficulties which teachers encounter in their best educational efforts do not come primarily from the reluctance of individual pupils but from definite values, opinions, and attitudes which the student shares with his peers. Without utilizing group pressure, the teacher will find the group as an anti-educational and an often-highly detrimental force. In contrast, a teacher who knows how to utilize the group for the benefit of educational goals will find the group a powerful adjunct to his efforts. This holds true for all students, children and adults alike, but even more so for young students.

For this reason, teaching music in a group setting may eventually prove to be far superior and preferable, even for advanced students. What one learns or fails to learn can make a strong impact on the other students, regardless of their own level of accomplishment. Solitary music practice often leads to a lack of motivation for study and practice. The demands of the teacher to do so are not sufficient, even when the help of the mother is enlisted. Doing that makes the whole project of music education a rather sordid affair; instead of stimulating interest and enthusiasm for music, the opposite often happens—the child begins to hate music because of the unpleasant pressure and scenes accompanying his musical activities.

Autocratic demands have to be replaced by stimulation of interest; and nothing can make music as stimulating as a group experience. Playing together and listening together are the most powerful inducements to enjoy music. Consequently, many music teachers who work with children in an orchestra or band encounter far less resistance and can create interest where teachers of piano and violin often fail, because their students always play alone, for themselves, with a minimum of enjoyment. As a matter of fact, the children who enjoy solitary music practice the most are often socially maladjusted. Instead of spending their time with their peers, they prefer to keep busy by themselves. They may indulge in fantasies while practicing, and for this reason enjoy what a healthy child would abhor, namely the mechanical and senseless repetitive movement of fingers on an instrument without any possibility of real musical expression.

It is obvious, then, that a group setting is advisable in as many forms and variations as possible. Ensemble playing should be
encouraged and is possible almost on any level of piano instruction, either through playing four hands or by arranging some tunes or simple pieces to be sung or played by two instruments, and the like. At home, it is possible to create situations where even the beginner can play for others. This may require more tact and psychological acumen than most parents possess. They enjoy having the child play for them, but either they cannot refrain from bemoaning and criticizing every little mistake, or, going to the other extreme, making so much fuss that the musical experience is completely forgotten in the light of the fuss made over the "most wonderful" jewel of a child. This is not exactly what music is here for either.

Naturally, it is up to the teacher to instruct the parents how to cope with the child in regard to his musical activities. The above suggestions would be preferable in contrast to those customarily given, namely, to make the mother insist that the child prepare his lessons, or if necessary, to sit with him for any given time so that he would practice. Apart from thus making music an unpleasant task, it compounds the detrimental after-effects which similar advice on the part of regular teachers have. If they do not know how to stimulate the child to better efforts, they turn to the parents and ask them to supervise homework and make the child study. This is an utterly futile and highly questionable practice, although it is done routinely all over the country. The mother, who usually is responsible for the poor working habits of the child, is then called upon to improve them. If she had known how to induce the child to apply himself and to assume responsibility, the child probably would have no difficulty in school. Since the mother did not know what to do before, and the teacher usually cannot tell her either how to influence the child without getting into conflict with him, the mother merely continues and intensifies the very same efforts which originally were inadequate and were responsible for the child's deficiencies. Learning, which can only be effective if it is done with enthusiasm and interest, becomes then utterly detestable and objectionable. The mother may succeed in "making" the child finish his homework, but at what expense? To make it worse, the child does not learn to take care of himself, although he may learn one lesson. He only depends more
on attention and service or; what is worse, to trust his ability to defeat and annoy his parents. (Such a sense of "achievement," is certainly quite different from that which teachers and parents had in mind.) Music teachers will need to reconsider this traditional appeal to parents. Either they must learn how to correct the child's motivation or help the parents so that the child's musical activities at home can be pleasant for both the student and his parents.

If the child takes his lessons in a group and the teacher knows how to take the greatest advantage of the group setting, then the child comes home with increased eagerness to prepare himself for his next lesson, not so much to please the teacher and to get her approval, but for the reaction which he may get from the other students. Moreover, the group is a value-forming agent. Many children who like music and would like to learn to play suffer from an insidious handicap, namely, the questionable value which music practice has in the eyes of other children, particularly of boys. To play a big brass instrument or the drum is one thing; but to study the piano or the violin is increasingly becoming an object of scorn. It is considered "sissy stuff" by many boys. The child may want to please his parents and teachers, but he is also affected by group standards. If they are faulty, there is need for another group to extricate the child from such influences. The classroom situation which the teacher arranges may be exactly such a necessary antidote, stimulating not only motivation for learning, but also the values which are inherent in such musical activities. But this kind of classroom teaching requires considerable change from the prevalent methods of conducting classes for music where the teacher merely teaches each individual child in the presence of others by a more or less unstructured and incidental procedure. It requires special skills and knowledge of group leadership before the music teacher can become an effective classroom teacher and group leader.

What has been said about music education applies to a much greater extent to the problems of the music therapist. In music therapy, the patient also is supposed to learn something, although the prime objective is not learning to play a musical instrument but to learn something about integration with his fellow patients, and about ways to get along with people in general. As far as the learning aspect implied in music therapy is concerned, the
above suggestions to the music teacher have validity for the
music therapist as well. However, other important aspects of
group activities become important when the musical activity is
directed toward the treatment and improvement of psychiatric-
ally and socially disturbed patients.

Fundamental in all mental and emotional disturbances is the
disruption of interpersonal relationships. Psychopathology in-
volves always a greater or lesser degree of social distance, an
increasing isolation and a diminished ability for cooperation. It
is actually the lowering of the tolerance level for unpleasant or
difficult experiences which distinguishes the mentally sick from
the healthy individual. The sick persons needs little if any
provocation to withdraw, either into sullen self-imposed solitary
confinement, emotionally speaking, or into uncontrollable fits
of rage which make any cooperative effort impossible. Regard-
less of the theoretical explanation of psychopathological condi-
tions which, at the present time, are at variance and often con-
tradictory, the behavior of the patient can always be understood
as a breakdown in cooperation and communication. This break-
down is the most severe and generalized in psychotics, but
equally evident in neurotic conditions and character disorders,
previously called psychopathic personalities.

Distance and defiance of order are predisposing factors in the
development of such disorders, and the symptoms in turn in-
tensify and express defiance and rebellion. This is obvious in the
outburst of temper and the apparently irrational fits of the schizo-
phrenic; they are equally evident but not as openly expressed
in the fears of the neurotic, the moody indifference of the de-
pressed, and the selfish indifference of the sociopath. All of
them have lost a feeling of belonging, if they ever had much
of it. They lack what has been called social interest, a feeling
of being a part, expressed in the willingness to contribute, to
be concerned with the welfare of others, to participate in and
endure the give and take which social living entails.

It has been possible to determine almost diagramatically the
extent of the social interest in psychiatric patients. In each of
them some important areas of functioning within the family,
within the community, on the job, or in regard to the opposite
sex were impaired by the absence of a feeling of belonging or of
interest in and concern with these specific areas of relationships.
The direct connection between the extent of symptomatology and the limits of the area of social interest can be well discerned in schizophrenics. They only withdraw to their own "private logic," disregarding the common sense which binds the rest of humanity, in the area where they do not feel belonging. Regardless of how disturbed the patient may be, if he has any close relationship, it limits the schizophrenic distortions of delusions and hallucinations and the patient's "irrational" behavior. He behaves "normal" as far as such a person is concerned.

A young woman who had been schizophrenic for several years showed a remarkable insight in her condition. She knew that she was schizophrenic and that she had hallucinations. Although she did not recognize all her acoustic sensations as hallucinatory, some were such that she realized immediately afterwards their delusional character. In examining her relationship to the world and particularly her social interest, the area where she felt belonging, we found two people to whom she felt very close and by whom she felt completely "understood." They were an older brother and her young son. She was greatly disturbed about the imaginary accusations made to her by her husband, her mother, her neighbors, and other people; but when I asked her whether she ever heard such remarks from her son or her brother, she answered, "Of course not; then I would be really crazy."

Improvement in the condition of schizophrenics, be it through chemotherapy, psychotherapy, milieutherapy, or music therapy, are not only accompanied by, but also probably are induced by, increased interest in others through activities related to the needs of others. The same holds true for the improvement of all psychiatric patients, although the change in social participation is never as dramatic as that observed in the awakening of a fully withdrawn catatonic, for example. His first indication of interest and communication is as impressive as the beginning of interest shown by the previously completely indifferent melancholic patient.

Music therapy is so highly effective because it can establish and increase communication and participation. It has been pointed out before that the factors making music therapy so well fitted for such purposes are the implied order through rhythm and a clearly established mood and the nonverbal character of its communication. The use of the group in music
therapy adds to its therapeutic effectiveness. Now, let us briefly analyze these elements as they affect the patient.

The mood and the rhythm of a piece of music are a cogent reality to which the patient is drawn and to which he submits, perhaps hesitantly at first, but then with greater pleasure and enthusiasm. His inner demands, which alone he is inclined to follow, become related and subordinated to the demands of the musical reality. It is a different reality from that to which he objected and against which he rebelled. The difference is primarily established through the nonverbal character of the musical order and demands. The demands of society are usually expressed through words, through verbal commands and verbal threats. It is interesting to note that schizophrenics are much more sensitive and able to respond to a natural cogent situation than to demands made by people. Such verbal provocations are completely absent in the musical experience. Therefore, its force, which is not less pervasive and imposing than a human or social demand can be, is not fought and resisted, but can be followed and accepted, even with a sense of pleasure, because it lacks any aspect of painful "submission" which acceptance to social order and to interpersonal demands so easily implies.

The group accentuates the significance of the order which music establishes. The individual listener experiences the binding and, at the same time, the compelling musical influence together with his fellow patients. In this way, his acceptance of the musical order involves other people, and his relationship to them. One can well see how giving in to music becomes much more therapeutically significant when it also leads to the experience of human fellowship, to a better perception of others. Many catatonics, who first are unwilling to listen and eventually "submit" to the influence of music, soon begin to talk, which means recognizing the people around themselves as friends; in this sense then, a feeling of belonging begins to develop, which is so essential for the therapy of psychotics. The mood evoked by music is then carried out by the group; the order of the rhythm is supplemented by the order necessary in any group activity. The reality of music becomes, through the group, part of a social reality. This is particularly effective when patients are induced to participate actively, as in a rhythm band or other forms of ensemble playing. With children, group participation can be considered almost as mandatory. Individual sessions
may be necessary as a first step to help the child relate to one other person, the therapist. However, in such a relationship between child and adult, the child may even be fortified in his autistic demands for service and attention, which he cannot claim to the same extent when participating in a group.

The greatest obstacle to the use of groups in music education and in music therapy is the limited preparation for group leadership which teachers and therapists presently receive during their training courses. In most cases, they are taught to teach and treat individuals. They and their instructors assume that the classroom or group permits traditional individual approaches, as if nothing were changed in a group setting except the presence of other students or patients while one of them is taught or treated. This is a widely held misconception of group activities. The teacher does not teach any given number of children in a group; she teaches one group which may consist of any given number of children or students. This is more than playing with words. The approach to a group of children is fundamentally different from that to individual children in a group. Skills and preparations needed for group leadership are different from those required for individual training. Some teachers have the ability to work with groups; they became efficient by their own efforts, as some people become excellent speakers without ever having studied the necessary and intricate requirements for effective public speaking. The same holds true for some teachers who understand children without ever having learned about individual motivation, because they just feel what the child needs and wants. However, we can no longer rely on the few who almost by "instinct" know what to do; the art and skill of group leadership must be systematically taught to provide sufficient personnel for the necessary work with groups. Space permits only a brief outline of the requirements for effective group leadership which every teacher and therapist will have to acquire. While we may emphasize here particularly the needs of the music teacher, the same principles apply to music therapy.

1. The ability to integrate every pupil in the group and to unite the group for a common purpose requires enthusiasm, the ability to provide inspiration and the establishment and maintenance of an atmosphere. Learning must be pleasant and enjoyable. Punitive scolding, rigid demands, severity, lack of humor
and humility will not permit the group to function with enthusiasm; rather they inhibit the integration of each individual into the stream of group learning.

2. Every disturbance of the group atmosphere caused by a student or patient has to be spotted and counteracted. One cannot divide the group into good and bad students and hope to work with an integrated, enthusiastic group. While dealing with one child, one never should lose sight of all the others.

3. The teacher must be able to see everything that goes on at every given moment, in order to respond correctly to any disturbance. The ability to encompass everything with one glance can be described as the “width of vision.” Experience with speed reading has shown that the faster one reads the better one remembers; and the speed of reading increases when the reader learns to encompass more words with one glance. This implies an increase in the width of vision. The better trained the teacher is to see everything that goes on in the group, the more effective she can be, and the more students she can teach at the same time.

4. Effective group work without group discussion is impossible. In order to keep interest alive and to overcome obstacles or resistance whenever they may occur, it is necessary to discuss the problems with the members of the group and to gain their voluntary cooperation toward a common goal. Disruptions may either come from conflicts between the pupils, rebellion of one or the other members of the group, or resentment of the teacher and her ways. (Such resentment is more frequent than most teachers can imagine.) Only through group discussions can the teacher get the whole group on her side. If she does not win the group to cooperate with her, the group can easily become the most powerful obstacle to any effective teaching. It can build morale as well as undermine it. Teachers must learn how to conduct group discussions in a democratic way without either dominating the discussion or becoming passive and renouncing leadership in the solution of common problems. The time spent with an apparent extraneous activity like talking is well saved through the greater effectiveness in obtaining the educational goal.

5. Special skill in understanding individual students helps maintain the group spirit. The discouraged or antagonistic student needs the help of the others. Many teachers are inclined to
increase antagonism in order to impress the deviant or deficient child. Such tactics never work. Children must learn to understand and to help each other. Particularly the isolated, the child who cannot relate well to other children, can well become a source of infection of the group morale. Helping him by winning support for him from the others will not only lead to greater learning motivation on the part of the child, but to an improvement of the group and of social adjustment for all. Eventually, everyone who works with groups will have to acquire skills in sociometry in order to understand the sub-group formation in every group and to overcome detrimental group alliances. The formation of strongly integrated groups requires establishing long sociometric chains, a technique hardly known to most teachers or group workers at the present time.

6. In a democratic atmosphere, one can no longer hope to make sufficient progress by imposition and demands. The teacher must learn to stimulate proper motivation and to stop and correct mistaken or inadequate motivations. For this reason, she needs the ability to encourage, to increase each child's self-confidence. Competitive teaching encourages a few at the expense of the many. If a good one alone has status, then the poor student gives up in despair. Differences in achievement can well be used for the benefit of the whole class. Advanced training and skill can imply responsibility to help and inspire.

7. In order to work effectively, to inspire and encourage others, the group leader must be self-confident. Such self-confidence is easy when the students do well and the patients respond. However, it must be maintained even in the face of adversities, when problems and conflicts arise which are beyond any immediate satisfactory solution. The teacher who becomes discouraged cannot fail to discourage further the student who is the source of her defeat. In this way, the child or patient who needs the most encouragement receives the least.

8. The greatest obstacle to self-confidence and encouraging teaching is a perfectionism, unfortunately widespread among music teachers. For many, only the best is good enough, and every mistake is just intolerable. However, being human means making mistakes; and anyone who wants to be perfect or demands perfection from others deprives himself and them of real fulfillment in music. Art requires spontaneity, creativity, even if it is reproductive. It would be sacrilege to many music
teachers to assume that Beethoven could have improved his Fifth Symphony, although there can be no doubt that he could have done so had he been a perfectionist. He went to his next work rather than stew over the further possibilities of the last. But then, they say, since Beethoven wrote his works as they are, anyone who wants to play them must do it perfectly as the master created them. Even that is impossible, because every rendition could be slightly improved, and every performing artist perceives and re-creates the piece differently, in his own way. One may like one performance better than the other, but only an authority can determine which is uncontroversially correct; and authorities fit badly into a democratic order where each individual can maintain his own likes and dislikes. This is a difficult lesson to learn for all our music teachers who set themselves up as authorities and impress nobody except themselves; their students either give up their own creativity for the sake of conformity, or rebel and give up music altogether.

An interesting incident has been reported about a famous American conductor who is known for his autocratic and forceful approach to his musicians. They are afraid of him; making a mistake usually has disastrous consequences. Once the maestro returned from an engagement in Vienna with high praise for the extraordinary ability of the Viennese players. He admitted that they sometimes hit wrong notes; but this did not diminish the excellence of their playing. And for a short while less stress was put on occasional mistakes. Unfortunately, this change of mind did not last very long, and the conductor returned to his old scoldings and threats.

The group leader needs the courage to be imperfect in his dealing with his group, and the music teacher needs it more than anyone else to create enthusiasm in his students. Nothing stifles musical expression as much as the fear of making a mistake. And perfectionism does not serve art, but merely vanity. The perfectionist is afraid of being a failure, both as a performer and a teacher. It is not love for music which makes him demand perfection; it is fear of his own inadequacy.

May I then conclude with a little story about a woman preacher who spoke with such fervor that people came from all over the country to listen to her sermons. Once a friend asked her how she became such a wonderful preacher. She thought for a while and then answered: "Frankly, I don't know."
All I know is that in the beginning the Devil came to visit me after each sermon. Once he gave me a pat on the back and told me how wonderful the sermon was. The next time he gave me a kick, because it was so bad. Each time I had to fight off the Devil. And since he no longer comes to visit me, I think I am doing all right.” She recognized the devil of vanity, in contrast to most of us who still worship him.

We can do our best only if we enjoy what we are doing and do not use our activities for self-glorification or self-elevation. Music lends itself unfortunately to such abuse. But, if we want to use music for the benefit of our students and our patients, then we have to eliminate every trace of this vanity, of this tradition of worshiping the glory of excellence, and substitute for it the deep satisfaction and fulfillment of enjoying music. Our students and our patients can grow only if we stop sitting in judgment. Believe in them and what they are doing; then we can lead them onward with a helping hand of a human fellowship which thrives on mutual confidence and respect rather than on demands and criticism.

The good or inadequate qualities of any teacher or therapist will become more accentuated in the group with which he works. It tests his or her human fellowship, and, for this reason, it may be threatening to some. But when and if they can learn to work with groups, their own effectiveness will transcend what they were able to do with individual students or patients.
PART V

MUSIC THERAPY IN GERIATRICS
THE VALUE OF MUSIC IN GERIATRICS

IRA M. ALTSHULER

INTRODUCTION

At the present time people live much longer than they did two hundred years ago. The life span is steadily rising due to sound clinical and preventive medicine practices and improved sanitation. Better safety measures in industry and efficient traffic engineering, in spite of numerous accidents, safeguard life. Education, mental hygiene, welfare of the poor, care of the child and the aged, unemployment insurance, all contribute to longevity, emotionally, psychologically, and physically. The arts—music, painting, sculpture, literature, poetry and the theater—relieve tensions, aggressions, hostilities, anxieties, and so make life less strenuous. But above all, the spirit and action of American democracy, all embracing permissiveness and our way of life, is a major factor in inner security, dignity, stability and thus, longevity.

Longer life has created, however, a new category of citizens—geriatricians; these men and women, sixty-five and over, have found themselves “misplaced” in our youthful and dynamically-oriented, forward-striving, complex civilization. There is perennial overt and covert aggression waging between the young and the aged, in which the young seem to have the balance of power. There is cultural taboo, legal and social discrimination, which tends to force out the aged from position, activity, and authority. The language too is constantly hammering: “old fogey,” “old-fashioned,” and “he has outlived his time.”

A report published in 1955, by the Committee on Labor and Welfare, United States Senate, revealed that there were 15.4 million persons aged sixty-five and over, which is 8.6 per cent of the total population. The increase of the aged is one thousand persons per day. In 1900, there were three million over sixty-five. By 1975, it is expected that there will be twenty million persons sixty-five and over. The life expectancy of a man sixty-five is about thirteen years; a woman’s fifteen and one-half years.

The percentage of senile dementias in our mental hospitals is high, roughly thirty-five per cent. A certain number of persons
committed to mental hospitals as senile dments are not de-
mented. They are “rejected persons” whose families got tired of them and send them to a mental hospital.

The prevalent attitude of the hospital psychiatrist toward the senile patient is laissez-faire, defeatist, and pessimistic. “What’s the use” and “anyhow, not much can be done” are the current feelings and themes. This cynical attitude is reminiscent of the “back halls” of yesteryears. The cue given by the physician readily communicates itself to the paramedical professions and, in this way, a great deal of neglect, injustice, and damage is perpetrated upon the senile patient. True, as far as medical and general care are concerned, the senile receives it too, but man does not live by bread alone.

Is the senile person as hopeless as we picture him to be? What are the facts?

In a recent speech to the United States Senate, the Honorable Patrick McNamara, of Michigan, referring to the rapidly growing aged population, observed: “If the medical program continues, there is no basic reason why human beings cannot live to the age of one hundred and twenty-five.” Theoretically and clinically, Mr. McNamara’s statement makes sense; it also has a good deal of scientific validity. Records show that many individuals reach ripe old age. Thus, Thomas Parr, a Shropshire farm hand, died at the age of one hundred and fifty-two. According to William Harvey, who performed the autopsy, the body was in good condition except the brain, which showed pronounced sclerosis. Another person lived to be one hundred and thirty and got married at the age of one hundred and ten. Now there are many people on record who have passed the hundred year mark. What does it prove? It proves that the human organism has the physical resources, equipment, energies, the will and the spiritual potential to live longer and, given suitable opportunities and under proper circumstances, will do so more regularly.

It is also of interest that the life span of certain body tissues, bone marrow and certain cells within the eyes, are considered potentially immortal. The various cells, organs, and systems, as well as the whole human apparatus have a strong capacity to recuperate, to regenerate, and to repair themselves. Everything in the human organism strives to live, to grow, to self-perpetuate, to improve, and to propagate. Certain tissues serve only intermediately so that life may go on. Thus, the placenta,
having served for months in the uterus, is discarded as an after-birth. The thymus gland is active only to a certain age and, having served the organism, shrinks. The female ovaries produce eggs for about thirty years and then stop. In twin organs, such as lungs and kidneys, when one becomes diseased the other takes over and grows in size. The human organism has long ago learned to perpetuate itself effectively, and there is indeed no room for "what's the use" sentiment.

The senile patient is in need of more vigorous "activation," for several reasons. First, his health must be checked frequently to correct possible physical and neurological defects. Good nutrition is another important factor. The senile patient should be kept busy most of the time, consistent with his strength, capacity, endurance, attention, and interest. Group therapy, occupational therapy, and religious support are essential. Music, however, plays a strategic role in the whole therapeutic scheme. Special music in combination with mild gymnastics, walking, dancing, and singing is stimulating and invigorating. Exposure to singing, instrumental music, and dancing is beneficial, because the patient can identify himself with the performer, and emote.

In preparation for a therapeutic attack, we divide our patients into two groups: (1) One group is made up of apathetic, immobile, mildly depressed, and underactive patients; (2) The other group is made up of patients who are alert, mobile, and hyperactive. Both groups are treated with the power and facilities of total music—its creativeness, aesthetics, and spirit, as well as through application of rhythm, tempo, volume, tone color, melody, and harmony.

Since the senile patient is limited in his ability to absorb, assimilate, detoxicate, and eliminate the poisonous effects of drugs and chemicals, prolonged medicamental treatment is contraindicated. Especially, the tranquilizers, energizers, and sedatives when cumulated in the system can do a great deal of harm and thus accent and complicate the existing morbid condition. Our experience is that, on the whole, senile patients, as mentioned, benefit much more by a musical approach than any other method. Even group therapy is frequently ineffective because of the senile's slower mentation, confusion, lack of interest, depression, and inability to quickly grasp and comprehend. For the same reason, occupational therapy is also ineffectual.
Some of the patients cannot mobilize the energy to do sustained work and thus derive a sense of frustration.

**Music Pharmacology: Method and Technique**

In the treatment of the senile patient, the general ward climate is important. The senile patient, especially during sessions, is in need of an atmosphere that suggests warmth, acceptance, calmness, and tenderness. Sessions should be planned thoroughly and in advance. There should be minimal interference; heavy ward traffic, clang and noise are to be avoided. The music therapist should work smoothly, be kind to all patients, while keeping her eyes open. Initiative on the part of the patient is to be recognized promptly, encouraged and augmented. An effectively conducted therapeutic session should give the feeling of a complete "ensemble," with nearly total participation and engendered spontaneity, which leads to enjoyment. The music therapist should call her patients by their first names, or even better, their nicknames. The nickname applied to an elderly person helps to recall the past, spells youth, and is stimulating.

As previously indicated, the total action of music operates via the creative, social, emotional, psychological, aesthetical, and spiritual spheres. This action, although not specific, is nevertheless powerful and all-embracing, affecting almost all persons.

The structural elements of music—rhythm, volume, tempo, tone color, melody and harmony—have a more direct and specific action upon the human organism and its respective symptoms. It works in various ways.

**Rhythm**

Of all the powers and facilities man possesses, the sense of rhythm is the most stable, durable, and permanent. It is never lost as long as a person is alive. Rhythm is not only an integral part of man's life, but its power and sense is keenly felt in the heartbeat, respiration, endocrine functions, and brain rhythms. Every human being—young, old, feeble-minded, psychotic—lives rhythm. The rhythm of the human apparatus keeps in unison with the vegetable and animal worlds, with nature and the whole cosmos, thus offering man a global feeling; that of oneness, continuity, reality, and even a sense of immortality. That which
pulses in one's self also pulses outside one's self, everywhere, in everything, and forever.

Musical rhythm is a replica of bodily rhythm. As pointed out elsewhere,\(^1\) we recognize only one rhythm—organic rhythm—which is a blend of cosmic natures and bodily rhythm. It is ubiquitous, steady, simple, and direct. It possesses the all-powerful, embracing property to arouse, to stimulate, to integrate, to organize and, in a sense, to heal. Music by activating the human rhythm exercises a therapeutic effect. Music rhythm added to bodily rhythm causes people “to do,” to act, to react, to move. Musical rhythm affects us automatically and moves the mechanical in us. Emotion reinforces this automaticity. The reason we feel music at all, experience it in a more or less identical way, is because of the universality and ever-present steadiness of bodily rhythms. Rhythm is perhaps that mysterious language for which man has been searching. Rhythm is forever young. Its substance never changes, although its structure and speed may vary. The geriatric patient needs mostly slow rhythm although certain reaction types require faster rhythm. The important thing, however, is that the musical rhythm is “organic” rhythm and not syncopated.

**Volume or Intensity**

The musical volume in geriatric practice is therapeutically important. The volume has a strong affinity for the primitive in us. Human beings and animals respond to volume promptly, spontaneously, and fully, because of survival values and signaling properties inherent in the sound. High sounds warn, caution, stir emotions and the endocrines; they engage the sympathetic nervous system. Low sounds lull, hypnotize, and comfort; they engage the parasympathetic nervous system. The geriatric patient, in our experience, does better with music of low intensity.

**Tempo**

The practical limits for the duration of beat are MM 50 and MM 120. MM 60–80 is representative of the normal physiological tempo as experienced in moderate walking and pulse.\(^2\) It has

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been observed that the frequency of the metronome beat which is faster than the heart beat is experienced as being fast; that which is slower than the heart beat is experienced as slow. Beethoven wrote a number of sonatas metronomically encompassing the human pulse beat. Who else could better sense human tempo! To determine the "mean" tempo of our senile mobile patients, we do employ a simple test. Each patient is asked to walk—his normal pace—a distance of twenty-four feet back and forth; the time is recorded mechanically. Then we add music of various tempi to the walking and measure the time element. Fast musical tempo accelerates the gait; slow tempo retards it. The "Iso-tempic" approach helps to expedite acceleration or retardation. Largo, adagio, andante, and moderato are the tempi most welcome on the geriatric ward.

**Tone Color**

The aged patient with fragile blood vessels, "little strokes," and a sensitive, irritable nervous system does not tolerate well brass or percussion instruments so stimulating for the younger patient. There are, however, "socialized instruments" such as the violin, viola, 'cello and harp, which one can use. The manner of generating musical tones, via strings, is also to be considered. "Bowing," for instance, is preferable to "plucking." Pizzicato, used gently, is tolerable especially when snapped with the fingers, producing a rather staccato effect. Another tone color, the human voice, is of therapeutic importance. On the male ward, we fare better with mezzo-soprano; on the female, with baritone or lyric tenor. Senile patients respond favorably to singing, provided it is soft, melodious, familiar, and not too long.

**Melody and Harmony**

In hospital geriatric practice these two structural elements are important, especially melody, which, according to our concept, is a metamorphosed piece of aggression, suitable in the treatment of cases where such symptoms as anxiety, tension, and hostility predominate. Familiar, tender, and nostalgic melodies

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have a stronger penetrating power and, thus, are more effective. In music, harmony, the vertical part of the texture, has psychodynamic action similar to that of the horizontal part of the musical texture, viz., melody. Each, melody and harmony, reinforce one another, and the combination is even more effective.

**Summary**

1. Senile patients are by no means hopeless.
2. They should be given frequent and intensive treatment of the “total push” kind, but with more emphasis on music therapy, since the other therapies, for obvious reasons, do not always succeed.
3. In the management of the hospital geriatric patient, the music therapist must work very closely with the psychiatrist.
THE DEVELOPMENT OF A MUSIC THERAPY PROGRAM IN A CONVALESCENT HOME

ANN HART

As music therapy becomes more established as a professional field, efforts are being made to discover areas not yet fully recognized as a field for music therapy. This progress report describes the development of a music program devised according to therapeutic principles of music therapy in a convalescent home. The term, convalescent home, is synonymous with the terms, nursing home, and home for the aged.

The increasing number of older citizens has created a great problem within our nation. Krauss\textsuperscript{1} informs us that, in 1958, the life span for a woman was about 70.5 years, and for a man, about 68 years.

Chronic diseases usually result in chronic invalidism. According to public health statistics there are 28 to 39 million people in the United States who are more or less disabled. . . . Throughout the country there are about 25,000 nursing homes for the chronically ill and approximately 1,500 homes for the aged.\textsuperscript{2}

Wolff,\textsuperscript{3} in reviewing similar statistics, presented the prediction that, in the year 2000, 13.2 per cent of the national population will be over 65.

Because of the number of nursing homes at present and because of the expected increase of such homes in the future, it seemed feasible to explore the possibilities of music therapy in this particular area.

The population of a nursing home or convalescent home is usually composed of people of geriatric age. Although they may be there for many reasons, the most common are: physical illness, senility, residual mental cases, and no place else to live. A sizeable proportion of the patients in such homes are still alert, intelligent, and have command or partial command of physical extremities. Many convalescent homes, due to the lack

\begin{itemize}
\item[2.] \textit{Ibid.}
\end{itemize}
of staff and monetary means, have no plans for their residents but to have them lie in bed or sit in the dayroom. The great majority of homes have television and small reading libraries; rarely are there any recreational activities or any other activities which produce creativity, self-esteem, and group interest and cooperation. Needless to say, this allows the residents too much time to manifest symptoms of their illness and life situations. It also allows them feelings of apparent isolation and abandonment. People of any age have a need for the desire to live and enjoy living through feeling they are a part of society and useful in their own environment. Those of geriatric age, particularly those who are still mentally capable, deserve some degree of rehabilitation. In addition, they need to make full use of what remains of their lifetime instead of letting it pass by.

The convalescent home selected for study was located in a city of approximately 35,000 inhabitants and was licensed by both national and state associations of nursing homes. Although it had a capacity of thirty-four beds, at the time of this project, the census was thirty-two. Seventeen patients were bedfast and the remaining fifteen were ambulatory. Subjects for this study were the ambulatory group.

Music activities were scheduled four times a week for a period of nine weeks. The activities, forty-five minutes to an hour in length, were held in the afternoon except for the Saturday program which was planned for the morning. Before each session began, the therapist spoke to each patient individually, and, following the activity visited with them as a group.

During the nine-week period, the types of activities initiated were:

1. Group singing. This activity consisted of singing well-known hymns, patriotic songs, folk songs, and recreational songs. Accompaniments were played on the piano, ukulele, or autoharp.

2. Rhythm band. The rhythm instruments were made by the patients. They were played to piano accompaniments and records.

3. Group listening. The records selected were predominantly folk songs, old popular songs, barber shop arrangements, hymns, and light classics.
4. Guest entertainment. College students presented piano, voice, and violin programs, or combinations of these performances.

Group singing was the most difficult activity to establish. The patients' protests can be summarized as: they would rather listen; they couldn't sing at their age; they couldn't read the words. At first, the only songs they would try to sing were hymns. It may be that the choice of hymns and the preference for listening can be linked to the only two programs given at the convalescent home for many years; these were given by church groups who, of course, sang hymns but did not invite the patients to participate. Thus the role of the patients in musical activities had been long established.

The therapist divided the music program into both sacred and secular activities. To aid their eyes, the song sheets were printed in large type. Approximately four sessions were necessary before they began to accept the new role of participating, making requests, and enjoying the activity.

While the rhythm band was not expected to be looked upon with favor, because the majority of the patients were mentally alert and, to a certain degree, sophisticated; the activity was readily accepted with an enthusiastic response. This may have been due, in part, to the fact that the instruments were made by and/or under their supervision. They liked to exchange instruments during the music activity, yet most of them had their one favorite which they enjoyed playing.

Group listening was always well received. There were numerous requests. The music recalled memories of past times; thus conversation was stimulated. The latter was especially valuable to the residents, because topics of conversation and contributions by the members had been stereotyped for almost as long as each had been living there. They were delighted and listened to recordings of present and past musical productions while the therapist told the story as the selections were played.

Guest entertainers came to the home once a week. During these visits, the patients liked to look their best and extended a warm reception to the new person. Comments were heard such as: "wasn't that lovely," and "how nice." According to the subjects, two programs were outstanding: first, a student who
did chalk drawings interpreting the music which was played; and second, the music of a girl from Hawaii who played the ukulele and sang songs of the Islands.

At the first meeting with the patients, the therapist visited with each patient and explained to him or to her the music programs that were being planned for them. The second time she came to the home they were watching TV and wanted to finish the program, but one of the men withdrew from the group and came to the front of the room. He began singing softly to himself. As the project progressed during the next few weeks, he wanted to learn to play the autoharp. Since one arm was paralyzed, he could never quite do it successfully without help; yet he enjoyed strumming while someone else depressed the keys. Later, he learned the chords and would depress the keys while another person strummed on the strings. He could have received no more pleasure had he been able to play it alone.

Another patient, a lady who was confined to a wheelchair, displayed a great deal of hostility to the therapist, because she didn't appreciate the television set being turned off. She would leave the room during all activities. The therapist made a special effort to find her and to greet her with an invitation to join the group. After several weeks had passed, she remained in the room at the far end. This room was divided by a partial partition between the television lounge and the visiting room where the piano was located. During the music activities, the therapist saw her peering over the partition trying to watch the activity. After that, she joined the group and held out her hand for a song book. Although she never sang, she would find the correct page and follow the words with her finger. She would accept a rhythm instrument, yet she never participated as much as the others. Her changed attitude and smiles indicated that she felt a member of the group in spite of her handicaps.

Another subject who suffered from arteriosclerosis had been a music teacher. She rarely played the piano any more because she said it hurt her hands. After a few of the music sessions, she asked the therapist for some music so she could practice; later, she volunteered and played for group singing.

No apparent changes were found in behavior patterns of the patients, but the manager and attendants stated that the patients looked forward to the musical activities and enjoyed participating
together. The therapist could see the increase in the patients’ interest and the degree of their contributions develop throughout the nine weeks. It is probable that other media could be utilized to accomplish some of the same results, because the subjects had a break in the monotony of the daily routine.

Only ten to twelve of the ambulatory patients participated; the remainder stayed in their rooms or in the hallway. One of the effects of the study on the nonparticipants was discovered when the therapist returned to the home six months later for a visit. One patient who had not participated wheeled up to the therapist and asked excitedly, "Are you Nancy Mullins?" The therapist answered "No," and proceeded to give her name. Then the lady said, "Oh, I thought you were that nice young girl who went to college here and used to come out and bring us some music. She said she’d be back in six months to see us and it’s about time for her to come."
PART VI

CONFERENCE REPORTS
MUSIC THERAPY CURRICULUM STANDARDS

DONALD E. MICHEL

The "Special Work Session" to discuss Curriculum Standards met in East Lansing, Michigan, on October 10, 1959, at 9:00 a.m. Dr. E. Thayer Gaston presided at the meeting, and Dr. Donald E. Michel served as recorder.

Dr. Gaston opened the meeting with a review of certain facts of background and history of interest to the group. His remarks covered the development of minimum music therapy requirements; approval by an accrediting agency, NASM; the development of clinical training requirements; and the development of registration and certification requirements.

There followed a general discussion of recent developments in curriculum standards, beginning with the American Medical Association's recent recognition of the paramedical status of music therapy, through conferences and cooperative committees. It was then pointed out that the purpose of the NAMT Certification Committee is assistive rather than restrictive, that it is our hope to be able to assist schools in setting up curricula which are adequate, and that most schools have been cooperative. It was generally agreed that the demand for music therapists continues and will not be met completely in the foreseeable future.

The two types of approval of music therapy curriculum were discussed: 1. "Full" approval, granted by NASM after it has received and approved transcripts of graduates in the Music Therapy curriculum from the school, and after NAMT has approved the Clinical Training part of the school's program; and 2. "Tentative" approval, which is the status of schools that are in the process of getting NASM approval, having followed NAMT-NASM minimum requirements.

Clinical training was discussed as a function of over-all training requirements. It was pointed out that the responsibility for clinical training is a joint one, shared by both academic and clinical centers. The NAMT official statement on the basic structure of clinical training was read and discussed. It was noted that this statement requires that clinical training follow academic work.

It was pointed out, in discussion, that as long as clinical training is a requirement of the degree, the academic institution is responsible for seeing that credit of some kind is given or that
its successful completion is recorded on the student's transcript of academic work.

While some persons may feel that clinical training should be extended to nine months or more, it was pointed out that NAMT is not yet ready to take a position on this, mainly because the field is not yet ready to support more intensive training by increased compensation. It was the feeling of the group that assistance with and approval of clinical training programs by professional medical associations may be a future development.

Basic qualifications necessary for persons teaching music therapy courses in academic institutions were discussed. It was generally agreed that they should be highly qualified, and that one course or one year of experience does not qualify a person to teach the music therapy “core” courses; the qualified person should preferably have had graduate training, including research, and, in addition, some clinical experience.

To the question of whether a college teacher of music therapy should be a Registered Music Therapist, the group consensus of opinion was “yes”; it was agreed that this should be recommended as a resolution to the Education Committee of NAMT. It was noted, however, that at present all Registered Music Therapists are not necessarily qualified to teach at the college level, and that a shortage of qualified persons to teach music therapy courses continues to exist. It also was agreed that Music Therapists supervising clinical training programs should be Registered.

It was suggested that the NAMT educational pamphlet, “Music Therapy as a Career,” when revised, should contain more detailed information about clinical training, at least to include the NAMT basic recommendations for clinical training structure.

There was insufficient time at this meeting to discuss the content of the “core” courses in Music Therapy. It was strongly recommended that this type of meeting be programmed at each annual conference, and that the matter of course-content be thoroughly discussed in such meetings in the future.
CLINICAL TRAINING STANDARDS

MYRTLE F. THOMPSON

In this "Special Work Session," the requirements for clinical training in music therapy, as approved at the annual NAMT Conference of 1957, were reviewed. An outline of the requirements follows:

Clinical training shall consist of a minimum of six months' resident internship in an approved neuropsychiatric hospital with an established music therapy program, and a psychiatric indoctrination course for professional disciplines in which music trainees participate. This is to be in addition to on-campus hospital orientation lectures. Thereafter, two months' training in specialty hospitals for work in mental deficiency, physical handicap, or special disease areas may be gained. Breakdown in hours should approximate:

- 20 clock hours of orientation to the institution.
- 40 clock hours of clinical psychiatry, by competent professional lecturer, on terminology, personality structure, general psychopathology, characteristics, treatment, and cure of patients.
- 200 clock hours of discussion of applications of music therapy, including discussion periods and advisory and staff meetings.
- 800 clock hours of music therapy practice in all phases, under competent supervision, with growing responsibility, including training in departmental management.

Entire course shall be supplemented by assigned reading.

It is the shared responsibility of the academic institution and the clinical institution to see that clinical training is adequately supervised and properly carried out.

Problems which were discussed included: screening of students by the school for suitable personality factors; adequate preparation in skills; pre-hospital orientation; shared supervision and evaluations by school and hospital; background of staff in the clinical training institution, and its content in psychiatric and music skill areas; opportunities for individual study projects, and for administrative training; advantages and disadvantages
of extending the trainee period from six to nine months; and future standardization of money allowances.

Requests for copies of the NAMT Clinical Training Outline, or for forms on which institutions contemplating clinical training programs should send in their descriptive material, may be obtained from M. F. Thompson, Overbrook Hospital, Cedar Grove, New Jersey.
In order to make clear the setting and content of the meeting of the Joint Committee to Study Paramedical Areas in Relation to Medicine in Chicago on May 16, 1959, it would seem helpful to introduce certain communications and documents which preceded and made possible the meeting. This is necessary because it is important to the members of NAMT to understand the significance of this meeting, the first official recognition of Music Therapy by the American Medical Association.

The first communication to NAMT, dated March 5, 1959, came on a letterhead of the American Medical Association through the Council on Medical Education and Hospitals, and was signed by Raymond M. McKeown, M.D., Chairman, Joint Committee to Study Paramedical Areas in Relation to Medicine. The letter, in part, follows:

In July 1957, the Board of Trustees of the American Medical Association appointed the Joint Committee to Study Paramedical Areas in Relation to Medicine. Three members are from the Council on Medical Education and Hospitals and one member is from the Council on Mental Health of the American Medical Association.

The Committee was created by the Board of Trustees to "consider how physician leadership can best be activated in relationships with professional and technical personnel closely related to medicine . . ." and further "to study the matter of liaison at the professional and technical level leading to the above objective."

Attached for your reference is a copy of Supplementary Report G of the Board of Trustees. This report was accepted on December 3, 1958, by the House of Delegates of the AMA as information on the Committee's activities in a continuing study.

On December 3, 1958, the House of Delegates of the AMA (Resolution #12, "Licensure of Paramedical Groups") went on record as encouraging the voluntary registration of the paramedical groups who assist physicians. The House adopted "a position of opposition to the extension of
governmental licensure and registration at this time.” A further position on governmental licensure and registration was not taken until a thorough study has been completed and considered by the Board of Trustees and House of Delegates. Accordingly, the Board’s Joint Committee to Study Paramedical Areas in Relation to Medicine has been instructed to study the subject of registration and licensure of paramedical groups.

As two important aspects of its study, the committee would like to have a representative of the National Association for Music Therapy (1) discuss your current liaison and over-all relationships with physicians, (2) discuss your position concerning voluntary recognition (registration, certification, etc.) or governmental regulation (state registration, certification or licensure) of your members.

A meeting of the Joint Committee will be held at the Palmer House, Chicago, on May 16, 1959. A round-table discussion, from 9:00 a.m. to 1:00 p.m., followed by luncheon with therapists, technologists, and technicians in fields closely related to medicine will be held to discuss (1) over-all relationships and (2) registration and licensure.

Dr. John Hinman, Assistant Secretary, Council on Medical Education and Hospitals, 535 N. Dearborn Street, Chicago 10, has been assigned staff responsibility for arrangements. We are extremely hopeful that you will let us know in the near future that a member of your organization will be able to attend to assist us in our consideration of these vitally important matters.

Cordially yours,
Raymond M. McKeown, M.D.
Chairman, Joint Committee
to Study Paramedical Areas
in Relation to Medicine

Report G, referred to in the letter immediately above provides, in part, further information as to why the meeting in Chicago was called.

For many years, and as a continuing evolutionary process in the development and provision of comprehensive medical care, our profession has delegated various phases of medical care to others. Our Committee is aware of more than sixty groups functioning in ancillary or paramedical areas. As
their level of formal training and the extent of their participation in patient care has increased, some of the para-medical groups, who assist medical practitioners, have tended to move away from the medical group and establish themselves separately. It is with a sincere desire to clarify the issues that the Board has established our Joint Committee and has presented to it one of the most complex problems on the American medical scene today.

The Committee considers the paramedical areas to be composed of two major groups. One group is made up of individuals who hold advanced degrees, such as Ph.D.'s, who are engaged in medical and allied teaching. The second component is comprised chiefly of the technical groups who are engaged in patient care under the more active direction and supervision of physicians. This group includes various therapists, such as physical and occupational therapists and the technologists; medical and X-ray technologists and some fifty other technical groups.

Our Committee has established a two-phase study pattern which it considers suitable for its purposes. The initial phase of the study is directed at those who hold a Doctor of Philosophy degree.

Phase two will be concerned with the paramedical technician-groups, which have less extensive formal academic training and yet are so essential to the total care of the total patient. Conferences with physician and technician groups will be held.

Implementation of further advances in medical care and in the art and science of medicine will most certainly be in direct relation to the ability of our profession to effectively understand and cooperatively work with these many disciplines which contribute to the total care of the total patient. The precise nature which these cooperative efforts will eventually assume remains to be determined. Our present efforts are properly directed toward gaining a broad, overall view of the disciplines closely related to medicine. Later, review of particular phases and features may be of value. It has been suggested by some that physicians could assist in providing continuity and coordination by stimulating the creation of an advisory board of ancillary or paramedical professions. Such a board could be composed of members of the professional and technical groups closely related to medicine and, conceivably, could be organized in a manner
similar to that of the Advisory Board for the Medical Specialties. Inter-relationships will and must vary with the disciplines working with physicians. All should have the goal of improved patient care. During the presentations made to it, our Committee has become increasingly aware of the unanimous advice of physician groups that physicians must become more actively interested in liaison with related disciplines.

Over our future course, we expect to determine the situation as it exists today. When the composite, with its multiplicity of variables, is available, we hope to set forth guiding principles for presentation to the Board of Trustees and the House of Delegates.

Responding to the letter of invitation by the Joint Committee referred to above, the following paramedical fields were represented at the Chicago meeting: Corrective Therapy, Dietetics, Hospital Recreation, Medical Record Science, Medical Technology, Music Therapy, Occupational Therapy, Physical Therapy, Rehabilitation Therapy, Social Work (Medical–Psychiatric), and X-ray Technology.

Each representative of these paramedical fields was given specific instructions as to his presentation. It was to be a fifteen-minute summary presentation dealing directly with: (a) Current liaison and interrelationships with physicians; (b) Current liaison and interrelationships with non-physician groups in closely related fields; (c) Position on voluntary and/or state regulation of members in his field.

The following is the prepared presentation of your representative:¹

Although the place and function of music therapists may be well known to some, it would seem, however, a necessary clarification to indicate the type of institutions in which music therapy has been most frequently employed. Its greatest employment thus far has been in mental hospitals and similar institutions. It is also used to a significant extent in hospital-school institutions for different types of exceptional children.

If there is one thesis of the National Association for Music Therapy which has had frequent reiteration both in discussion and writing, it is that there should be an active and

¹ E. Thayer Gaston, Ph.D., Chairman, Committee on Registration, National Association for Music Therapy, Inc.
close liaison and interrelationship with physicians. Philosophically and with small exception in practice, music therapists have striven zealously to work, not independently, but in close relation with supervising physicians.

In an official publication of NAMT entitled *Music Therapy as a Career*, there appears the following statement: “Music may possess therapeutic value—when used for recreation, but only when its use is prescribed by a physician [or] psychiatrist . . . can it be considered as a therapy.”

**Current Liaison and Interrelationships of Music Therapists with Non-Physician Groups in Closely Related Fields**

In most institutions in which music therapists are employed they function on a “therapeutic team” made up of members of other paramedical groups, and, of course, a physician is a member of the team. Each member is not only confident in his own role, but is able, to some extent, to change roles, thus, through a more varied approach, bringing greater benefit to the patient. “The value of music therapy lies in its contribution to the total program for the patient and the place of the music therapist on the therapeutic team.” (*Music Therapy as a Career*)

The first sentence of the Editor’s Preface in the yearbook, *Music Therapy 1956*, is as follows: “If one central theme or message can be deduced from the volume of which these lines are a preface, it is the greater realization on the part of the music therapist of his function as a person on the therapeutic team.”

It would seem clear, at least from the viewpoint of the music therapist, that his greatest service becomes more possible through close association not only with the physician, but with the members of other groups closely related to his in function and treatment aims. In confirmation of this belief, NAMT has, for several years, sent a representative to an interdisciplinary meeting of several therapies, for the discussion of items of common interest.

**The Position of the National Association for Music Therapy on Voluntary and/or State Regulation of Its Members**

All efforts of NAMT have been for voluntary registration. Never at any time has there been any ambition or effort for other regulations regarding registration. As early as
1954, it had become evident that two accomplishments were necessary for professional growth: (1) voluntary registration of members, and (2) stabilization and improvement of the academic and clinical training of music therapy students.

From the Editor's Preface of Music Therapy 1957: In the fall of 1956, at the National Association for Music Therapy Conference 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. 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 plans 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 . . . for review and change, where necessary. . . . [Then] the plan was brought before and shown to each member [of NAMT] at the business meeting, and . . . unanimously adopted.

Registration proceeds at the present time in terms of the plan unanimously adopted, and which plan of registration is appended to this presentation.

Parenthetically, it may be stated that the Committee on Registration along with the Committee on Education were also unanimously charged with the responsibility of assisting colleges and universities in realizing the desired standards of academic and clinical training. Both committees are active in accomplishing their responsibilities.

In summary, then, the National Association for Music Therapy believes: (1) that its best service and most efficient function will be achieved through active and close liaison and interrelationship with physicians; (2) that its contribution to the total program for the patient will be most valuable when carried on in collaboration with other therapists on the therapeutic team; and (3) that the registration of its members should be voluntary.2

2. Dr. Gaston subsequently noted that there are approximately 675 members in the National Association for Music Therapy.
We are grateful for the invitation to be present on this occasion.

After each paramedical field had made its presentation, a round-table discussion took place centered on these points:

a. Do you believe the medical profession has a responsibility to assist groups in fields closely related to medicine in developing the medical aspects of their education and training?

b. If the medical profession has a responsibility in this regard, how can it best be assumed?

c. Suggested means to best activate close liaison among physicians and those in areas allied to medicine.

d. Summary and Conclusions.

Each representative was asked for extempore remarks in regard to these items. Your representative had this to say.

We are a young organization and we feel very gratified to have been asked to this meeting. As far as I know, this is our first official contact with the A.M.A. as a representative group.

Certainly we feel that the medical profession does have some responsibility in assisting us, because we are in a formative stage, being in the process of our first registration and being in the process of examining the curricula of some twelve to fifteen schools wishing to offer a degree course in music therapy.

We feel that it would be greatly to our benefit to have a closer liaison with the medical profession. We are also certain that by working with older and longer established paramedical groups, we will receive ideas of assistance and worth.

If we must suggest, then, we would ask for either some kind of joint committee or some kind of working together for advice and help in the establishment of our academic and clinical criteria for training of our students, and, perhaps, some help in evaluation of the hospitals where our students intern for at least six months. We feel that this would be of great value to us and, although we have had physicians on the advisory committee, we know that a representation from the A.M.A. would be most helpful. It seems to me that this would add very greatly to our efficiency in the difficult task with which we are confronted now. Certainly, I think that a meeting such as this is very much worthwhile and of great profit to all of us.
After President Crocker and your representative had each written our appreciation and our desire for advisory help from and closer liaison with the American Medical Association, the following letter was received from the Council on Medical Education and Hospitals of the American Medical Association:

We have and greatly appreciate your letter of July 16, 1959, relative to the transcript of the meeting of the Committee to Study Medical and Related Professions and Services, formerly the Joint Committee to Study Paramedical Areas in Relation to Medicine, held on May 16.

When your thoughts have been crystallized on the specific form of liaison you wish with the American Medical Association in reference to possible appointment of a member or a committee to serve as liaison representative to the National Association for Music Therapy, we will be most pleased to present such a specific request to the committee for its consideration of referral of the request to the Council on Medical Education and Hospitals.

Looking forward to continuing liaison with you, I am

Very truly yours,
John Hinman, M.D.
Assistant Secretary

It now remains for NAMT to make its suggestions and requests.
PART VII

RESEARCH IN MUSIC THERAPY
CONCLUDING REPORT: A SURVEY OF THREE HUNDRED SEVENTY-FIVE CASES IN MUSIC THERAPY

DONALD E. MICHEL

INTRODUCTION

In Music Therapy 1958, the preliminary report of this research was presented. Since that time the data has received further, detailed evaluation and some reorganization. While some repetitiveness in this present version with that of the preliminary report is bound to occur, this report will include references to related literature and, in addition, some conclusions and implications arising from the study. Basically, as it must be, this report is a summary of the complete study.

Since about 1944, Music Therapy has been developing in this country as a profession, and it has become a part of the accepted group of adjunctive therapies now available to physicians for use with patients in the modern hospital. New as a profession, yet old in traditional application in human illnesses, music as a therapy today, however, still needs much continued study, evaluation, and research, if it is to reach its highest potential as an important and effective therapy. Scientific validation of results is important, just as is experimental exploration under scientific conditions. In an attempt to contribute toward the improvement of music as a therapy, this study, which is essentially a survey analysis of results as seen in actual cases from a music therapy program in operation, was undertaken. Its undertaking seemed further justified by the fact that there is always a need for "microscopic" analysis of phenomena, as well as for "macroscopic" study, such as that which was done in two surveys of the use of music in institutions in this country in recent years: by the National Music Council in 1944, and by the National Association for Music Therapy in 1954-55.

The general purposes of this study were: to provide an analysis of certain aspects of a music therapy program which

had been in operation for several years at one mental hospital, in order to determine what some of the main problems of operation of such a program were; to determine, if possible, what potentials, limitations, and ultimate results of such a program were in terms of treatment; and to otherwise learn as much as possible about the conduct of music therapy for mental patients on an individualized basis as could be seen through such a detailed study and analysis. The principal sources of data for the study were the retained records on individual patients of the Music Therapy Department of the Veterans Administration Hospital, Topeka, Kansas, and the permanent hospital case records of these patients who had participated in music therapy during the period of time under study.

THE PROBLEM

To provide more definitive direction to the study, the purposes were recast into more specific statements as the “problem” of the investigation and were formulated as follows:

1. To describe and analyze music therapy procedures for individual patients as carried out in one program over a period of about six years, in the following terms:
   a. types of patients prescribed (sex, age, diagnosis, etc.)
   b. types of musical activities employed
   c. treatment goals prescribed
   d. progress observed by therapists
   e. prescribing physicians’ participation, cooperation, evaluation.

2. To delineate and clarify some of the problems involved in carrying out such a program, in terms of methods, procedures, mechanics of operation, and the like, and to suggest possible means for improvement.

3. To determine whether or not there are significant factors and problems in such a program which bear upon the ultimate results of music therapy, insofar as treatment results can be ascertained, from the standpoint of relationships between some of the factors outlined in (1) above, e.g., age, and type of musical activity employed, and from other standpoints which might develop.
Research

RELATED LITERATURE

To provide a more complete frame of reference within which the findings of this study might be better understood, the general background and status of music therapy were reviewed. Such a review, logically, begins with definitions of music therapy. In its broadest common usage, the term "music therapy" seems to apply to almost any type of music found within treatment or rehabilitation institutions. Under a more restrictive usage of the "therapy" part of the term, as therapy is usually defined in medicine, the term music therapy must be defined more precisely as a means or a "tool" which is used in treatment, directed toward rather specific goals which have been determined by medical authority. Gaston, Gaston, Masserman, and the National Association for Music Therapy provide definitions of music therapy which illustrate this latter concept, i.e., music as a therapeutic tool directed toward specific treatment goals by skilled, trained therapists, under medical supervision.

A summary of developments in the field of music therapy provides the best means for determining the status of the field and probably should begin with the two important surveys of uses of music in institutions, previously mentioned. The investigator felt that these surveys found relatively few instances of music in institutional application which could be called music therapy under the more restrictive definition. The surveys are quite valuable, of course, in showing what and where music was being used and in showing the great amount of interest in its therapeutic potential. Other studies seem to substantiate the impression that few reported music therapy programs could


meet the more stringent definition of therapy; however, a few case studies do illustrate therapy under that definition.  

Studies by West and Bond, and by Dreikurs and Corsini, deal with more general problems in the field of psychiatry, but serve to illustrate the usefulness of the survey method in research dealing with therapy problems. 

A report by Michel, with additional material uncovered by this study, provides a general background picture of the music therapy program with which this study was concerned. This program, undoubtedly one of the pioneering efforts in music therapy in the post-World War II period, was one which operated in the rather unique milieu of a large psychiatric training hospital. Treatment programs of this hospital were oriented toward the medical prescription of music and other adjunctive therapies, on an individualized basis for patients (and shaped by the demands of a training and research hospital). 

Besides background and status of music therapy, generally and specifically, theories of music therapy as stated by leading authorities add to the frame of reference for this study. Early theories seemed more concerned about what music does to people rather than how it could be used in therapy as a tool. Several more recent theorists, including Dreikurs, Kohut, and Barnard, seem to agree, however, with the theory that it is not


so much the music which is "doing therapy," but the ways in which it is used to establish therapeutic relationships between therapists and patients that is therapeutic. Fultz's "Musical guidance theory of music therapy" differs slightly from this by proposing that the whole process of musical performance and learning can be controlled in such a manner as to make it therapeutic.¹⁵ Dreikurs points out, however, that many other theories such as those of psychotherapy may apply to a theory of music therapy in explaining how it works.¹⁶ He does recognize the special qualities of music as a form of nonverbal communication, however, and that these have potential therapeutic value. Although there appeared to be no single, complete, and unified theory of music therapy stated in the literature, Gaston's statement of the "nature and principles of music therapy" seems to come closest to summarizing several theories and to recognizing the many potentials of music in therapy.¹⁷

**Design and Procedures**

It already has been noted that the design of this study was primarily that of the survey or status study. The survey coverage originally included music therapy department records for 424 cases, but only 375 of these records met the criteria for inclusion in the study, i.e., relatively complete information on prescription forms and on progress note forms. As a means of more intensive study of some of the cases, a random sample of 50 cases, drawn from the 375, was selected for follow-up analysis in terms of information in permanent hospital case records, and a questionnaire sent out to those patients who had been discharged from the hospital. An additional follow-up technique was employed through another questionnaire which was sent out to 200 psychiatrists who, as former residents at the hospital, had been involved in the prescription of music therapy for the total group of cases. The scope of the survey covered a wide range of facts, from those descriptive of the patient, his background, his illness, and his treatment in music therapy, to music therapists' reports

of his progress; information in permanent hospital case files concerning the place of music therapy in the patient’s over-all treatment program, and responses to the questionnaires sent to former patients and to former psychiatric residents.

Organization of the data was accomplished by codifying the myriad facts to IBM punch cards which were processed and sorted by IBM machines, resulting in numerous distributions of various types. The 50 cases used as a sample were drawn by using a table of random numbers, with the group of 375 cases being considered the total population, without stratification according to any classifications such as “psychotic,” etc.

Treatment of the data was mainly in distributional or proportional terms (percentages). None of the data lent itself to statistical evaluation or prediction, principally because there were no adequate criteria of evaluation found, e.g., there was no precise way for determining the amount of treatment progress made by individual patients. Data, which at first appeared promising for such evaluative purposes (the progress note reports written on patients by music therapists), proved upon further inspection to be too nonprecision and nonspecific for statistical uses, because they were basically means of communication between therapists and prescribing physicians, and only estimates of behavioral progress or change were indicated. The investigator’s evaluations of such reports could be only estimates, also. In addition, in this type of study the opportunities for the application of controls necessary for the establishment of evaluative techniques are rarely available.

Results

Results of the study were presented mostly through tabular means and fell into four basic groupings as follows: (1) data from music therapy case records; (2) data from permanent hospital case records for the sample group; (3) data from the follow-up questionnaire sent to former patients; (4) data from the follow-up questionnaire sent to former psychiatric residents.

These four groupings were sub-divided to show more specifically the resulting tabulations from data factors such as prescription forms, progress note forms, other material found in music therapy case records and in permanent hospital case records, and from comparative distributions of two or more such factors. A total of thirty-three tables presented most of
the data, accompanied by interpretive comment as appropriate. The results of the study may be summarized as follows:

1. Thirty-nine different diagnoses were encountered among the patients individually prescribed to music therapy. A majority of the diagnoses was in the schizophrenic reaction group (46 per cent); another large group was in the psychoneurotic reaction group (21 per cent); and the others were distributed through nearly all of the standard diagnostic categories of mental illness.

2. From patients’ age data, found in 52 per cent of the cases, the range of ages found was from 18 to 61 years. The average age was 29.4 years, and, if this represents the total group, it indicates that the average patient was in the late twenties in age.

3. Most of the patients were male (89 per cent). A wide range of educational backgrounds was found, from 6 to 16 years of schooling. The average educational level was 13.2 years of school, which may be interpreted as being one year beyond high school. Occupational backgrounds of patients also covered a wide range, from the category of “student” to that of “unemployed.” The largest number of patients was from the “student” category, but large groups also were from the categories of “clerical-sales,” “unskilled labor,” and “agricultural.”

4. Only four per cent of the cases provided any information about the amount of musical background. Fifty-four per cent of the cases did give some indication of the type of previous musical experience of patients and found seventy-two patients with some private study, eighty with “informal” types of experience with music, and two with professional musical training.

5. Most of the patients in music therapy were assigned from “open” or privileged wards (72 per cent), but a fairly substantial number were assigned from “closed” or otherwise restricted-privilege wards (28 per cent).

6. Twenty-one different treatment aims were prescribed by physicians who assigned patients to music therapy. The treatment aim “narcissistic gratification” was most frequently prescribed (35 per cent of the cases), while “socialization,” “release hostility,” “develop hobby interest,” and “establish compulsive routine defenses” followed in a partial rank order of frequency.

7. As a part of the system of adjunctive therapy prescribed in the hospital, specifically prescribed attitudes often accompanied treatment aims. Such prescribed attitudes, however, were
found specified in only thirty-six per cent of these cases, and the three most frequently prescribed ones were “active friendliness,” “passive friendliness,” and “kind firmness.”

8. Nineteen different musical media were used by therapists in working with patients. They ranged from the standard musical instruments, voice, and record-listening to activities such as song-writing and radio programming for the hospital radio station. Piano was the most frequently used medium (in 45 per cent of the cases), with guitar, voice, and record-listening in the next three “most popular” categories. In 46 per cent of the cases, the patients were “beginners” in music; in 34 per cent of the cases they were “intermediates”; and in only 6 per cent of the cases were they “advanced” level.

9. The average length of participation time for all patients in music therapy was 4.41 months, with a range of from less than one month to as much as forty-eight months. Ninety per cent of the cases could be grouped in the category of twelve months or less participation time; 80 per cent could be grouped in the six months or less participation time category; and 47 per cent fell into the category of two months or less. An average participation time for patients from the restricted-privilege (Closed) wards was longer than that for patients from privileged wards; five and one-half months as compared with three months, respectively. In terms of the number of music therapy sessions, an average of fifty-six was found, with a range of from one to 583 sessions in individual cases.

10. Although all cases studied had been individually prescribed to music therapy, it was found that twenty-seven per cent of the cases were involved in both individual and group therapy situations in music.

11. Progress reports on patients, although routinely expected, were specifically requested by physicians in 58 per cent of the cases, with requests for frequency of the report ranging from one per week to one per month. Therapists wrote an average of four progress reports per case, mostly on the monthly basis, but the range was from one to forty-four progress reports written in individual cases. Physicians made specific written replies to the progress notes in 54 per cent of the cases, averaging 1.29 replies per case.
12. An estimate by the investigator of the amount of progress reported in all the cases by therapists in their progress notes to physicians showed that 69 per cent of the cases had "some" or "much" progress reported. In the other 31 per cent, no progress was estimated to have been reported, or it was impossible to determine from reading therapists' reports whether or not patients had made progress. (See Table 1.)

**Table 1**

**ESTIMATE OF PROGRESS FROM THERAPISTS' PROGRESS REPORTS**

<table>
<thead>
<tr>
<th>Estimated Amount of Progress</th>
<th>None*</th>
<th>Some</th>
<th>Much</th>
<th>Maximumb</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of cases:</td>
<td>118</td>
<td>206</td>
<td>50</td>
<td>1</td>
<td>375</td>
</tr>
<tr>
<td>Per cent of total:</td>
<td>31.4</td>
<td>55</td>
<td>13.33</td>
<td>.27</td>
<td>100</td>
</tr>
</tbody>
</table>

* Refers to cases where no progress was shown as well as cases impossible to evaluate for progress.

b Category adopted to use for one especially outstanding case, from standpoint of progress shown in music therapy.

13. The total number of psychiatrists involved in prescribing patients to music therapy was two hundred. The total number of therapists was fifteen, six of these being permanent staff at one time or another during the period surveyed, the remaining being student interns.

14. From several comparative distributions of one factor by another, the following were obtained:

a. Musical media were about equally distributed among the various treatment aims prescribed, i.e., no special use of musical media with certain treatment aims was found; however, there was some indication that percussive instruments were more frequently used with the more severely ill patients than with those who were less ill, and that piano was used more frequently with female patients than with male patients.

b. Estimates of progress as reported by therapists varied somewhat for different diagnostic categories of patients, e.g., "some" and "much" progress was reported in 73 per cent of the cases diagnosed "schizophrenic reaction" as compared with those amounts in 69 per cent of the cases in all categories.
c. Estimates of progress as reported by therapists varied when distributed by the various musical media employed, e.g., positive progress was reported in 68 per cent of the cases where piano was the medium as compared with such progress in 72 per cent of the cases where guitar was used.

d. Estimates of progress as reported by therapists varied when distributed among the various treatment aims, e.g., positive amounts of progress were reported in 78 per cent of the cases where the treatment aim was to establish compulsive defenses as compared with positive progress in 66 per cent of the cases where the aim was to develop a hobby interest.

15. Examination of permanent hospital records for the fifty sample cases disclosed that 70 per cent had been discharged from the hospital from the category "MHB," or maximum hospital benefit, while the remaining had been discharged "AMA," or against medical advice, sent out on "trial visits," decreased, or remained in the hospital (the latter category being 18 per cent of the cases).

16. Examination of permanent hospital records also found music therapy progress reports filed in most of the fifty sample cases, and in most cases there were one or more references to music therapy made by physicians and other medical personnel. In more than 50 per cent of these references, there was positive evidence that music therapy was considered an important part of the patient's treatment program, and in some cases, considerable stress was placed upon the importance of music therapy as the central part of the treatment effort.

17. A follow-up questionnaire to former patients (from the sample group) received a 38 per cent return. However, 35 per cent of the original mailing group could not be located. Nearly all patients who responded indicated that they felt music therapy had helped them get well; none said it did not help, but a few were uncertain. Most felt that it was the music itself which had been most important in their treatment, but many seemed to recognize the importance of relationships established with music therapists as a factor in their rehabilitation.

18. A follow-up questionnaire to two hundred psychiatrists who had received their training at the hospital and had prescribed patients to music therapy received a 60 per cent return.
Of those responding, 59 per cent answered that music therapy had been helpful as a part of the treatment of patients formally in their care; another 14 per cent answered it had not been helpful, and 16 per cent were uncertain, while 11 per cent did not answer this question.

19. Psychiatrists named many ways in which they felt music therapy can contribute to treatment of patients (see Table 2).

### Table 2

**Psychiatrists' Responses to Question 2**

“What do you consider to be the most effective contributions to patient treatment and/or care that can be provided by music therapy?”

<table>
<thead>
<tr>
<th>Specific answer*</th>
<th>No.</th>
<th>Specific answer*</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannot contribute</td>
<td>1</td>
<td>Provide ego strength</td>
<td>25</td>
</tr>
<tr>
<td>Uncertain</td>
<td>18</td>
<td>Provide new interest</td>
<td>14</td>
</tr>
<tr>
<td>Need more research</td>
<td>2</td>
<td>Sublimation</td>
<td>10</td>
</tr>
<tr>
<td>No answer</td>
<td>3</td>
<td>Relaxation, sedation</td>
<td>6</td>
</tr>
<tr>
<td>Specific answers*</td>
<td>237</td>
<td>Mood-ameliorating</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mood-tone influence on wards</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Help establish interpersonal relationship between patient and therapist</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Like any other adjunctive therapy</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Re-establish compulsive defense mechanisms</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-discipline</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Its flexibility</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Meet specific diagnostic needs</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Vocational rehabilitation</td>
<td>1</td>
</tr>
</tbody>
</table>

* Specific answers are paraphrased and grouped together into these categories; in addition, categories are grouped by single-spacing where apparently related to others.
They also provided much potentially useful information and many suggestions regarding improvement of communication between physicians and therapists, orientation and education of physicians to music therapy practices and theory, and important factors for music therapists to know in order to become better therapists. In addition, psychiatrists gave many comments, suggestions, and criticisms about music therapy, generally and specifically, which should have potential value to the field.

CONCLUSIONS

Conclusions in the form of answers to questions or hypotheses stated as the problem ordinarily will not arise from this type of study, because no controlled experimental procedures have been employed. The results of this investigation, however, do seem to have met the purposes of the study as they were originally stated, i.e., they (1) provide a description and analysis of the program and procedures carried out in music therapy with 375 patients in a mental hospital, (2) delineate and clarify certain problems encountered in such a program, and (3) determine whether or not there were factors which were pertinent to the ultimate results of music therapy in terms of treatment. In addition, the results seem to make possible a few broad, concluding statements. These statements follow.

Taken as a whole, this study of 375 cases of patients treated through music therapy in a mental hospital over a period of about six years would seem to indicate that a music therapy program of considerable scope and effectiveness was in operation at this particular hospital (Veterans Administration Hospital, Topeka, Kansas). Although no absolutely reliable or valid measures of the effectiveness of the program in terms of treatment appeared in the study, there were several data sources which seemed to give a strong indication that the program was effective. One such source was the progress note data accumulated on individual patients, which were read by the investigator and given relative ratings as to amount of progress reported by different therapists. Another was the group of responses received as answers to a questionnaire sent out to a sample of former patients from the study group; a third source was the responses to questionnaires sent out to former psychiatric residents who had had responsibilities related to treatment of patients in the study group.
More specifically, this study illuminates some important aspects which appear in the organization and operation of a music therapy program for mental patients on an individualized, prescribed basis. For example, if music therapists are to carry on their work in the most effective way, with adequate opportunities for evaluation of what they are doing, it would seem important that they have adequate access to individual case histories, that they have frequent and meaningful communication with prescribing physicians, and that they conduct periodic evaluations of the progress of patients under assignment to them. Further, more detailed observations and suggestions such as these, which arose from the results of this study, might better be called "implications" and will be listed as such in the following paragraphs.

**IMPLICATIONS**

Since there seemed to be a sparsity of detailed information (at least in written form) available to music therapists with regard to pertinent facts about individual patients who were prescribed to music therapy, there is an implied need for better provision of such information, e.g., more complete diagnostic information, some form of case history data, and, if possible, more information on the musical background of the patient. The latter factor of musical background seems especially important for therapists to have, and this might well be extended to include some forms of musical tests such as tests of musical taste, musical ability, and musical achievement. In many cases, it also would seem indicated that the patient's experiential-associational background in music would need to be explored, and such information made available to music therapists. Whether this would be obtained through the rather laborious and lengthy process of interviews with the patient, as one psychiatric resident has explored it,18 or through testing techniques, remains a problem for future research.

The fact that patients in this program averaged only slightly more than four months' participation time in music therapy implies that there is a need for the development of relatively short-term techniques, methods, and materials in music therapy, which

could be effectively used as media in treatment situations. This is especially pertinent when it seems certain that much of the treatment in mental illness will continue to develop, through improved techniques and through more treatment on an emergency basis, toward shorter periods of hospitalization.

There is an over-all impression from the results of the study that intra-hospital communications are very important to the effective operation of a music therapy program, with the corresponding implication that specific attention needs to be given to the various aspects of such communication. In the matter of treatment of patients in music therapy under the prescription and guidance of physicians, this communication takes place in the form of both written and verbal means, from prescription forms to progress reports and notes on case conferences. It would seem that these forms, whatever they may be, should be given periodic evaluations of their efficacy and of their need for revision and improvement. In addition, it would seem important to get into written form as much of the verbal communications as possible, so that later reference to them may be made with accuracy, and so that reflective thought as well as possible research techniques may be applied to them.

Another part of intra-hospital communications is the constant, and never very easy, matter of "public relations" of the music therapy department. Letting the physicians and other medical staff know what the potentials of music therapy are, and what kind of program is offered in a particular hospital music therapy department, probably is of primary concern here. This part of the problem may be complicated in a hospital where there are various training programs, as was the situation in the hospital from which the cases of this study were taken. In such situations, there certainly is an implication that definite provisions should be made in the training program for proper orientation of psychiatric residents to the music therapy program (as well as to other modalities of treatment, of course), but most of the responsibility for communication of music therapy potentials resides in the department itself. Besides this type of communication, there also is the very important, almost daily matter of relating and describing the offerings of the music therapy department to other hospital departments and services, and, indeed, even to the patients themselves. A further implication here is that not
only should attention be given to such communication within a hospital music therapy department, but also, perhaps, it should be made somehow a part of the training of music therapists.

There is another general, over-all impression gained from this study which leads to some additional implications. This is that the organization and administration of a music therapy program, in itself, may have great bearing on its efficacy and end results, in terms of treatment of patients. It would seem important that considerable attention be given to the details of organization and administration, as well as to the procedures of music therapy itself. This would imply a need for a statement of theory and principles upon which a particular program is based as well as a need for attention to the details of operation of the program, from its place and status in the over-all hospital set-up to the mechanics of scheduling patients and patient activities.

A number of unanswered or partially answered questions arising from this study indicate that there is an implied need for more research along certain, rather specific lines in music therapy. Some of these problems for which research seems to be implied are as follows:

1. Can the results of music therapy in a hospital program be isolated from results of other hospital treatment? Can the relative importance of music therapy or any other therapy be determined when treatment of patients is of the "total push" or teamwork type?

2. What is the relative therapeutic value of patient participation in music activity itself, e.g., learning, performing, listening, etc., as compared with the therapeutic value of interpersonal relationships (therapists with patients, patients with other patients) fostered or mediated by music and music activity?

3. What procedures in music and music activities may be developed to meet both short-term musical goals as well as to provide effective media for working with patients toward treatment goals over a relatively short period of time, e.g., one to four months?

Finally, since this study seemed to point up the importance of the interpersonal therapeutic relationship in music therapy, as it is in nearly all psychiatry, research which concerns itself with personality characteristics, selection, and training procedures of music therapists would seem to be implied.
While much research is needed in music therapy, beyond that which is implied by this study, this study would seem to show that music therapy can be carried out in an organized program within the modern psychiatric hospital, which operates under adequate treatment theory and methods, resulting in its acceptance as an effective part of the over-all treatment program.

**Bibliography**

**Books**


**Articles**


AN EXPERIMENT IN MUSICAL ACTIVITIES
WITH DISTURBED CHILDREN
EILEEN ALWARD AND BETTY RULE

INTRODUCTION

Musical activities for the exceptional child have been reported as being beneficial to the functioning of these children and have served as valuable aids in their therapy and educational programs. To date, very little has been reported concerning the technique of using music as a therapy in the public schools.

In February of 1959, a music therapy workshop was held in Flint, Michigan. It was conducted by Mr. Robert F. Unkefer, music therapist from Michigan State University, in cooperation with Mrs. Eileen Alward and Mrs. Betty Rule, consultants in Special Education and Elementary Music, respectively, for the Flint Public Schools. The purpose of this workshop was to explore the use of music as a therapy with exceptional children in the schools.

Mr. Unkefer emphasized the difficulty of generalizing the aims and goals for the total group of exceptional children except in the area of common emotional needs which are frequently more difficult to fulfill for the physically or mentally handicapped children. These common needs are acceptance and personal gratification through accomplishment. He stressed that music is a therapeutic and educational tool and can be made to serve the child in his striving to fulfill these common emotional needs.

In the spring of 1959, an experiment was conducted in the Flint Public Schools to study the effects of music on children who were exhibiting socially unacceptable behavior in the classroom. The study utilized the services of persons in the psychological, musical, and educational departments of the public schools. This paper reports the procedures used in and the results of this work.

PROCEDURE

Subjects

Teachers of fifth and sixth grades in a selected school were asked to submit the names of children in their rooms whom they found more difficult to supervise than others in the group. This included pupils who had been of unusual concern to them, either
because of the constant, close personal attention they required and the disrupting effects their behaviors tended to have on the group, or because of their extremely withdrawn tendencies. Twenty names were submitted, sixteen boys and four girls. Interviews were held with the three teachers concerned in an effort to discover the kinds of behavior exhibited, so that behavior could be considered when matching individuals for the experimental and control groups. Of the twenty potential candidates, sixteen were selected; eight to participate in musical activities and eight as the control group. Of these sixteen, one subject was diagnosed as having Chorea and he, along with his control subject, was excused from the experimentation. The fourteen remaining pupils completed the project.

The experimental group was equated with the control group on chronological age (within a range of six months), grade placement, sex, IQ as measured on the Wechsler Intelligence Scale for Children, and musical aptitude as measured on the California Musical Aptitude Test. The group was comprised of ten boys (ages 10 yr., 4 mos. to 12 yr., 1 mo.), and four girls (ages 11 yr., 2 mos. to 12 yr., 1 mo.). The IQ scores ranged from 72–126. Table 1 shows that there were no significant differences between the paired members of the group.

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>COMPARATIVE DATA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EXPERIMENTAL</td>
</tr>
<tr>
<td>1</td>
<td>X</td>
</tr>
<tr>
<td>2</td>
<td>X</td>
</tr>
<tr>
<td>3</td>
<td>X</td>
</tr>
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<td>4</td>
<td>X</td>
</tr>
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<td>11</td>
<td>X</td>
</tr>
<tr>
<td>12</td>
<td>X</td>
</tr>
<tr>
<td>13</td>
<td>X</td>
</tr>
</tbody>
</table>
Materials

Classroom Behavior Checklist. A twenty-four point classroom behavior checklist was constructed (Figure 1). The three teachers used this instrument to note incidence of individual, unacceptable, afternoon behavior during a ten-day period prior to the initiation of musical activities.

During the eight-week experimental period, the teachers were asked to use the checklist again and note the incidence of unacceptable, afternoon behavior for each child. It was felt that significant differences in behavior patterns could be observed.

Children in the experimental group participated in musical activities on an individual basis for a thirty-minute period once each week. Each child's attitude during each session was noted.

<table>
<thead>
<tr>
<th>CHECKLIST CLASSROOM BEHAVIOR PROBLEMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name ----------------------------------</td>
</tr>
<tr>
<td>PROBLEM</td>
</tr>
<tr>
<td>1. Disturbing others</td>
</tr>
<tr>
<td>2. Generally disorderly</td>
</tr>
<tr>
<td>3. Unreasonably restless in seat</td>
</tr>
<tr>
<td>4. Out of seat without permission</td>
</tr>
<tr>
<td>5. Making unacceptable noise</td>
</tr>
<tr>
<td>6. Attracting attention</td>
</tr>
<tr>
<td>7. Talking out of turn</td>
</tr>
<tr>
<td>8. Disobedience to authority on class rules</td>
</tr>
<tr>
<td>9. Rude or discourteous</td>
</tr>
<tr>
<td>10. Inattentive</td>
</tr>
<tr>
<td>11. Doing careless work</td>
</tr>
<tr>
<td>12. Work not done</td>
</tr>
<tr>
<td>13. Wastes time</td>
</tr>
<tr>
<td>14. Quarrelsome</td>
</tr>
<tr>
<td>15. Striking out physically</td>
</tr>
<tr>
<td>16. Talebearing</td>
</tr>
<tr>
<td>17. Stealing</td>
</tr>
<tr>
<td>18. Careless with property</td>
</tr>
<tr>
<td>19. Cheating</td>
</tr>
<tr>
<td>20. Lying</td>
</tr>
<tr>
<td>21. Using profanity</td>
</tr>
<tr>
<td>22. Truancy or tardy</td>
</tr>
<tr>
<td>23. Acting silly</td>
</tr>
<tr>
<td>24. Withdrawing</td>
</tr>
</tbody>
</table>

Figure 1. Classroom Behavior Checklist
Structured interviews were held with each child in the experimental program immediately following a music activity session. Data on each child was compiled from these reports.

Structured Interview—Number 1. This consisted of six questions aimed at probing the feelings of the subjects towards the music activity sessions. It gave the analyst additional information regarding the personality of the individual (Figure 2). It was used at the end of the first week of music and every two weeks following.

Structured Interview—Number 2. This was designed to help in determining both the background and the interest of the child in music. Sixteen questions dealt with the child's training in music; thirty-four were designed to show how much information he had about music. Fifty items covered all types of music (Figure 3). It was possible for the child to give a "yes" answer to all of the

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did you like what we did today?</td>
<td></td>
</tr>
<tr>
<td>2. What (did - didn't) you like?</td>
<td></td>
</tr>
<tr>
<td>3. Did you like what we did today better than the last time? Why or why not?</td>
<td></td>
</tr>
<tr>
<td>4. Why do you think you were chosen for this experiment?</td>
<td></td>
</tr>
<tr>
<td>5. How did the music make you feel today?</td>
<td></td>
</tr>
<tr>
<td>6. Do you think this will help you to act better this afternoon?</td>
<td></td>
</tr>
</tbody>
</table>

---

**GUIDE FOR STRUCTURED INTERVIEW TO DETERMINE MUSIC BACKGROUND AND MUSIC INTEREST**

Introduction: For a few minutes I want to talk with you about music. I will ask a few questions that will help you show me what you like about music. Remember that I want to know about any kind of music that you have heard.

**PART A**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. (a) Do you like music in school?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(b) Do you sing?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(c) Do you play rhythm instruments?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(d) Do you have a musical instrument in your home?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(e) Do you take lessons on any musical instrument?</td>
<td></td>
</tr>
<tr>
<td>2. Do you sing in church or Sunday School?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Do you sing at a party when other children sing?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Can you tell me the words to any song?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. Do you have a favorite radio or TV musical program?  

6. Do you play the jukebox when you are in a restaurant?  

7. (a) Do you have a record player and records?  
(b) Do you play them every day?  

8. (a) Do you remember hearing any music yesterday or today?  
(b) Can you tell me the name of the piece?  

9. (a) Can you remember any musical program which you attended?  
(b) Do you remember the music that was played or sung on this program?  

**TOTALS**  

**ADJUSTED SCORE**  
(Score equals total of yes answers minus total no answers)

### PART B

1. Here is a list of some famous music names. Can you tell me about them?  

<table>
<thead>
<tr>
<th>Name</th>
<th>Yes</th>
<th>No</th>
<th>Name</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pat Boone</td>
<td></td>
<td></td>
<td>Tschaikowsky</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perry Como</td>
<td></td>
<td></td>
<td>Debussy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elvis Presley</td>
<td></td>
<td></td>
<td>Bach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tommy Sands</td>
<td></td>
<td></td>
<td>Beethoven</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dinah Shore</td>
<td></td>
<td></td>
<td>Brahms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patti Page</td>
<td></td>
<td></td>
<td>Victor Herbert</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eddie Fischer</td>
<td></td>
<td></td>
<td>Sousa</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burl Ives</td>
<td></td>
<td></td>
<td>Mozart</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Here are some words that we use in music. Can you tell me what they mean?  

<table>
<thead>
<tr>
<th>Word</th>
<th>Yes</th>
<th>No</th>
<th>Word</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>high</td>
<td></td>
<td></td>
<td>soft</td>
<td></td>
<td></td>
</tr>
<tr>
<td>low</td>
<td></td>
<td></td>
<td>loud</td>
<td></td>
<td></td>
</tr>
<tr>
<td>fast</td>
<td></td>
<td></td>
<td>fiddle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>slow</td>
<td></td>
<td></td>
<td>licorice stick</td>
<td></td>
<td></td>
</tr>
<tr>
<td>harmonica</td>
<td></td>
<td></td>
<td>tom-tom</td>
<td></td>
<td></td>
</tr>
<tr>
<td>guitar</td>
<td></td>
<td></td>
<td>chord</td>
<td></td>
<td></td>
</tr>
<tr>
<td>march</td>
<td></td>
<td></td>
<td>soprano</td>
<td></td>
<td></td>
</tr>
<tr>
<td>lullaby</td>
<td></td>
<td></td>
<td>bass</td>
<td></td>
<td></td>
</tr>
<tr>
<td>piano</td>
<td></td>
<td></td>
<td>ukelele</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

|              |     |    | Total           |     |    |

### PART C

Summary by Interviewer: (Suggestions—(1) Allow the interviewee to enlarge his answers if he desires, or if it is thought that a more nearly accurate picture can be gained. (2) At times it may be necessary to encourage him to talk more by asking additional clarifying questions. (3) Describe the interview, making some estimate of the interviewee’s interest in music by noting his willingness to respond to questions, etc.)  

Interviewer:  

---

**FIGURE 3. Structured Interview II**
items without having had formal training in music. An interview score was obtainable by a simple counting of yes-no answers. It was known that a high score does consistently indicate both a richer background and a higher interest in music. This interview was based upon a questionnaire published by the Kansas Rehabilitation Center for the adult blind.

The Musical Activities

In building a program of individual music experiences for the disturbed children, it was necessary for the music specialist to have certain general and specific knowledge about the musical interests of each child. The structured interview, designed to indicate specific interests, and a general information sheet were employed as tools to collect the needed data. From the collected data, provision was made for a varied program of musical and related activities emphasizing rhythms, listening, singing, playing of instruments, and creative self-expression.

The following criteria were used in structuring the individual programs of music experiences: (1) Developing of social awareness, (2) Providing for emotional release, (3) Building feelings of security, (4) Stimulating communication, (5) Increasing the span of attention, (6) Helping the child accept limits, (7) Fostering satisfactory interpersonal relationships, (8) Bringing about body release through rhythms, (9) Channeling latent music abilities, and (10) Releasing creative self-expression through music.

The extent to which each child achieved these goals depended on his specific deviancy, the therapeutic and experimental approach to his problem, a dynamic music program in terms of needs, interest, and aptitudes of the individual and projects carried over from the music session into the school classroom, home, and community.

Case Reports

Pair 1
Observations During Musical Activities

Subject, a very quiet child, displayed facial expressions and used one-syllable words to indicate that he enjoyed the recorded

---

musical selections during the first session. He became physically involved, danced, beat the bongos and other rhythm instruments, during the second through the fifth sessions. During the remaining sessions, he sang (out of tune) loudly, giggled, and seemed to express freely his likes and dislikes in music. The behavior checklist, marked by the classroom teacher, indicated an ambivalent behavior pattern—see-sawing from aggressive to regressive behavior traits in the classroom situation.

**Classroom Behavior Patterns**

**Experimental.** This boy seemed withdrawn and unable to concentrate. He was nervous and jumpy at times. His total number of acts is not large, but they decreased after musical activities. His predominant trait of withdrawal almost completely disappeared at the close of this study.

This is substantiated by the following data from the behavior checklist:

<table>
<thead>
<tr>
<th>Time</th>
<th>No. of Acts</th>
<th>Predominant Acts</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before:</td>
<td>5</td>
<td>Withdrawing</td>
<td>5</td>
</tr>
<tr>
<td>During:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd week</td>
<td>6</td>
<td>Jumpy, confused</td>
<td>5</td>
</tr>
<tr>
<td>5th week</td>
<td>7</td>
<td>Withdrawing</td>
<td>4</td>
</tr>
<tr>
<td>(4 days)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8th week</td>
<td>0</td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

**Control.** At the beginning of this study, the subject showed tendencies of carelessness and inattention. There was a constant pattern throughout the entire study of work carelessly done and not completed. The total acts showed a very gradual decrease, but the work pattern remained the same.

This is evidenced by the checklist as follows:

<table>
<thead>
<tr>
<th>Time</th>
<th>No. of Acts</th>
<th>Predominant Acts</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before:</td>
<td>34</td>
<td>1. Talking out of turn</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Work not done</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Disturbing others</td>
<td>4</td>
</tr>
<tr>
<td>During:</td>
<td></td>
<td>1. Disturbing others</td>
<td>7</td>
</tr>
<tr>
<td>3rd week</td>
<td>14</td>
<td>2. Wasting time</td>
<td>4</td>
</tr>
<tr>
<td>(4 days)</td>
<td></td>
<td>1. Talking out of turn</td>
<td>8</td>
</tr>
<tr>
<td>5th week</td>
<td>20</td>
<td>2. Careless work</td>
<td>4</td>
</tr>
<tr>
<td>(4 days)</td>
<td></td>
<td>3. Work not done</td>
<td>4</td>
</tr>
<tr>
<td>8th week</td>
<td>16</td>
<td>Work not done</td>
<td>5</td>
</tr>
</tbody>
</table>
Observations During Musical Activities

The behavior of this subject, an extremely aggressive boy, indicated a decrease in his demands for attention during the music sessions. He freely engaged himself in rhythmic activities during every session, but it wasn’t until the last session that he listened quietly to anything (e.g. one stanza of the "Battle Hymn of the Republic"). The behavior checklist, marked by the classroom teacher, indicated a drop of from 22–23 per cent to 3.6 per cent aggressive behavior.

Classroom Behavior Patterns

Experimental. This subject showed an unusually large number of aggressive acts during both the pretherapy and therapy periods. He disturbed others innumerable times in various ways. Toward the end of the study, however, his aggressiveness changed. There was an increase in time wasted and in carelessness. The behavior checklist indicated this, as follows:

<table>
<thead>
<tr>
<th>Time</th>
<th>No. of Acts</th>
<th>Predominant Acts</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before:</td>
<td>88</td>
<td>1. Disturbing others</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Restless in seat</td>
<td>8</td>
</tr>
<tr>
<td>During:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd week</td>
<td>96</td>
<td>1. Talking out of turn</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Disturbing others</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Restless in seat</td>
<td>10</td>
</tr>
<tr>
<td>5th week</td>
<td>35</td>
<td>1. Work not done</td>
<td>16</td>
</tr>
<tr>
<td>(4 days)</td>
<td></td>
<td>2. Wasting time</td>
<td>9</td>
</tr>
<tr>
<td>8th week</td>
<td>54</td>
<td>1. Work not done</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Careless work</td>
<td>11</td>
</tr>
</tbody>
</table>

Control. This subject demonstrated many and varied types of aggressive behavior. He seemed to be especially careless with property belonging to others. Throughout the study, there was a repetitive pattern of such aggression.

This was verified by the behavior checklist, as follows:

<table>
<thead>
<tr>
<th>Time</th>
<th>No. of Acts</th>
<th>Predominant Acts</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before:</td>
<td>32</td>
<td>1. Restless in seat</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Wasting time</td>
<td>5</td>
</tr>
<tr>
<td>During:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd week</td>
<td>51</td>
<td>1. Careless with property</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Disorderly</td>
<td>7</td>
</tr>
<tr>
<td>5th week</td>
<td>15</td>
<td>1. Restless in seat</td>
<td>4</td>
</tr>
</tbody>
</table>
Observations During Musical Activities

Subject, an aggressive, intelligent boy, exhibited signs of wanting to be accepted by the therapist by sharing choice "tid-bits" of musical information that he had acquired over a period of years. During the first three sessions, he verbalized constantly about the musical stimuli presented to him. He gradually decreased his verbalization and increased his physical participation by beating on the bongos, by dancing, and singing. The classroom teacher noted a similar trend in his classroom behavior.

Classroom Behavior Patterns

Experimental. In the period before the experiment started, the subject was very tense and very demanding of attention. He talked out of turn a great deal in order to receive attention. This aggressiveness lessened during this study, and in the afternoons immediately following music, the classroom teacher reported that he was much more relaxed.

These facts are substantiated by the following data from the behavior checklist:

<table>
<thead>
<tr>
<th>Time</th>
<th>No. of Acts</th>
<th>Predominant Acts</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before:</td>
<td>35</td>
<td>Talking out of turn</td>
<td>14</td>
</tr>
<tr>
<td>During:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd week</td>
<td>18</td>
<td>Talking out of turn</td>
<td>10</td>
</tr>
<tr>
<td>5th week</td>
<td>2</td>
<td>Careless work</td>
<td>1</td>
</tr>
<tr>
<td>(4 days)</td>
<td>0</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>8th week</td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Control. This subject had many and various aggressive acts each week at the beginning of the study. He was rude, made unnecessary noises, and, in other ways, displayed aggressive behavior in order to attract attention. The number of overt acts lessened considerably toward the end of the study.

The behavior checklist shows this, as follows:

<table>
<thead>
<tr>
<th>Time</th>
<th>No. of Acts</th>
<th>Predominant Acts</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before:</td>
<td>16</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Unacceptable noise</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Attracting attention</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Restless</td>
<td>2</td>
</tr>
</tbody>
</table>
Observations During Musical Activities

The subject started his musical activities by enthusiastically sharing his favorite Elvis Presley records with the music therapist. After running out of his “good” music, he politely and quietly participated in anything that was set up for stimuli. He listened, danced, beat the drums, and sang without offering any comments until the last session. At this session, he shyly suggested that he could play his clarinet. (The music specialist had requested this at an early session, but the subject did not respond until the last session.) After playing the clarinet, he started to talk intensively and enthusiastically, and freely participated in the other activities. The behavior chart, checked by the classroom teacher, indicated a trend from aggressive to normal behavior patterns in the classroom situation.

Classroom Behavior Patterns

Experimental. During the pre-experimental period, this subject displayed a varied number of overt acts. During the first half of the study, the number remained fairly constant. The most common behavior patterns were discourtesy or acts of rudeness. However, toward the end of the study, although aggressive behavior was still displayed, the number of acts decreased sharply, except for the final week.

The behavior checklist confirms this, as follows:

<table>
<thead>
<tr>
<th>Time</th>
<th>No. of Acts</th>
<th>Predominant Acts</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before:</td>
<td>19</td>
<td>Before:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Talking out of turn</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Attracting attention</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Talebearing</td>
<td>3</td>
</tr>
<tr>
<td>During:</td>
<td></td>
<td>During:</td>
<td></td>
</tr>
<tr>
<td>3rd week</td>
<td>28</td>
<td>1. Talebearing</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Attracting attention</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Discourteous</td>
<td>4</td>
</tr>
<tr>
<td>5th week</td>
<td>4</td>
<td>5th week</td>
<td>Inattentive</td>
</tr>
<tr>
<td>(4 days)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8th week</td>
<td>14</td>
<td>8th week</td>
<td>1. Talking out of turn</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. Discourteous</td>
</tr>
</tbody>
</table>
Control. Previous to the study, a great variety of aggressive acts was displayed. This number remained quite constant during the complete study. One of the most predominant behaviorisms exhibited was “out of seat without permission,” but other overt acts to attract attention showed a constant trend.

The behavior checklist shows the following total number of acts and the predominant ones:

<table>
<thead>
<tr>
<th>Time</th>
<th>No. of Acts</th>
<th>Predominant Acts</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before:</td>
<td>34</td>
<td>Before:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Restlessness in seat</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Out of seat</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Attracting attention</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Talking out of turn</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Inattentive</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. Talebearing</td>
<td>5</td>
</tr>
<tr>
<td>During:</td>
<td>36</td>
<td>During:</td>
<td></td>
</tr>
<tr>
<td>3rd week</td>
<td></td>
<td>1. Disobedience</td>
<td>8</td>
</tr>
<tr>
<td>5th week</td>
<td>15</td>
<td>2. Discourteous</td>
<td>6</td>
</tr>
<tr>
<td>(4 days)</td>
<td></td>
<td>Attracting attention</td>
<td>5</td>
</tr>
<tr>
<td>8th week</td>
<td>15</td>
<td>1. Attracting attention</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Quarrelsome</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Acting silly</td>
<td>5</td>
</tr>
</tbody>
</table>

Pair 5

Observations During Musical Activities

Subject, a realistic child, freely participated in the musical activities of listening (rock 'n' roll), dancing (simple folk dances), and beating on rhythm instruments during the first three sessions. During the fourth and fifth sessions, he assumed the role of the therapist, carefully watching an adult reaction to a group of antisocial records (e.g. Charlie Brown). When he discovered adult acceptance “of his choice in recordings,” he resumed his free participation and exploration of multimusical experiences. His behavior chart, checked by the classroom teacher, indicated a regressive period during his “therapist role playing,” with a tremendous upward aggressive swing upon “acceptance.”

Classroom Behavior Patterns

Experimental. Before the study, this subject displayed such regressive acts as withdrawal and inattention. He was quite self-centered and showed introvertive tendencies. The number of
acts was fairly low and constant throughout the entire study. There was a gradual change from regressive to aggressive behavior.

This is evidenced by the data from the behavior checklist, as presented below:

<table>
<thead>
<tr>
<th>Time</th>
<th>No. of Acts</th>
<th>Predominant Acts</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before</td>
<td>11</td>
<td>Before:</td>
<td>1.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Withdrawing</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Inattentive</td>
<td>3</td>
</tr>
<tr>
<td>During</td>
<td></td>
<td>During:</td>
<td></td>
</tr>
<tr>
<td>3rd week</td>
<td>0</td>
<td>3rd week</td>
<td>0</td>
</tr>
<tr>
<td>5th week</td>
<td>11</td>
<td>5th week</td>
<td>1.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Concern for self</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Withdrawing</td>
<td>4</td>
</tr>
<tr>
<td>8th week</td>
<td>11</td>
<td>8th week</td>
<td>1.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Attracting attention</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Acting silly</td>
<td>5</td>
</tr>
</tbody>
</table>

Control. This subject showed a constant yet conflicting pattern of aggressive and regressive behavior. He showed a great deal of withdrawal, but also attracted much attention by acting silly and talking out of turn.

His behavior checklist indicated this, as follows:

<table>
<thead>
<tr>
<th>Time</th>
<th>No. of Acts</th>
<th>Predominant Acts</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before</td>
<td>22</td>
<td>Before:</td>
<td>1.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Talking out of turn</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Careless with property</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Acting silly</td>
<td>5</td>
</tr>
<tr>
<td>During</td>
<td></td>
<td>During:</td>
<td></td>
</tr>
<tr>
<td>3rd week</td>
<td>16</td>
<td>3rd week</td>
<td>1.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Withdrawing</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Acting silly</td>
<td>5</td>
</tr>
<tr>
<td>5th week</td>
<td>16</td>
<td>5th week</td>
<td>1.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Disturbing others</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Careless with property</td>
<td>4</td>
</tr>
<tr>
<td>8th week</td>
<td>12</td>
<td>8th week</td>
<td>1.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Inattentive</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Acting silly</td>
<td>5</td>
</tr>
</tbody>
</table>

Pair 6

Observations During Musical Activities

This girl, an extremely negativistic, quiet child, displayed slight signs of facial expressions and foot tapping to indicate that she liked the highly rhythmical, recorded music during the first session. During the second session, she became physically involved, danced the Irish jig, smiled slightly, and uttered guttural sounds to express her enjoyment. In the following two sessions, she aided the music specialist, at the latter's suggestion, in setting up the phonograph. She beat the bongo drums, tapped other rhythm instruments, whistled tunes softly, and danced simple folk dances.
with the music specialist. During the remaining sessions, after listening to vocal recordings, she progressed from singing undistinguishable words and tunes to singing expressive tones and understandable words. The behavior patterns, as recorded by the classroom teacher, indicated a similar trend. The subject seemed to be exhibiting more outgoing behavior in the classroom situation.

Classroom Behavior Patterns

Experimental. The subject's behavior at the beginning of this study was extremely negativistic and withdrawn. She evidenced only regressive actions for several weeks. Gradually, she became more outgoing and aggressive in her behavior. The predominant act of withdrawal almost completely disappeared.

The behavior checklist indicated a fairly constant number of total weekly acts, as follows:

<table>
<thead>
<tr>
<th>Time</th>
<th>No. of Acts</th>
<th>Predominant Acts</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before:</td>
<td>5</td>
<td>Withdrawal</td>
<td>5</td>
</tr>
<tr>
<td>During:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd week</td>
<td>1</td>
<td>Withdrawal</td>
<td>4</td>
</tr>
<tr>
<td>5th week</td>
<td>1</td>
<td>Withdrawal</td>
<td>1</td>
</tr>
<tr>
<td>(4 days)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8th week</td>
<td>5</td>
<td>Attracting attention</td>
<td>5</td>
</tr>
</tbody>
</table>

Control. This subject showed an almost constant pattern of such aggressive acts as attracting attention and being quarrelsome.

The number of acts did not materially decrease, as evidenced by the behavior checklist:

<table>
<thead>
<tr>
<th>Time</th>
<th>No. of Acts</th>
<th>Predominant Acts</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before:</td>
<td>19</td>
<td>1. Quarrelsome</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Attracting attention</td>
<td>5</td>
</tr>
<tr>
<td>During:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd week</td>
<td>28</td>
<td>1. Quarrelsome</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Attracting attention</td>
<td>5</td>
</tr>
<tr>
<td>5th week</td>
<td>6</td>
<td>Attracting attention</td>
<td>3</td>
</tr>
<tr>
<td>(4 days)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8th week</td>
<td>10</td>
<td>1. Inattentive</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Acting silly</td>
<td>5</td>
</tr>
</tbody>
</table>

Pair 7

Observations During Musical Activities

This compulsive-acting girl was very inconsistent in her behavior during the music sessions. During the first three meetings, her aggressive actions gradually decreased. However,
during the fourth and fifth sessions, her aggressive responses increased; but during the last three meetings, aggressive signs decreased. The same trend applied to her classroom behavior as tabulated by the classroom teacher.

**Classroom Behavior Patterns**

*Experimental.* The subject displayed a large number of aggressive acts before this study. She was inattentive and unusually restless. At the end of the study, the number of acts dropped off sharply. The classroom teacher reported that she seemed much more relaxed and calm.

The behavior checklist substantiated the above facts as follows:

<table>
<thead>
<tr>
<th>Time</th>
<th>No. of Acts</th>
<th>Predominant Acts</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before:</td>
<td>43</td>
<td>Before:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Inattentive</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Restless</td>
<td>8</td>
</tr>
<tr>
<td>During:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd week</td>
<td>12</td>
<td>1. Wasting time</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Inattentive</td>
<td>7</td>
</tr>
<tr>
<td>5th week</td>
<td>26</td>
<td>1. Inattentive</td>
<td>7</td>
</tr>
<tr>
<td>(4 days)</td>
<td></td>
<td>2. Out of seat</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Work not done</td>
<td>4</td>
</tr>
<tr>
<td>8th week</td>
<td>2</td>
<td>1. Wasting time</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Inattentive</td>
<td>0</td>
</tr>
</tbody>
</table>

*Control.* The subject displayed a similarly large number of aggressive acts in the pre-experimental period. She wasted time, and her work was either carelessly done or not completed. While these acts decreased somewhat toward the end of the study, the subject continued to display the same type of aggression.

This was indicated by the following data based on the weekly checklist:

<table>
<thead>
<tr>
<th>Time</th>
<th>No. of Acts</th>
<th>Predominant Acts</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before:</td>
<td>36</td>
<td>Before:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Wasting time</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Work not done</td>
<td>4</td>
</tr>
<tr>
<td>During:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd week</td>
<td>22</td>
<td>1. Work not done</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Inattentive</td>
<td>5</td>
</tr>
<tr>
<td>5th week</td>
<td>4</td>
<td>3. Careless work</td>
<td>4</td>
</tr>
<tr>
<td>(4 days)</td>
<td></td>
<td>Work not done</td>
<td>2</td>
</tr>
<tr>
<td>8th week</td>
<td>11</td>
<td>1. Talking out of turn</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Careless work</td>
<td>3</td>
</tr>
</tbody>
</table>
CONCLUSIONS

Since the control group added very little, if any, to our ability to judge progress, it would seem that the growth or differences in the behavior of the individual child are a better criteria than trying to match him with another child. This is particularly true when there are so many variables. Our conclusions, therefore, are based on the changes in behavior exhibited by subjects in the experimental group.

1. Children with withdrawing tendencies seemed to become more outgoing both in the musical activity session and in the classroom. Whether this trend would continue, is speculative.

2. There was not much evidence that the overt actions of a child of normal intelligence were quieted by the musical activities, but his aggressive behavior seemed to take a different form.

3. The music had a quieting effect on the acting-out, mentally retarded child.

4. In the child who was not deeply disturbed, but who was under pressures to achieve, the musical activity sessions seemed to afford relaxation and release from some of the pressures.

5. It was difficult to determine whether it was the specific music activity that was beneficial, or whether it was the personal attention the child received.

LIMITATIONS

1. The length of time involved in the study was so limited that no conclusive evidence can be presented. However, certain trends appear which indicate a need for further study.

2. The number of subjects was too small to warrant any predictions regarding the value of such a program on a large-scale basis.

3. The emotional disturbances exhibited by some of the subjects were so deep seated that careful and long-range planning was indicated for certain of these individuals. The musical activity program might be used as an adjunct to therapy, if qualified personnel feel that this plan has merit.

4. The personalities of the teachers involved in rating the behavior of the pupils might be considered a limiting factor. However, such limits were eliminated as much as possible through
a careful selection of the teachers and through using a control group of pupils.

5. The home and daily influences on the child tend to reflect in his behavior at school. Therefore, one might question the daily behavior pattern in the light of what factor or factors caused him to react as he did on a given day.
INTRODUCTION

Since the earliest days of mankind, music has played a profound part in his everyday individual and communal existence. The power and fascination of music lies in its potentiality to influence the emotions and passions, and this is apparent today from the most primitive Zulu War Dance to the most modern symphonic overture.

From the foundation of mental hospitals, the value of music as an agent of entertainment in the form of concerts and dances has been appreciated and applied. In recent years this has been expanded by the introduction of radio and television to mental hospital wards and by the realization that concerts by highly skilled musicians are of special benefit. The services of such artists are now available in this country through the auspices of The Council for Music in Hospitals. In the United States, the Guild of St. Cecilia is said to have "organized curative concerts for the Mental Hospitals" at the end of the last century. During the last few decades music therapy has been introduced in many mental hospitals in the United States, with its application to large assemblies of patients, to small groups in hospital wards, and to individual patients. Favorable results have been published by numerous writers. In comparison with the United States, Great Britain lingered behind in this project. Nevertheless, Mitchell and Zanker² stressed the value of inducing certain patients to participate in musical production themselves instead of always being a passive audience, and Zanker and Glatt,³ at Warlingham Park Hospital, have investigated the value of music in the treatment of groups of neurotic and of alcoholic patients.

Music therapy was introduced to St. Bernard's Hospital in February, 1955, when a music therapist first joined the staff. We

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1. Report of a project conducted at St. Bernard's Hospital, Southall, Middlesex, England.
decided to use the following activities: group singing, percussion band, music appreciation classes, music therapy on small groups of six to ten patients, and individual music therapy. Our observations and investigations confirmed the opinion of other psychiatrists that group musical activities have a definite place in the modern therapeutic armatorium although we stressed the importance of the multi-dimensional therapeutic perspective in assessing their real value in relationship to other forms of treatment. During this time we became particularly interested in the results we obtained from individual music therapy and since then have focussed our attention in particular on this aspect of the treatment.

This paper is devoted to a description of our investigations into individual music therapy and the results we have obtained.

RATIONALE

The Promises of Individual Music Therapy

Before we commenced individual music therapy in 1955, we considered the generally accepted ways in which music may affect any ordinary individual, and these we summarized as follows: 5

1. Music of all categories may produce pleasure to the listener by merely being heard.
2. Rhythmic music is the basis for the deep satisfaction experienced from the various types of dancing, and other rhythmic movements.
3. Certain compositions can arouse emotion and produce feelings of exhilaration and excitement.
4. Some pieces have a soothing and relaxing effect upon mind and body.
5. Certain music can stimulate the imagination and give rise to new thoughts.
6. Some tunes may revive past memories, either pleasurable or painful.
7. Some people enjoy the study of music as a subject and thereby increase their knowledge of the works of composers and of the theory of music.

8. Participation in the production of music in one form or another has produced in the majority of human beings a feeling of great satisfaction. In a few persons satisfaction is obtained from individual performances, but group activities are favored by the majority. In either case an elevating feeling of accomplishment is prompted by those taking part in these activities and an attendant feeling of social fellowship is experienced.

We decided to apply these potentialities to individual patients. Patients were selected by the psychiatrist for individual music therapy to attain one of these specific reactions. The case was then discussed with the music therapist and the objective explained. The patient then attended music therapy for three-quarter hour sessions twice a week, and the technical use of music was left entirely to the discretion of the therapist. Almost without exception, the desired end was achieved within a few sessions, and this was found to be particularly important in those cases receiving psychotherapy. It soon became evident that during the inevitably fluctuating emotional state of a patient undergoing psychotherapeutic treatment the desirable objectives changed, from one session to another.

This initial period of approximately two years of reconnaissance led us to the tentative conclusion that individual music therapy has potentialities as a valuable adjunct to individual psychotherapy and Dr. Werner willingly agreed to join us in a further, wider, and more thorough investigation. The procedure we adopted was as follows: after the psychiatrist had discussed a selected case with the music therapist, sessions (once or twice per week) were allotted to the music therapist. Each session took place in the music therapy room, which has a fireplace, three large windows, and is quite pleasantly decorated in pastel shades. It contains several arm chairs, a comfortable couch, a Steinway grand piano, and an electric phonograph with an ample supply of records. The atmosphere of the room is a warm, friendly one conducive to relaxation on the part of the patient. It is in this atmosphere that the sessions, each of three-quarter hour’s duration, took place with only an individual patient and the music therapist present in the room.

The music therapy sessions involved not merely the playing of music by the music therapist, but friendly chats and discussions if
the patients felt so inclined. These often resulted in the patients telling the therapist about their worries, troubles, and symptoms. She listened carefully and sympathetically while being careful never to give advice or interpretation. A description of the relevant material divulged was forwarded by the therapist to the psychiatrist concerned. Careful interrogation of the patients by the psychiatrists confirmed that in all successful cases a strong degree of rapport had been established between the music therapist and the patient, and it was difficult to assess the proportionate benefit obtained from the music itself and from the satisfactory interpersonal relationship prevailing.

The question arose whether an adverse effect would result from the same patient having some degree of transference with the music therapist as well as with the psychotherapist. The theoretical disadvantage of this situation from the strictly psychoanalytic viewpoint would cause many psychotherapists to deem the use of individual music therapy unwarranted. However, our experience over the previous twelve years, as psychiatrists treating patients in a mental hospital by psychotherapy, had led us long before to the belief that the welfare of such patients depends not merely on the affective relationship between the patient and the psychotherapist but on the relationship between him and the whole therapeutic team—psychotherapist, ward psychiatrist, art therapist, occupational therapist and ward sisters—and that success is only achieved when close collaboration and understanding exist between members of this team. We, therefore, had no misgiving in the addition of a music therapist to the team, despite the fact that the circumstances of individual music therapy are calculated to produce stronger emotional relationships between the patient and the music therapist than between him and other members of the team (with the possible exception of the psychotherapist).

Contrary to the opinion expressed by some authorities that certain musical compositions always produce certain definite changes of mood, we found that individual patients varied in their reactions to any one composition and that any one patient could vary from time to time in his individual reactions to the same piece of music. Moreover, variation of tempo and technique in playing a specific composition could produce a variation of emotional response in an individual patient, and finally, responses varied to the same composition rendered on the piano by the
music therapist or on a phonograph record by an orchestra. Thus, the results we obtained depended not on the simple deterministic principle of a predetermined definite response to a specific composition, but on the technique applied by the music therapist, which called for a skillful variation of the music used at each session according to the patient's mental condition and the objective to be achieved. We decided to continue this technique and to observe its value in relationship to full psychotherapy, despite the disadvantage that the results obtained could obviously not satisfy the requirements of strictly scientific tests.

An Adjunct to Individual Psychotherapy

Our theoretical knowledge regarding the effect of auditory stimuli on human beings is still rather scanty. We do not yet know the degree to which rhythm, pitch, timbre, and volume of music are important in producing the various emotional tones we experience from music. Music leads to measurable physiological reactions (pulse, respiration) and, if the James-Lange theory holds, these physical reactions must have their emotional concomitant which vary over a large range. It seems to us that music may, from the psychotherapeutic viewpoint, lead to emotional catharsis, to self-expression and to evoking subjective experience. It is the language of feelings; it is revealing where words are often obscuring; its wordless meaning gives music its potency and value as a means of communication, allowing an expression of feeling which is beneficial as well as socially acceptable. Man is not hesitant to express in music thoughts and conceptions which he is unwilling to express in words. Furthermore, music affords a milieu of “closeness,” emotional as well as physical—an intimacy which does not threaten and which arouses no apprehension. In our culture most music seems to derive from the so-called tender emotions such as love in all its aspects, sympathy, altruism, wonder, on which great value is placed by our society. Therefore, music arouses what may be at low ebb in patients—namely some or another of the various manifestations of love. Music may, and generally does, mean something different for each listener, and it may arouse different imagery in different individuals, depending on their life circumstances and background.

From the psychoanalytic point of view one can correlate the effects of music on any person with those on his Id, Ego, and
Superego. An example of music's effect on the Id is seen in the power of rhythm to satisfy unconscious drives as evidenced by the rocking rhythmic movements of children or of regressed schizophrenics on the one hand, and by the ecstatic rituals of primitive tribes on the other hand. The sense of mastery achieved in playing music is an example of an effect on the Ego. In the everyday life of the ordinary man, the ethical and moral codes to which he adheres are imposed by his Superego. Music offers an opportunity to sublimate into the field of aesthetics, his desires to escape from these moral obligations.

Individual psychotherapy has been carried out by us in this hospital for over ten years with considerable success. The question we now posed for investigation was: could the effects of music therapy assist the psychotherapist in such a manner as to curtail the duration of the psychotherapy required and improve the qualities of remission obtained.

We decided that selected patients (all of them females by administrative necessity) who would receive individual psychotherapy twice a week would also each have a music therapy session twice a week. In as many cases as practically possible (which amounted to about fifty per cent of all our cases) the music session was timed to precede immediately the psychotherapeutic session. That is, the patient proceeded straight from the music session to the psychotherapist. The psychotherapist then discussed the music listened to (or played by some of the patients who were pianists) and the feelings aroused. With other patients, where the sessions were not approximately synchronized, the music therapist forwarded a report to the psychotherapist after each session regarding the patient's reactions, statements, and conversation. One objective was to find out whether either or both of these methods provided material of psychotherapeutic value.

Techniques of the Music Therapist

Consultation. When a patient is referred for music therapy the first step is a consultation between the psychotherapist and the music therapist. At this meeting the psychotherapist explains what he hopes to achieve through the use of music. This may be one or more of the objectives listed above. All the necessary information about the case history is given, together with any relevant advice in approaching the patient. It is also decided how
many music sessions a week are likely to be useful (two three-quarter hour periods are the maximum possible) and arrangements are made for exchange of information about the patient’s progress or otherwise.

**Technique.** First, it is necessary to obtain the confidence of the patient, who is frequently nervous and ill at ease when facing a new experience with an unknown person. There is usually a need to stress that musical knowledge and lack of ability to play an instrument are irrelevant. Popular or classical music is selected initially according to the patient’s taste, though possibly varied later on as occasion demands. During the first session, however, it is advisable to play music which has happy associations for the patient. A cup of tea and a cigarette also may help to overcome initial embarrassment.

At this early stage it is usually helpful to explain what we (the staff) think music can do to help people and how we hope these sessions will benefit the patient. It is made quite clear that the psychiatrist is the senior partner and any difficulties arising in the music room which are insoluble will be dealt with by him later. This encourages confidence in the team aspect of the work which becomes progressively more important as the patient’s relationship to the psychiatrist and the music therapist changes in emphasis.

Since music in these circumstances is likely to have a powerful emotional effect, it is necessary in the early sessions to lay a foundation of trust in the music therapist’s ability to honor confidence; to explain that as a member of the psychiatric team her confidence is binding just as much as that of the psychiatrist. Information which has been forgotten, or deliberately withheld from people in authority, is often forced to the surface. The patient must be urged to tell the psychiatrist such things herself on occasions when this has not been done—away from the protective atmosphere of the music room which is regarded frequently in the light of a sanctuary from the more exposed life in wards and clinics. This idea of the music room should be encouraged, both by its physical position and its atmosphere, since it is a most valuable asset not only to the individual patient, but to the hospital population as a whole.

Having first established a friendly relationship and confidence in the team’s determination to help in every way possible, it is
then time to start working towards the chosen objective. In the course of treatment the patient can become very much upset. If it proves impossible to calm her by the end of the session it may be necessary to take her over to the Ward Sister and explain the circumstances. Fears and horrors aroused by the music may prove difficult to allay and sometimes recur at night. On the other hand, relaxation induced in the music room is seldom maintained longer than a few hours and often for much shorter periods.

Where tension is the main difficulty, if one can give a patient the experience of relaxing while listening to music it becomes possible to build on that experience, week by week, until she has confidence in the possibility of obtaining relief—at least in the music room. The procedure is usually to get the patient to lie on the couch, teach her to relax the big, main groups of muscles and then work on those with which there is special difficulty. Similarly, breathing can be controlled and deepened in conjunction with rhythm (improvisation on the piano) working from the present normal rate. The aim is first awareness and control of physical responses so that this may lead to a certain control of mental processes. Later on this should be extended to cover all everyday activities. The patient should be encouraged to appreciate that she is in fact doing all these things herself; that she will be able to achieve this relaxation for herself in due course, but that it is likely to be easier if she has access to a phonograph and the means of acquiring a few records. This is an important aspect of music therapy later when the patient is well enough to go home but still needs some support. On leaving the hospital she is given a list of music (with record catalogue numbers) which, in her own experience day by day, has brought relief and which she should then be able to use for herself at least between visits as an out-patient.

If a patient plays an instrument the same process can be initiated by teaching her how to use her executive ability to relax herself physically and mentally. This entails bringing herself into a state of awareness in relation to the instrument, herself, and the room, and later, possibly, the people at concerts to whom she is playing so that she may develop confidence in herself as a person with something of value to contribute. This is a valuable experience since she thereby acquires gradually a permanent technique
for dealing with some part of her difficulties by her own efforts. Apart from the obvious emotional relief, she gains self-confidence, becoming automatically less dependent on the help of the music therapist.

The importance of the last point can hardly be over-emphasized. No music therapist dealing with patients who are receiving psychotherapy can long remain unaware of the highly charged emotions which sway the patient during successive stages of treatment. Clearly it is beyond the competence of a music therapist to disentangle or interpret the excessive sway in feelings which may occur. It is sufficient here to say that the music therapist must be able to get advice from the psychiatrist on how to meet these conditions as successfully as possible. This may involve, at one end of the scale, becoming for a time the most important influence in the patient’s life, or, at the other, maintaining a calm, impersonal, but friendly relationship—an atmosphere of noninterference in which the patient feels she can rest secure without demands being made upon her. Such circumstances, of course, make very considerable demands on the music therapist and presuppose an absolute confidence between both members of the team in order that the psychiatrist may use the situation to the best advantage.

**Relationship Between Psychiatrist and Music Therapist.** The above illustrations have made clear the necessity for absolute confidence between the members of the team and the closest cooperation possible in the circumstances.

1. To instruct the music therapist so that the maximum advantage may be taken of any situation as it arises.
2. To avoid the music therapist unwittingly working against the psychiatrist, e.g., if the patient uses the friendly relationship with the music therapist destructively against the psychiatrist or vice versa.
3. To ensure that the music therapist should avoid developing strong views—remembering that this could operate disastrously against the patient’s best interests when working with psychiatrists who may have widely differing methods.

**Results**

During this investigation, which covered a period of two and a half years, we dealt with thirty female patients. This is not a vast figure but our numbers had to be limited because our music
Music Therapy 1959

therapist only attends the hospital on two days of each week, during which time she is concerned with group music therapy activities as well as with individual music therapy.

These are our honest beliefs based on our personal knowledge of the patients' life histories and psychiatric conditions, on our observations of their clinical progress during psychotherapy and music therapy sessions, and of their demeanor, behavior, and symptoms in their wards throughout their treatment in the hospital. Added to our observations are the patients' personal descriptions of their feelings towards music therapy and the effects it has produced upon them. In making a comparison between patients treated by psychotherapy and music therapy with those treated by the former alone, we have ten years experience on which to base our comparison. Our results and findings are as follows:

1. Without exception the patients enjoyed attending music therapy and most of them said it played a definite part in their improvement.

2. It was found that music could influence patients in all the ways we had anticipated, i.e., calming and relaxing effects, mollifying their resistances, etc.

3. The psychotherapists found that music therapy sessions immediately prior to psychotherapy sessions facilitated the emergence of repressed unconscious material which was of much psychotherapeutic value. It was worked through forthwith and this seemed in particular to increase the patients' insight. An analysis of the interpersonal relationship established by the patient and the music therapist was very significant and important with the clues it provided towards understanding the patients' psychopathology.

4. In those cases where interviews did not precede psychotherapy, the reports forwarded to the psychotherapists were valuable, but the value of the music therapy session seemed to be diminished by the interval before psychotherapy took place.

5. Some cases who had been treated with little effect for several weeks by the psychotherapist, started to show obvious improvement as soon as music therapy was combined with psychotherapy.

6. It was due chiefly to close cooperation between the psychotherapist and the music therapist and to the music therapist's understanding and sympathy, that there were only rare occasions
when our common work seemed temporarily threatened by the inherent instability of a three-person group.

7. As far as we could judge, patients treated with psychotherapy in combination with music therapy usually responded to treatment more rapidly and required total treatment of a shorter duration than those receiving psychotherapy alone.

8. Music therapy used for relaxation and pleasure acted as a valuable stop gap in the absence of the psychotherapist due to holiday leave or sick leave.

It is quite impossible to convey adequately the effect of music therapy in the above respects. Only personal observation of the patient at the time could demonstrate the effects thoroughly. Our few case histories given below will give some idea of the part music therapy played in the patients' progress.

Case Histories

Case No. 1. Mrs. X., age thirty-nine, had two months psychotherapy before she started music sessions. She was emerging from a schizophrenic-like episode with hallucinations and confusion—being still depressed and inclined to violent outbursts. Though obviously anxious to cooperate, she was unable to open up and became resistant to discussions of her past or her relations with her husband and her two daughters. The condition changed markedly after a few weeks of music therapy. Gradually a wealth of psychopathological material was revealed and the patient was stressing repeatedly that music made her remember events of the past and enabled her to speak about herself.

The case is an example of how a person with very average musical interest and no playing ability can be helped by music used as a therapy. It must be emphasized here that it would certainly not have been enough simply to play the music selected. The development and possible recession of her illness had to be anticipated (as far as possible), the music deliberately chosen for her according to her condition at a given moment (the actual interpretation matching the state of mind); and the effects of it used to carry the plan forward. Each situation had to be exploited as it arose and often—for this reason—music selected before the session had to be replaced by something more appropriate. This skill, if such it can be called, is acquired as a result of the experience of the person involved. It will, therefore, be
understood that this particular selection of music would not by any means necessarily be appropriate for another patient suffering from the same kind of illness.

The skeleton of the program, however, has been used in this hospital many times. In this work the technical musical factors are: (1) selection, (2) presentation, (3) persuasive playing, (4) exploitation of results arising from the first three. Failure to synthesize this process, not only session by session, but throughout the entire period of treatment in and out of hospital, entails a serious weakening of this form of therapy. The final and perhaps most important point to note is that in spite of the apparent success of this program (and others like it), under no circumstances could it have been effective in securing a remission of the illness by its own unaided effects.

At this point it may be helpful to give in some detail the step-by-step music therapy program of this patient who provides an illustration of what has happened many times in the experimental period covered by this paper. Mrs. X attended music therapy sessions over a period of thirteen months; twenty-two sessions while in the hospital, and nineteen as an out-patient.

1. **Inpatient:** A Selection of the Music Played During Twenty-two Music Therapy Sessions.

   A. **First Session:** Favorite Music. No appreciable effect.
      
      Debussy  Claire de Lune
      Chopin  Study, Op. 10, No. 9
      Chopin  Fantasia Impromptu

   B. **Relaxation:** 1. Building confidence in relationship with music therapist.
      
      Brahms  Intermezzo, Op. 76, No. 6
      Brahms  Intermezzo, Op. 118, No. 2
      Chopin  Berceuse, Op. 57
      Mozart  Minuets with Trios (KV 315a)
      Purcell  Air on a Ground Bass

   **Relaxation:** 2. First sign of real feeling.
      
      Chopin  Nocturne, Op. 15, Nos. 1 and 2
      Chopin  Sonata, Op. 35, Funeral March (middle section)
      Mendelssohn  Rondo Capriccioso, 1st Section
      Schumann  Sonata, Op. 22, Andante
      Schubert  Cradle Song
      Schubert  To Music

   C. **Turning Points:** 1. Dramatic uprush of suppressed material.
Berlioz  
*Te Deum*

Distress soothed.

Chopin  
*Nocturne*, Op. 15, No. 1

Debussy  
*Claire de Lune*

**Turning Points:** 2. High level volume to release suppressed aggression.

Bartok  
*Concerto for Orchestra*, 1st Mov.

Beethoven  
*Symphony No. 5*, Last Mov.

Tschaikowsky  
*Symphony No. 6*, 3rd Mov.

Ravel  
*Daphnis and Chloe* (2nd)

**Turning Points:** 3. To give sense of enjoyment.

Debussy  
*Claire de Lune*

Mendelssohn  
*Rondo Capriccioso*, 1st Section

Schumann  
*Sonata*, Op. 22, Andante and Scherzo

**D. To ascertain emotional response:** Degree and intensity of response (very marked) gauged only by personal experience of patient.

**Sadness**

Brahms  
*Intermezzos*, Op. 118, Nos. 1 and 6

**Peace**

Brahms  
*Intermezzo*, Op. 116, No. 3

**Excitement**

Chopin  
*Studies*, Op. 10, Nos. 9 and 12

**Tension**

Chopin  
*Study*, Op. 25, No. 7

de Falla  
*Pieces Espagnoles*, Andaluza

Mozart  
*Sonata in B Flat*, Adagio

Beethoven  
*Sonata*, Op. 79, Andante

**2. Out-patient:** A Selection of the Music Played During Nineteen Music Therapy Sessions.

**A.** To maintain confidence in renewed ability to experience ordinary emotions, to stimulate re-awakening interests, and to give support in reassuming family responsibilities.

**B.** To use recordings as background for discussion of problems, and to stimulate imagination. Playing the piano to induce relaxation and to give relief from over-concentration on worries which from time to time threatened to overwhelm her.

Beethoven  
*Piano Concertos*, Nos. 4 and 5

Bruch  
*Violin Concerto*, No. 1

Rachmaninoff  
*Piano Concerto*, No. 3

Tschaikowsky  
*Swan Lake*

Beethoven  
Debussy  Bruyeres  
Estampes—La Soiree dans Grenade

Mendelssohn  Songs Without Words

Mozart  Sonata in B Flat, Adagio

Mozart  Fantasia and Sonata in C Minor

Schumann  Arabeske, Op. 18

Schumann  Album Leaves, Nos. 3, 4, 5, 6, 8, 16, 18.

The pieces listed are a sample only of the music used. Naturally over such a long period a great deal more was used. All the music above has been used for other patients, sometimes to achieve different objectives, which is only to reiterate that how one interprets a piece, and in what circumstances, is vastly more important than what it is. Routine, unimaginative performances are not only a waste of time and effort but can become a detrimental influence with the patient.

Case No. 2. Mrs. Y, age thirty-two, was suffering from a neurotic anxiety depression. Disturbed relationships in early childhood and present marital difficulties gave rise to severe conflicts. Her realization that she would never bear children led to an acute breakdown.

In this case, value of music therapy was very marked: the psychotherapeutic sessions centered on emotions and memories awakened by music, and the patient's early resistance was quickly broken down. She improved steadily and found deep satisfaction in her own music playing.

Mrs. Y attended twenty-four music therapy sessions over a period of five months. Her case illustrates how music used as a therapy can help someone who has attained a moderate amateur standard of playing. She was also a good listener with wide tastes and an intelligent understanding of what she was asked to do. She was keen to practice both for her own improvement and also to accompany her husband who played the violin rather above the level she was then able to achieve on the piano. She played musically but her technique, and, therefore, performance, was limited by excessive tension not only in her hands but in her neck, shoulders, and arms. Her breathing was also restricted by reason of being very shallow and also by bad posture. In a short time relaxation technique had initiated a marked improvement in her performance which was noticed, independently, by her husband. Their increasing pleasure in playing together became a source of comfort and encouragement to both of them. After a period of study and regular practice she was encouraged to play
Research

song accompaniments for other patients and to perform in ward concerts. Her husband felt music therapy had helped her so much that when she was ready to leave the hospital he asked for the name of a suitable teacher so that she could maintain her interest in playing the piano. Mrs. Y also listened to music as an additional means of counteracting lack of emotional response. During the period she developed a marked preference for Beethoven whose music had not interested her before entering the hospital.

1. **Inpatient: A Selection of Music Played During Twenty-four Music Therapy Sessions.**

A. Played by Mrs. Y.

- Beethoven: *Bagatelles, Op. 33*
- Beethoven: *Für Elise*
- Chopin: *Waltz, Op. 69, No. 1*
- Handel: *Sonatas for Violin and Piano*
- Schumann: *Cradle Song*

B. To initiate emotional response.

- Barber: *Adagio for Strings*
- Bellini: *Songs (set by Gounod)*
- Bizet: *Symphony No. 1*
- Bloch: *Jewish Prayer*
- Brahms: *Violin Concerto*
- Beethoven: *Violin Concerto*
- Beethoven: *Symphonies, Nos. 5, 6, 7, 8*
- Debussy: *L'Après-Midi d'un Faune*
- Milhaud: *Nothing to do Bar*
- Mozart: *Don Giovanni*
- Ravel: *Daphnis and Chloe (2nd Suite)*
- Strauss: *Till Eulenspiegel*

**DISCUSSION**

The use of music therapy as an adjunct to psychotherapy is a novel conception, but it presents many problems. Recently "music therapy" has become topical in this country and has been prone to produce irresponsibly enthusiastic protagonists (especially among musicians), or equally irresponsible antagonists (especially among psychiatrists). In no field is there less room for irresponsibility than individual music therapy along the lines we have indicated above.

From the results of our previous investigations (Blair and Brooking, 1957) and those described in this paper, we personally believe that individual music therapy has a valuable place in the
modern therapeutic armatorium of psychiatry, but this opinion is only held with certain very important provisos, namely:

1. The psychotherapist must have a personality of a type which will enable him to work in close and adequate cooperation with the music therapist and with a psychotherapeutic perspective and system that allows him to incorporate the assistance of a music therapist in a manner that will allow him to deal advantageously with the three-person group situation despite its inherent instabilities and difficulties.

2. The music therapist must have a first-class knowledge and skill in music and also the type of personality essential for this work as described above. Our therapist commenced with no knowledge or training in psychiatry. Future therapists should have appropriate instruction and training for this work although we do not believe a full-scale personal analysis is necessary or even desirable.

3. It is strongly contraindicated for any psychotherapist to undertake music therapy himself. Our reasons for this contention are: Music has a very powerful effect on the emotions and patients may crave for certain musical effects. If the psychotherapist were also to perform the function of the music therapist the patients would unconsciously (or even consciously) use their wiles to induce him to play music which evaded the real psychotherapeutic issues.

Our work is pioneer work and, we are aware, open to much criticism by the sceptic. Nevertheless, abolition of mechanical restraint, opening of hospital wards, the introduction of art therapy, and even psychotherapy itself have had numerous antagonists in their early years and we envisage that music therapy, if properly handled, will like them, eventually be vindicated.
THE INFLUENCE OF FAMILIAR HYMNS ON MOODS AND ASSOCIATIONS: POTENTIAL APPLICATIONS IN MUSIC THERAPY

ROBERT FRANKLIN BURNS

INTRODUCTION

Men of all ages continuously have relied on some form of religion or power greater than themselves for support and guidance in times of need and for help in maintaining inner harmony and peace of mind. Communion with, or worship of this greater power, which most men seem to have a need for at one time or another, is sometimes difficult because of inability to attain the correct state of mind for such an act, or because man often feels inhibited by his own lack of the means for adequate self-expression under such circumstances. To overcome this problem, many rely on the church which, in turn, attempts to provide its people with the necessary means of relating to the power or God which they have chosen to worship.

One of the means which the church has found to be successful in bringing its people to the right state of mind for worship and communion with God, is using music which is appropriate to the type of worshipful atmosphere it is trying to create. Music in the church has become an important means of implementing devotion and materially aiding the communicant in "attaining the correct mind set for communion with his God."

In the Protestant Church, the hymn has come to be the most widely used and meaningful form of music. "It is safe to say we have no medium of expression which is more helpful by way of nourishment of our spiritual lives and religious culture."

The most successful of the Protestant hymns are those which may quickly become a part of one's frame of reference and which

1. An abstract of a thesis submitted to the School of Music, Florida State University, in partial fulfillment of the requirements for the Master of Music Degree in Music Therapy (1958).
are, therefore, available to each individual and can be called upon at will when the type of help which they are able to provide is needed. The familiar hymn may become something which we may rely on to give us spiritual strength in our daily routine of living and to provide a means of heightened self-expression. "Nothing else save prayer succeeds in voicing our innermost yearnings so simply and directly."7

Hymns seem to reveal the individual's philosophy of life, and to express his need of and dependence on the Divine.8 Hymns, therefore, satisfy the needs of many different people under many different circumstances. The fact that they are able to provide a realistic source of strength in our daily living would seem to indicate that they have an unusual functional value, some of the aspects of which are worthy of more extensive investigation and understanding. "In the minds of the thoughtful, there can be no doubt that hymns have been, and continue to be, a tremendous force for good in the lives of men."9 In the same manner that hymns may be a force for good, they may also be a harmful force. If hymns have power over a person's imagination and emotions, their power will not always be a comforting or sustaining one, but sometimes deadening or provocative.10 It is also possible that people who have learned to associate certain hymns with unpleasant experiences may be negatively affected by these hymns.

Considering both the positive and negative powers of hymns, there seems to be very little specific information concerning their influence on human behavior and emotions as well as other functional values which they may possess. Young, in his study, "The Psychology of Hymns,"11 states that there are two features of hymns which must be kept in mind when studying them psychologically: emotional appeal of the musical rhythms, and the content of the hymn. Young studied the content of eight

thousand Protestant hymns, and found that the majority of hymns dealt with "infantile return" and "future reward." Other dominant appeals or motives which he noted were "sinfulness," "exaltation (joy) in religion," "struggles," "masochistic projection," "redemption and salvation," "purification," "inferior feelings," "devaluation of things of this world," "sadistic projection," and "prayer." Young's statements give one indication of the type of conclusions which may be derived through an objective study of hymns.

Kempson, in "A Study of Factors Influencing Hymn Preference Among the Mentally Ill,"12 used three groups of five hymns each, to which 188 mental patient-subjects responded in terms of preference. The three groups were classified as (1) familiar hymns, (2) less familiar hymns, and (3) non-familiar hymns. In each group there were five hymns classified as to psychological connotation: (1) objective, (2) infantile return, (3) introspective, (4) struggle-sadism, and (5) inferiority-masochism. In illustration, the five hymns under the "familiar hymn" classification were (1) "Holy, Holy, Holy," (2) "Jesus, Lover of My Soul," (3) "Just as I Am," (4) "Onward, Christian Soldiers," and (5) "Alas! and Did My Savior Bleed!" It was found that the hymns of "infantile return" were definitely preferred while those of "inferiority-masochism" were favored. Neither "introspective" nor "struggle-sadistic" hymns were liked while "objective" ones were definitely not preferred.

In discussing the influence of associations and familiarity on hymn preference, Kempson states, "It seems that where there is a familiar hymn it might be preferred to others regardless of their thought content."13 This statement gives a possible indication of the important role played by individual associations in influencing personal response to familiar hymns. It also seems to invalidate, to some extent, the conclusions reached by Kempson in his study.

It seems that music of this type could have a wide variety of beneficial uses in the field of music therapy, especially in the mental hospital situation where there are many who are in need of a closer contact with a realistic source of strength and inner comfort as well as a more adequate means of self-expression. If this music is to be used to its maximum effect in this field, with a

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13. Ibid., p. 60.
minimum of negative results, a greater knowledge of its functional aspects and practical applications is necessary.

**Problem**

This study attempted to investigate (1) the consistency of moods influenced by the playing of familiar hymns to a group of mental patients and how the mood responses of these mental patient subjects compared with the responses of non-patient “control” subjects to the same hymns, (2) the moods most often influenced by the playing of familiar hymns and any differences which may exist between the mood responses of the patient and non-patient subjects, (3) possible correspondence between mood responses and responses of like and dislike to the familiar hymns, (4) the type of familiar hymns best liked by mental patients as compared to the type best liked by non-patients, and (5) the possibilities of using familiar hymns as a topic of group discussion to stimulate associative responses and individual verbal expression within the group.

**Method**

**Subjects**

Two types of subjects were used in this study. The experimental group of subjects was composed of mental patients while the other group of subjects, which served as a control group in some phases of the study, was composed of non-hospitalized individuals.

The mental patients used in the study were eight males and nine females selected from a list of forty patients in a New Jersey county psychiatric hospital. This list was provided by staff physicians and ward personnel with the criteria (1) that all patients be between the ages of thirty-five and seventy, (2) that they be of Protestant faith, and (3) that they be in such a condition of mental alertness that they would be able to take part in a meaningful and intelligent group discussion.

These criteria for selection of patients were developed with the aid of a staff research psychologist. The age limits of thirty-five and seventy were established because it was felt that individuals in this age group probably would be more stable in their religious attitudes and should have a wider background of experience in which associative responses might have developed. Since the
hymns to be used were all Protestant hymns, the requirement that all subjects be of Protestant faith was made to better assure the probability of their having had previous contact and familiarity with the hymns. The forty patients which were provided under these criteria included twenty male and twenty female patients whose diagnosed illnesses represented a wide variety of mental disorders.

Many of these patients, for various reasons, refused or were unable to take part in this study. Those that were available were brought together and given the Allport, Vernon, and Lindsey, Study of Values\textsuperscript{14} test. The results of this test provided a profile of each subject's religious values in comparison to several other values and showed how high were his religious values in comparison to organized norms for a "normal" population. Because of the inability of some of the patients to follow directions and the amount of concentration required in taking the test, only seventeen of the patients were able to adequately complete the test. These patients, eight male and nine female, comprised the group of mental patients used as subjects in this study.

The non-hospitalized subjects, serving as a control group, were all volunteers from a regularly scheduled adult Sunday School class. There was a total of sixteen subjects, nine male and seven female, all in the same general age group as the patient-subjects. The same questionnaires and hymn recordings as were used with the patient-subjects were used with these subjects.

The mean age of the patient-subject group was 46.3 years, while the mean age of the non-hospitalized group was 45.6 years. The ages of all subjects fell between the pre-set limits of 35–70.

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The questionnaire which was used for gathering data for this study was divided into two sections. The first section offered a choice of five descriptions of the degree to which each subject liked each hymn. (Dislike Intensely, Dislike, Neutral, Like It Somewhat, Like It Very Much.) It was felt that a representation of all the degrees of like and dislike which could be felt while listening to this type of music was presented.

The second section of the questionnaire offered the subject a choice of twelve mood descriptions from which to choose the feelings aroused while listening to the hymns. (Rest, Sadness, Joy, Love, Longing, Amusement, Dignity, Reverence, Stirring Disgust, Irritation, and Indifference.) Eleven of these mood descriptions, all except "indifference," are descriptions used in a study by Schoen and Gatewood,\(^\text{15}\) and were found by them to represent the effects usually derived from listening to music. The term "indifference" was added to allow for the possibility of this effect and because this is a rather common effect with certain types of mental disorders.

The same questionnaire was used for all the subjects, and each patient-subject used the same questionnaire for both of the sessions which he attended, completing it for hymns number one through five at the first session, and six through ten at the second.

**Hymns**

The hymns used in the study were the ten hymns which were found to be most popular in the United States by a nation-wide survey of the *Christian Herald*,\(^\text{16}\) and are the following, presented in the order in which they were played: (1) "Nearer, My God, to Thee," (2) "Jesus, Lover of My Soul," (3) "Sweet Hour of Prayer," (4) "What a Friend We Have in Jesus," (5) "Rock of Ages," (6) "The Old Rugged Cross," (7) "In the Garden," (8) "I Love to Tell the Story," (9) "Abide With Me," and (10) "He Leadeth Me."

These hymns were all presented from a single Long Play record entitled, "Eighteen Favorite Hymns." They were recorded by a small mixed choral group called "The Bible Choristers" with electronic organ accompaniment under "Today’s" record label. All the hymns were performed at a moderate tempo with little variation between hymns or use of special effects such as solo voices, male voices alone, etc. Two or three verses were presented for each hymn, depending on the length of the hymn, and the hymns were all sung in the same approximate vocal range.

**Procedure**

The group of seventeen patient-subjects was divided into two smaller groups of nine and eight to better facilitate individual

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participation in group discussions. Both of these subgroups, hereafter referred to as group A and group B, were made up of both male and female patients.

Group A was brought together first. The nine members of this group were seated informally in a semi-circular arrangement around a record player. The members of the group were each given a pencil and a questionnaire and asked to read the directions and fill out the questionnaires during the playing of recordings of the first five hymns. It was suggested that it might be helpful in remembering associations which were aroused during the playing of the hymns, if they were to write them down on the back of the questionnaire as they came to mind.

After the playing of the first five hymns, the members of the group were asked if they wished any of the hymns replayed to aid them in completing the questionnaires. After this was done, and all the patients had indicated that they were finished writing, the questionnaires were collected.

Following the completion of the questionnaires, as the five hymns were replayed, the members of the group took part in a discussion of their personal responses to, and associational responses with each hymn. The experimenter, serving as discussion leader, provided such "lead" questions as, "Does this hymn remind you of anything?" "Does this hymn mean anything special to you in your religious life?" Selection of leading questions was made under the consultation of a clinical psychologist. A hospital psychologist and a music therapist both attended the discussion sessions and offered advice and suggestions to the discussion leader after each session.

At the completion of the first session with group A, arrangements were made with the group for a convenient time at which they could all meet for the second session. The members of the group were then thanked for their cooperation and the session was completed.

At the time that group A was brought together for the second session, the procedure used for conducting the session was the same as that used at the first session, except that the second five hymns were played. This session completed the procedure with the members of group A.

In working with the eight members of group B, the same general procedures as were used in the two sessions with group A were again applied.
The questionnaires were given to all the non-hospitalized subjects in one group, and they were asked to read the directions and fill out the questionnaires as the hymns were being played. The number of each hymn, corresponding to its number on the questionnaire, was called out before the playing of each hymn. All of the ten hymns were played at this one session. When the subjects had completed their questionnaires, they were asked to write their ages somewhere on the questionnaires before turning them in. They were then thanked for their cooperation and the procedure with the non-hospitalized subjects was concluded.

Discussion sessions were not held with the non-hospitalized subjects because it was felt that an adequate comparison between patient- and non-patient-subjects of their mood responses to, and preferences for each hymn could be obtained from the results of the questionnaire. The purpose of the patient discussion groups was mainly to determine the therapeutic aspects of this activity when used with mental patients. It was not felt necessary, therefore, to repeat this procedure with the non-hospitalized subjects.

There were seventeen patient-subjects responding to the first five hymns and fifteen responding to the last five (two dropped out) on the questionnaire and in discussion. There were sixteen non-patient subjects responding to all of the ten hymns on the questionnaire.

Results and Conclusions

When listening to familiar hymns, the mental patients responded fairly consistently with positive moods which could be considered appropriate to the type of words and music which exist in these hymns. Such moods as "reverence," "love," "rest," and "joy," seemed to be quite commonly felt, while such moods as "longing," "sadness," and "amusement," were less consistently felt and probably were related, to a greater degree, to the personal and associational backgrounds of the individual patients. The patients responded more often and with greater consistency to the former moods than did the non-patients, which probably indicates a special need in the patients for these feelings and a strong dependency upon religion. Especially important in providing feelings of comfort and support to these patients, and indicative of a salient need, was the strong response of "love" which seemed to be felt while patients were listening to these hymns. Of further interest in this area, was the relatively infrequent response of
“sadness,” being less frequently found among the patients than the non-patients. Familiar hymns seemed to have the potential for evoking beneficial therapeutic responses.

The hymns which were most liked tended to receive the greatest number of mood responses. Hymns which are generally well liked, therefore, would be most likely to arouse the greatest amount and variety of mood response.

The patients showed a preference for hymns which seem to hold the connotation of comfort and refuge. Hymns which tend to connote suffering and sacrifice were less preferred by the patients than the non-patients. This seems to be a further indication, generally, of the patients’ strong needs for emotional comfort and security. Hymns of this type, therefore, might be used for such purposes as satisfying these emotional needs.

When used as a topic of group discussion, familiar hymns may serve as a stimulation to individual verbal expression. The topic often seemed to be one which the patients enjoyed discussing and which evoked meaningful associational responses from many of the patients. These seemed to be of potential value in understanding the personality dynamics and emotional needs of certain patients. The insight gained under these circumstances might well aid in the treatment of certain mental patients in group and individual therapy.

Generally, the responses of the mental patients to familiar hymns were of a positive (i.e., accepting) nature. In obtaining the maximum therapeutic benefits in this area, however, careful evaluation of the words of the hymns for their psychological implications should be made, and, when possible, an understanding of the backgrounds and emotional problems of the patients involved would seem important. When this is possible, it is felt that familiar hymns may afford a unique means for providing therapeutic aid under a variety of circumstances.

When used in hospital worship services, the type of familiar hymn which offers feelings of comfort and support would probably be most effective in creating a receptive frame of mind, since these hymns tended to stimulate the greatest amount of mood response and were most liked by the patients participating in this study.

**Recommendations**

A possible area of research, which should prove of value in better understanding the therapeutic potentialities of familiar
hymns, is in distinguishing the separate influences of the words and the music of the hymns. Greater knowledge in this area would provide better understanding of how the hymn influences response and would aid in the selection of hymns for different occasions and purposes.

Another possible area of investigation would be to determine what means of presentation of hymns are most effective (e.g., organ, choral, congregational participation, etc.). Greater knowledge in this area should enable more effective use of the hymn in the therapeutic situation.

These are only two examples of areas which seem to require better understanding if a more beneficial therapeutic use of familiar hymns is to evolve. It is felt that a greater insight into the potentialities of the familiar hymn would be of significant value to the field of music therapy.

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THE EFFECTS OF INSTRUMENTAL TONE QUALITY UPON MOOD RESPONSE TO MUSIC

JOAN KINNEAR VAN STONE

One of the acknowledged goals of a music therapist is the establishment of a therapeutic relationship between himself and his patients, and it is important that he develop an understanding of the psychological effects of music if he is to use it effectively for establishing such relationships.

Numerous studies have been made of the mood characteristics of the individual isolated musical aspects of rhythm, harmony, melody, major and minor modes, tempo, and pitch ranges. The reports of Hevner\(^2\) provide some of the most useful references on the effects of various musical factors upon mood (i.e., factors such as tempo and harmony), and Rigg’s studies\(^3\) seem to confirm those of Hevner, while reports by Gaston\(^4\) and Hanson\(^5\) discuss the specific importance of rhythm. Little has been done, however, to investigate the specific effects of either musical form or tone quality, although two studies have been reported in which implications for mood effect of tone quality developed as a rather unexpected result of the experiment.\(^6\)

The question of why tone quality, or any of the elements of music, may affect mood is a problem that is beyond the scope of


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this study. It might reasonably be assumed, however, that most of the mood effects of music are basically stylized responses—a result of cultural conditioning. Any present day effects of tone quality may be largely a result of the type of music that traditionally has been written for specific instruments. Even if this is true, there may be some inherent quality in these instrumental sounds that has predisposed composers to choose them to depict particular moods, and there is some evidence of a belief in a cause-effect relationship between tone quality and mood response among composers and musicologists. Whether or not there is a factual basis for this belief can only be demonstrated by experiments designed specifically to isolate the influence of tone quality.

Whatever the possible causes, it seems appropriate that the effects of tone quality should be investigated as a potentially useful criterion for choosing, composing, or orchestrating music for especially desired psychological effects.

THE PROBLEM

The specific problem of the study was to determine whether or not there are statistically significant differences in musical mood effects due to changes in tone quality when selected musical examples (wherein other affective factors of mood are held constant) are experimentally presented to a group of subjects.

EXPERIMENTAL DESIGN

Preliminary Procedure

The three instrumental groups chosen for comparison in this study were as follows: (1) Strings—two violins, viola, cello; (2) Woodwinds—flute, oboe, clarinet, bassoon; (3) Brasses—two trumpets, French horn, trombone.

Eight musical excerpts were selected to represent the eight moods described in the Hevner adjective circle\textsuperscript{10} and for ease of referral have been labeled in this text as follows: (1) Category A—“majestic,” (2) Category B—“agitated,” (3) Category C—“happy,” (4) Category D—“whimsical,” (5) Category E—“serene,” (6) Category F—“plaintive,” (7) Category G—“sad,” and (8) Category H—“serious.” These excerpts were chosen from a list of thirty selections that had been played on the piano for a panel of six judges who were experienced in recognizing mood representation in music.

The main problem in measuring the mood effects of any musical composition is in isolating the one aspect being studied without destroying the musicality of the material used for comparison. As a solution to this problem the excerpts were orchestrated by the investigator so that they could be recorded by the three instrumental groups without changes in pitch or voicing. The performers were volunteers, ten students and two faculty members of the School of Music, Florida State University, and the performances were equalized as nearly as possible through the use of a metronome for tempo, a VU meter for dynamics, and verbal instructions as to articulation and phrasing. The recorded tape was then spliced into a relatively random sequence with the following exception: sedative selections were alternated with stimulative selections so that any possible carry-over influence of one on the other might be controlled.

\textit{Testing Procedure}

Twenty-five students (thirteen male and twelve female) from a music appreciation class at Washburn University (Topeka, Kansas) volunteered as subjects for the study. The course was an elective in the humanities division and none of the subjects was majoring in music. The experiment was carried out during a regular class hour, lasted approximately thirty minutes, and the prepared tape was played on a high fidelity portable tape recorder.

In order to have a standard of comparison for the subjects’ responses, the Hevner adjective circle was used, allowing each

\textsuperscript{10} Kate Hevner. “Experimental Studies in the Elements of Expression in Music,” \textit{Amer. J. Psychol.}, 1935 (April), XLVIII:249.
subject a choice of eight different categories of mood-feeling. The subjects were asked to choose a category (rather than a single adjective) for each selection which best represented, in their opinion, what mood the composer intended to convey in the music. The subjects were not told that tone quality was the variable being investigated.

**Statistical Analysis**

This study was designed to be evaluated with the statistical tool, “the binomial index of dispersion,” a variation of the chi-square test of significance. With this type of treatment it was necessary to consider responses as being either “right” or “wrong,” using the moods assigned to each selection by the six judges as a standard of “correctness.”

**Results and Interpretations**

In order to facilitate discussion of the results, it was necessary to define some of the terms used in this study. “Excerpt” referred to any one of the eight pieces of music used in the study, designated A, B, C, D, E, F, G, or H. “Selection” referred to any one of the recorded versions of the excerpts, e.g., woodwind A, brass A, and so on. There were eight excerpts and twenty-four selections. The eight mood categories, which corresponded to the excerpts, were referred to by the adjective previously designated for those moods, e.g., “whimsical” for Category D.

Results from the experiment showed that when total “correct” responses for all excerpts were compared for the three groups of selections, there was no over-all statistically significant difference found between instrumental groups. There were, however, highly significant differences found for the “whimsical” excerpt and the “serious” excerpt. A further comparison of each instrumental group of selections indicated that the strings appeared to be rather equally effective in eliciting a chosen mood, but that the woodwinds and the brasses both showed statistically significant variations in effectiveness for the different excerpts.

A comparison of “correct” responses does not show the difference in the kinds of “wrong” responses given for each instrumental group of selections, and a comparison of these two types of

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responses revealed that the woodwinds were not only most effective in excerpt D, "whimsical," but also received more "wrong" judgments of "whimsical" than of any other mood category. The brasses were most effective for excerpts G and H ("sad," and "serious," respectively) and also received more "majestic" and "serious" misjudgments than any other type of mood category judgment. The strings, which appeared to be very similarly effective in all excerpts, received nearly the same number of "wrong" responses in all mood categories.

A further comparison of all mood responses (both "correct" and "wrong") showed a similar result, i.e., the woodwinds were very often judged "whimsical," and the brasses "serious," and "majestic," irrespective of the excerpt performed. The responses to the string performances were considerably less varied.

**Conclusions**

Limited to the scope of the study, the following conclusions may be drawn:

1. There were no statistically significant differences in mood response to music due to tone quality for the excerpts labeled "majestic," "agitated," "happy," "serene," "plaintive," and "sad," but there were significant differences for those labeled "whimsical," and "serious."

2. The woodwind versions of the excerpts tended to sound "whimsical" to the subjects.

3. The brass versions of the excerpts tended to sound "serious" and "majestic" to the subjects.

4. The string versions did not tend to represent any one particular mood.

**Implications for Further Study.**

One of the major problems in a study of mood effects of music is that of determining whether or not the responses of the subjects are judgments of their own mood during the listening period or recognition of the mood depicted in the music. Subjects who receive a period of training could probably more adequately discriminate between the two types of responses, but such training might force the particular opinion of the investigator upon the subjects, e.g., telling the subjects what the investigator feels are representative examples of music depicting specific moods. It might be possible to have a discussion period concerning mood
representation in music so that the subjects could develop an understanding of the meaning of "mood representation" yet retain an awareness of the fact that each individual subject may have a different concept of the mood itself.

It is essential in studies of this type that high fidelity equipment be employed. The recording apparatus used for this experiment was of excellent quality, but the tape machine used during the test had a rather disturbing motor hum. The hum was not loud enough to disturb the hearing of the selections, but was a possible source of annoyance to the subjects and may have lessened their ability to concentrate.

In addition, since even the best recording is still less than true representation, future studies might attempt to investigate the differences in mood effects found (due to tone quality) with live performances. This would necessitate having performers who had rehearsed thoroughly, but such rehearsing might help overcome the variation in quality of performance that was found in the present study. Whenever different performers are used in each instrumental group there is no way to equalize performances accurately, but the variation might be lessened by careful rehearsal.

Some of the variation in performance is due to the differing technical problems found in the different instrumental groups. The woodwinds, for example, can play fast passages more easily than can the brasses. The strings, on the other hand, can play those same passages more easily than the woodwinds, and in addition the strings can play sustained passages much more easily than any other type of instrument except the pipe organ. All of these problems exist, however, in any musical performance and therefore probably are as important a cause of variation in mood effects due to performances on different instruments as the differences found in characteristic sounds of single notes. Indeed, a description of tone quality must include articulation factors (generation and termination noises such as the slight rasp of a violin bow setting a string in vibration) because those factors help distinguish between different instrumental sounds.

Even a consideration of these differences in articulation ability, however, cannot explain all of the particular differences in mood effect found in this study. Is there simply a conditioned (cultural) response, or is there some inherent quality in the sound of these instruments that seems particularly suited to one mood or
another? It is the opinion of the writer that cultural conditioning is the most important cause of mood effects due to tone quality, but only further investigation can demonstrate the correctness of such a statement.

Whatever the explanation, the present study has shown that within our culture, some mood effects tend to be more effectively depicted with specific instrumental groups. Such findings, along with the evidence presented by previous investigators for the predictable influence of the other musical factors upon mood response, might well facilitate composition of "functional" music. From a practical viewpoint, the strings appear to be the most useful instrumental group since they were relatively equally effective in all moods, but the special effectiveness of the woodwinds for "whimsical" music, and the brasses for "serious" music could be of great value both in composition and orchestration. Further investigation is needed (particularly with more subjects than the twenty-five used in the present study) to establish whether or not these tendencies will appear consistently, and whether or not any differences are significant enough to warrant the special attention of those who wish to use music for its specific psychological effects.
PART VIII
ASSOCIATION GROWTH
ASSOCIATION GROWTH

WILHELMINA K. HARBERT

In 1957, I reported on ways in which we might vitalize the whole national structure of NAMT through more active work in our respective regional chapters.

At that time I listed ten points which seemed essential in making our total program more effective. Restated briefly, they were as follows:

1. Better communication between all regionals,
2. Inclusion of other areas of activities than music in our regional programs,
3. Speakers from other disciplines,
4. Careful screening of regional members (for national memberships),
5. Use of our National Bulletin to distribute helpful information,
6. Improvement in the quality of the academic part of our programs,
7. Encouragement of research among members, and use of reports on current studies in music therapy,
8. Appropriate demonstrations of techniques,
9. Stronger interpersonal relationships between regional chapters, and
10. Efforts to become more articulate parts of the total structure of NAMT.

During the past two years it has been gratifying to note the growth in several of our regional chapters, not so much in numbers but in the quality of their annual and semi-annual programs. Certainly each program, copies of which I have received, has indicated the achievement of many of the goals which we set in 1957.

On the west coast there has been one very important change, the union of the northern and southern chapters in California, and the addition of six states, the Hawaiian Islands, and Alaska. With this development we are hoping to strengthen the whole western area.

If each regional president could be allotted enough time, we would learn of very significant developments throughout the
country which are making our regional chapters much more articulate and effective members of the national organization.

Although the goal which I set one year ago for one thousand members of NAMT by 1960 has not yet been achieved, with six hundred seventy-five as of today, and one year still in which to grow, we still may reach the thousand mark by our next annual meeting.

The reports which follow present summaries of the activities conducted by each regional chapter during the past year.

**GREAT LAKES REGIONAL CHAPTER**

**CURT DOLLINS**

The Great Lakes Regional Association had a successful year of activity. The membership under the guidance of the membership chairman, Doris Robison, has increased steadily. The officers for the year were: Curt Dollins, President; Christine Miles, First Vice President; Doris Robison, Second Vice President; Richard Kauffman, Treasurer; and Carol Collins, Secretary.

A most successful workshop was held at Alverno College, Milwaukee, Wisconsin. The entire membership felt that it was one of the best workshops held in recent years. There has been an attempt to focus the Workshop each year on a different aspect of music therapy in order to bring to the music therapist a better understanding of the many facets of the field. Some consideration also has been given to the administrative aspects of the Association, with the hope that such experience in the Regional Chapter will eventually lead to an opportunity for appointment to the executive committee or an executive post in the Association.

The influence of Past President, Janet Lindecker, continues to be a guiding force as this group goes forward with plans for constitutional revision to keep the Great Lakes organizational structure as much like the parent association as possible.

**MID-ATLANTIC REGIONAL CHAPTER**

**MARIAH CHACE**

Two committee meetings were held in East Lansing at the National Conference. The discussion at both meetings was centered around the need to provide useful activities to the music therapists in the Mid-Atlantic area.
Association Growth

An executive committee meeting was held the first week of November to organize our conference in January on a workshop basis and to work out plans for more adequately contacting music therapists in the area. The January conference will be held in New York at the Turtle Bay Music School. Plans have been made to conduct three workshops on practical levels for the worker in the field.

At the present time our membership is a comparatively stable one, but consists of less than fifty members. We hope to increase the membership this year, as there are many more members of the National Association for Music Therapy in this area who have failed to join the chapter. The new officers of the Mid-Atlantic Chapter elected in May 1959 are: Marian Chace, President; Mrs. Eleanor Wallace, First Vice President; Mrs. Elinor Parker Behrens, Second Vice President; Mr. Roman P. Mocherman, Treasurer; and Mrs. Hermina Brown, Editor.

MIDWESTERN REGIONAL CHAPTER

MARTHA A. LOVEN

The Midwestern region held its Annual Spring Conference at the Nebraska Psychiatric Institute, Omaha, Nebraska, on April 17–18, 1959. Worthy of note was an especially effective session—"The Group in Activity Therapy"—which was presented to answer the requests of many of our members, and which included members of the audience as part of the presentation.

The chapter has been more active this year. Special attention has been given to various projects aimed at strengthening our present relationships, seeking new members, and making more people aware of the work of music therapy in this area. All communications of the chapter were sent to members and interested people, hospitals in the region having 100 or more patients, and the federated music clubs of each state. To strengthen communication, the publication of a regional bulletin called "The Newsletter of the Midwestern Region of NAMT," was established.

Other activity in the region includes that of the local Topeka, Kansas Chapter, which holds four meetings a year in and around the Topeka area. This is perhaps the largest group of music therapists in our area, and thus forms the nucleus for the entire region. The Spring Conference is scheduled for April 22–23, at the Cornhusker Hotel in Lincoln, Nebraska.
The New England Regional Chapter has held one meeting since the last Annual Conference. This occurred on April 18, 1959, at the Bedford VA Hospital with Mrs. Blossom Zecha, the music therapist at the hospital, serving as local chairman.

Thirty-three bona fide members are now on our rolls. Since we are assigned a region including the six New England states and Canada, we believe that we have a potential membership of fifty-two from these areas who are members of the National Association.

Another fact which we wish to acknowledge as the direct result of the widening influence of the New England Regional Chapter is the recognition which is beginning to be accorded to music therapy in the Commonwealth of Massachusetts by the Department of Mental Health. Recently, a conference was requested by the Assistant Commissioner of Mental Health asking for full descriptions of the meaning of music therapy, its training, and organizational dimensions. We believe that a new and important door has been opened in the East in official medical circles. In addition to this, many of the regional auxiliaries to the Massachusetts Medical Association have extended invitations to us to present discussions of music therapy at their meetings.

The last portion of this report has to do with something which we feel is of great importance both to the local chapter and to our National Association for Music Therapy. This is the value and impetus which an active and interested local regional chapter can have upon our international relations. Dr. Martha Brunner-Orne, director of the Westwood Lodge, a private sanitarium near Boston, wanted to report as a member of NAMT on her participation in a joint meeting of German and Austrian physicians and members of ancillary professions which took place in September of this year at Velden am Woerthersee, a lovely summer resort in Austria. A large section of this conference was devoted to music therapy and was attended by music therapists, psychiatrists, and other physicians from many parts of the world.

I mention this report of Dr. Brunner-Orne because of the fine contribution she has made in our New England Chapter and as a member of the NAMT Research Committee for five years, which contribution she has extended in commendable fashion at
the above-mentioned meeting. Also, I wish to call attention to
the fact that having a very strong regional group was one of the
contributing factors in helping Frau von Koffer-Ulrich who was
our guest in Boston for six weeks during the summer of 1958.
Another important relationship has been created through
regional chapter influence in the uninterrupted efforts of Mrs.
Isabelle Lang-Goldsmith in Frankfurt am Main, Germany. She
has recently been exploring the work of Mr. Hans Bachaus who
uses music in developing greater coordination and rhythmic-
expressional controls in persons in need of physical exercise for
relief of various somatic complaints. We also have several vitally
interested music therapists in Toronto and other places in Canada.
Certainly, the usefulness of regional chapters in cementing such
relationships and guiding them into sounder practices in this field
should not be overlooked.

SOUTHEASTERN REGIONAL CHAPTER

JOSEPH B. BASSICH

The sixth Annual Conference of the Southeastern Chapter was
held March 20 and 21, 1959, at Loyola University, New Orleans,
Louisiana. An excellent program had been prepared by the
Program Director, Mr. Charles Braswell, Chairman of the
Department of Music Therapy of Loyola University.
The Southeastern Chapter is happy to report that a Music
Therapy Workshop, the first ever scheduled in the state of
Mississippi, was held at Mississippi Southern College at Hatties-
burg. The workshop coordinator was Dr. Roger P. Phelps. The
workshop featured Dr. E. Thayer Gaston, who spoke on “The
Nature and Principles of Music Therapy,” and “The Influence of
Music on Behavior.”

One of the achievements of the Southeastern Chapter this
year is a project recently completed by Mr. Charles Braswell. He
has developed an Outline of Courses in Music Therapy which will
be used as a training manual by the students in his department at
Loyola University. This is a clear and distinct statement of the
curriculum which he considers advisable for students of music
therapy, and a bold criticism of the practice of including too
much important instructional material in a few core courses and
within the important period of clinical training.
The Southeastern Chapter would be ungrateful if it did not recognize the many benefactions to music therapy of Mr. Durel Black, philanthropist, business, and civic leader of New Orleans. The establishment of music therapy as a recognized profession in New Orleans and in Louisiana must be attributed to Mr. Black. Loyola University, the City of New Orleans, the State of Louisiana, the Southeastern Chapter of the National Association for Music Therapy are deeply grateful for the contributions, assistance, and leadership given by Mr. Black.

The officers of the Southeastern Chapter for the year 1959–1960 are: President, Rev. Joseph Beauregard Bassich, S.J., Faculty Counselor, Jesuit High School, New Orleans, La.; First Vice President, Ruth Boxberger, Director, Department of Music Therapy, Mississippi Southern College, Hattiesburg, Miss.; Second Vice President, Ellen Glenn Lightsey, Music Therapist, South Carolina State Hospital, Columbia, S. C.; Secretary-Treasurer, Carol Marsh, Director of Music Therapy, Central State Hospital, Pineville, La.

SOUTHWESTERN REGIONAL CHAPTER
VANCE W. COTTER

The Southwestern Regional Chapter plans to hold its next annual meeting on April 22, 1960, at Texas Woman’s University, in Denton, Texas. The program will contain a business meeting at which new officers will be elected, lectures, and reports of the use of music in therapy from various hospitals in the three-state region.

WESTERN REGIONAL CHAPTER
WILHELMINA K. HARBERT

The most significant thing that has happened to us on the West Coast during the past year has been the unification of the Northern and Southern Chapters of NAMT. The distances have made it almost impossible for us to attend the meetings in both parts of the state of California, but somehow we have managed to draw our forces together and feel sure that the forming of the Western Regional Chapter is going to be a real step ahead for us.
APPENDIX
SUMMARY OF THE BUSINESS SESSION RECORDS OF THE TENTH ANNUAL CONFERENCE OF NAMT, INC.

DONALD E. MICHEL

Association business was conducted in two general business sessions, open to all conferees present, and two Executive Committee meetings. Members of the Executive Committee and the officers of this Association once again served the membership by arriving early and staying late to conduct its business. (They do not receive any sort of recompense for such service other than the honor of serving the organization. It is to be hoped that NAMT may in the future help bear some of the extra expense of individuals so involved.)

FIRST BUSINESS MEETING

1. First Vice President Unkefer stated that this year's convention was planned partially on the basis of evaluation sheets filled in by members attending last year's convention; therefore, the program was planned for the maximum participation and benefit of conferees. Of course, the conference program itself, and its preparation represented the year's work of the First Vice President who is Program Chairman.

2. Second Vice President Harbert, as Membership Chairman, reported that the membership as of conference time, including all categories, closely approached a total of 700. She mentioned the important work done by Assistant Membership Chairman, Mrs. Helen Rosenthal, through her efforts with volunteer groups in Cincinnati.

3. Treasurer Grisham reported that the Association business had netted an "earned surplus" balance of over $1,000, largely due to the fees collected in registration of music therapists. He pointed out that this was due to efficient handling of such registration by the Registration Committee, and that this amount helped put the Association further "in the black." Naturally, as the organization increases in size, the work increases and it is only by virtue of continued hard work volunteered by all officers and committee members that NAMT continues to remain "in the black." We should anticipate, however, the increasing need for
paid help as the tasks grow beyond the scope of what it is possible for individuals to do voluntarily, he pointed out. He announced his own resignation at this time, regretfully, but for essentially these reasons.

4. Chairman of Certification-Registration Committee, Gaston, reported that as of conference time 225 music therapists had become registered.

5. Chairman of Education Committee, Thompson, reported the compilation of syllabi from a number of schools and colleges offering music therapy degrees, such syllabi describing the outline and content of core courses in a music therapy degree program. These were being used for study by the Education Committee, not only toward ultimately making recommendations but also toward potential use by the Certification-Registration Committee in recommending approval of schools to the official accrediting body, the National Association of Schools of Music.

6. Research Committee Chairman, Sears, reported the proposed project of developing an "abstract library" of all articles dealing with or related to music therapy research, for future reference by all researchers in this field. (This project later was approved by the Executive Committee and a sum of money donated by the Sinfonia Foundation was designated for carrying it out. It is now in process.)

7. Editor Schneider reported the publication of Music Therapy 1958, with its up-to-date revised bibliography. He presented some of the items which had been earlier presented to the Executive Committee regarding his suggestions for future policies regarding submission of papers, deadlines, style sheets, and selection of additional materials for publication in the Yearbook.

8. In the absence of Bulletin Editor Zack (since deceased), Schneider presented the recommendations and report of this editor. Consideration of adding one issue of the Bulletin per year to make it a quarterly publication was requested (Executive Committee action later postponed doing this until it could be certain that it could be financed and that enough material could be obtained for another issue).

9. Chairman of Constitutional Revisions Committee (and President-Elect) Michel, reported on the proposed changes in the NAMT Constitution and Bylaws. (Up-to-date edition appears
Main changes concerned addition of a Clinical Practices Committee as a standing committee to study and recommend ideal clinical practices in music therapy under various clinical conditions; streamlining and bringing up to date certain general procedures (internal consistency); establishment of new type membership, "Music Club Affiliate"; and raising student membership dues to $2.00 per year.

10. Chairman of Sinfonia Foundation Committee, Civil Service Study Committee, and Local Program Chairman, Underwood, presented reports for all three of these responsibilities. For the Foundation Committee he reported that the proposed uses of the research fund, originally voted by members of Sinfonia (Phi Mu Alpha—national music fraternity) at the 1958 biennial convention, was to begin the Music Therapy Research Abstract Library. For the Civil Service Study Committee he made a preliminary report of the work begun, i.e., a survey of position titles, salaries, etc. in all of the United States. Certain facts of interest appeared such as that there are 19 different titles being used for music therapists in state institutions, and there is a salary range of $1680–$7200. (This study should prove of considerable interest to NAMT and will be continued, to include federal and municipal categories as well as state.)

11. Archivist Carol Collins reported the acquisition of more permanent storage facilities for the NAMT archives, in the form of filing cabinets, etc., located at Michigan State University, and noted that provision of budgeted funds would assist furtherance of this important work for the Association. All members were urged to contribute to the archives from any records of permanent value to the music therapy movement.

12. Insignia Pin Committee Chairman Michel reported on the Executive Committee adoption of a pin design for NAMT members, and the restriction of the first such pins to registered members (by Executive Committee action). Balfour was named the NAMT official jeweler.

13. Nominating Committee Chairman Underwood reported the slate of officers for 1959–61, and tellers were appointed by President Crocker for the election, to take place at the Second General Business Session.
SECOND BUSINESS MEETING AND FINAL EXECUTIVE COMMITTEE MEETING

The Second General Business Session was held on October 11, 1959. General action taken included: (1) final approval of constitutional and bylaws changes, (2) balloting and election of officers and executive committee members-at-large, and (3) reports of unfinished business and committee action not reported previously. Convention site for 1960 was discussed, as were possible dates for convention. An October date for the convention in San Francisco seemed to be tentatively approved (and was given final approval by Executive Committee in its last meeting).

At the final Executive Committee meeting following close of the conference, the official budget for the ensuing fiscal year was adopted. The need for development of an executive secretariat for the Association was discussed, as it had been in previous years, but under the present income status, it did not appear feasible in the near future.

A complete report from the Public Relations Committee was received, to be acted upon by the incoming administration. Outgoing Public Relations Chairman Bing was appointed as Co-Chairman of Public Relations to ensure a bridge between old and new committees.

Official action was taken to use the letters RMT for Registered Music Therapist, rather than MTR as previously had been adopted.

A proposal was received which offered assistance in distribution of public relations materials through business house mailing lists, and was deferred for later action by incoming administration.

A number of suggestions for action by incoming administration were received, and taken under advisement.

Dr. Gaston was asked to continue to serve as NAMT representative to the American Medical Association paramedical committee, and to act as our spokesman in seeking assistance and guidance from AMA, especially with regard to our educational requirements.

Eleventh Annual Meeting is to be held in San Francisco, California, October 20–22, 1960, with the Hotel Whitcomb as convention headquarters. Local Chairman is Betty Isern, Music Department, College of the Pacific, Stockton, California.
Appendix

OFFICERS OF THE
NATIONAL ASSOCIATION FOR MUSIC THERAPY 1959-60

Elected Officers

President:
DONALD E. MICHEL, Ph.D., Assistant Professor and Director of the Music Therapy Program, School of Music, Florida State University, Tallahassee, Florida; Past President, Southeastern Regional Chapter, NAMT.

President-Elect:
ROBERT F. UNKEFER, Assistant Professor, Department of Music and Department of Psychology, Michigan State University, East Lansing, Michigan.

First Vice President and Program Chairman:
WILHELMINA K. HARBERT, Formerly Professor of Music Education and Director of Music Therapy Clinic, College of the Pacific, Stockton, California; Chairman, Committee on Music for Exceptional Children, Music Educators National Conference; Advisor, Western Regional Chapter, NAMT.

Second Vice President and Membership Chairman:
MARThA A. LOVEN, Director of Music Therapy, Childrens Center, Hamden, Connecticut.

Recording Secretary:
MARIANA BING, Western Reserve University, Cleveland Ohio; Formerly Director of Volunteer Services, Fort Wayne State School, Fort Wayne, Indiana.

Treasurer:
WALTER LANCASTER, Director, Department of Music Therapy, Evansville State Hospital, Evansville, Indiana.

Appointed Officers

Editor:
ERWIN H. SCHNEIDER, Ph.D., Professor and Head, Department of Art and Music Education, The University of Tennessee, Knoxville; Past President, Southeastern Regional Chapter, NAMT.

Editor of the Bulletin:
WILLIAM SEARS, Ph.D., Lecturer in Music Therapy, Department of Music, Ohio University, Athens, Ohio.
MEMBERS-AT-LARGE OF THE EXECUTIVE COMMITTEE

DOROTHY BRIN CROCKER, Immediate Past President, NAMT; 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 Committee, Southwest District of the Music Teachers National Association; Member, Public Relations Committee of American Society of Group Psychotherapy and Psychodrama; Member, Committee on Music for Exceptional Children, Music Educators National Conference; Member, Texas Composers Guild.

RUDOLF DREIKURS, M.D., Director, Alfred Adler Institute, Chicago; Professor of Psychiatry, Chicago Medical School; Past President, American Society of Adlerian Psychology; Past President, American Society of Group Psychotherapy and psychodrama. (1961)

ARTHUR FLAGLER FULTZ, Chairman, Department of Music Therapy, New England Conservatory of Music, Boston; Music Therapy Consultant, Metropolitan State Hospital Children's Unit, Waltham, Mass., and Bedford VA Hospital, Bedford Mass.; Director of Affiliate Training in Music Therapy, Boston State Hospital, Dorchester, Mass.; Past President, NAMT; Member, Eastern Psychological Association. (1960)

REVEREND JOHN H. REINKE, S. J., Professor of Psychology, Xavier University, Cincinnati, Ohio. (1960)

RUTH BOXBERGER, Assistant Professor of Music Therapy and Music Education, Mississippi Southern College, Hattiesburg, Mississippi. (1962)
EDWINA EUSTIS DICK, 30 East 81st Street, New York 28, New York; Formerly Director of Special Projects, Musicians Emergency Fund, New York City. (1962)

BEN W. JENKINS, Box 1840, San Antonio, Texas. (1961)

ERNEST H. GRISHAM, Director of Music Therapy, Veterans Administration Hospital, Murfreesboro, Tennessee; Past President, Southeastern Regional Chapter, NAMT. (1960)

PHILIP N. McCARTY, Coordinator, Music Therapy and Recreation Therapy, State Hospital No. 1, Fulton, Missouri. (1962)

WAYNE W. RUPFENTHAL, Director of Psychiatric Music Therapy, Topeka State Hospital, Topeka, Kansas; President-Elect, Midwestern Regional Chapter, NAMT. (1961)

ADVISORY COMMITTEE

JESSE F. CASEY, M.D., Head, Division of Psychiatry, Veterans Administration, Washington, D.C.

EDWARD D. GREENWOOD, M.D., Staff Psychiatrist, The Menninger Foundation, Topeka, Kansas.

HON. CARROLL D. KEARNS, Mus.D., Member, United States Congress, from Pennsylvania; Formerly concert artist; Soloist, the Chicago Symphony Orchestra; Superintendent of Schools, Farrell, Pa.; Head, Department of Music, State Teachers College, Slippery Rock, Pa.; and Guest Conductor, United States Air Force Symphony Orchestra and Band.

JULES H. MASSERMAN, M.D., Professor of Neurology and Psychiatry, Northwestern University Medical School, Chicago; Director of Education, Illinois State Psychiatric Institute; 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.

KARL MENNINGER, M.D.; Chief of Staff, The Menninger Foundation, Topeka, Kansas.

AUDITING COMMITTEE

ALLEN WINOLD, Chairman; Assistant to the Dean, School of Music, Indiana University, Bloomington, Indiana.

RICHARD GRAHAM, Director of Music Therapy, Logansport State Hospital, Logansport, Indiana.
PAULINE HECHT, Director of Music Therapy, Richmond State Hospital, Richmond, Indiana.

BUDGET COMMITTEE

HERBERT GOLDSMITH, Chairman; Director of Music Therapy, Madison State Hospital, Madison, Indiana.
DOROTHY BRIN CROCKER (See Executive Committee)
JACK GRIFFIN, Director of Music Therapy, Muscatatuck State School, Butlerville, Indiana.

CERTIFICATION-REGISTRATION COMMITTEE

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.
WAYNE W. RUPPENTHAL (See Executive Committee)
MYRTLE F. THOMPSON, Past President, NAMT; Director, Department of Music and Creative Art Therapies, Essex County Overbrook Hospital, Cedar Grove, New Jersey.

CLINICAL PRACTICES COMMITTEE

BETTY ISERN, Chairman; Director of Music Therapy Clinic, College of the Pacific, Stockton, California.
RICHARD GRAY, Director of Music Therapy, Winter VA Hospital, Topeka, Kansas.
FORREST SLAUGHTER, Music Therapist, Adjunctive Therapy Department, The Menninger Foundation, Topeka, Kansas; Past President, Mid-West Regional Chapter, NAMT.

CONSTITUTION AND BYLAWS

ROBERT F. UNKEFER, Chairman (See Elected Officers)
CAROL I. COLLINS (See Appointed Officers)
ROY UNDERWOOD, Mus.D., Director, Division of Fine Arts, Michigan State University, East Lansing; Past President, Music Teachers National Association.
Appendix

EDUCATION COMMITTEE

MYRTLE F. THOMPSON, Chairman (See Certification-Registration Committee)
RUTH BOXBERGER (See Executive Committee)
ESTHER G. 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.

EDITORIAL COMMITTEE

ERWIN H. SCHNEIDER, PH.D., Chairman (See Appointed Officers)
RUTH BOXBERGER (See Executive Committee)
E. THAYER GASTON, PH.D. (See Certification-Registration Committee)
WILLIAM W. SEARS, PH.D. (See Appointed Officers)
ROBERT F. UNKEFER (See Elected Officers)

NOMINATING COMMITTEE

MYRTLE F. THOMPSON, Chairman (See Certification-Registration Committee)
DOROTHY BRIN CROCKER (See Executive Committee)
ARTHUR F. FULTZ (See Executive Committee)
E. THAYER GASTON, PH.D. (See Certification-Registration Committee)
ESTHER G. GILLILAND (See Education Committee)

PUBLIC RELATIONS COMMITTEE

CHRISTINE MILES, Chairman; Director of Music Therapy, Cleveland State Hospital, Cleveland, Ohio.
MARIANA BING, Co-Chairman (See Elected Officers)
LOIS BENEDICT, Music Therapist, Resthaven Hospital, Los Angeles, California.
CHARLES BRASWELL (See Student Affairs Committee)
MARIAN CHACE, Dance Therapist, St. Elizabeths Hospital, Washington, D.C. and Chestnut Lodge, Rockville, Maryland.
VANCE COTTER, Instructor of Music Therapy and Music Therapy Research, Texas Woman’s University, Denton, Texas.
EDWINA EUSTIS DICK, 30 East 81st Street, New York 28, New York.
CURT DOLLINS, Music Therapist, Richmond State Hospital, Richmond, Indiana.
LOUISE FRAZER, Founder and Director of Home Study School, Inc., Minneapolis, Minnesota.
RICHARD GRAY (See Clinical Practices Committee)
DOROTHY HALL (See Student Affairs Committee)
ANNE W. HOWE, Director, Music Therapy Department, South Carolina State Hospital, Columbia, South Carolina.
BETTY ISERN (See Clinical Practices Committee)
MARTHA A. LOVEN (See Elected Officers)

RESEARCH COMMITTEE

WILLIAM W. SEARS, Ph.D., Chairman (See Appointed Officers) (1960)
ARTHUR F. FULTZ (See Executive Committee) (1961)
HAROLD N. HANSON, Ph.D., Psychology Department, Essex County Overbrook Hospital, Cedar Grove, New Jersey. (1963)
JOHN REINKE, S. J., Professor of Psychology, Xavier University, Cincinnati, Ohio. (1962)
WAYNE W. RUPPENTHAL (See Executive Committee) (1964)

STUDENT AFFAIRS COMMITTEE

ROBERT F. UNKEFER, Chairman (See Elected Officers)
CHARLES BRASWELL, Director of Music Therapy Program, Loyola University, New Orleans, Louisiana.
DOROTHY HALL, Music Therapist, Essex County Overbrook Hospital, Cedar Grove, New Jersey.
BETTY ISERN (See Clinical Practice Committee)

CIVIL SERVICE STUDY GROUP

ROY UNDERWOOD, Mus.D., Chairman (See Constitution and By-laws Committee)
DOROTHY BRIN CROCKER (See Executive Committee)
Appendix

James Gregory, Director of Music, Veterans Administration Hospital, Salisbury, North Carolina.
Wayne W. Ruppenthal (See Executive Committee)

Interdisciplinary Study Group

Robert F. Unkefer, Delegate (See Elected Officers)
Martha A. Loven, Alternate (See Elected Officers)
Myrtle F. Thompson, Alternate (See Certification-Registration Committee)

American Medical Association

E. Thayer Gaston, Ph.D., Representative (See Certification-Registration Committee)
Roy Underwood, Mus.D., Alternate (See Constitution and Bylaws Committee)
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 $2.00.

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.
Music Club Affiliate Membership shall be open to all music clubs supporting the objectives and purposes of NAMT and contributing $15.00 or more annually to the Association. Rights and privileges shall be the same as those for Associate Membership when the membership is listed in the name of an individual club member.

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. 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.

HONORARY LIFE MEMBERS

Dr. E. Thayer Gaston, Chairman, Department of Music Education, The University of Kansas, Lawrence.

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.
National Autoharp Sales Company, Mr. L. H. Martin, 560-31st Street, Des Moines 12, Iowa.
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.
Nutone, Inc., Mr. Ralph Corbett, Madison and Red Bank Roads, Cincinnati 27, Ohio.
Sigma Alpha Iota, Mrs. Jeanette W. Kirk, 3229 N. W. 33rd Street, Oklahoma 12, Oklahoma.
PUBLICATIONS
OF
THE NATIONAL ASSOCIATION FOR
MUSIC THERAPY, INC.

MUSIC THERAPY 1951

The book of proceedings of the Second Annual Conference of NAMT, held in Chicago, November 9-11, 1951, is available from The Allen Press, P.O. Box 4, Lawrence, Kansas, for $3.68 postpaid U.S.A.

Preface—The Development of Music Therapy as a Profession

Part I—Music to Aid the Handicapped Child

Part II—Demonstrations

Part III—Scope of the Hospital Music Program and Professional Opportunities

Part IV—Volunteer Music Service in Hospitals

Part V—Musical Creativity and Emotional Conflict

Part VI—Patient Benefits of Community Concerts

Part VII—Report of Research Committee

Part VIII—Bibliography on Music Therapy

(600 Classified Items)

MUSIC THERAPY 1952

The book of proceedings of the Third Annual Conference of NAMT, held in Topeka, Kansas, October 30-November 1, 1952, is available from The Allen Press, P.O. Box 4, Lawrence, Kansas, for $5.20 postpaid, U.S.A.

Preface—NAMT Accomplishments and Future Possibilities

Part I—Psychiatric Viewpoints on Music Therapy

Part II—Music in Mental Hospitals

Part III—Music Therapy for Tuberculous Patients

Part IV—Music in Correctional Institutions

Part V—Music for the Mentally Retarded

Part VI—Music for the Physically Handicapped

Part VII—Music for the Emotionally Maladjusted Child

Part VIII—Volunteer Services

Part IX—Research
MUSIC THERAPY 1953

The book of proceedings of the Fourth Annual Conference of NAMT, held in East Lansing, Michigan, October 19–21, 1953, is available from The Allen Press, P.O. Box 4, Lawrence, Kansas, for $5.20 postpaid U.S.A.

PART I—The Dynamics of Music Therapy
PART II—Applied Techniques of Music Therapy
PART III—Music Therapy with Children
PART IV—Music in Geriatrics
PART V—Music Therapy for Tuberculosis Patients
PART VI—Music in the Religious Program
PART VII—Music in Surgery
PART VIII—Volunteer Service
PART IX—The Music Therapy Education Program
PART X—Research

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

MUSIC THERAPY 1957

The book of proceedings of the Eighth Annual Conference of NAMT, held in East Lansing, Michigan, October 10–12, 1957, 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—Music Therapy in the Psychiatric Hospital
PART III—Music Therapy for Exceptional Children
PART IV—Music Therapy, Music Education, Special Education
Appendix

PART V—Dance Therapy
PART VI—Research in Music Therapy
PART VII—“Question Box Session”
PART VIII—Association Growth

MUSIC THERAPY 1958

The book of proceedings of the Ninth Annual Conference of NAMT, held in Cincinnati, Ohio, October 30 to November 1, 1958, is available from The Allen Press, P.O. Box 4, Lawrence, Kansas, for $5.20 postpaid U.S.A.

PART I—The View of Hospital Administrators
PART II—The Hospital Show as a Therapeutic Instrument
PART III—Group Psychotherapy
PART IV—Music in Physical Medicine
PART V—Music Therapy and Special Education
PART VI—Music Therapy for Exceptional Children
PART VII—Dance Therapy
PART VIII—Volunteer Services in Music Therapy
PART IX—Reports of Special Interest Groups
PART X—Research in Music Therapy
PART XI—Association Growth
PART XII—Music Therapy Bibliography

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 $1.50 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, 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, 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.
Appendix

REGISTRATION OF MUSIC THERAPISTS

(Adopted 1957)

WHO SHALL BE ELIGIBLE

For the present, and for the next year, 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 hold 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.¹

A person graduating from a “tentatively approved” institution after this date may become eligible only after the Certification Committee of NAMT shall have examined and found satisfactory the transcript of his academic and clinical training.

¹. The equivalent of such a four-year course, substantiated by transcripts of academic and clinical training, when such has been obtained through a combination of another bachelor’s degree in music with additional work, will also suffice.
MACHINERY AND REQUIREMENTS FOR REGISTRATION

The applicant must present evidence of the following types:

(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.

APPLICATION MATERIALS

Application blanks may be obtained from Dr. E. Thayer Gaston, Chairman, Committee on Registration, Department of Music Education, The University of Kansas, Lawrence, Kansas.
Appendix

CONSTITUTION AND BYLAWS OF THE
NATIONAL ASSOCIATION FOR MUSIC THERAPY
Revised, 1959

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 nine classes: active, associate, student, contributing, sustaining, life, patron, honorary, and music club affiliate.

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 a regular annual meeting and, following the election at the 1959 annual meeting, shall continue in office for a term of two years, 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 one term.
SECTION 4. Elections shall be conducted as stated in the By-laws.

SECTION 5. The appointive officers of the Association shall be an Editor, an Editor of the Bulletin, an Archivist, a Parliamentarian, and a Publisher who also may be Acting Business Manager. 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-two members: the President, the President-Elect, 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, Public Relations, and Certification-Registration 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.
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 all persons who are interested in the purposes of NAMT but who are not professionally engaged in the use of music in therapy. Such persons as music therapy volunteers, private music teachers, public school music teachers, and any other musicians, interested in supporting the program of the Association, are usually included in this type of membership. 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 persons enrolled in music therapy degree programs at tentatively approved or fully approved institutions. Student members are entitled to receive all issues of the NAMT Bulletin and to attend meetings and programs of the Association but shall not have the right to vote or to hold office.

Section 4. Contributing membership shall be open to individuals who contribute $25.00 annually to the support of the Association, and shall have rights and privileges at whatever type of membership he qualifies.

Section 5. Sustaining membership shall be open to individuals, organizations, institutions, or business firms which contribute $50.00 annually to the support of the Association. Sustaining membership may include an individual membership assigned to a person designated by the sustaining member organization, institution, or firm. Such individual membership shall convey to the person to whom it is assigned rights and privileges at whatever type of membership the designate himself would qualify.
SECTION 6. Life membership shall be open to individuals upon the payment of $100.00. A life member shall have rights and privileges at whatever type of membership he qualifies.

SECTION 7. Patron membership shall be open to individuals, organizations, institutions, business firms, or foundations contributing $500.00 or more. These funds may be used for scholarships, endowments, research, or special projects as designated by the donor with the approval of the Executive Committee. Patron membership may include an individual membership assigned to the person designated by the organization, institution, firm, or foundation. Such membership shall convey to the person to whom it is assigned rights and privileges at whatever type of membership the designate would himself qualify.

SECTION 8. Honorary life membership may be conferred upon any person in recognition of distinguished service in the field of music therapy. Such election shall be made by the Executive Committee and be confirmed by the Association at a regular business session. Honorary life members who qualify for active membership shall have all the rights and privileges of such membership without the payment of annual dues. Honorary life membership shall not be conferred upon more than one person in any one fiscal year.

SECTION 9. Music Club affiliate membership shall be open to all music clubs interested in supporting the objectives and purposes of NAMT and contributing $15.00 or more annually to the Association. Rights and privileges shall be the same as those for Associate Membership when the membership is listed in the name of an individual club member.

SECTION 10. Membership privileges may be revoked by a two-thirds majority vote by ballot of the Executive Committee, when after proper submission of charges, provisions of opportunity for self-defense by the member(s) concerned, it has been shown that such membership privileges have been abused and/or the general good of the Association has been harmed.

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 two dollars ($2.00).
SECTION 2. The membership year shall coincide with the fiscal year.

SECTION 3. Members failing to pay dues by November 15 shall be sent a second notice by the Treasurer, and those not paying by the following January 1 shall forfeit all rights of membership, including receipt of the NAMT Bulletin.

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, and to assume all duties of the President in case of the resignation, disability, or absence of the President. In addition, the President-Elect shall serve as chairman of a continuing Committee on Constitution and Bylaws Revision.

SECTION 4. The First Vice-President shall succeed to the Presidency in case of the disability or resignation of both the President and the President-Elect; serve as Program Chairman, taking complete charge of program planning for the Annual Meeting, conferring on all details of management with his Chairman of Arrange-
ments and Special Convention Committees, and supervise 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 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 November 15 that their names will be removed from the rolls if dues are not paid by the following January 1; present a monthly financial report to the President, and a statement to the Executive Committee each six months; and present a written report to the Association at the first business session of the Annual Meeting. The book in which the record of receipts and disbursements for the year has been kept, together with the checks and vouchers, also the annual report of the Treasurer, shall be submitted to the Auditing Committee in sufficient time for an accurate report by that committee at the annual meeting of the Association.

Section 8. A. The Editor shall 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 9. The Archivist shall keep in a secure place all items of historical interest to the Association, such as programs, newspaper and magazine articles, photographs, items of correspondence, and supervise suitable displays, as requested, for NAMT and other conferences.
SECTION 10. Officers, upon retiring from office, shall arrange to confer with their successors during the Annual Meeting, to clarify procedures and responsibilities, and shall deliver to their successors within two weeks all record books, papers, and other property belonging to the Association.

ARTICLE IV

Committees


SECTION 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 appointed by the President with the approval of the Executive
Appendix

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 chairman of this committee shall automatically become a member of the Executive Committee. 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-Registration 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 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 Certification-Registration Committee shall annually choose its chairman for the year. The Chairman of this Committee shall automatically become a member of the Executive Committee. Any vacancy occurring during the year shall be filled by Executive Committee appointment.

The Certification-Registration Committee shall (1) establish standards and procedures for the certification of Music Therapists, and (2) institute formal approval of training programs. This Committee shall work in close cooperation with the Education Committee, and the actions of this committee shall be subject to the approval of the Executive Committee.

SECTION 8. The Clinical Practices 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 manner that one new member is appointed each year. This Committee shall annually choose its chairman for the year. This Committee shall study and make recommendations to the Executive Committee and the Association concerning clinical practices in the various fields in which music is employed in therapy.

SECTION 9. 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 10. 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 composed of Past Presidents of the Association, 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.

SECTION 2. Any auxiliary organizations so authorized by the Executive Committee shall adopt the purposes and objectives of NAMT, shall agree to conform to the Constitution and Bylaws of NAMT, and shall submit a copy of their Constitutions to the Executive Committee for formal approval.

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.
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