MUSIC THERAPY 1962
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

Chace, Marian, Dance Therapist, Saint Elizabeth’s Hospital, Washington, D.C.

Boxbberger, Ruth, Ph.D., R.M.T., Department of Music, Ohio University, Athens, Ohio.

Davidson, Henry A., M.D., Superintendent, Essex County Overbrook Hospital, Cedar Grove, New Jersey.


Gaston, E. Thayer, Ph.D., R.M.T., Department of Music Education, The University of Kansas; Committee on Psychology of Music, Music Teachers National Association; Member, Music Education Research Council, Music Educators National Conference; Consultant on Music Therapy, Winter V.A. Hospital, Topeka State Hospital, and The Menninger Foundation; Associate, American Psychological Association; Past President, NAMT; Honorary Life Member, NAMT.

Goodglass, Harold, Ph.D., Psychologist, Boston Veterans Administration Hospital, Boston, Massachusetts.

Greenblatt, Milton, M.D., Assistant Superintendent and Director of Research, Massachusetts Mental Health Center; Associate Clinical Professor of Psychiatry, Harvard Medical School.

Klingler, Herbert, Ph.D., Speech Pathologist, Veterans Administration Hospital, New York, New York.


Lafave, Hugh G., M.D., C.M., Medfield State Hospital, Harding, Massachusetts.

Lathom, Wanda, R.M.T., Director, Music Therapy Department, Parsons State Hospital and Training Center, Parsons, Kansas.

McCawley, Austin, M.D., Institute of Living, Hartford, Connecticut.

Michel, Donald E., Ph.D., R.M.T., Associate Professor and Director, Music Therapy Program, Florida State University, Tallahassee, Florida; Past President, NAMT.


viii
Schneider, Erwin H., Ph.D., R.M.T., Professor of Music Education, Ohio State University, Columbus, Ohio; Associate, American Psychological Association.

Sears, William W., Ph.D., R.M.T., Director, Music Therapy Program, Indiana University, Bloomington, Indiana.

Sharpe, Norma, R.M.T., Director, Music Therapy Department, Ontario Hospital, St. Thomas, Ontario, Canada.

Shatin, Leo, Ph.D., Professor of Clinical Psychology and Director, Division of Behavioral Sciences, Seton Hall College of Medicine, New Jersey.

Sherman, Lewis J., Ph.D., Chief, Psychology Service, Veterans Administration Hospital, Brockton, Massachusetts; Research Associate, Harvard Medical School.

Tyson, Florence, R.M.T., Director, Music Rehabilitation Center, New York, New York.

Unkefer, Robert F., Assistant Professor, Department of Music and Department of Psychology, Michigan State University, East Lansing, Michigan.

Weigl, Vally, R.M.T., Chief Music Therapist, New York Medical College, Flower and Fifth Hospitals, Mental Retardation Clinic, New York City; Director of Music, Roosevelt Cerebral Palsy School, Roosevelt, Long Island, New York.

Wrobel, Ardo M., R.M.T., Consultant, Rehabilitation Therapies and Education, Minnesota Department of Public Welfare.
CONTENTS

PART I

CONFERENCE ADDRESSES

President's Address ........................................ 3
Robert F. Unkefer

Address of Welcome ....................................... 6
Milton Greenblatt, M.D.

Keynote Address
Interdependence and Communication .................. 11
E. Thayer Gaston, Ph.D.

Banquet Address
Coordination, Communication, and the Team Approach . 17
Hugh G. Lafave, M.D.

PART II

THE HOSPITAL ADMINISTRATOR AND MUSIC THERAPY

Creative Arts and Hospital Administration ........... 23
Henry A. Davidson, M.D.

The Relationship of the Music Therapist to the Total
Hospital Treatment Program ............................ 31
Austin McCawley, M.D.

PART III

THE MUSIC THERAPIST

Roles of the Music Therapist in the Open Institution .... 43
Ardo M. Wrobel

Group Dynamics for the Music Therapist ............... 50
Lewis J. Sherman, Ph.D.

PART IV

DANCE THERAPY

The Structuring of Dance Sessions for Varying Needs of
Patients .................................................. 63
Marian Chace
CONFERENCE ADDRESSES
PRESIDENT's ADDRESS

ROBERT F. UNKEFER

The practice of presenting the presidential address during the opening session of our Association's annual conference is apparently one that has not been questioned in the thirteen years of our organization's life. It may be assumed annually by the program chairman that the president will have something new and interesting to say. But it is probably closer to the truth to note that he may be afraid to break the tradition. May I here and now relieve him of any responsibility for inviting this kind of a presentation next year. He can be the first program chairman to present a program free and clear of a presidential speech. It is probably wise to refrain from breaking the tradition during a thirteenth meeting, so I will proceed to find some appropriate remarks, and I propose to find them in a brief critical look at the job we have been doing. I have asked myself many questions recently and I propose to ask a few here.

One which may be startling in its nakedness is this: Should the National Association for Music Therapy continue to exist? I have asked myself questions about each organization in which I hold membership. I have a very demanding job in the university I serve, and a more demanding one as a parent. And each of these positions requires that I belong to many groups and the committees and the subcommittees of these groups. Home to me, in the last few years, has become just a place to go to pick up the materials for the next committee meeting, or a place to take the car so that my wife can go to her group meeting. Each organization we serve has its charter and its carefully phrased goals. Each strives to do the greatest moral good, and each demands our membership. The cub scout pack, the dean's advisory committee, the cooperative nursery school, the educational policies committee must be served. All rank alongside motherhood and the Miss America pageant as vehicles for promoting the American way. But there isn't time to serve in as many ways as one is encouraged to do.

A few weeks ago, I attended four meetings between 8 o'clock one night and 12 noon the following day. When I returned to my office, I made a list of criteria to measure my professional duties and the other service jobs that come to me. I have
managed to decline five speeches and two new committees in three weeks. If I can continue to do this, I may be able to accomplish something in those still-too-numerous jobs that I have kept on my list.

Now this is not my own personal tale of woe. All of us suffer this same tiredness from this haste to belong, from the hurry to do, and from the sprint to get in under the deadline. When the pressure finally gets too great, we are willing to face up to reworking our patterns, to breaking the vise of doing the same things and saying the same words. Thus in this context I propose to examine here, out in the open, if we are in a pressure vise or actually reaching or approximating some of our goals. I again ask, should the National Association for Music Therapy continue? My answer, which I assure you will be in the affirmative, can be charted in several ways.

I could say "yes, we should continue," just to preserve the friendships I have made over twelve years. I would not like to miss the fun at the annual meeting. I like to meet the new members, even though they appear younger each year. I like the Executive Committee meetings and the arguments. And I go home so tired it takes me until the spring regional meeting to reorient myself.

I could say "yes, we should continue," because we have served to lift the professional level of our members. We have established standards of training backed up by sturdy educational goals, and we have done a most adequate job of sticking to these standards.

I could say "yes," because my activity with NAMT looks good on my part of the annual report of my university, or because I can publish whatever I write in our Bulletin or Yearbook. There are other personal reasons that continue to attract us to NAMT, but these are nothing more than fringe benefits to members, and will not serve as adequate answers to the question of whether or not we should have an Association. Our single objective has been, and continues to be, better care and treatment for the patients we serve. Our only reason for growth, either in numbers or in professional behavior, is to allow us to serve more patients in better ways. Every single action related to the Association must be measured and evaluated in terms of giving better service to patients.

Now, it is possible to move an organization through a lot of
activity which runs alongside this goal of better treatment without ever producing an effect on the treatment. We could have a successful membership drive. We could organize more area groups and more committees and more subcommittees, but unless we move with care we could easily fail to aid one single patient in one single hospital, and there are still so many thousands of patients who could benefit from our efforts. There are several avenues open to us to promote a rapid gain in service to many more patients.

One of these avenues is extending service through volunteers, and this can be done even in hospitals where there is no music therapist, where there is no music therapy position, or no money for one at the present time. As a national goal, I have adopted the training of volunteers through a series of short schools or conferences sponsored through NAMT. One such school was held last spring under co-sponsorship with NAMT and the National Federation of Music Clubs. Several others have been held in Michigan and Ohio. I have appointed a national coordinator of this training plan for volunteers. It is my hope that this effort will be continued and enlarged through our regional structure in every area in the country. This activity has already begun to reap benefits for us. More patients are being served by trained volunteers. Some jobs for trained music therapists have resulted from volunteer activity in hospitals where no music programs existed. Three scholarships have been established for students because of the work with volunteers. These gains are appropriate and fit with our single objective. I don’t propose here to go further in describing this plan. We will be discussing it during this conference.

This one example serves to spell out our job, to re-focus our efforts for patients. We do have a valid base on which to build our Association. We can continue to be proud of our Organization.
ADDRESS OF WELCOME

MILTON GREENBLATT, M.D.

I have the very great honor of welcoming you to Massachusetts and to this area for your thirteenth annual meeting. Massachusetts has a long and distinguished history in the struggle for liberty and for the advancement of education and science; it is, however, currently in a political turmoil, as you may gather from the national magazines, in its search for clean and honest government. In the midst of these tensions, we can use all the help we can get—musical and otherwise. I was told that in past meetings you have been greeted by a high government official, but I was not told the significance of your choice this year of a mere scientist, and psychiatrist at that.

We are glad to have you and hope that you will enjoy a rewarding and stimulating conference and leave some of the inspiration with us when you depart. Your program and arrangement committee has left no stone unturned in an effort to provide rich enjoyment—both social and scientific—and we hope you will be pleased as we are honored by your presence here.

We live in a world of music and entertainment, and Boston and Cambridge, with their pioneering schools at Harvard, New England Conservatory, Boston University, and many, many other educational institutions, have done their share to produce musicians of enthusiasm, talent, and high standards. The contributions of musicians to the welfare and enjoyment of man are inestimable; it is indeed as difficult to imagine a world without music as it is to imagine a man without feelings. The two go hand in hand. Neurologists tell us that certain parts of the brain are specialized in their receptivity to sounds and their storage of musical memories. We are apparently born with an innate capacity to recognize and differentiate a tremendous variety of sounds, rhythms, cadences, and phrases in all their permutations; and when musical effects produce a profound experience within an individual, it is fair to say, and indeed it is supported by physiological studies, that music is felt, understood, and experienced by the whole body. As the notes and combinations become more moving, larger and larger aspects of the organism vibrate, so to speak, in resonance; thus music reaches to the very fiber of one's being; it knows no boundaries.
between brain and bone, so to speak—all the tissues may be affected. It knows no separation, necessarily, between conscious and unconscious mind; and by the casual playing of a few innocent notes, we may awaken the deepest and most timeless sentiments. This is its great power, and the great potential which you who are trained will be trying to master and control for the common good.

The range of effects upon the human organism that can be obtained from the influence of music are indeed very broad. It is not commonly recognized how sensitive some humans and other organisms may be. Allow me to draw a little upon my experience as a physician as to its more dramatic manifestations. Perhaps you have heard that some persons with epilepsy may suffer seizures only when they hear music; indeed, it may be utterly specific as to strain of music. I saw one of these cases myself some sixteen years ago—a young girl of about eighteen who fell into a seizure when she played a specific passage on the piano or danced to a given musical selection. Studies revealed that a small tumor pressed upon the temporal-lobe musical center, which, when removed, was followed by total relief from the disorder.

For years, neurologists have remarked upon the wondrous effects of disorders of the thalamus of the brain, a sensory way-station of strategic importance in the cerebral organization of perception, upon the elaboration of sensory stimuli. The brushing of a breeze over the skin can elaborate the most exquisite and often most disturbing musical reverberations within the individual. A state of heightened sensitivity prevails that renders musical stimuli, in some cases, as dreadful as the most traumatic event.

At the other end of the spectrum is audio-analgesia—a newly discovered addition to the anesthetist’s armamentarium. Perhaps I should say rediscovered, for centuries ago it was remarked how music could soothe pain and promote tranquillity. Now it is a welcome addition to the pain relievers in the dentist’s chair—and the neurophysiological studies of how this magical effect is produced bid fair to enlighten a significant segment of neural functioning that has hitherto been obscure.

Speaking of tranquilization, and to elaborate further upon the power of music, did you know that autistic children are unusually sensitive to music and that music is standard treatment
for them at bedtime? It is used regularly, for example, at the Children’s Unit here in Waltham, and is found to be superior to drugs and tranquilizers as a means of inducing sleep. Autistic children live in a world of their own, often oblivious to other human beings, extraordinarily disorganized in their behavior, and not infrequently hampered by curious disabilities related to diffuse brain damage. It is impossible to help them by the familiar bedtime stories, and pharmacological agents may often, for various reasons, be contraindicated—hence the discovery of music’s benign effect upon him is a Godsend to the child, not to mention those responsible for his welfare. It is posited that music helps control the world of sound, to which he is abnormally reactive; but this is just a hypothesis which, like the rest of our knowledge of musical effects, will require much study to understand truly.

You are about to concern yourselves with music in its recreational versus its therapeutic dimensions, with passive versus active involvement in music, music for the individual versus the group, music in the home and in the hospital, and so on. Let me remind you that although we have a powerful weapon here, we are still infants in its use. Not only are we uncertain as to its true therapeutic efficacy in any given case, we are guided by very nebulous principles of prescription; and we do not appreciate fully how to differentiate the effects of music on the one hand from those of the musician on the other. Interpersonal relations is a science still in the making, but its influence, like music, is profound and subtle. Music therapists, with regard to this problem, are in the same boat as psychotherapists, social workers, occupational therapists, and all the motley members of the so-called therapeutic team, struggling with the problems of self versus techniques. Let us enjoy each other’s company while we strive simultaneously to assist the patient and to allay our ignorance.

I hope that these problems challenge the scientist in you to ask searching questions about the efficacy of your approach. Any of us who claim to treat people must constantly scrutinize, revise, and improve our techniques. The questions forever before us are the following: What approach is best for which type of patient at what stage in his clinical course? We have to be, in the long run, just about as specific as that; else we will be practicing a healing art which is all art and no science. The
more we can be explicit about the indication and use of our modalities of treatment, the better for all concerned, and especially the better for those of us who have to transmit our knowledge from this generation to the next.

If music therapy is to become increasingly recognized as a profession in its own right, then it will have to establish a more solid scientific basis, facing the same challenges, therefore, as any other treatment activity in the medical realm.

The challenge of scientific validity is one important problem in the future that I hope will concern you. Another worth mentioning is the fact that all therapeutic endeavors, music therapy included, will have to adapt themselves in the future to the rapidly changing times. Psychiatry is in an almost revolutionary period. The awakening of the federal government and the states to the needs of the mentally ill, the increased public interest, and the focusing of a program by the government-sponsored Joint Commission on Mental Illness and Health have created a swiftly moving tide of events that you and I must reckon with.

Without question, increasing amounts of money will be allocated to the states in the immediate future for broad planning. Whether this will mean new opportunities for music therapists will depend in part on the value placed on music therapy by the state planners. The likely trends of planning will include the following: First, to facilitate the movement from custodial institution to therapeutic community, with all that means in terms of the full mobilization of the resources of each individual in the system. The second trend to be emphasized is the change from isolated hospitals to community mental hospitals. This involves emphasis on rehabilitation, smoothing the transitional phase, producing transitional facilities of all types, and mobilizing the community in the work of resettling the patient. The day hospital, the halfway house, the expatient clubs, the highly touted all-purpose community mental health centers will be the motif of the future. Music therapists will have to plan not only to work with patients in the hospital but to direct their efforts to rehabilitation, discharge, and community resettlement. Continuity of personnel working with patients from within the hospital to outside will be the keynote. Much more thought will be given to prevention of relapses—and, if relapses occur, to partial rather than full hospitalization.
The implications for music therapy at present can only be understood in vaguest terms. It will probably be wise for an Association such as this to begin to explore how it will participate in the rapid changes taking place. Much of the exploration could be done in company with other disciplines seeking this same solution.

I am sure that, whatever happens, there will be exciting times ahead for all of us.
KEYNOTE ADDRESS
INTERDEPENDENCE AND COMMUNICATION

E. THAYER GASTON, PH.D.

Two years ago when I spoke to you in San Francisco my last words were, "Perhaps, in the decade to come... more can be learned about man's relatedness to his fellowman and to the universe: to truth and to beauty. To these things we must be dedicated, because from all of these comes true humanitarianism."¹

It is perhaps, then, not coincidence that I have been asked to speak to you today on Interdependence and Communication. The greatest problems of our time are no longer the problems of production and control of "things" but of communication and cooperation among people. ... Yet the fact of the matter is that we live in the most cooperative, interdependent society the world has ever known. ... The welfare and safety of each of us rest upon the cooperation and understanding of our fellow citizens.²

To me, at least, these words are true and bespeak a personal credo in that, whatever beliefs a man may have, they will best be exemplified by the manner of his consideration for his fellowman. If society is truly interdependent, and I believe that it is, then there can be no unimportant people. The behavior of any individual is the concern of all of us. John Donne wrote as much over two hundred years ago, but it remained for Ernest Hemingway to name a book For Whom the Bell Tolls.

The major problem on earth is not the bomb. The bomb is actually the product of the problem. The main problem is that human imagination has not yet expanded to the point where it comprehends its own essential unity. People are not yet aware of themselves as a single interdependent species requiring the performance of certain vital services. ...³

Not only is man a member of a single interdependent but polytypical species, he is an interacting part of what is and what has been the cosmos. From the simplicity of the concept of the universe by the ancient Greeks—earth, air, fire, and water—man progressed to one hundred and two elements; then to three hundred isotopes; then to nine hundred man-made isotopes; and finally to a total of over twelve hundred nuclear species. It is thought that all had the same source: the primordial hydrogen atom in the interior of hot stars. And these, now more complex elements, make up our bodies, the earth, and what is known of the universe. The thin layer of soil that forms a patchy covering over the continents controls our own existence and that of every other animal of the land.

But this is an aside to our major thesis. Man is a member of a single, interdependent species. He must discover his relatedness, his interdependence—or remain always in conflict. For too long those who have known what to say have kept silent, and this is as bad as cowardice or compromise. To refuse to dispel ignorance is to dehumanize man. Later we will see how this refers to each of us. There remains the truth, and it must be sought and maintained by millions of Europeans, by a billion Communists, by millions of Indians, by hundreds of millions of Chinese, by millions of Latin Americans, and, not last of all, by us. Three-quarters of the human race are colored peoples, who are striving for equality of opportunity.

It does not seem necessary, nor shall I take time, to present biological and zoological data to substantiate the fact of the relatedness of man. Such data are easily accessible to all. For many, the substantiation of the relatedness and interdependence of man would be incomplete without reference to religion.

If, then, for all mankind, interdependence is true, there can be no doubt as to its existence for each of us in music therapy, and between us and those people with whom we work. Whether we work in a clinical situation, as an administrator, as a researcher, as an educator, as a psychologist, as a psychiatrist, or

whoever, we are all interdependent. Who can say we have no need of any of these? Who of these can say in truth that they have no need of us?

But, you may think, is this true in fact, is it actual in practice, or is it only theoretical? I believe it is true in fact and actual in practice. It is likewise true that our interdependence is often obscured and felt to be nonexistent. What one of us has not felt alone, has not felt misunderstood, and has not been certain of the stupidity, or the prejudice, or the egocentricity of those around us—and probably of other music therapists? I firmly believe it is our duty to help relieve these painful and disagreeable feelings, not only in our patients, but whenever we can in our fellow music therapists. Granted that we cannot be entirely successful, let us try to find the main reasons for some of our insecurities and lack of knowledge.

One could answer truthfully that our chief difficulty is lack of communication. But this answer is far too simple. There are a number of factors which need to be taken into account in order to see the picture more clearly. Let me skip ahead to several conclusive statements in order to show the direction of the development of this paper.

It seems certain that as a composite, taking all of our group together, we know far more than we realize. I must emphasize this by repeating it. We know far more than we realize. We have just never been able to make all of this knowledge available to each of us. We have had insufficient means or motivation for setting it down in words or by demonstration. We have not had adequately developed theory which could encompass this knowledge.

Let us suppose that we could develop a sort of psychological “Telstar” that could look down on the theories, beliefs, methods, and practices of everyone working in music therapy. Let us further suppose that we could make available to a group of wise people this vast picture, both as a whole and in detail, so that they could see all of those practices by every clinician; so that they could see the picture long enough to determine what works and what does not; see the teachings of every educator, what works, what does not; see all of the tentative and informal research, what works and what does not. If we could have even a part of such a picture, then we would see how much we know, and our communication would increase by leaps and bounds.
No such “Telstar” picture is available, but there are a number of things we can do.

NAMT is a young organization and represents a young discipline. In spite of this, our progress and unification are remarkable. We have come a long way much faster than many groups. Consider psychiatry or psychology for a moment. A new book on contemporary psychotherapies lists Adlerian, client-centered, existential, interactional, interpersonal, psychoanalytic, reparative-adaptational, transactional, and group psychotherapies.\(^7\) This is in no way a criticism of psychiatry but only to show that no group has a complete corner on truth. Whenever you hear of some group that claims its has, run—because perfect homeostasis means that all progress has stopped. Parenthetically, it should be said in all fairness that a number of psychiatrists and psychologists would disagree with the inclusiveness or exclusiveness of the book contents listed above.

It should be clear, then, that every group has a multiplicity of theory, a multiplicity of practice. Our multiplicities should not discourage or frighten us. We do, however, need to know what they are, in as far as such knowledge is possible. We need in our Organization what is so badly needed in the world: frank, honest, and objective dialogue between those who realize their interdependence and, more so, between those who do not.

But such dialogues are particularly difficult for us, at times, because we use a medium which is generally nonverbal—music. It is probable that none of us had thought of music therapy when we began our study of music. For whatever reason—e.g., personality needs and structure—we each chose or adopted an endeavor whose chief valence derives from its wordless meaning. We chose that which in many cases seeks meaning through feeling, at least partially.\(^8\) So what became, for us, true nonverbally needs now to be repeated verbally. We were further handicapped by explanations of music derived from German transcendentalism, which should have been discarded years ago.\(^9\) Music

---


is a human phenomenon and not something mystical. It is a folkway, a cultural specific available to all.

Furthermore, the musical education of most of us contained little or no participation in, or knowledge of, scientific method; yet we must become more and more scientific. We must show whenever possible scientific description, prescription, and application. How many times we are asked: "Specifically what does music do, how do you use it, is it yourself or the music, what research can you cite to defend what you are doing?" We need to be able to answer all of these questions as exactly as possible, and to do that we need the help of science. We cannot work with science as nonscience.

We have not been assisted to any extent by those whose concern has been the study of the conscious states of men. In consideration of the amount of man's preoccupation with the aesthetic, and there is far more than you think, there has been a surprisingly small amount of research done. If this seems doubtful, examine the tables of contents and the indices of books on psychology or psychiatry. Rarely will you find aesthetics even mentioned. We know little about the aesthetic state. The intricacy of the problem has been indicated by Kety.

What is that enchanted state of ecstasy we all know so well but cannot research? What is "beauty?" Polanyi thinks it is "simply" understanding (but one would have to know his definition of understanding before agreeing with him). And that is why he says that more scientists than art critics use the term "beauty."

Then there are the personal factors, and I will speak of only one. How dearly we love our own hypotheses! Scientists are just as prone to such love, however. We must realize that the same fact may have different aspects to different people, and may not be seen exactly the same by any two or more individuals. Never forget that your personal bias often will trip you down, not up.

But, in spite of all of these things, our “aloneness,” our lack of being able to see the whole picture, our youth, our multiplicity of practices, perhaps our theories, our lack of sufficient frank, honest, and objective dialogue, the nonverbal nature of our medium, the pitiful paucity of aesthetic research, and our defensiveness—in spite of all of these, we each could know far more than we know now, if we each would communicate that which we know best.

And now I lay before you the plea to accept the fact of our interdependence, and in the light of that acceptance to devise more adequate communication. Behavior has form and shape. It is not something mystical and completely defiant of prediction. Can we not bring our best individual knowledge to objective verbalization of that aspect of music therapy which we know best, that one behavior, treatment, teaching, helping, in which we are most expert? Could not each choose that segment of method, of practice, or of theory in which you excel, which has been most successful, and which achieves the most predictable results? Could you describe it objectively so that another could know what you did? I know personalities are different, but let us try. Is there not some way we can all possess this knowledge? We need to know all of the theory and all of the practice possible, because theory without practice is barren, and practice without theory is blind.

How much wiser and more productive we each could be if we could know the best from everyone else. May I challenge you to find some good means of communication? Let us dissolve false polychotomies. This is the maturity for which we all strive. This, it seems to me, is our best hope for greatest progress and the greatest good for all.
Coordination, communication, and the team approach are three useful ideas currently very much in vogue in our fields. The importance of these ideas is clearly pointed out by Stanton and Schwartz.

Yet the impact of these ideas is scarcely felt on the back wards of our state mental hospitals. A good music therapy program, for example, may be found flourishing in a wilderness otherwise devoid of treatment programs. Again, someone may start a remotivation group. But, should the patient respond, what is to happen then? Or a patient who for months has had nothing to interrupt a monotonous daily routine suddenly finds himself choosing between a shopping trip and a birthday party.

As one final example, five years ago I examined one of the best wards in our hospital (a well-regarded hospital). I was concerned to find that 16 of the 65 patients were in bed all but four hours of their day. There was no systematized treatment program, and each department took responsibility for accounting for narrow sections of the patients' time. This emphasizes the lack of planning and coordination and integration of goals. It dramatizes the need for an approach which would correct such situations.

I would like to spend our time describing for you an attempt to put these ideas into practice. For the past 14 months, under a National Institute of Mental Health grant, we have been working at Medfield State Hospital with 140 chronic schizophrenic patients. We have used a rehabilitation program which includes a coordinated treatment program using a team approach. The patients are hard-core patients randomly selected for the rehabilitation program, with an average length of 13.5 years of hospitalization.

The emphasis of this rehabilitation project is on work. Each patient is expected to work a regular, eight-hour day. The entire program is a coordinated and integrated one which incorporates all means available in a state mental hospital into a structured program.

Under the direction of the rehabilitation counselor, emphasis is on meaningful work which will prepare the patient for society's regular work day, and which will train patients in work areas where they will be able to find employment upon release from the hospital. Around this program of work, other activities are coordinated and an effort is made to blend these aspects into a day comparable to that of the outside world.

Each patient is a member of a group in which he is able to discuss the rehabilitation program and where he has an opportunity to see how each aspect of the program fits into the next. Each group is held once a week at a fixed time, so that the hospital work supervisor can anticipate patients' absences and can make appropriate arrangements. Whenever possible, these groups are held outside work hours.

Other activities also take place outside work hours—with the exception of special "earned" privileges, such as trips off the grounds to do shopping. When possible, even these trips take place on days off. If an outside activity is felt to be vital to a patient's rehabilitation and it cannot be otherwise fitted in, then arrangements are made for the patient to make up for work time missed. In this way, disruptions in the work program are kept to a minimum and are similar to the usual community work day, where there may be disruptions such as dental appointments.

In the usual state hospital program, recreational and avocational activities are in progress during the daytime hours. In our coordinated program, an effort has been made to provide these in an evening and weekend program, with the feeling that this more closely parallels the typical day of the outside community. To accomplish this, the occupational therapist works from 2 P.M. to 10 P.M. on Tuesdays through Saturdays. With the help of 22 regular volunteers, evening groups have been formed to help patients develop avocational and social interests. One night a week, in groups of ten, patients and volunteers work together to develop skills (carpentry, electronics, domestic science, music, art) that will help to fill evening hours as well as facilitate further development of such interests for patients re-entering the community.

Weekend evenings are spent in recreational activity: games nights, bingo, square dancing, sing-alongs, and sports. With occasional consultant help from a recreational therapist, a
patient committee sparks these weekend endeavors. The usual movie and special program nights that are part of the hospital routine are further enriched in this project by special lecture series, good grooming, and social adjustment courses run by student nurses and volunteers.

This will give you a picture of the way in which the patient’s day is coordinated into a total treatment plan. This is a plan designed to reach all the patients—in contrast to the usual back ward program, which reaches a select few. I would like to spend the remainder of our time in a discussion of how communication and the team approach are used to make this coordination meaningful and effective.

Communication within the project attempts to make the patients aware of the aims and methods of the rehabilitation project. At the weekly group meetings led by project personnel, a great deal of time is spent in explaining the rehabilitation project to the patients. The project and the roles of the staff members are discussed along with a discussion of each patient’s progress. Decisions to be made by the project are discussed in the groups, and patients share in some of the decision-making. In the groups, the patients are encouraged to ask questions and to give their opinions on various aspects of the project.

In addition to the group meetings, patients are made aware of their progress and the rules of the project by means of a step system, in which patients are rated and under which they achieve certain steps. On the basis of steps, each patient is entitled to certain privileges. The steps needed for each privilege are posted in the wards. Patients are informed of requirements to be met in order to attain more steps.

A second aspect of the communication within the project centers around the staff and an effort to make all members of the staff familiar with the aims and methods of the project. It also attempts to enable all personnel to have some voice in the planning and implementation of the program. The major way by which this is accomplished is through weekly staff meetings attended by all project personnel. At these meetings individual patients are discussed by everyone involved, and plans for patients are made on the basis of combined information. In addition, time at these meetings is spent discussing policies and plans for the entire rehabilitation program. All personnel work-
ing on the project freely voice their opinions and offer criticisms and suggestions.

There are numerous smaller meetings among project personnel directly involved in certain cases. As an example, when a patient is reaching a point where plans are to be made for him to go into the community, meetings with his ward personnel, the rehabilitation counselor, and the social worker are held. At these meetings, plans are made for the patient on the basis of their combined knowledge of the patient’s assets and liabilities.

This brief outline of the rehabilitation program will give you some indication of the way in which coordination and communication are made important aspects of a treatment program. This has meant that a more meaningful and therapeutic program can be planned for each patient. It has further meant that the talents and special aptitudes of each staff member can be utilized, with the result that more is known about each patient and more can be done to work with each patient. Each member of the staff working in the project has a specific role and function which provides for effective use of individual talents in an integrated team approach.

As Richman and Zinn have pointed out, “...although many hospitals are seriously understaffed, understaffing is not the core of the problem. It is the coordinated use of available staff and staff time as an integral part of total patient treatment that presents the foremost challenge.” We feel that our program is an example of the way in which coordination, communication, and the team approach have been used to meet this challenge successfully.

PART II
THE HOSPITAL ADMINISTRATOR
AND MUSIC THERAPY
CREATIVE ARTS AND HOSPITAL ADMINISTRATION

HENRY A. DAVIDSON, M.D.

In mental hospital operation, we rely on certain premises. We think that music in particular, and the creative arts in general, can make unique contributions. First let me spell out these premises.

The first premise is that people are committed to us because they do not get along in the outside community. The second is that if a patient adapts too well to the hospital, he is learning to adjust to failure, not to success. Third, we believe that the patient will get well quicker if we maintain his self-respect and dignity. Fourth, many apparently “administrative” decisions are, in effect, medical and therapeutic, and therefore medical-psychiatric control is essential to good mental hospital practice. This may sound as if I am taking sides in a jurisdictional dispute, but I will explain it in a moment. The fifth premise is that, to retain a good staff, we must interest our staff in the long-range adjustment of the patient, not just in his adaptation to the hospital. The sixth is that deterioration in a patient is more likely the effect of hospital life than it is the result of a disease process. The seventh premise is that there ought to be constant interchange between the hospital and the community.

Let us examine these seven premises and see how the creative arts contribute to our mission.

1. People are committed because they do not get along outside the hospital. Neither a diagnosis nor a set of symptoms leads to hospitalization. It is simply that family, neighbors, or officials find the patient’s behavior intolerable. Generally, a family is reluctant to apply for commitment. They do not do it until the situation becomes unbearable. If unacceptability to society is the reason for commitment, it follows that the hospital must try to teach the patient to fit into the community. He must learn how to be a member of the orchestra, not a soloist; a member of the chorus, not a prima donna. As you can see by the very word choice, the music department is uniquely equipped to get the patient to see how he can fit into a group or team, and to see how such participation can be fun.

2. A hospital provides an artificial environment where everybody knows where his next meal is coming from. It may not
always be a good meal, but he knows where it is coming from. His day is planned. He is often told what to wear, when to eat, when to go to bed. The kinds of leadership, initiative, and self-determination needed for success in life are discouraged in the hospital. Too often we mould a patient into a life of passive cooperation and ultimate dependency. These are not assets in the great outside world; and, thus, this kind of life really trains a patient for failure. That is a harsh statement, but in too many hospitals it is true. When you consider the drab life most of our patients lead, you will agree that anyone in his right mind would rebel against it. When an attendant reports a patient as cooperative, this may not be a good sign. If he is cooperative in a normal-life function, in a function appropriate to the great outside world, that is fine. But, if he is cooperative to a shabby and uninspiring ward routine, this is nothing to be proud of. Yet in day-by-day hospital administration, this goal may be necessary. We cannot have a ward full of temperament mental individualists. Thus, the creative arts offer an unusual outlet; through them, we can encourage both individualism and teamwork, initiative and a sensible conformity; here, the patient can learn to be creative in a socially useful way.

3. Hospital life often impairs the dignity of the patient. He may be called brusquely by his last name. He loses every shred of privacy; even his bowel movements have to occur more or less in public. His requests, no matter how reasonable, often lead to patronizing dismissal and sometimes to a reprimand. The employees in closest contact with the patients are the nonprofessional aides and attendants. Too often, we handle these attendants with little respect; and they, in turn, do nothing to develop self-respect in the patient. In a well-organized music and creative arts department, each patient is treated with individualized dignity. For example, his name appears on the printed programs of plays and concerts. It is written with his first and last name following a Mr., or a Mrs., or a Miss, just as the employee’s name or the professional person’s name is written. Choruses, duets, orchestral numbers, and plays are shared by patients and employees. Before the footlights or at the piano, they are all equal. This department offers us an unusual opportunity for showing that we can and will treat the patient with dignity and respect.

4. In a general hospital, unlike a mental hospital, there is a
sharp cleavage between administrative and medical decisions. You might go to a general hospital for a few days for observation, or to have a baby, or to have a hernia repaired. As far as you are concerned, the hospital is simply a hotel. The administrator makes decisions which have little meaning to you, whether they concern police protection, elevator service, pension plans for employees, or the installation of a bread-wrapper in the kitchen. You will be out in a few days, and what goes on behind the scenes of the “hotel” is of scant interest to you. However, in a mental hospital, the situation is different. The average stay is much longer. In a mental hospital, the doctors are salaried employees professionally subordinate to senior physicians; whereas, in a general hospital, each doctor is an independent entrepreneur selected by the patient, and is in no sense subordinate to hospital management. In a psychiatric hospital, every administrative decision makes an impact on the patient’s personality. For example, take the point I made about the way a patient’s name is listed on a printed program. On the face of it, this seems like an administrative rather than a medical decision. Yet, it has real impact on the patient’s morale, which means also on the progress of his emotional illness. If a music department is thought of as a kind of entertainment or diversional operation, it would come under administrative management and not under the medical staff. But, in a mental hospital, it is a therapeutic instrument and must be placed under one of the medical directors, the chief of a service, the director of therapy, or the like.

Let me insert a footnote at this point. It is a fashion to tack the word “therapy” to everything in a mental hospital. The librarian says that hers is a department of bibliotherapy. The physical education staff would rather be called recreational therapists. We can exploit patients to do menial work on the grounds, and console ourselves by calling it occupational therapy. There might be a patient separating dirty underclothes in the laundry; if so, we can salve our conscience by saying that he is getting the benefit of sanitation therapy. The same benign term could be applied to the patient who collects garbage pails in doctors’ row. Now, we ask: Is the phrase “music therapy” or “arts therapy” really justified, or is this a euphemism? I am satisfied that the word “therapy” is a proper one. Sometimes music itself is a direct therapeutic instrument tapping profound layers of the unconscious mind, and thus it becomes a precise therapeu-
tic tool. More often, however, the therapeutic value of this program inheres in its normalizing social effect. In either event, "therapy" is a well-earned designation.

5. Our fifth premise concerns our personnel problem. We sometimes wonder why anyone works in a mental hospital. Its location is usually bad; the meals are typically institutional; cures are rare; working conditions are marginal and include a lot of evening, holiday, and weekend duty. And, no one works in public mental hospitals because of high salaries. For personnel at the professional level, the answer has to be this: We cannot recruit nor retain staff unless the work is made professionally satisfying. Generally speaking, our patients improve only slowly. We do not have the short-term results that follow the treatment of pneumonia, the surgical removal of an intestinal obstruction, or the delivery of a baby. Consequently, professional satisfaction must accrue out of following patients for a long period of time to note the changes. Here we are up against the frustrating fact that we do not get the patient until he has made a failure of life outside—which may be years after the beginning of his illness. And we cannot see the long-term results, because as soon as the patient improves he leaves us, and we seldom participate in long-term post-hospital follow-up. The only cure for this is to interweave the hospital more closely with the community at both ends. Here is where the music and arts department has another unique role. Because it reaches into the outside community so well, it helps us in this phase of our program.

6. We are all familiar with the deteriorated patient. Many of us believe that deterioration is more the result of hospital life than of its being inherent in the disease process. Too often our hospital routine isolates the patient from all the excitements, and stimuli, and hopes, and satisfactions that make life worth living. We invade the patient's privacy, deny his dignity, coop him up with others. We feed him meals which are fattening without being pleasing to the eye or satisfying to the palate. We deprive him of any choice about what he may eat. He has to wear what we give him, bathe when we tell him, and go where we send him. This injures his morale and lowers his self-respect. This loss of morale occurs wherever human beings are penned up with nothing to interest or excite them, and are given no hope of change. Under the title of "institutional neurosis," Russell Barton has described it in concentration camps, pris-
ons, orphanages, and wherever people are treated en masse. When we see patients deteriorate, we console ourselves with the thought that this is inherent in the disease process, and that therefore there is nothing we can do about it. But any psychiatric administrator knows, in his heart, that much of this deterioration is man-made. See what an exciting challenge this offers to the arts and music departments—for with them, you have the chance of reversing this process. You can individualize patients. You can give them a fragment of outside life, bringing parts of the community into your shops or bringing patients to the great world outside. You can give patients the opportunity to be creative, to take initiative, to find a new interest, and to learn the joy of working on an equal plane with others.

7. And now for our last, and in some respects most important, premise: that of maintaining a two-way integration with the outside community. Traditionally, the mental hospital is very sharply separated from the community. If we no longer have walls of brick or iron, we still have spiritual and emotional walls around our institutions. But we know that this is all wrong.

Ideally, hospitalization should be a casual and simple part of the continuum of the patient’s life. Instead, it is a formidable break with the continuity of life. Entering the hospital is a dramatic and frightening experience. The family speaks of it as “sending the patient away,” and sometimes acts as if the patient were thereby dead. And discharge from the hospital is another dramatic break with the life before. The concept is that the person either is or is not a mental hospital inpatient. We will not accept the idea that he can have a slight touch of psychosis; this we reject as being as silly as a slight touch of pregnancy. Really, though, people have all grades of emotional involvement, and a patient might have a brief episode requiring brief hospitalization. Instead of having this rigid concept of his being either in or out of the hospital, we would hope that hospital admission would be no more solemn an episode than going to a clinic to have his eyes refracted. We want the hospital to be woven into the community around it, and we want to drop from our thinking and our vocabulary the idea of the world inside versus the world outside.

Under the present system, the doctor who commits a patient has no responsibility for that patient after that. And, the staff doctor who releases a patient to the community terminates his
responsibility at the hospital’s front door. Neither doctor is involved in the consequences of his decision. We would like to change that. We would want the committing physician to come to the hospital, and to see his patient, and to attend staff meetings about him, and to participate in his treatment. Conversely, we want the hospital doctor to go into the community, to work in mental hygiene centers and follow-up clinics, and to see in the community the patient he knew in the ward. In view of the fees available to private practitioners, there is no likelihood that they will spend much time in our hospitals. But we are now getting more and more of our hospital psychiatrists, psychologists, and social workers into community agencies; to that extent, at least, we can achieve a better integration with the world outside.

Many hospitals are proud of the amenities they bring to their patients. On the hospital grounds they hold concerts, put on theatricals, show movies, have church services, hand out clothing, set up bowling alleys, and schedule bingo games. In truth, it would be better if we took the patients out of the hospital for all those things. We do not want to make the hospital a self-contained island. On the contrary, we want to flow into the community around us. We want the membrane between hospital and community to be a permeable one.

I think you can now see where you music therapists come in. In an almost unique way, your programs can keep one foot in the community and one in the hospital. You can bring volunteers in from the outside world. You can take patients out to music halls and theatres. School and civic orchestras and acting groups can come in and perform; and patients’ groups can go out and perform. You can help us realize this ideal of community integration. As a corollary, I would hope that all who work in hospitals would maintain good community contacts: that you would involve yourselves in PTA’s, if you have school children; that you would take part in outside church activities, in civic associations, and, in general, in community life outside the hospital.

I have thus listed seven premises of modern mental hospital operation and have pointed out the special role that music and the other creative arts can play. Let me close with a word about the overall administrative problems of a music and creative arts department in relation to the rest of the hospital.

I see this operation as a specific kind of therapy. In a mental hospital, all therapies should be under the professional leader-
ship of the institution. Thus, the head of a music and arts department should report directly to the clinical director, the medical director, or a chief of staff. I would not want to see music considered a subdivision of special services, nor otherwise administratively placed under a nonprofessional executive officer or business manager. In some hospitals, it is a subdivision of occupational or recreational therapy. But occupational therapy has a long and honorable heritage of its own and should not be asked to carry the new, highly individualized, and relatively unstructured program of creative arts. I have great respect for the contributions made by occupational therapy. There is, however, a great difference between making ceramic ashtrays and weaving rugs on the one hand, and creating free-form ceramic objects or creating music on the other. Each has a unique, important, and separate role to play. Nor would I put music under recreational therapies. This would underline the diversional phases of the program and, to that extent, soft-pedal its more creative and therapeutic aspects. It is thrilling to see a team of patients welded into a calisthenic unit, performing with the beautiful precision of West Point cadets or Radio City Music Hall ushers; but this is quite different from seeing a presumably deteriorated patient play a violin or sing a solo. I would not assign music and creative arts to any department except its own; nor would I place it in any line of responsibility except to the hospital's professional leadership.

The role of music and creative arts may be hard to explain to an unimaginative official. A budget-conscious administrator is understandably bothered by the money needed to buy pianos and to keep them tuned. He frowns at the cost of purchasing and maintaining other musical and artistic supplies and equipment. Certainly it is hard to justify this if he does not have enough to buy the drugs and X-ray supplies he wants. Direct medical needs are simple and appealing. Any superintendent knows that he has to spend money for drugs or medical services. But, it takes a fair degree of sophistication to see that the several creative arts are also important to his program. The whole business may look like boondoggling. A naive superintendent cannot understand why he should use tax money for bongo drums or castanets when his budget is so tight. This imposes on the leadership of music and arts a duty in educating the administrator. Do not blame him if he sees no connection between getting
pianos tuned and getting patients well. You have to show him.

This is one of the advantages of theatricals and concerts with many patients participating. When the administrative officials see what these patients can do, they get the point. Take one mute catatonic and show that he can be drawn out of his dream world into good reality contact through the language of music and the wordless medium of artistic creativity—do that, and you are really communicating. In a way, you are the youngest of the modalities of psychotherapy; thus, you have an infinite capacity for growth.
THE RELATIONSHIP OF THE MUSIC THERAPIST TO THE TOTAL HOSPITAL TREATMENT PROGRAM

AUSTIN McCAWLEY, M.D.

It is a pleasure to speak to an organization such as the NAMT, which is experimenting in new directions, which is exploring new areas of therapeutic benefits to patients at the same time as it already contributes so much to the total rehabilitative program of mental hospitals. I know that there are those among you who will say that the field is not as new as I seem to indicate, but the uses of music in conjunction with psychotherapy are still somewhat of an innovation, and there is much to be learned. We still need detailed and controlled studies on the effects of music as a therapy for the mentally ill, and, inspite of the many excellent theoretical formulations which have been advanced, I do not feel that as yet we have any satisfactory scientific basis for the theory of music therapy based on psychological function and structure.

There are some writers in the literature who say that no scientific statistics are likely to be produced from music therapy. I do not know whether this is so, but certainly the varieties of response to music are quite variable and indeed hard to measure. Of course, there are many other things in psychiatry which are quite difficult to measure: the relationship between the psychotherapist and his patient, the dedication of a nurse or an aide, the human interest and desire to be of help, which must be there before psychiatric treatment is meaningful. These are all hard to quantify. End results can be put in statistical form, but it is hard to measure all the various factors which go into producing these results.

Certainly the response to music is a very individual matter. To some it means little. You may have heard the story of General Ulysses S. Grant, who, while he was President of the United States, attended a concert at the Peabody Institute in Baltimore. He was accompanied by a friend, Mr. Winthrop, who halfway through the performance turned around and asked him how he liked the concert. "Mr. Winthrop," President Grant replied, "I only know two tunes; one of those is Yankee Doodle and the other isn't."

Music has been effectively used as an adjunct to psychotherapy in many individual cases more responsive to its influence than
General Grant. Whether this technique could be effectively extended on any larger scale is still questionable. There is no question, however, about the value of music in a hospital program as a form of recreational and occupational therapy.

The topic for discussion is "The Relationship of the Music Therapist in the Total Hospital Program." All these considerations do have some bearing on the music therapist's position in the hospital staff and his relations with his colleagues. A music therapist who is concerned with extending the possibilities of his work, and who is attempting to use music as more than just a patient activity, must be prepared for a certain amount of uncertainty in the reactions of the other members of the staff, and with this a certain reservation which may cause him to feel that he is not accepted. That part of a music program which runs on traditional lines as a form of recreational or occupational therapy, or as a means of promoting socialization, is accepted without question by the hospital. Indeed the value of such a program is taken for granted. However, unless a more advanced program of music therapy has obtained general acceptance in the hospital, the therapist who tries more must be prepared for a certain amount of questioning, a certain amount of skepticism, a certain amount of competition with the other established adjunctive therapies and therapists.

Now this is the inevitable accompaniment of change, innovation, and experimentation, and indeed must be regarded as healthy. However, some music therapists complain of a sense of isolation; others, of an attitude of hostility on the part of certain members on the staff, particularly adjunctive therapists. There is also a more general concern about their status as therapists. To some extent this is a reflection of the changing status of music therapy itself. It may occur in a hospital where there is an organizational problem in the hospital departments, and a measure of the lack of cooperation or coordination between the various sections in a particular organization, rather than some special problems of the musical therapist. There are also some other factors which are not peculiar to music therapy but are rather by-products of the total functioning of a mental hospital. I would like to consider these in more detail.

In group participation of any kind, there are certain dynamic factors which operate. This is particularly true in a mental hospital, where the emotional factors and the interpersonal situations
arising in a group which concerns itself with emotional disturbances are both complex and far-reaching in their effects. As in any other organization, situations of difficulty arise which can be attributed to a variety of obvious causes: friction between various personalities; the fault, inefficiency, or lack of competency of one or another individual; lack of leadership by those in a position of responsibility; and so forth. Quite often, however, the real basis for conflict is to be found in a process not quite so obvious on the surface, but one which has been operating for some time. Eventually, certain discords and certain disturbances result, as an end product of this conflict, which may not be recognized at its origin.

We are all familiar, from our own experience, with situations of disagreement among hospital personnel. When such disagreement is overt, the effects are usually short-lived. More serious disturbances occur when the disturbance is covert. Then you find that the staff members involved, when face to face, are often quite polite and understanding of each other's point of view. By themselves, with friends, or with those whom they consider as sympathetic, they express very different attitudes towards the opposition's point of view, ranging from concern over what has gone wrong with "Doctor X or Nurse X" to more open expressions of hostility. Instead of talking about the patient, they generally talk about what a time they are having with their colleague. The staff becomes more preoccupied with treating each other than the patient.

In such a disagreement around a particular patient, you usually find that the antagonists line up in two camps and that there are two opposing arguments which are almost traditionally obligatory in the situation. This does not seem to be peculiar to any particular hospital, but rather a common experience in hospitals with quite different systems of organization. On the one hand, you find a group arguing that a particular patient should be treated permissively in line with his individual needs, that his requests should be met, and that, although they may seem at times unreasonable or demanding, this must be tolerated and gone along with as far as practical. The patient must not be treated punitively; he must be given maximum responsibility within the hospital and allowed to make his own mistakes. This group feels that the need of the individual comes first, and that often in a particular case the needs of the patient are being sub-
ordinated to the needs of the hospital. This last argument is not usually advanced openly until the discussion has heated up considerably.

On the other side of the fence, you find the group which holds that the patient should not be pampered; that no special exceptions should be made; that any special consideration is simply catering to his sickness; that the patient must accept the necessary controls and limits of the hospital, face reality, and not be shielded from it. The argument is advanced that the present disturbance is a reflection of the patient's problem with authority. Both points of view make a good deal of sense and are quite appropriate to the consideration of administrative problems and the management of the individual patient; often, however, they have only a tangential reference to the real cause of a disagreement, and the vigor and lucidity with which they are advanced is related more to the personal involvement of the disputants rather than to the facts of the case.

When disagreements are not resolved, the attitudes of the staff members involved become rather fixed, and their response to anyone who does not agree with them is usually tinged with hostility.

The music therapist approaches the patient with a point of view unlike that of other members of the staff. His contact with the patient differs in a number of important ways. The cultural value and generally satisfactory quality of any form of musical activity permit a bond of interest between himself and the patient which may be lacking in contacts with other members of the staff. The music therapist is generally not identified with the authoritarian structure of the hospital and is not personally responsible for administrative decisions. This may tend to place him in the middle. He may stand in a favorable light with the patients, but on the other hand finds that he does not agree with other members of the staff and experiences certain hostilities from them, the source of which he might misunderstand, attributing either to some personal quality of his own or perhaps linking it with a more general concern about the status of his position as a music therapist. At this point his own defensive operations go into action and he becomes involved as a participant in the staff disagreement.

This kind of conflict between members of the staff generally reflects itself in a more or less obvious disturbance of the patient's
behavior. There are also effects on the staff, who may complain of a variety of emotional reactions, ranging from anxiety to outwardly directed aggression. They find that they cannot sleep, and lie awake thinking about the situation within the hospital. They feel restless and bored with their work; or they become openly dissatisfied with the hospital, complain about the working conditions, and quite often say that they are fed up and want to quit, perhaps even handing in their resignation. In this atmosphere, minor personal antagonisms and frictions become magnified.

At this point the administrator of the section of the hospital becomes involved, attention is focused on the situation, and various efforts are made to straighten it out. In a situation like this, the temptations towards bias of one kind or another are considerable. It is essential to be quite objective—and not just objective, but also very critical in the evaluation of any statements which are made. One can take it for granted that any simple statements made about the situation are distortions of fact, simplified in line with the preconceptions and fixed ideas of the speaker. On the other hand, fact is not just oversimplified; it is also submerged under a mass of circumstantial and partially irrelevant information, conveyed with much emotion and a great deal of indignation.

The administrator who is attempting to unravel the situation has to have the passion for accuracy which distinguished Cordell Hull. He is said to have been one day riding on a train across the country when a friend, sitting beside him, looked out the window and remarked on a flock of sheep, saying: “Those sheep have just been sheared.” Hull studied the flock closely. “Sheared on this side, anyway,” he grudgingly admitted.

The most useful approach to the problem is to get the people involved together, either at one of the regular ward conferences or at a conference specially called to discuss the matter. If ward conferences are held regularly and are functioning in the way they should, a situation of this kind, ideally, should not get to the point which I have described. It should be handled before things get out of line. Once the trouble has started, however, the unit conference has to be strengthened and supported in an open discussion of the problem—or if necessary a special conference has to be called.
Stanton and Schwartz, in their book *The Mental Hospital*, have described this kind of situation with a wealth of illustration; and they make the important point that, by the time a disagreement of this kind has arisen, the controversy rather than the content is important, or, to go further, that the concealment of the controversy is the important thing. The ward conference should aim at bringing the difficulty out into the open, where it can be discussed and some workable solution evolved. By this time it may be found that the original dispute is secondary in importance. It is, I think, common experience that when a conference of this kind has reached some more-or-less amicable agreement, then the disturbance in the patient or in the ward subsides. The conflict within the staff is resolved; and it becomes apparent that the personal animosities which have been aroused in the course of the argument are irrelevant, and only the clinical facts are important.

The process which I have described is essentially one of breakdown in communication. It is the covert nature of the disagreement which keeps the ball rolling. From then on, information is selected and presented to advance a particular point of view. Facts are reported in line with the preconceptions of the observer, and emphasis is displaced in accord with what he thinks the facts should really mean. At the same time, the importance of much significant information is overlooked because of inaccuracies in the method of reporting. This, I should say, is done with all the best intentions in the world, but the communication of facts about human behavior is subject to many errors and distortions.

You may know the story of the mate aboard a cargo ship who, one night while off duty, got quietly drunk. The next day, the captain, who did not like him very much, wrote in the log: "The mate was drunk last night." The mate, who was a very capable and conscientious man, who always did his job well, and who knew what this report might do to him, pleaded with the captain to erase this entry. He pointed out that he had been off duty, that he had not neglected any responsibility in consequence of his drinking bout, and that he had never once drunk while on duty or failed in the performance of his duty during a long career. The captain remained adamant, pointing out that the

ship's log was a narration of day-to-day events and that he had simply recorded a fact. The following day the captain opened the log and found that the mate, who made the next entry in the log, had written: "The captain was sober today."

Fortunately, our reporting is not as prejudiced as this, but prejudice does creep in and often perpetuates itself. A good example of this is the phenomenon which we might call "patient reputation." A patient becomes known as a difficult or dangerous case, the staff reacts to this against and away from the patient, and the patient further reacts to this attitude. You then have a fixed situation in which there is no prospect of change. Curiously, this is a situation which in some way reassures the staff's anxiety. For one thing, it determines a fixed course of action or a set pattern of management for this particular patient. There is no need to make individual decisions about the different problems which arise in the course of this patient's care, and the anxiety of indecision is avoided. The staff knows how to handle him! They know what attitude to take, and there is no need to examine their own reactions to the patient. They know what their attitude should be. This is not a conscious or deliberate process, but happens on an involuntary and unconscious level.

We are all people, and when we are involved in an interpersonal situation, we react to pressures just like people do; no matter how sophisticated we are about our own motivations and our own behavior when we are discussing this with a friend, we also have unconscious motivations which come into play when we are personally involved; no matter how well-trained we are, we do have reactions to patients which are not therapeutic. They may not even be very rational, if we examine them closely. Anyone dealing with psychiatric patients must examine his own reactions to them, and guard against his own emotional reactions and personality defenses operating to the detriment of the patient.

Now when a staff member adopts a certain fixed attitude towards a patient and this attitude serves the function of removing his own anxiety, he will become very anxious when someone else questions his approach to the patient. His experience with the patient and perhaps other more personal difficulties have made it necessary for him to feel about this particular patient in a certain way. When a patient acquires a reputation among members of the staff, this process operates on a larger scale; and
when someone comes along who takes a different approach and thinks of the patient in quite a different way, there is usually a reaction to the newcomer which is both anxious and hostile.

I have said that at times the music therapist may have a different attitude towards a patient from the point of view of his quite different contact with him. In such an event, he may experience similar reactions from other members of the staff towards his difference in attitude.

One of the essential functions of any program of unit conferences is to permit the scrutiny of staff attitudes towards patients, and particularly the modification of those fixed attitudes which are destructive towards therapy and hostile towards the patient. There is always some truth behind a reputation, a reason why it started in the first place, but this fact is only partially true. Nothing is completely black or white, and as long as the patient's "reputation" is held to be totally accurate then another aspect of his personality is being denied. We all know that patients can be difficult and hard to deal with, but the situation becomes quite different when the staff feels that they have to be that way and that there is no possibility of the patient behaving in any other way. At this point the outlook for the patient becomes rather poor.

Conflict is a necessary part of human growth, and a necessary part of experience in psychiatric treatment. It is the ability to look at and face up to this conflict, to discuss it and work it out to some feasible solution, which determines the success of psychiatric treatment. It is not an easy process for the patient or for the therapist. Its course does not run smoothly, and problems are inevitable. The outcome of therapy depends on how these are confronted and how they are handled.

Conflict is indeed an inevitable part of human existence. We cannot avoid it. We cannot expect to be free from its presence in a hospital, which by its very nature deals with conflict, psychological conflict in all its complex, baffling, and disturbing manifestations. Nor can we ignore the psychological realities, which apply also to the emotional reactions of the staff members.

I recall some years ago a patient who was the son of a psychiatrist and had great difficulties with his father. One comment which he made rather impressed me. He said: "You know, the trouble with my father is that he just does not believe in psychiatry." Sometimes I feel that the same criticism can be leveled
at us when we attempt to deal with our own staff and hospital problems.

In summary, what I have said is this. There are problems in communication in terms of disagreement over patients and of misunderstandings which accumulate in the hospital setting. These problems influence the social functioning of the hospital and reflect themselves in various phases of the patient's illness. They can produce disturbances and excitement in the patient or patients around whom there is disagreement, and these can be of major proportions. These breakdowns reflect themselves in a staff disturbance which can be responsible for many difficulties between members of the personnel.

This all may seem rather divorced from the subject of music therapy! I don't think it is irrelevant. As a member of the hospital group, one becomes rather involved in such situations. It is important that they be understood for what they are. It did seem to me that some discussion of them might be helpful to your work as a member of the total hospital treatment program.
PART III
THE MUSIC THERAPIST
ROLES OF THE MUSIC THERAPIST
IN THE OPEN INSTITUTION

ARDO M. WROBEL

Those of us who are called upon to make decisions as to whether a music therapy program will be started, continued, or expanded are well aware that there is very little in the literature that defines the roles and responsibilities which the therapist has toward the total population in the institution. In reviewing the increasing amount of literature in music therapy, one cannot help but be impressed by the rapid growth of music as a treatment modality. By the same token, I fail to find any one document that can be used to define music therapy's "job description," or to answer the question: What is music supposed to do in the institution?

I would like to share with you some of the concepts that are currently being considered in our effort to establish a sound music therapy program. We are developing music therapy programs within the framework of a limited complement of positions—a problem that exists in most institutions. When a music position is created in the institution, it is usually done so by sacrificing another hospital position, and therefore the question of determining its contribution to the overall treatment program is weighed by administrators who may or may not have a clear picture of what music therapy can offer in a treatment program. I suggest that this is also a rather universal problem not peculiar to one or two states. Another problem naturally follows: Should music programs function under the recreation or occupational therapy sections, should they function separately in horizontal relationship to the other therapies, or should music be under the supervision of a psychiatrist? Put into proper perspective, these questions give rise to the basic and fundamental question: What are the roles of the music therapist in an institution?

Before we can proceed to identify roles, we need to develop the concept that the music program in an institution should be viewed in relation to the community of patients it serves. Patients in our institutions have certain needs for social experiences that transcend the fact that society is divided and subdivided into various ethnic groups. We must consider the patients as people who continue to function quite normally in some areas
and, in addition, that they have certain physical, psychological, and/or social disabilities that interfere with their ability to function normally in certain other areas of social activity.

Patients in institutions for the mentally ill and mentally retarded should then be engaged in two very different types of music activities: (1) conventional activities, conducted in such a way that their social structure resembles the usual community activities as nearly as possible; and (2) therapy activities, conducted in such a way that patients who are unable to function in conventional groups will become able to do so through the special, planned efforts of the therapist.

We can now identify the two main roles of the music therapist, because they are related to these two types of activities, conventional and therapy activities. The roles of the music therapist are the Teacher-Group Leader role and the Therapist role. In addition, there is one other role that is not as directly related to patient care but which, nevertheless, should be considered: the Consultant to the Staff role.

Within the society of an institution, we have certain patients who can sing, play an instrument, or entertain others. Many of these people do not have any particular problem in functioning adequately in such music groups as the dance band, orchestra, or chorus. Such groups can be considered a part of the conventional social activity of the institution community.

In addition, music, through its wide variety of activities, can be used as a medium of therapy. However, the process of therapy is quite different and distinct from the conventional activities of the chorus or orchestra. For example, a planned therapy program would be indicated when a patient is unable to function in the music group—or, for that matter, any other kind of normal social activity in the institution—if his emotional state interferes with participation. Music therapy, then, has the broad objective of improving the patient's social adequacy by improving his ability to accept the rules of the activity and to accept the responsibility for his behavior.

I would like to start identifying the roles of the staff musician; first, by considering the therapist role; next, the teacher–group leader role; and finally, the consultant to the staff role.

Therapist Role. In this role, the therapist needs to proceed with the concept that the patient in therapy may be so removed from his contact with others that he is, in fact, a “society of one.”
He can, at best, communicate with himself and his imaginary friends or enemies; his social functioning is suspended.

The first objective of the therapist is to add to this society of one so that it becomes a society of two. This aspect of treatment is generally known to psychiatrically trained music therapists. The society of one becomes a "society of two" when the patient can interact with the therapist. The therapist adds to this small society by involving more people, using techniques calculated to help the patient gain confidence in his own ability to deal with problems of interpersonal relationships. The therapist needs to know when the patient is ready for the next step, no matter how small this step may be. By the same token, he needs to know when the patient is not ready. In addition, it should be understood that "fallout" is to be expected, and that the patient may need to be returned to the less demanding environment.

The therapeutic relationship with the patient may be established through private lessons, listening to records, or any other means—music or not. As the patient is able to expand his society of one to include others, the therapist needs gradually to reduce his active supportive role, as the patient is able to be more independent.

Expansion of the patient's interpersonal relationships involves his ability to accept rules of membership, his learning to deal with conflicts with other individuals, and his ability to give to and receive from others. At some point in this process of planned therapy, the patient will need to test his normal functioning. Membership in the hospital-community chorus, then, becomes the "proving grounds," a place where the therapeutic relationship is reduced so that the patient has an opportunity to be on his own.

As the patient improves and expands his social world to include larger numbers of people, his need for support and encouragement from the therapist is proportionately reduced. We should also consider that such improvement in functioning may gradually reduce the patient's dependency on music (or other activities) as a medium of socialization. The theory of "expansion" should also include participation in other hospital activities so that music (or any one activity) does not, in fact, represent the only area of social restoration.

If one were to start a new music program in an institution, newness of the program or smallness of the population might
preclude starting a band or chorus. The therapist's long-range objective should be to organize such groups. One may find that the majority of patients who want to play or sing in the group cannot do so because of various emotional problems. Therefore, the therapist may need to begin with various kinds of therapy activities, which can range from individual lessons to small and large ensembles. In effect, then, the therapist may need to concentrate on a variety of therapy sessions so that, ultimately, these patients will form the conventional choir or band. It would be appropriate here to consider the need for musicians from the community (or the staff) to assist in developing the hospital-community band or choir. In addition, it may be feasible to use the local band or church choir as a placement for certain patients.

Before we proceed to the next major role, I would like to make a brief observation. The objective of expanding the patient's society is perhaps the common thread of similarity between the therapists in social recreation, music, occupational therapy, education, and industrial therapy. Each therapist uses different media and skills to reach, or plan to reach, these objectives. However, each medium has its individual characteristics and, of course, its natural limitations. The same could be said of the therapist; he has his personal characteristics and natural limitations.

Teacher-Group Leader Role. This role places the music director in the position of leading music groups that are, or should be, similar to those usually found in the community: band, choir, chorus, dance orchestra, drum and bugle corps, and other similar groups. These organized groups represent the "core" program of music activities in the institution. Patients will participate as members (1) if they have the desire to do so, (2) if they possess the minimum skills needed, and (3) if they are emotionally equipped to accept the rules of membership.

The director of the music groups establishes certain rules of membership and recognizes the unwritten rules inherent in the nature of the group. These rules should not be materially different from the rules of membership in a similar extramural music group: excellence of performance should have strong emphasis.

In this role, focus should be on teaching and helping members learn skills of playing or singing. One should do this about the same way as if directing a school band, a church choir, or an
orchestra. Certain modifications may need to be made to accommodate the patient groups, but quality of performance should not be sacrificed on the assumption that patients cannot do better simply because they are patients.

Here is an example of role-functioning as the teacher or director of a chorus. If one were to start from the beginning, initial organization of the chorus would begin by advertising for members. Patients should be encouraged to join, especially if they have had previous singing experience. You may want to include volunteers or employees as members to help it along, as well as offering lessons and section rehearsals. A conservative guess is that about two percent of the patient population will initially join without much coaxing.

Matters pertaining to teaching and leading the chorus are the sole responsibility of the director. However, other matters related to absenteeism, tardiness, performances, or purchase of robes may be referred to the "choral club," even though the final decision may need to be made by the director.

The role of the director is so firmly established that it is almost never challenged. Taking direction in this setting is not difficult for most patients. By the same token, in an industrial therapy job setting a patient may not be able to tolerate supervision. Membership in the music group could then play an important role in helping the patient accept supervision in other areas as well.

Public performances (in the institution and the community) are essential to the life of a music group. Performances need to be planned so that patients have opportunity to entertain others and to demonstrate that they can function with fewer controls by the leader. Performance by a music group is one of its greatest assets, because it gives us an opportunity to observe the patient's ability to function in normal settings.

Questions will arise as to whether the teacher role includes giving private or group lessons and, if so, is this more properly a part of the therapist role? This depends upon the purpose of the lesson. If the lesson is given to improve the patient's skill in playing or singing, then this is in the teacher role. If the music lesson is used as a medium of bringing about planned improvement in the patient's internal organization, or in his ability to tolerate the social demands of group membership, then this is in the therapist role.
Conflict in roles will arise if the therapist is unable to differentiate between the therapist role and the teacher-group leader role. Here is an example. If I go to my doctor with a complaint about not being able to sleep, being constantly tired, and other such complaints, the doctor may prescribe certain drugs or changes in my daily routine. My doctor, by coincidence, happens to be the director of the city band, in which my functioning as a member has gradually deteriorated so that coming late to rehearsals and not paying attention has tended to disrupt the group. It would be inappropriate for the doctor to accept such behavior, or to stop the rehearsal in an effort to establish a therapeutic relationship with me. It would, on the other hand, be appropriate for him to suggest that I see him in his office, even though he may have to dismiss me from the band. In the office, the therapeutic relationship between the doctor and myself would probably involve the suggestion that more private lessons are needed, or that I take a vacation or see a psychiatrist. This is, then, a therapy plan to restore adequate social functioning.

There are similar patient-therapist relationships in the hospital setting, even though they may be more complicated. If the patient is unable to function by not accepting the rules of behavior, then the suggestion that he needs more private lessons may be more acceptable (and hopefully more accurate) than to tell him that he is no longer wanted in the group. Such therapy sessions in the form of music lessons may involve planning with other therapists, discussing the problem with the patient’s doctor, or bringing the problem up at a clinical staff meeting.

Consultant to the Staff Role. It must be borne in mind that this role does not have the same direct relationship to the patients as do the others. The theory of the consultant role is that music (or recreation or crafts) is not the exclusive medium of the professional leader. It would seem reasonable to expect the music therapist to promote and encourage other employees to use music in connection with their activities. The music therapist should advise the nurse, occupational therapist, recreation therapist, and others how they may use music more effectively in their programs. For example, the recreation therapist may find that certain kinds of recorded music (or rhythm bands) are helpful in bringing about better patient participation. The ward nurse may ask for advice about the kinds of music she
might use in her remotivation groups. The librarian might want to have music appreciation for her patient groups in order to bring them gradually to higher levels of participation in storytelling and reading. The occupational therapist may find several ways to use music. By the same token, other therapists should be available to advise the music therapist on ways and means of using different media when music might fail.

Before we continue, we should make reference to the relationship these roles have in the institutions for the mentally retarded and physically handicapped. The roles of the music therapist have similar application; but we should add that, for the physically handicapped, the therapist role can be viewed as a planned effort to help the patient live with his disability, to learn alternate skills, and/or to improve the patient's ability to substitute for or to overcome his physical impairment. In the institutions for the mentally retarded, the therapist role is similar to that with the mentally ill, even though it may get less emphasis. It is of secondary importance, here, that the hospital-community music groups in the retarded setting may be less capable of performance in terms of quality and social normalcy. The teacher–group leader role is perhaps larger because such music groups are usually more closely related to the school and classroom setting.

Let us return to the original question: Where should the music therapy program function in relation to the other programs? This decision would be based on the relative emphasis one wants to put on one or all of the major roles. I do feel that, in those institutions having an organized rehabilitation therapies (also known by activity, adjunctive, or ancillary therapies) department, the music program should operate in this department.

Hopefully, the music program would represent balance in all three roles. This would then lend itself to functioning as a music therapy section—just as recreation, industrial, and occupational therapies function as separate sections. If, for various reasons, the music program needs to function with emphasis on activities such as dances, concerts, dramatics, and shows, supervision by the recreation therapy director might be considered. In the institutions employing two or more professional musicians, it might be feasible to have a music educator in the teacher role and a music therapist in the therapist role.
GROUP DYNAMICS FOR THE MUSIC THERAPIST

LEWIS J. SHERMAN, PH.D.

Group Dynamics is that field of knowledge that studies the nature of groups and attempts to provide techniques for achieving more efficient group performance. Since most music therapy involves group activity, the importance of the group dynamics findings has long been recognized by experts in the field.

At the tenth annual conference of the National Association for Music Therapy, Rudolf Dreikurs said:

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.

Arthur Flagler Fultz remarked at the following NAMT meeting that: “Another pattern of assumptions is related to the music-making of small groups. These are derived from research in group dynamics. The hypotheses and structure of group action provide the key to problems encountered in every music-making group.”

In 1961, Myrtle Fish Thompson, in a paper congenial to the present author's intention, commented that:

Whatever the job of the moment we cannot afford to be ignorant of techniques [of group dynamics], nor unsure and slipshod in our use of them. Our weakness will not be in good will. It may not even be in lack of theoretical knowledge. But, until we convert [group dynamics] theory into realistic application, we will lose the greater potentials of our media through lack of direction.5

In essence, Mrs. Thompson has specified the purpose of this paper. It is to translate the theoretical, obscure, and even esoteric theory and findings of group dynamics into practical, concrete, and specific suggestions that music therapists can utilize with their patient groups.

Four major topics that promise to have the greatest application will be presented, viz.: How to achieve group unity? How to encourage positive group contagion? How to establish appropriate group standards? What is an effective leader's role? Each of these questions will then be discussed in terms of the several factors necessary to achieve unity, contagion, standards, and leadership.

GROUP UNITY

Group unity or cohesiveness is probably the primary goal of any group therapist. This is what accounts for the cooperativeness, group-ness, and "we-ness" of one group as compared to another. These are the factors that will transform an aggregate or assemblage of persons into a smoothly functioning and integrated group unit. Without group unity we merely have a collection of individuals working in a group, not as a group. There are six conditions that must obtain before unity and cohesiveness can be achieved.

1. Members must feel that the preservation of the group is of vital importance to their personal welfare. That is, the group must satisfy some of their psychological needs. These may be needs for status, security, self-esteem, work, acceptance, altruism, etc. The actual needs being satisfied are determined both by the group and by the leader and will undoubtedly differ from one group to another. However, once they are realized, overtly

or covertly, the group will maintain its unity in order to achieve them.

2. Each group member must have a sense of sharing in the achievement of the entire group's objectives. He must feel that without him the group would be less of a functional organization and that his contribution is essential to the overall group performance. Each member must believe he has a unique role to play in relation to all others and that the entire sum will be the less for his absence or lack of participation. In short, he feels important and needed by perceiving himself as a valuable participant in the total group action.

3. The relations between group members must be of an intimate and personal nature. There must be free channels of communication from group member to group member and from leader to group member. Words of encouragement and praise should flow freely from one to the other. Obviously, members should know each other well and have been together for some period of time. They must like each other and display the feeling of camaraderie that is so essential to the achievement of unity.

4. The group's objectives should not be attained too easily. Group unity is enhanced by the exercise of concerted effort. People gain a sense of achievement when they accomplish something difficult. In music, practice makes perfect and this very practice, involving as it does an expenditure of communal effort, will contribute to the unity of the group.

5. The common interest of the group should be symbolized in some visible fashion so that members are readily recognized as belonging to that group. This can be achieved in several ways—uniforms, slogans, rituals, or, typically, names can serve as symbols for a group's unique identity. By these techniques, each member recognizes his involvement in the group and its concomitant separateness from all other groups.

6. Members should be aware of their group's significance and superiority in comparison to other similar organizations. This can be accomplished through acquaintance with the group's tradition and history. Scrapbooks, pictures, or simply a recollection of past achievements will endow all members with a necessary feeling of loyalty and tradition that motivates them to greater accomplishments.
A Case History

The practical application of these six factors can be illustrated by citing the Brockton VA Hospital Patient Chorus. The unity and cohesiveness of this group is extremely high and reflects clearly the operation of these principles. First, members of the Patient Chorus satisfy needs for self-esteem and status by participating in this organization. They frequently perform at hospital and community functions, where they receive considerable praise for their efforts. Second, each member understands that he has an important role to play in the overall group performance. It is made quite clear whenever there is an engagement that everyone is needed, because the absence of any single member would adversely affect the entire group. Third, the most friendly and personal relationships exist between members and leader. A true feeling of intimacy and sharing in a common cause is clearly evident. Fourth, their high musical quality has been achieved only after considerable effort. Their lack of professional training has compelled them to work very hard to attain their common goal. Fifth, their separate identity is visibly symbolized by their distinctive title—Patient Chorus—and their frequent practice sessions and organizational meetings. This individuality is made evident to all staff and patients by means of the hospital newspaper and radio station. Sixth, this group has its own tradition. It has a bright though brief history in the hospital and community which enables the group members to point with pride to their past accomplishments. Thus, it is evident that the factors contributing to group unity are not merely academic but have demonstrated their utility at the Brockton VA Hospital, where they have worked extremely well.

It may be appropriate here to specify three of the factors that can endanger group unity and cause splintering and fragmentation. First would be permitting the uninhibited expression of aggressive drives. Nothing is more guaranteed to frighten or disorganize a group than to allow unrestrained expressions of aggression. In traditional group therapy it might be appropriate, for there it can be worked through and handled by members

6. Of course, these conditions for establishing group unity also obtain with large organizations. An obvious example is the United States Marine Corps, probably the most cohesive unit in our society. The reader may wish to apply these six factors to the Marines and see how well they fit.
and leader. However, in focused group activities, such as music therapy, uninhibited expression of impulses can only cause fear and withdrawal. Second, extreme jealousy or competition between members for the leader's affection and support should be avoided. The leader must play no favorites, although patients will undoubtedly vie for his attention and approval. However, the minute he demonstrates by word or deed that one member is more favored than the next, the essential ingredient of unity—the interdependence and feeling of equality—has been destroyed. Third, the leader should not make excessive demands or apply unrealistic pressures on group members. You can push groups as well as individuals too far. Once pressed beyond their limits of tolerance, frustration and anger will result, and the cohesive qualities formerly present in the group will evaporate.

**GROUP CONTAGION**

Group contagion refers to the spontaneous pickup or imitation by other group members of behavior initiated by one member. It concerns the rapid spread of behavior through the group. Why in some groups when one person starts singing, all other members follow him; in other groups, however, when one person starts singing, he sings alone. What determines the imitation and participation by other members once a behavioral activity is started? Why does one behavior spread while another does not? How can group leaders encourage group involvement and imitation of positive behavior? As one of our primary goals is the fostering of group participation, it is necessary to recognize the variables that determine this contagious effect.

Of primary importance is the hierarchical role occupied by the behavior initiator. In general, higher ranking members in terms of perceived status and prestige will most likely be followed by other group members. Although the criteria of rank will vary in all groups, there are always some members who possess higher status and prestige than others, and these are the behavior initiators whom others will imitate. Leaders can determine who they are by observing which patients seem to be the center of attraction in the group and on the ward. With

whom do the other members congregate, who has the most friends, who is most respected? These are the men the leader should cultivate and engage on his side, for their behavior will more than likely be contagious and followed by the group.

The second factor influencing contagion is that the behavior to be spread must be meaningful and important to the members. It must be consistent with their value system, need satisfying, and intrinsically rewarding. Obviously, knitting or sewing behavior in a male group would not spread, regardless of the status of the initiator. However, musical activities—almost always desirable and pleasurable—have a great potential for contagion. Music therapists are fortunate that they start with this initial advantage which enhances the likelihood of active group participation.

Finally, the organizational and physical structure of the group must be conducive to spread. That is, small, unified, close groups are more likely to manifest a contagion effect than large, fragmented, separated ones. Sub-groups should be minimized and physical separation reduced. Although practical considerations may be involved, it is important that a reasonably small space be set aside for group activities so that members can easily interact with one another in fairly close proximity. In many cases it is obvious that you can not rely on the internal motivations of patients to bring themselves together. Direct intervention is often required with those patients who persist in remaining outside the group. These members should be actively encouraged to take their places with the rest, for the evidence seems clear that only where a small, single, and close group exists are you fairly sure that a contagious effect will occur.

**Group Standards**

When a group is organized to any degree, a set of norms and standards arise to shape and regulate behavior of members in that group. We desire our groups to behave in as responsible and mature a fashion as possible. However, when working with severely disturbed and regressed mental patients, how do we limit the expression of deviant behavior and encourage the expression of more normal behavior? How do we direct the proper shaping of behavior in the group so that positive and responsible standards of conduct will develop?

The emergence of any behavior is typically determined by the
joint function of two field forces. One, the degree of external structure placed on the field—what is impinging on the person from without. Two, the degree of internal push or drive—what is seeking expression from within. These two motivators of behavior act in tandem so that the greater the ambiguity in the external field, the greater is the influence of internal and personal characteristics while, conversely, the greater the definiteness in the external field, the less is the influence of internal and personal characteristics. Thus, with disturbed and regressed mental patients, we need great structure in the external field in order to inhibit the outpouring of their internal psychotic material.

One way to achieve this structure is to establish the group contact in the initial session. This is a means of ritualizing the group process by specifying the rules that will govern the meetings. Members should be clearly informed in advance concerning the following four aspects of the contract.

1. **Formal Characteristics.** Who will belong to the group, when and where it will meet, the length of the session, and the procedures to follow when absent are the purely formal characteristics of the group. However, they form the base upon which all subsequent group activities rest and, once agreed upon, everyone is committed to honor them.

2. **Group Purpose.** The aims and intention of the group meetings should be explained to the members. The purpose may be phrased in terms of “therapy,” “education,” “entertainment,” etc., depending upon the orientation of the leader. The exact term used is not as important as the fact that some meaningful reason is offered the members to encourage their presence at the sessions.

3. **Member’s Role.** The type of behavior expected of the members that will help the group achieve its purpose should be clearly outlined in advance. What activities are encouraged because they will help the group attain its goal. What activities are prohibited because they will disrupt the group and defeat its purpose.

4. **Leader’s Role.** The role the leader will assume in the group should be detailed. What may be expected of him and what may not be expected of him during the subsequent meetings. How he will perform in relation to the member’s role and the group purpose.
If these four details of the group contract are unambiguously announced in advance, two purposes are served. One, reality is brought to the group and limits imposed so that the likelihood of internal psychotic material emerging is reduced. Two, if during the course of later meetings any disagreements or arguments arise, they can then be settled by reference to the initial contract. Distortions will always exist in patient groups but with a clearly defined external structure available, these distortions can be corrected more readily.

Another condition that music therapists can manipulate to maximize the possibility of achieving responsible group behavior is to engage all members in interdependent activity. With this type of participation we encourage norms of cooperation, social living, and mutual respect. It is the responsibility of the leader to insure that this interaction takes place by affording everyone an opportunity to become involved in the group program. In addition to the initiative shown by the leader, the nature of the activity can also determine whether this interdependency will occur. Community singing, for example, might not achieve this end, but round singing might.

Along with interdependency we also wish to instill feelings of individuality and specialization so that patients may derive some personal satisfaction from their behavior. Patients need desperately to maintain a separate identity and to feel a sense of accomplishment. We can, once again, assist them in this quest by our choice of materials and techniques. Thus, it might be preferable if each member played different instruments or sang different roles so they would not feel too anonymous in a large group.

A final suggestion that can assist in establishing appropriate group standards is to maintain a relatively homogeneous level of ability among members. Too great a disparity in ability would only reinforce the less talented members' feelings of inadequacy and cause them to withdraw or react against the group. A concert pianist, for example, in the midst of an amateur music-making group would likely induce feelings of frustration and futility in the nontrained members and disrupt the group functioning. However, it sometimes does occur that extremely competent musicians are involved in our therapy groups. What do we do with them? We should use them as leader surrogates and place them in positions of responsibility as our assistants. By
this procedure, patients who do not have talent no longer feel the skillful member is on a par with them and a threat to their self-esteem. By making him an auxiliary leader, you remove him as a peer threat and reduce the likelihood of his frustrating the others or disturbing the group norms.

**Role of the Leader**

In any discussion of group dynamics it is essential to specify some of the basic characteristics of the efficient leader. It is obvious that the leader is not separate from or outside the group; he is as much a member as anyone else, perhaps more so. He can assert powerful influence on the group, for good or ill, and set the entire tone of the sessions. Of the many roles and functions the leader must assume, there are five that deserve special mention.

1. The leader must serve as protector, controller, and limit setter for the group. It is his responsibility to set guidelines, establish structure, and delineate the contract under which the group will operate. He must instruct the members what will be done, what cannot be done, why it is to be done, and when it is to be done. It is evident from the above that music therapists should be active and directive leaders. Nondirective techniques are more appropriate for traditional, uncovering, insight group therapy. For focused, objective music therapy, a much more forceful role is required.

2. The leader functions as an expert in music. He presumably has the most information and knowledge in the group. He should therefore be able and willing to communicate this information to members in terms understandable and meaningful to them. A brilliant teacher at Julliard would not necessarily qualify as a good group therapist. He must first recognize the social class, intellectual, and personality differences in his audience and adjust his expert role accordingly.

3. The leader must function as the supplier of rewards to the group members. There is an extensive literature demonstrating the efficacy of rewards in shaping and controlling behavior. By the judicious administration of rewards we can often obtain the type of behavior we desire. These rewards need not be material ones: praise, support, and reassurance can all contribute mightily

---

in determining behavior. The leader must remain alert to what is going on in his group and respond immediately and appropriately to that behavior he wishes rewarded. Patients cannot read minds but need to be informed in very concrete fashion that they are performing properly.

4. The leader must serve as mediator, arbitrator, and referee in the group. He must always be alert to conflict and discord. When it arises he must intervene, judge the merits of the situation, and make the appropriate decision. Although he must act in an impartial and democratic fashion, he should not abdicate his responsibilities as a group leader for an instant. Patients will gain security if they realize someone is there who can protect them, not only from other patients, but from themselves.

5. The leader must serve as a model for members of his group. He should possess sufficient positive qualities so that patients can properly use him as an identification figure. It is likely that he will be imitated and copied by many group members, so it behooves him to display the personality attributes we desire to instill in our patients. In brief, the leader must be a good person. No more than this need be said.

It is probably unrealistic to assume that any music therapist (or anyone else for that matter) can function expertly in all these roles. Nevertheless, if we set these standards up as goals to be achieved, our performances will inevitably improve and thereby result in more effective group leadership and music therapy.
PART IV
DANCE THERAPY
THE STRUCTURING OF DANCE SESSION FOR VARYING NEEDS OF PATIENTS

MARIAN CHACE

From past experience in speaking to music therapists about dance in institutions, I have become aware that people are often under the impression that I always conduct sessions in the manner in which I lead them with the very withdrawn and regressed groups. I feel that this is natural, as these are the groups about which I speak most frequently. They are composed of people who are the most difficult to reach in any way, or with whom one rarely can form even a tenuous relationship. However, there are many other people in the hospital who can gain great satisfaction through working in groups or individually in dance or body action for communication and emotional release. While the same principles hold true, the actual structure of the specific sessions is very different in various areas of the hospital.

Today, the problem is not only one of assisting with patients who will stay in the hospital indefinitely, but in structuring dance sessions to give support to the people who are making an all-out drive to leave, or to keep from having to seek the care within it. When I speak of indefinite periods of time for staying in the therapeutic community, I am referring to those who come because of an acute break, whose stay may be a very short one, from a matter of a few weeks' time to six months or a year, as well as to those whose stay may be a matter of years or even a lifetime. These patients will be part of the hospital community for some time to come, and, consequently, they take a great deal of the time of the hospital staff.

Today, with the new attitudes and new help from many directions, the interchange between the hospital and the community, new drugs for assisting patients in functioning, and the need to reduce the population of the ever-growing large hospitals, changes in approach must be sought by all members of the staff. This means changes in the structuring of dance sessions as well as nursing care and the other ancillary services.

Day-care clinics are a usual part of large hospitals today. The people who remain at home, but who are having difficulty surviving the pressures of daily living, are the citizens of these clinics. It would be pointless to have the care of these patients
structured in the same way as in-service care. The problem is to see that they remain out of the hospital, if possible—not to give them hospitalization, as such, for a part of the day. They must at all times feel a part of the outside community, rather than become adjusted to the hospital community.

Although the duties of the housewife, the student, or the family provider are such that little time is given, as a rule, to active participation in painting, music, or dancing by this group of people while at home; this is a deprivation that may contribute to their difficulties. It is felt that the arts may aid in sustaining some of these people in a functioning capacity; consequently, these activities play a large part in the programs of day-care centers. At least, superficial communication in the day-care center is not the problem that exists with many patients. New learning, as well as functioning in already-learned activities, is possible without the patient meeting defeat. Silence where people are in the same room is not so overwhelming. Hope and the possibility of drive toward goals are more a part of the picture. Consequently, in the rehabilitation of these people, dance sessions should fit into the pattern of preserving a degree of intactness, rather than restructuring what has been lost temporarily through defeat and withdrawal from contact with the community. Dance sessions should be conducted more as classes and have more similarities than dissimilarities to outside dance sessions.

Another problem in the large hospital is the increasing number of children absorbed into the therapeutic community. They need help in development and growth as well as care and treatment. For too long, due to the expense of such care as well as the fear of frustration on the part of the staff, the children admitted to a hospital were lost to the community as future citizens. While health might be regained to a degree over a period of time, many of the aspects of learning, both formally and informally, were denied to him. He was absorbed into an adult community of patients whose members either were irritated with him or spoiled him. Not by intention, but only through ineptitude and lack of a structure to care for him properly, the child grew up within the hospital without having proper experiences to aid in his emotional growth. Grew up chronologically, that is, but was still often a child in his functioning. For this reason, his need to stay in the hospital too long sometimes was necessary,
or his return home would be on the basis of having permanent care by the family. Fortunate, in the midst of his misfortune, was the child whose family could afford to send him to a special school where his needs in growth were cared for as well as those caused by his illness. Within the past ten years the attempt has been made, often inadequately, to change this gloomy outlook for the child who becomes ill. Today, child centers within the hospital setting are being established. These range from areas where the child lives on a 24-hour basis to day treatment centers which provide school programs, therapy, and other activities geared to his needs while he continues to live in a ward with adult patients. I am not speaking here of the many different clinics, special schools, and remedial education centers, but only of the large adult hospital which accepts the child for treatment.

Dance sessions in many or all of these settings, whether the large hospital or the small clinic, should contain the same elements. These are not too different in overall structure from creative dance sessions in any community. Opportunity should be given to the child to have subjective expression, learning about his own body in its motor functioning, new coordinating skills, growth in poise and self-control, and awareness of music in its rhythm and tonal sound.

The difference between the classes in the community and in the clinic or hospital setting lies in the goals of the leader and his awareness of the great variety of special needs on an emotional and functioning level of the different children. These needs will have little compatibility with the child’s chronological age. The leader must be aware especially of the emotional age level at which the child is functioning. Then, and only then, can he supply the structure in body action into which the child can fit and from which he can gain some benefit. It is possible to furnish the child a group experience with his peers in spite of the many individual differences in ability and levels of functioning.

However, I am at a loss, personally, if I try to work with a group of children some of whom are emotionally disturbed and some of whom are brain damaged. One group needs rapidity of shift, as they are essentially over quick, and the other needs a slowness of approach and infinite patience in repetition of the action. It is my personal opinion that it is harmful to each group for them to be combined in joint sessions.

One important aspect of dance therapy is the conducting of
sessions with individuals. The majority of sessions which I lead involve several patients, but there are a number of sessions each week with individual patients. These vary greatly in approach and method of leadership.

One interesting series of such sessions was with a schizophrenic boy of about fifteen years of age. He was a ward problem because he was very restless and overactive in spite of being essentially withdrawn from others. He was involved in considerable acting out, and in the course of this was often assaultive. Unfortunately, he would choose as his target student nurses and the nurse in charge of the ward.

I was asked by the clinical staff to attempt to make a contact with him in dance, and thus to enable him to express some of his anger through body action which might be useful to him. During the session he was permitted to choose his own music, and at first he was fascinated by pantomiming swordplay with me to a paso doble record. For weeks on a once-a-week basis he would ask for this music and repeat much that he had done in the previous session. However, after having danced the swordplay, which had obvious symbolic meaning to him, he would want soft music and, quite logically (from his point of view), he would want to be held like a baby and rocked. This I would not do, stating that he was not a baby and was quite capable of his own independent action. However, I would then do swinging and rocking movements with him while we were standing together.

Occasionally, he would accept joint endeavor in walking, running, or jumping. After expressing different basic emotions from the symbolic aggressiveness of the swordplay to rocking and then to more outgoing movement, he suddenly said one day: "It is good to express your feelings, but what do you say when people never say anything warm?" This was a realistic question, as his parents were both very rigid and anxious people who rarely expressed anything verbally, other than irritation with him for being ill or worry about his ever getting well. His mother substituted bringing him food for any expression of warmth of feeling, even though she often held him in her lap.

At one point not long after we had started working and after a forced absence on my part for two or three weeks, he became more withdrawn and mute on the ward. The staff was concerned about the necessity for tube-feeding him, as he was refusing to
eat. He had expressed the fear that his food was poisoned. The staff felt that since I worked in the area of body action, it might be acceptable for me to try to eat with him. Lunches for both of us were served on the same plate and he accepted from me the food which I was eating. I did not spoon-feed him but would hand the food to him. He resumed eating in the dining room at the next meal.

Soon after this, he was assigned to a therapist from the psychology department. We agreed between us and with the ward psychiatrist to make the dance sessions a three-way session, to prevent rivalry, so that he could see that it was possible to relate to more than one person at a time. These sessions seemed to go well, and he used the dance to test one and then the other alternately. Occasionally, the three of us would have lunch together, and he would ask that we exchange food again—with obvious implications.

Through many ups and downs, he has gradually lessened his retreating from others. At one point he asked to do things with other boys in the way that they do things. His doctor felt that he was not yet ready for this, and consequently this new phase of activity was delayed temporarily. However, he is now working with a group of other boys; while his acceptance of them is still tentative, he seems to be able to join in their activity with a gradual lessening of anxiety.

The majority of individual sessions are on an entirely different level, however. These hours often are scheduled to enable one patient who finds it difficult to express emotion to use free and spontaneous dance action to say nonverbally those things he is unable to say when he is with others. Miss D., who is usually very constricted in her relationships with others and equally stereotyped in speech, was dancing recently with warmth and expansiveness. Another person, who was watching her, suddenly spoke. "Why, Miss D., you are a dancer. I don’t think I have ever known who you really were before.” This was an exciting moment for the person watching the dance which had such an impact on her, as she has spoken very rarely in the last two years.

Sometimes individual sessions are held for the purpose of developing body control with people who can tolerate a group only with extreme anxiety. In these instances, an attempt continually is being made to help the patient to accept others in functioning with her.
The final type of session which I am presenting will be with a group of people who are psychotic but who can communicate verbally, although with difficulty. Often they can talk about feelings and ideas while they are moving together. Their conversation will travel from talk of home, their feelings of neglect, frustration, and fear of inadequacy, to delusions of themselves in positions of importance or even religious identification. In presenting this kind of session I have attempted to structure it as a scene, since one of the difficulties of the person functioning in the world is a lack of spontaneity in response to stimuli which call for unstudied speech as well as unstudied movement. One of our assets is self-control, which keeps us in the thinking area with other people who are essentially strangers to us. Our failure is fear of nonconformity. One asset of the mentally ill patient is the ability to respond emotionally regardless of the situation. One of his failures is his fear of lack of ability to conform or control his emotions.

Therefore, the session will need to be structured and enacted. The two groups of people function in different ways. In relating across the chasm in this area, one can only attempt to understand and empathize.
PART V
TECHNIQUES AND ACTIVITIES IN MUSIC THERAPY
THE RHYTHMIC APPROACH IN MUSIC THERAPY

VALLY WEIGL

Rhythm is the primary and most elemental force in music. It is one to which music mainly owes its strong hold on individuals and groups of all ages, races, and nationalities. Its strength lies, in great part, in its physiological roots—the innate rhythm of pulse, heartbeat, blood pressure, and respiration which governs our lives from the cradle to the grave, any disturbance of which is reflected in an imbalance of our well-being, efficiency, and enjoyment of life. A similar, strong physiological component is also inherent in outside man-made rhythm and accounts for its effects through kinetic impulses as manifested both in voluntary and involuntary reactions and movements. Among the involuntary effects is, for instance, the fact that some people become hoarse from just listening to music attentively as their vocal chords follow the music; among other effects is the involuntary pupillary reflex to light under the influence of music which delays the onset of fatigue and of corresponding reflexes. I hardly need to mention here the effects of rhythm on kinesthetic movements, inciting people to march, dance, fight, or otherwise giving invigorating impulses by rhythmic shouts, calls, or drumbeats. In all parts of the world, and in all times, war leaders, priests, and medicine men have used rhythm to overcome fatigue and fear in their followers, and even to excite them to states of frenzy. In their primitive origin, these practices can be traced back to archaic times of mankind. They have been utilized, at all times, to counteract fear, fatigue, and boredom.

Primitive man depended on his acoustic perception and acuity for his survival. He had to discern between sounds of nature, such as oncoming storms, of approaching animals, of friend and foe, of drumbeats, or other signals, which were usually the only means of warning or communication between distant tribes or individuals on scouting or hunting expeditions. Meanwhile, much of primitive man's sensitivity to sound has been lost to the average modern man and drowned out, especially in our noisy city life. We cannot hermetically close our ears; we are defenseless against noise and the constant exposure to a deluge of sounds: of "honking" cars, sirens, and trains or planes; of penetrating advertising voices, commercials, jingles, and popular dance bands.
over the radio, the juke boxes, in eating places, and even in elevators. Therefore, we, and even our children, will have to regain sensitivity to sounds, to re-learn selective listening.

We do not know how much damage is being done to our nervous systems by this constant exposure to sound, this assault by that multitude of sounds, even though some of them we hardly notice any more. It may very well be that they at least contribute to the ever-mounting number of emotionally unbalanced or neurotic people in our society. Yet, when psychiatrists and psychologists try to get to the roots of some of their patients' disturbances, how may search for acoustic impressions which may have left an imprint on the child's early memories or his emotional development? Perhaps it was the barking of a dog, some screaming voices, the sudden sound of thunder, or roaring planes, or air-raid whistles, or other personally frightening sounds of past history. We know that sudden loud noise can produce the feeling of fear and, in the immature nervous system of the newborn, arouse the startle reflex. In psychological tests, too, items including reactions to sound could contribute significantly to the picture of the total personality.

How does acoustic perception come about? Sensory impulses arising in the cochlea are transmitted by direct passageways from the ear to the thalamus and from there to the cerebral cortex. Perception of sounds occurs in the auditory cortex and is a conscious process through which a variety of memories and associations may be evoked; however, the effects of sound are not limited to conscious perception. The elements of sound—rhythm, pitch, and intensity—mediated by the thalamus, affect the functioning of the autonomic nervous system also. Thereby, even when conscious perception through involvement of the cortex does not take place, feelings can be aroused, and patients—such as certain mentally disturbed or retardates—can often be reached, when on a conscious or intellectual level they may be inaccessible. Thus, music and rhythm are often the only bridge to such patients and are important means of communication in dealing with them, and thereby are potentially, basically "therapeutic," meaning originally "helpful."

Anyone who has worked with emotionally or mentally disturbed patients knows how acoustic memories can sometimes penetrate through the fog of mental disturbance and illness, when everything else may have failed; how, now and then,
amnesia patients would suddenly remember their names, their origin, their past, at the sound of some early childhood song; how, in some patients, such deeply ingrained sound impressions, when awakened, could unearth other emotionally loaded memories which might lead their psychiatrists to the source of the trouble, open up the clogged channels, and bring relief. I remember one young singer; she used to come with us to sing for the patients at various hospitals. She once came to a ward where an amnesia patient, probably shell-shocked in the war, had not been able to speak for years, so that no one knew his name or his origin. Yet, when our singer happened to sing “O Sole Mio,” tears were running down that patient’s cheeks, and he started to mumble: “Mama mia! Bella Italia.” Once these childhood recollections had been reawakened, the hospital staff could trace his background, name, and family as he slowly regained more memories and more speech. Another case was related to me by a New York psychiatrist who had worked for years with a patient without succeeding in getting him to speak about his troubles. One day the psychiatrist happened to be sitting at the piano playing a Chopin nocturne when the patient arrived. The patient suddenly became very excited and shouted: “That was the selection my mother used to play when I was a little boy. She always has dominated me and never let me be myself. She has manipulated every step of my life.” It was as though that music had opened the locks of a dam holding back all the repressed material, which could at last flow over, easing the tension.

I mentioned before that we do not consciously notice many of the sounds and noises surrounding us day in and day out. We may hear them; but without focusing our attention on them, without really “listening,” we cannot clearly perceive them or understand their meanings. Listening, on the other hand, is one of our important goals in music education.

A selective listening process means perceiving individual sounds and rhythmic patterns, the recognition and enjoyment of their reoccurrence and their variations, a prerequisite as necessary for the learning of a spoken language as it is for understanding the nonverbal language of music. The process of combining sounds in rhythmic patterns is similar to that of grouping in vision. Yet this gestalt element is one that many of our mainly visually oriented educators and psychologists often overlook. It could play a more important part in childhood education as well
as in psychological testing. It could supplement results from visual items, and through the pleasure element inherent in rhythm it might yield more information, especially when used with speech-handicapped, retarded, or emotionally disturbed children who otherwise present testing difficulties. That tendency of grouping separate items of experience into unitarian wholes of configuration is a main characteristic of the realization of rhythm and might be helpful also in teaching such children in their "reading readiness" stage. Just as letters have to be combined into words and words into sentences, so the ability to combine separate sounds into rhythmic groups or patterns can be a helpful preparatory experience. It also seems obvious that any experience coming from two or three, rather than just one, of the senses will be more vivid and lasting. Thus, the visual approach to reading is, of course, reinforced by the acoustic impression of reading aloud, while at the same time the motoric element can contribute by having the child follow the words with his finger and move his vocal chords and speech muscles; even if he cannot use them for producing audible speech, he can often move his lips accordingly and "mouth" the words. The noted Russian psychologist Luria, in his lectures in 1960 in New York, reported on experiments he undertook with mentally retarded children whom he conditioned to the meaning of various rhythmic knocking signals. He then introduced colors and numbers, and stated that these were best absorbed and recognized by the retardates when he had them name the colors and numbers orally. He suggests that the peripheral memory is thus effectively reinforced by the cortical function of the spoken language.

Meyer has based his analysis of music on the principles of Gestalt Psychology. He translated certain ideas about visual perception into auditory terms, thereby making it possible to relate music more directly to other psychic functions, such as memory, learning, and enjoyment.

The approach through different senses is also one of the basic starting points in Carl Orff's approach to music education, as he also stresses the importance of having the child experience sound kinesthetically with his body, first by clapping, tapping, or marching a rhythm and only then translating it into vocal or instrumental sound. Gradually thereafter, movement and sound

Techniques and Activities

are combined into the exhilarating musical experience which through early achievement gives the children so much natural enjoyment. I have always, wherever possible, used a similar approach with mentally or physically handicapped children and also found that at first pitch differences and the wide range of melody are usually less important to them and are only developed after much experience. In chants and songs of primitive tribes everywhere, we find the same stress on rhythm and usually a limitation to a few tones, often just four or five. Here too, melody and a wide range in pitch follow only gradually; larger intervals are usually an expression of stronger emotional excitement, but are not too frequently found in early chants of primitive tribes. However, in such primitive music as well as in most original folk songs, traditional children’s songs, and lullabies, we find another important common denominator: the enjoyment of the element of repetition. They never seem to get enough of it. In starting with the rhythmic approach in the child’s education and initially limiting the melodic range to five tones and introducing the pleasure factor of repetition, we may thus just be following the old, basic “phylogenetic principle,” according to which ontogeny repeats phylogeny or the individual repeats in condensed form the evolutionary development of the race.

Another related concept may be Jung’s “collective unconscious,” which comprises the early memories of the race yet unknowingly influences the reactions of the individual to his personal life experiences and his emotional stability.

It is interesting to realize that long before these theories were formulated and modern physiologists and psychologists became interested in exploring the effects of music and rhythm on human beings, ancient philosophers and scientists such as Aristotle, Pythagoras, and others had believed in the beneficial, remedial power of music and had experimented with it. Plato, centuries ago, stated: “Music penetrates into the secret places of the soul.”

After having reviewed these more general theoretical aspects of the effectiveness of music and rhythm as therapeutic agents, I should like to mention some of the goals and means of their practical application with different groups of mentally and physically handicapped children.

With whomever we work, the establishment of rapport through music and of overcoming apathy, suspicion, and anxiety through
the invigorating and socializing force of rhythm are the most important immediate goals. These are prerequisites for any effective aid to any patient, especially in trying to reach the mentally retarded. Lacking intellectual outlets, they need these emotional outlets all the more.

Almost invariably, mentally retarded children respond to rhythm, as do infants and senile, regressed patients. The retarded, having the same needs, desires, and aggressions as others, yet lacking normal intellectual modes of expression, crave all the more such an emotional outlet, which is within their reach and may yield immediate gratification. Verbal symbols are often too complicated and bewildering for these youngsters, causing them to withdraw, but rhythm and melody may still provide contact and reach them on a nonverbal level.

Functional music is music used not only for any aesthetic value, but for its effectiveness in reaching practical therapeutic goals. Music therapy, like other therapies, can only help eliminate road blocks, show the way toward improvement, furnish the incentive for taking that road, and lead the individual on as far as he can go. Yet, the child's will to expand and to explore his own potential can also be strengthened by this effective stimulus. Some children may benefit more from individual treatment which can improve their attitude in other learning situations and be a preparation for group work later on. For others, integration into the group is the immediate need, which can be met through the organizing force of rhythm in the structured situation of systematic group music. All need self-confidence and security, which they can derive from even the smallest achievement in a field which is not beyond their reach.

In working with mentally retarded children, we would start with the same basic rhythmic approach of coordinated body movement, while at the same time realizing that we cannot expect more than very slow and minimal progress. With the severely retarded without speech, sometimes just a flicker in his eyes, a timid smile, or movement of his head may show that he has been reached. With others you may find that even requirements which four- or five-year-old "normal" children can do already or will master within a few sessions may have to be further simplified and adapted to even much older mentally retarded or brain-damaged children. Most of them show marked clumsiness in their movements, often visual or auditory imbal-
Techniques and Activities

ance, or lack of coordination. Marching, running, skipping are among tasks which even some ten- or twelve-year-old children have not yet mastered. Yet, with the incentive of rhythm and music and maybe some imaginative device (such as acting out songs, role playing, etc., which reduces their self-consciousness), it can be achieved.

It is very important to go step by step, no matter how small and repetitious these may have to be, in keeping with what these children are able to accomplish. This feeling of accomplishment is what they so seldom get in their daily life at home, in the classroom, or on the playground; it is what they therefore especially crave. By following rhythmical directions and experiencing the joy of no matter how small an achievement in rhythmic expression both individually and in groups, they can get this feeling of greater self-confidence and security, which will encourage them to go on trying. Doing things is what counts. If you build your music program around the principle of having children doing things, they will really absorb them and benefit from them the most.

Wherever feasible, we try to gear our methods to the children’s special needs, encouraging rhythmic movement in the clumsier ones, humming, choral speaking, or singing even in the “monotones” and those with speech impediments, social give and take in all of them. The autoharp is a helpful instrument which can be used for accompanying their singing but also one which the children themselves can easily manage. It is gratifying to see how often quite withdrawn youngsters are eager to strum this instrument and to push down the few buttons needed for simple harmonizations of songs. By marking these buttons in bright colors one can further facilitate the playing of the autoharp, which gives them the feeling of immediate accomplishment and raises their self-confidence. Others may be attracted by the xylophone, the glockenspiel, or the piano, and even if they just manage to pick out some simple tunes in the correct rhythm, they are impressed with themselves.

Anything that stirs their imagination and reduces their self-consciousness and self-distrust is helpful. Songs and dances, among them some well-known rhythmic ones which are contrasting in tempo, usually appeal to these children. Fairy tales and daily life experiences, such as a bus ride, a birthday party, a trip to the zoo, can be successfully dramatized. I made up a song
about “traffic lights,” having one child raise a red and one a green flashlight, one acting as the policeman while the other children “on their way to school” will “safely cross the street”—a daily life situation with which they learn to cope. There are other safety rules or similar situations they can be familiarized with through action songs. The give and take of carrying letters to everyone who will clap in time with the approaching “postman,” carrying a real shoulder bag and collecting the letters again before marching back to the “post office,” is an activity which most of these children favor especially. It is remarkable how much such a simple device as a shoulder bag can help a child identify with the function of a postman, and thereby overcome his shyness and inhibitions. Even children who never before have dared to give anything to others or accept any object from them may forget and overcome their isolation and anxiety in this dramatized “give and take.”

Although much of what I just discussed can be applied to working with various mentally or physically handicapped children, I should like to mention some other techniques which can be used effectively with those brain-damaged children who are afflicted with muscular involvement such as cerebral palsy.

Cerebral palsy is due to brain damage incurred prenatally or at birth, and impairing, from a light to a very severe degree, muscular control of any one or all limbs, speech, and/or other parts of the body. It is certainly difficult for these children to adjust to a world in which all that seems worth taking part in, education, work, recreation, and social life, is planned for “normal” people, for those sound in body and mind. Their handicap is a barrier which keeps them out of that normal world and often inhibits self-expression and communication almost completely. Many additional disorders may result from that inability to communicate and to find an emotional outlet. Some may give up the fight and withdraw within their own shell. Others may become antisocial and aggressive. Music and rhythm can offer them a means of nonverbal communication and expression; they can be valuable incentives to the handicapped for getting out of their loneliness, for taking part in the enjoyment of group music activities, for learning to adjust to others in their environment to the best of their ability—thereby gaining in mental and emotional balance.

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

After the rhythm band has played for a time in unison, one can divide the children in two groups for playing phrases as questions and answers, just as one can do in singing songs in that fashion. One can then proceed to three groups of instruments playing at different times. Then, gradually and wherever possible, one can proceed to rounds and to the simultaneous combination of rhythmical and melodic patterns.

Picking out little tunes on the recorder or the electric chord organ, the xylophone or the piano, then proceeding to the reading and writing of music, can be done as soon as their curiosity and interest has been awakened to know more about “how it works.” Of course, many of these children, especially athetoid patients, have very poor control of their arm movements and great difficulty in hitting the right single keys on the piano. To overcome this difficulty, I devised a supplementary piano keyboard which can be put on top of the regular keyboard and which I call the “typewriter piano.” The keys are manipulated by buttons attached to little sticks supplied with springs and spaced far enough apart from each other so that the children will not usually hit two keys at a time, as this so frequently happens to them on the regular piano. Although you cannot play a Chopin étude or other complicated music on it, the “typewriter piano” has enabled some of these athetoid children to play simple tunes without frustrating mistakes and thereby has given them quite a bit of pleasure. Another instrument which they enjoy and which can be used for improving coordination and coopera-
tion between the children is the electric chord organ. One child can play the melody, another can push down the buttons which provide the accompanying harmonies, while a third child can indicate which chords to select and when. This is a venture in ensemble playing and may give the children almost as much gratification as we may get from playing a Mozart or Brahms trio together.

Another important function of music is the instigation of more and better performance in physical exercise. One can include body movements such as stretching and bending or raising and lowering the arms to the tempo and dynamics of an ascending or descending scale; one can personify windmills to some songs without the children even suspecting that these might be "physical exercises." Other improvements may simply come from the children's eagerness to grasp and to use their instruments.

In summary, I wish to stress that music therapy is a way, not a goal. It has to be modified to the needs of the patients or pupils and cannot be applied dogmatically or inflexibly. The great value of the rhythmic approach is (1) it provides the children (or patients) with a creative emotional outlet so essential in our over-mechanized world of today; (2) it involves the entire participation of the whole child in the enjoyment of musical form and melody through coordinated movement; (3) it facilitates coordination with others through the organizing, stimulative force of rhythm; (4) it gives them a chance for early success by eliminating tedious drill, finger exercises, and complicated harmonies; (5) it teaches them organization through the structure and genuine discipline inherent in musical form and rhythm, while still giving opportunity for "nonconformity" through individual improvisation and listening to others within the group; thereby (6) increasing their self-esteem, feeling of security, and the courage to go on trying and exploring.
THERAPEUTIC ELEMENTS IN OUTPATIENT MUSIC THERAPY

FLORENCE TYSON

The Music Rehabilitation Center, New York City's first outpatient music therapy service, is at the threshold of a new development—incorporation as an independent, nonprofit agency. The Center was originally established in October, 1958, under the sponsorship of the Musicians Emergency Fund, in order to ascertain the workability and usefulness of a music therapy resource for psychiatric outpatients, and in an effort to help meet the need for nonmedical rehabilitative services1 at a community level.

As noted in my report four years ago,2 exploratory music therapy projects had been initiated by Musicians Emergency Fund at Fountain House, Brooklyn Day Hospital of the New York State Department of Mental Hygiene, the Day Center of the Veterans Administration Brooklyn Outpatient Clinic, and the Social Therapeutic Club of the Alfred Adler Mental Hygiene Clinic. From direct experience we learned that rehabilitation programs in the community emphasized social, recreational, educational, and vocational aspects in a group environment. There is no question of the usefulness of music activity in a social or recreational program; it takes the form of group participation in singing, dancing, ensemble playing, or presenting a variety-type show. However, we did find that many of the most musical outpatients disassociated themselves from these general group activities; they craved more individualized and personalized work and relationships. In the difficult post-hospital phase, many patients suffered the lack of sustained, supporting relationships and of opportunities for ego-strengthening. It became apparent that the encouragement of individual musical capacity

and interest as a source of health depended upon the availability of a separate music therapy resource in the community.

This interpretation was confirmed subsequently, when all of the aforementioned agencies, plus The Bridge, The Strauss League of Hillside Hospital, and Alto Health and Rehabilitation Services (all with ongoing group programs), referred patients to the Center for individual music therapy, to the extent of one-third of the intake.

There are two prerequisites for referral to the Music Rehabilitation Center: a sincere interest in and a love for music on the part of an individual who is under psychiatric treatment on an outpatient basis. Previous musical training is not a criterion. In all cases, the attending psychiatrist effects the referral and provides the rehabilitation directives. Continuous liaison is maintained with the referring psychiatrist or agency; from the Center in terms of a patient's behavior and progress during music therapy sessions; and to the Center in terms of a patient's total treatment plan.

To date, 160 patients have been referred by 37 psychiatric outpatient clinics, hospitals, and rehabilitation agencies, as well as by 31 private psychiatrists. A total of 5,094 individual sessions have been held. The schedule during the past year averaged 45 sessions, weekly (part-time), with studios open on Mondays, Thursdays, and Fridays from 1 P.M. until 10 P.M. Evening hours became necessary as patients improved and obtained employment. The majority of the patients requested piano, voice, or guitar experience. Others worked with recorder, saxophone, clarinet, flute, trumpet, violin, ukulele, harmonica, drum pads, ear-training, theory, applied harmony, music listening and analysis, coaching, accompanying—both classical and popular. The staff consists of eight registered music therapists and three music specialists who work on an hourly or part-time basis. Patients' fees are nominal, based upon ability to pay.

This report attempts to describe the approach and the content of outpatient music therapy, as they evolved in the service of rehabilitation objectives.

At the Music Rehabilitation Center, the therapeutic intention takes precedence over music learning considerations. This is evident in two ways: (1) in the awareness of creating a total

environment or community\(^4\) conducive to promoting emotional and social growth, and (2) in the awareness that while the music therapist is working to develop the individual's musical capacities, his primary concern is that this experience contribute to a more mature level of functioning in the patient's total life situation.

Thus, the environment is consciously "open" (although not lacking in necessary firmness and structure). Its character is informal, warm, permissive, and highly personal. The filled candy-pot on the waiting-room table is not an accidental symbol of the intention behind our service. In four years in this relatively unprotected setting, there has been a remarkable absence of aggressive or destructive behavior; rather, we have noted an ever-growing response in the sense of belonging, in the patients' identifications with the Center and with those who attend it. The only stricture which it has been necessary to create and enforce is consideration and respect for the rights of others.

The Music Rehabilitation Center provides us with an informal "laboratory" for the study of individual outpatient music therapy. Here, relationships become considerably more complex, intense, and significant for both patient and therapist; here, responses and patterns of both patient and therapist show up in larger outline, in magnified close-ups, as it were. In this setting, as compared to hospital music therapy, the responsibilities and demands upon the music therapist are unquestionably increased.

More than half the patients referred have been recently discharged from mental institutions, and the difficulties they face are overwhelming. Gone is the regulated, secure existence where decisions involve little responsibility, where it is not imperative to act or conform or relate, where the warping influences are far removed. All at once, they must cope with the harsh realities of job-seeking, difficult family relationships, and inadequate social development in a generally unaccommodating society. Under the circumstances, the outpatient is at times more frightened, more anxious, more hostile, and more despairing than when in the hospital.

The music therapist, like the teacher, is concerned with the learning process, with skill in communication, with promoting the growth of his charges towards reality and maturity. Like the

teacher,\textsuperscript{5} he must know his subject well and believe in it; he must care about people and be able to maintain satisfactory relationships with them; he must invest his role as an authority figure with kindness, firmness, and understanding.

Unlike the teacher, the music therapist regards his subject as a tool, as a means of achieving objectives which aim at influencing behavior and adjustment. Whereas the teacher-pupil relationship is teacher-centered and based upon the pupil meeting the standards and expectations of the teacher, the music therapist-patient relationship is patient-centered and based upon the therapist meeting the emotional needs of the patient.

To approach his task, the music therapist must possess stability and a well-integrated personality; he must be knowledgeable in the dynamics of human behavior; he must have had applied, supervised training in a hospital or clinical setting. If the music therapist is to assume a significant and dynamic role in relation to the outpatient, he must recognize the possibility that unresolved conflicts or lack of self-awareness on his part might impede the development of a therapeutic relationship.

In the phenomenon of "transference," the music therapist assumes a parental role in the patient's eyes and becomes the recipient of the emotional attitudes held by the patient towards the assigned parent. It is no problem to maintain a positive relationship when benevolent attitudes are acted out. But it takes knowledge and self-awareness to absorb the hostilities projected in a negative transference or in one marked by clinging dependency. The music therapist should be thoroughly familiar with the dynamics of transference so that his own reactions, or countertransference, may not involve the need to retaliate or compensate.

In a recent article, Dr. John H. Fischer, Dean of Teachers College, Columbia University, stated, "... formal education is always a deliberate cultivation. The principal source of energy the teacher uses in the process is the dynamic power of the student's growth and maturation."

This source, this power, is not readily available in the emotionally ill individual in whom it has become arrested or deflected.


Unlike the teacher, it is the province of the music therapist to deliberately cultivate growth and maturation, not so much through the patient’s possible love of learning as through his love of music. To do this, the music therapist works at the roots of developmental and motivational forces. Slowly, patiently, and repeatedly, he seeks to gratify the patient’s love of music as the means of preparing new conditions, new soil, favorable for growth. At the same time, he is strengthening the existing healthy parts of the patient’s personality.

The underlying approach is the freest possible gratification of instinctual aims through the medium of music. These aims include immediate satisfaction, pleasure, joy (play), receptiveness, and absence of repression. The greatest gratification derives from the freest possible outflow. This reinforcement of the pleasure principle may appear a regressive measure, but it is regression "in the service of the ego." Under the control of the music therapist, it allows for the release of current tensions while fulfilling infantile yearnings. It requires foregoing academic considerations, and the taking of as many (musical) steps backward as may be necessary to impel the first involuntary steps forward. Once these steps are taken and strengthened, we can prepare the patient for progressively more complex (musical) steps. It is the pre-condition for learning, and for the patient’s eventual acceptance of the reality principle, with its attendant restraints.

To achieve outflow is by no means simple in patients overwhelmed by guilt, immobilized by anxiety, or engulfed by the tides of self-destructiveness. It is an aim that must be carefully and gradually encouraged as the patient warms and expands, and attains greater ease and relaxation. It also does not depend upon technical accomplishment.

At times, the outflow may be nonmusical in character, as when it represents the release of hostile feelings. Many patients who feel the need to scream or pound or beat are unable to do so directly; we must find ways to accomplish this within a musical context that are not frightening to the patient or damaging to his self-esteem. The scream is incorporated at the apex of an ascending vocal scale; a solidly chpered or turbulent forte passage

in a piano score presents an opportunity for repetitive pounding. Invariably, the patient communicates his need for such an outlet, but not always verbally. Both patients and music therapists tend to be timid about the use of music in this respect. I venture to attribute the therapist’s reluctance to the possibility that the violence inflicted upon music is a threat to his own defenses. The patient will generally not make the attempt unless he feels the wholehearted encouragement and approval of the therapist. The music therapist should not be satisfied with tentative efforts—he should ultimately lead the patient through ever-louder and more intense repetitions until signs of relaxation (deep breathing, dropped shoulders, loose hands and arms) indicate that release has been achieved. The patient obtains satisfaction from the combination of kinesthetic elements with the symbolic, as the action is destructive of music itself. It is important never to end such a session before guiding the patient back to sublimating musical activity. At no point can there be any doubt of the therapist’s ability to control the extremes of emotional expression.

The character of the sessions is determined by therapeutic considerations—they do not always resemble a music lesson. A patient may enter the studio, carefully adjust his chair before the piano keyboard, place his music on the rack, and then proceed to talk of his problems, all the while subtly resisting any attempt to work with music. Or a guitar may be painstakingly tuned, only to provide a background of strumming for a stream of conversation. Such behavior is accepted as an indication of need, whether arising from a pressing reality situation, or a desire to test, or as a defense mechanism. We allow it considerable latitude, to the point where the patient himself would have to agree to the lack of musical activity involved. If the pattern persists over a period of time, it is discussed with the referring physician and, possibly, dealt with directly.

At other times, one might be surprised to see the music therapist joining a patient’s fantasy, perhaps both sitting cross-legged on the floor, enjoying together the warmth of an imaginary campfire. Sometimes, when a patient appears in the depths of despair or depression, the therapist may offer to play for him, making no other demands. This “gift” seems to have inestimable restorative power, with its unspoken values of sharing and caring. Or, a “musical conversation” may take place, with the patient playing as he feels, and the therapist answering musically in kind. Upon
Techniques and Activities

occasion, art, dancing, eurythmics, dramatic play, "conducting," and improvisation are incorporated into the sessions.

We define music therapy as an adjunctive activity therapy utilizing the elements of music to provide gratifying learning and participation experience in support of medically prescribed rehabilitation goals. It is central to the program that patients be drawn into musical activity—that they make music by singing, humming, playing, dancing, composing, or conducting. Patients are helped to make music in the area of their choice, at whatever emotional or performance level they present.

This confrontation by the necessity to do is often an anxiety-evoking prospect for the new referral. It involves self-disclosure, and the patient fears that the revelation of his inadequacies will invite ridicule and rejection.

For many outpatients, it has been an ordeal simply to come to the Center—to manage the right transportation for themselves, to face new people, to expose themselves to the possibility of failure in an activity close to their hearts. As one caseworker reported: "Miss B. is practically a recluse in her furnished room . . . she stays at home engaging in ritualistic physical exercises for hours a day, writing prose and poetry which she usually destroys—often oblivious of the passage of time. Weeks of preparation were necessary before she would venture to make her first appearance in your Center. Additional help was needed so that she would not retreat again when instruction on the accordion was unavailable. It is a great achievement for Miss B. to come even though sometimes late to a new setting and to sing in the presence of another person."

Therefore, in the initial contacts with a patient, the director and the music therapist must be extremely patient, reassuring, and accepting. The more completely receptive they can make themselves to each patient, the sooner can the patient reveal himself, even musically. It is important that the patient comes to perceive the interest in him as an individual, as this will convince him that he is being met at least halfway.

Upon receiving a new application, the director arranges to see each patient in what can best be described as a "music-centered interview." The patient is told that we simply wish to learn about him and music—how he feels about it, what meaning it may have in his life, what previous training he may have had, what kind of music he prefers, and whether or not he comes from
a musical family. In this way, it is possible to elicit important information of a nonmusical nature. For example, a 25-year-old man with the diagnosis of schizophrenia, mixed type, spoke of studying the violin since the age of five. With skillful questioning, it was possible to ascertain that it was his mother's wish that he play the violin, and that he strove to excel in order to please her and to win her praise. He felt he could not win her love unless he were superb on the instrument. Although he felt nagged by his parents in relation to other activities, he did not mind their nagging about the violin, as he actually loved the instrument, himself. Despite the nagging, he felt that his parents had neglected and overlooked him, and he felt threatened by the loss of integrity.

Many patients reject the association with therapy; they are "pupils" who wish to attend a "music school." Great tact is required to maintain an attitude which will enable these patients to participate without losing sight of the realities of the situation. Reassurance is generally provided by the explanation that they can go as far as conservatory training, but not at the expense of their well-being. Questions about therapeutic aspects are answered directly, but in a way to encourage and to motivate the patient. "There are no set rules or courses here; everything is individual, based upon the recognition of your needs and preferences." Or, "We look for what is unique in your personality, for your particular strengths and talents, in order to bring them out and build upon them."

There are practical reasons, not solely financial, for inquiring about job status and living arrangements. This information may uncover obvious frustration factors, such as the unavailability of practice facilities, and may suggest the wisest immediate choice of instrument.

Therapeutic considerations influence the assignment of a patient to a music therapist, especially parental attitudes. Occasionally, the sex of the therapist has already been specified in the psychiatrist's directives. An attempt is also made to "match" personalities, whenever possible, according to depressive, extrovert/introvert, and creative/imaginative characteristics. If, subsequently, a therapist's personality or color or physical anomaly creates a barrier or threat which the patient is consistently unable to cope with, then a reassignment is effected.

The director remains the link between the patient and his
music therapist, and the patient and his world beyond the Cen-
ter; she is available to patients for discussion of special problems
before or after sessions; she reviews each patient's sessions and
course of development, weekly, with therapists; she compiles the
periodic progress reports; she maintains liaison with the referring
agency or psychiatrist. Undoubtedly, as expansion and funds
permit, some of these functions will be delegated to other
personnel.

The preliminary music therapy sessions are exploratory, of both
the patient's personality and his musical potentialities. It is
necessary to discover what is acceptable, in order to minimize
resistance and anxiety. Most often, a patient's strong interest in
music coincides with some degree of natural endowment or
talent. Those with the greatest endowment of musicality seem
to derive the greatest gratification from music itself, despite
emotional problems. Even partial endowment or functioning
provides gratification as, for example, in a patient with highly
sensitive aural perception who may be inhibited or poorly coor-
dinated in the area of rhythm. The starting point, or base for
new learning, is the area in music in which the patient experi-
ences the greatest gratification.

Incidentally, high musicality is not an automatic indication for
successful music therapy, as conflicting values may lead the
patient to ignore this aptitude and seek fulfillment in other areas.
We have worked with patients of average or low musicality in
whom all we could discover was a single positive quality in
relation to music, such as the capacity to sing on pitch. Yet this
single attribute was revelation enough to build feelings of self-
worth and self-assurance strong enough to result in markedly
improved emotional stability and adjustment. This applies as
well to individuals who may have had extensive prior training.

The music therapist must subject himself to one discipline in
the course of his relations with the patient: the consciousness
that his every word and gesture may have therapeutic implica-
tions of which he may be unaware. No matter how informal and
relaxed the attitude or how sincere the warmth and interest, he
must never completely forget himself, or permit the relationship
to become personal. He offers his skills and friendship objec-
tively, to help the patient regain or acquire the inner strength to
meet normal challenges independently. Self-control is equally
important to conceal negative reactions such as irritation, impatience, and annoyance.

The experienced music therapist "suggests"—he favors an indirect approach over direct means; he chooses to wait rather than to proceed impulsively; he would rather listen than tell; he knows when and how to employ a bit of humor to break the tension of a trying moment.

The proper sphere of the music therapist's influence is the patient's conscious behavior, and the management of the surface manifestations of his illness as they pertain to musical activity. Although the music therapist may be aware of the unconscious forces affecting the patient's behavior, he should refrain from interpretations. If the patient spontaneously reveals repetitive patterns in specifically musical activity during sessions, then it is permissible for the music therapist to analyze them. For example, one middle-aged patient persisted in ignoring fingering indications, particularly of the right middle finger. Resistance and defiance could be detected beneath her pleasant, polite manner, and the therapist was unsuccessful in effecting a change in this pattern. Many months later, when the patient happened to be reminiscing about her childhood, she recounted an incident when she had been severely reprimanded for incorrect fingering by an authoritarian music teacher who had sharply rapped her right middle finger with a ruler. When the therapist thereupon pointed out that the patient had been getting back at her childhood teacher ever since, she laughed gleefully. Needless to say, her fingering subsequently improved.

Individual music therapy provides the patient with an important new setting for discovery and self-discovery of both problems and potentialities, and for the application of insights obtained under psychiatric treatment. Several patients who responded to frustration by a tendency to rush tempi and rhythms verbalized the cause as early parental pressures! Conversely, the psychiatrist has found useful information in the periodic progress reports sent out by the Center, which indicate a patient's progress towards objectives, and the conflicts arising during sessions.

We have also seen that there is considerable justification in reality for the frustration and anxiety which many of the most musically educated patients have developed. Histories of instrumental and vocal instruction reveal that many were subjected in their early years to a one-sided teaching approach which
emphasized technical proficiency. The lack of preparation in musicianship resulted in insecurity and immaturity in their musical experiences (particularly in the area of rhythmic stability), which acted to intensify growing emotional problems.

The touchstone of the patient's early progress lies in the combination of the gratification he derives from music and from the quality of his relationship with the music therapist. As trust and confidence develop, the patient gains the courage to discard old ways, and he becomes more receptive to new learning. At times, new musical insights permit the replacement of entrenched habit-formations with new patterns of reaction and response. It is far more difficult to work through this phase with patients who have already received musical training, as they tend to cling to previously learned patterns and misconceptions.

While this report does not cover musical or teaching aspects, it may be of interest to note that no single approach or system seems to meet all the needs. It appears more efficacious to permit each music therapist the freedom of his own approach, as long as his basic training is sound in these areas. With the goal of facilitating immediate satisfaction, materials and methods may be shaped by the individual therapist's flexibility and ingenuity to bypass anxiety and tension-creating factors. Many innovations arise from the need to develop concrete representations for abstract musical ideas. Devices such as numerical or alphabetical notation, lateral notation, numerical patterns or shadow-playing may be universally used, but they are not universally applicable or acceptable—each patient presents an individual problem and, frequently, an uneven or erratic training background. Despite good results, patients may require reassurance that these devices are not childish and do not reflect unfavorably upon their intelligence.

Results after four years have been extremely gratifying, both in terms of meeting a need, and of effectiveness in serving rehabilitation goals in a new setting via the extension into the community of a hospital-developed practice. Dr. Donald M. Carmichael, Chairman of our Medical Advisory Board and Director of Aftercare Clinics, New York State Department of Mental Hygiene, has noted: "... with the addition of your music therapy service to the rehabilitation plans for the patients referred, there has been a greater all round improvement in the particular patients' mental health. This includes progress in individual psychotherapy,
adjustment in the home, and improvement in interpersonal relations.”

Just as in hospitals we have seen that music therapy helps render patients more accessible to other prescribed therapies, so do we see that it facilitates the vocational and social rehabilitation of the musically motivated outpatient: the intrinsic nature of the activity itself provides the opening wedge to emotional and social growth within the music therapy setting which, in turn, carries over to other settings. A patient described it as follows: “... above all, isn’t it easier to relate to people through music rather than through continually harping on mutual experiences of emotional illness? I feel the latter tends to destroy any possibility for a satisfying give-and-take relationship.” In a number of instances, the threat of being dropped from the Center’s program has been persuasion enough for patients to remain in psychiatric treatment during particularly difficult phases.

At the patients’ urging, group activities were initiated during the past year. Two musicales were held in which the majority of patients willingly participated, without concern for performance level. These events resulted in strikingly improved socialization and interaction, and led to the formation of an informal autonomous drama group, which meets regularly once a week. We are now considering the formation of a patient-led recorder group; vocal and chamber-music groups are also in the offing. A patient who participated in both musicales wrote in her letter of thanks, “I just love to remember the two parties we had. What a way of creating a pleasant gathering of people united, maybe every single one in a different approach, but in a pure love of music. Who wants to, can perform, without any form or thought of competition. That is what I love about it.”

The new development referred to in the beginning of this report is the consequence of severe financial pressures on the Musicians Emergency Fund. Despite its concurrence with the prevalent high regard for the Center, the Fund has regretfully found it necessary to discontinue this most recent affiliate as of July 31st, along with other cut-backs in its allover program. The decision came at a time when demand for our service was at its highest point, when plans for broadening the scope of our pro-

gram to include group work with emotionally disturbed and retarded children were under consideration.

The Center's staff of registered music therapists, unwilling to abandon the work, were overwhelmingly in favor of continuing without remuneration, if necessary, while new avenues of affiliation and support were explored. We are presently seeking ways and means of maintaining the service without interruption to the patients and, to this end, are in the process of reorganizing as a nonprofit, membership corporation. It would also be desirable to preserve the Center because of training implications. We have been fortunate to establish a working relationship with the Metropolitan Music School, which has provided us with headquarters and studio space, and thus have been able to resume the music therapy schedule of the Center.

The problems before us are manifold and difficult: to find the funds to support the program through its first years of independent operation; to find the individuals, potential Board members, who will take a serious and abiding interest in the Center's function, survival, and development; to establish a possible basis for a research program. We are confident that the unique contribution of the Music Rehabilitation Center and its place as an integral service in psychiatric rehabilitation will be appreciated sufficiently by others to help us achieve solutions to these problems.
WORKERS' MUSIC CLUB
NORMA SHARPE

At a certain point in a therapy program, an assessment of structure and effectiveness is indicated from the standpoint of the originally expressed or implied goals. This stage has been reached with our Workers' Music Club.

The problem of involving the patient worker in our music therapy program had been a matter of concern for some time. They participated regularly in structured music groups, chorus, choir, harmonica band, and orchestra (release time from work was arranged for this purpose). But they missed the weekly ward group music sessions, due to being off the ward for all or part of the day. By coincidence, we were approached by a nursing supervisor with the request that we organize a music group for working patients—to use some of their time on their "day off." This was gratifying to have such a suggestion come from another department.

The working patients were contacted through the ward supervisors, who invited them to attend the first organizational meeting. Two criteria were selected for determining membership. The first was that the patient had to be a worker, whether for an hour, half day, or full day in one of the Hospital industries—kitchen, laundry, landscape, farm, etc. Consequently, the group that was accepted was heterogeneous, varying with regard to age, intelligence, educational and cultural background, race, and nationality. They also varied in length of time in the Hospital, as the group included new admissions and chronic patients as well as those who went home for trial visits and those who never leave the Hospital grounds. The second requirement was that the patient had to be "privileged," from either an open or closed ward, so that they could arrive at the Club without staff escort. This gave the patient a sense of independence and also relieved the nursing and attendant supervisors of the necessary responsibility of providing staff for patient "pick-up." We realized, however, that many "underprivileged" working patients were thus excluded, and also that their inclusion in the Club might change the character of the group and its activities.

In setting the meeting time for the Club, we avoided the evening hours as this might conflict with other activities. We
selected the 9 o'clock hour on Saturday morning as an appropriate time for the Club meetings. This hour precedes our choir rehearsal in which the music therapy staff is already involved. This was an extra encroachment on our time, but we felt it was worthwhile because of the benefits that could be obtained.

To follow the usual club organization pattern on the "outside," patients were asked to nominate and elect officers. They have a chairman (rotating) who welcomes new members, announces the program, and asks for a volunteer chairman for the next meeting; a secretary (permanent) who calls the roll, takes attendance, writes the minutes as the session progresses, or at its close; a treasurer (permanent) who takes the collection (a contribution of pennies or small change), keeps a record of total contributions, expenditures, and balance. The secretary and treasurer have assistants who substitute in their absence due to illness or a weekend home visit. These two officers are permanent until they are discharged from the Hospital. Then, other patients may volunteer and be elected to these offices.

The policy of using patients' money to buy refreshments was started to allow them to feel they were contributing to the support of the Club. Also, when so much is given to patients daily, free of charge, it is an opportunity for them to give for something received. Again, the patient who purchases refreshments with this money has to make a choice, however small, giving him experience in making decisions.

Patients who volunteer to go to the Canteen for cookies and candy and to the kitchen for the "standing order" of beverage (fruit juice, chocolate milk) act as hosts, setting out paper cups, pitchers, plates, and also serving. This is an outlet for the "helpful" patient, and is an experience in the social graces for patients who are daily in the reverse role of being served.

It was felt that the Club should have a name. After many titles were submitted, the name, "Happy Tones," was selected. The name is descriptive, signifying pleasantness in both music and mood.

The music program, usually prearranged by the music therapy staff as a matter of expediency, consists of: (1) quiet background music while patients are assembling, (2) patient performance, either vocal or instrumental, (3) poetry readings with staff accompaniment on the piano or other instruments, (4) recordings played for listening and discussion, and (5) a short
sing-along. Roll call and the collection are taken during the serving of refreshments. The meeting usually closes with the national anthem.

When the Club was first organized, we anticipated that the interest might wane, particularly in the summer months. But it has been functioning every Saturday for fifteen months with fairly consistent attendance, an average of 33 patients. Of interest are the following observations: (1) male patients outnumber female patients, five to one, (2) some patients occasionally are absent for several weeks, and (3) a few patients have missed only one session. At the present time the patients are periodically prompted to come to the Club by ward or music therapy staff members. An eventual goal will be to have attendance more patient-motivated, on the patients' own initiative completely with no reminder whatever from the staff, thus developing more self-discipline and responsibility.

On the basis of the attendance, we can assume that the members are finding the Club satisfying and enjoyable, whether the motivating factors are diversional, participatory, or gustatory. Pertinent to this, we asked this question at a recent meeting: "Why do you like Workers' Music Club?" Replies included: "It gives one a chance to meet other people. . . . Sometimes we have great music (classics). . . . It takes the blues away. . . . It gives those with talent a chance to perform and also encourages others. . . . It lets us all get together and sing together. . . . It's relaxing. . . . We have fun. . . . We like the lunch as well as the social part. . . . It helps you not to be so self-conscious. . . . It spreads fun and fellowship."

Other values in terms of group dynamics include identification, both individual and group. The patient receives individual attention through roll call and our practice of introducing patients to their neighbors thus encourages them to recognize and address each other by name. The patient officers and performers likewise are the focus of group attention. The Club itself is unique in the Hospital setting. It is the only social group organized especially for workers. To the members, this involves the effort of working in order to qualify and implies an award or recognition of their status as workers. This serves to counteract any feeling of deprivation of music therapy activities on the wards or in the music room due to being occupied in a Hospital industry.
The Club provides, as well, an experience in acceptance: (1) of the officers and the performers by the group, (2) of each other as co-members, (3) of change of patient leaders, and (4) of change of staff. Our five music therapy staff members divide this weekend responsibility.

The music therapy staff plays a minimal supportive role in the various features of the Club meeting, giving direction and suggestion only when needed and then mainly in musical accompaniment. Patients whom we have invited to perform select music of their own choice.

Further developments will include more responsibility of patients in planning and executing the "entertainment" program. On the few occasions when a patient organized the program, "gaps" occurred in the continuity with loss of emphasis and direction. This, however, can be tolerated in the interest of independent action. Patients also will be encouraged to suggest innovations in programs, to express their aesthetic preference in recordings to be used, and to contribute more folk music from their varied backgrounds.
PART VI
MUSIC THERAPY WITH
APHASICS
MUSICAL CAPACITY AFTER BRAIN INJURY

HAROLD GOODGLASS, PH.D.

In a treatment setting, where we deal with disturbed human beings, we are often told to consider the patient as a whole person, a whole man, and not to attempt to treat one disturbed aspect of the person and to ignore all the rest of him. In fact, we would probably cringe at the suggestion that a human being consists of some limb-moving machinery, a set of touching, hearing, and seeing machinery, a talking machine, and, perhaps, a music mechanism, all hooked together in some way with something on top of it that has the idea that this is all one self. In fact, for mental health, it is very important for each person to view himself as a single personality which is responsible for and controls all of its language, its bodily attributes and expressive behavior.

For example, could we conceive of a Robert Frost as an individual without his language? My idea of Robert Frost cannot be separated from his poetic creations. The same would apply to any great musician or composer. We think of their musical expression as very much an integral part of their personality. However, as students of human behavior and of the human mental apparatus, we are often forced to consider that our mental makeup can be divided up in such an arbitrary way. In fact, the facts of nature, the way that injury in the nervous system affects the performance of patients whom we see; these facts force us to recognize that our mental apparatus can be isolated into segments that are very much at variance with our common sense, subjective experience as to how we operate.

The general group of defects resulting from injury to the nervous system that best illustrate the loss of isolated segments of our mental capacities, are called aphasic disturbances.

Many of you have heard the term aphasia, which is applied to the loss of speech that often follows a brain injury, of whatever cause, whether a stroke, an accident, or a brain tumor. In people who have become aphasic in some way, we often see these losses of abilities which the patient considered so much a part of himself that at first he may feel that he has lost his mind, or in some way lost part of his personality. For example, people who have learned to speak several languages may, after becoming aphasic,
suddenly discover that they can no longer speak the language that was current for them in everyday life; that, all of a sudden, they can communicate only through their mother tongue. Sometimes it is not the mother tongue that is preserved, but the more current language. There are several alternative theories for how this dissociation comes about, but the fact remains that this appears to be a paradoxical separation of one's mental abilities. Why should they be sliced this way? How can the brain be organized in such a way that an injury can separate a new language from an old language? Another kind of disturbance that conflicts with our common-sense ideas is that in which a person who can write, speak, and understand as well as he ever could, may be unable to read any longer. In fact, he may write perfectly well and a short time after having written something—just long enough for him to have forgotten what he put down—be unable to read back his own writing.

Now you would think that writing is built upon the ability to read. This is common-sense experience. The ability to recognize something is ordinarily preserved longer than the ability to recall it and reproduce it yourself. And yet in these rare cases we find that the person can produce and yet no longer recognize his own production.

Another illustration of an isolated loss which seems incomprehensible to our preconception of being one person, with one mind and one consciousness, is the observation that with certain kinds of injury a person who is intact in speech and in writing with his right hand may lose his ability to write with his left hand. We recently had the opportunity to see a patient who, when given something to identify by touch alone, would indicate his recognition whether with his left hand or his right hand. However, if it were in his right hand he could tell you what it was, immediately. If it were in his left hand, he also felt that he knew what it was, but although his speech was perfectly normal in conversation, he couldn't tell you what it was. He would misname it. If given the opportunity to point out the felt object with his left hand, although still misnaming it, he would immediately find it. However, if he were to hold an object in his left hand and try to point to another one like it with his right hand, there would be no connection. Now, he didn't experience himself as two people, yet in a rather concrete way his nervous system was divided in half, so that what he knew in one part, the rest of him didn't know.
Now, these are unusual phenomena. The fact that they can and do occur at rare intervals, and the fact that the injury that produces them can be predicted and verified at autopsy, gives us some basis for looking at our mental apparatus as something that can be subdivided in various ways by brain injury.

Why put music in the context of these disturbances that we call the aphasic disturbances? Music, in a way, is one of the higher mental functions, and it is associated with many of the same operations—very closely related operations—to spoken language. It depends originally on hearing, as a spoken language depends originally on hearing. It is executed either with the vocal apparatus as is speech, or with the hands as writing is, and music is read just as words are read. Thus, many of the skills which are lost when a patient becomes aphasic through brain injury may also be expected to disappear from his musical performance. However, our experience with brain-injured patients tells us that what looks to us like two different applications of the same skills are probably two sets of separate skills: those of musical and of verbal expression.

In aphasic speech disturbances, we find that patients may lose the ability to produce speech voluntarily without much impairment in their comprehension. Other patients may be very severely disturbed in their understanding of speech and have no interference with the mechanical production of words. In music, analogously, there is the possibility of having a loss that affects primarily the production of music, as in playing an instrument or in singing. In this case, the appreciation of music may remain undisturbed. However, the one thing that seems always to be lost with any significant degree of aphasia is the creative aspect of music, and I think that this applies as well to the creative aspect of verbal language. I don’t think there are any instances in the literature of people who have lost their effective use of spoken language, and yet have retained their ability to produce original and worthwhile creative works by writing. We know of some instances where composers have suffered aphasia, and have lost the ability to create original music anymore. One of these I will describe shortly. Although musical creativity is lost to the aphasic patient, the ability to perform musically can still be well preserved.

As for the ability to appreciate music, this must be divided into two aspects. One is the perceptual discrimination between
tones, the ability to appreciate differences in pitch, the ability to retain and recognize melodies. And second, the aesthetic aspect, what we usually mean by “appreciation” in everyday speech, or the ability to gain some emotional gratification from a musical experience, and particularly from repeating a familiar musical experience.

Alajouanine, a French neurologist who is well known for his work in this area, had occasion to treat the famous composer, Ravel, who suffered a stroke and became aphasic. Ravel spent the last years of his life with a very severe speech disturbance. He could just barely hint at the ideas that he wanted to express by a few laboriously chosen words. He was no longer able to compose. He could not read music any longer, although in scanning through a musical score, he could immediately identify any of his pieces just by the configuration of the music on the staff. He continued, however, to have an acute appreciation of everything that he had ever written. His sense of pitch remained very exact, so that when a piano was slightly out of tune, he was able to demonstrate how far off pitch some of the keys were. He could explain, when there was an accidental omission of a passage in the playing of one of his pieces, what had been left out, and why he had originally composed it that way. Ravel's case provides an extremely dramatic distinction between the finest level of musical appreciation and the capacity to perform: the one being retained, the other being completely lost.

Now, in cases of aphasia where a part of the brain that is essential for speech has been injured, it is very common to find a relative preservation of the ability to appreciate music, and, to some degree, to sing. There are many instances of patients who completely lose the power to speak effectively, and yet retain an amazing ability to sing. I have on tape a very short extract of the performance of one of these patients that will be of interest.

Dr. G: “Good morning Joe.”
Patient: “Joe ... good morning, Joe.” (echoing)
Dr. G: “How are you?”
Patient: “How are you?” (echoes)
Dr. G: “Do you know my name?”
Patient: “No.”
Dr. G: “Doctor Goodglass ... Can you say it?”
Patient: “I don’t know.” ...
Dr. G: “Who is your singing teacher, Joe?”
Patient: “Teddy McKay.”
Dr. G: “That’s right.”
Patient: “Teddy McKay.” (re-echoes with satisfaction)
Dr. G: “What have you been singing recently?”
(Patient sings through “Red River Valley,” with good rhythm and pitch, but “dee-dee-dee” in place of words.)
Dr. G: “That’s very good. Do you know ‘Home, Home on the Range’?”
(After several false starts, prompted by Dr. G, patient sings most of the tune correctly, using “Dee-Dee” in place of words, until he comes to the chorus, when he produces a distorted, “Ho’, ho’, on de wange, de de deer n de antedo’ pway, dedo de do de, etc.,” reverting to “dee-dee” after this point.)

That sort of performance is a bit more dramatic than what we hear most of the time. This is a man who has an extremely well-preserved ability to sing, and finds enormous satisfaction in singing, as you probably could hear on the tape, while his speech is very sparse, very limited. In fact, when he first joined us, he had practically no speech at all. He could echo a few words here and there and you can still hear his tendency to echo. From the beginning, however, his singing was very nearly as good as it is now. Thus, there was even more of a contrast at the beginning, but his work with Miss McKay, his music therapist, has been a tremendous boost to him.

For an illustration of an even more marked dissociation of musical performance from language I should like to describe the case of a patient who was in our hospital for a number of years until her death recently. She was intensively studied by Dr. Quadfasel and Dr. Segarra. About twelve years ago, she was found unconscious from gas poisoning, and after being hospitalized, she never recovered any real functioning as a human being. She did not understand the meanings of words, nor did she ever respond to any kind of spoken communication. She could take food by mouth, but that was about all. However, the strange feature of her situation was that the mechanics of her speech production remained intact. Although she did not respond meaningfully to anything that was said to her, she would echo many things and would spontaneously babble things, so that there were certain jingles which she would say to herself over and over again. If she were started on a poem that happened to be
familiar, she would continue along with it, as if she were a sort of music box. If you sang along with her softly and gave her a little cue now and then, she could go right along to the end, singing words and music very clearly. One of the features that I think is true in all of these instances of isolated preservation of music is that these patients probably have had a better than average musical talent to begin with. These people usually have a great repertory of songs. The man that you heard on tape today probably has at his command a good many more folk songs, and gets a good deal more pleasure out of them than the average person whom you would ask to sing. The same was true with this girl, who was something of an oddity in the hospital, since there was no real communication with her at any time. Even music did not seem to afford any communication to her, since her performance was mechanical.

However, the fact that she did survive in this way with these abilities, and the fact that it was possible after her death to see just what had happened in her brain to permit this peculiar preservation of abilities, tells us something useful about the location of the structures that make possible the continued production of music.

The most significant findings in the examination of this patient's brain were the preservation of the structure known as Broca's area and the preservation of a small island of tissue near the front tip of the temporal lobe. All of the surrounding grey matter was either shrivelled or isolated from useful function by the destruction of the interconnecting fibres lying below them. The preservation of the anterior portion of the temporal lobe nearly coincides with earlier findings in cases where musical abilities have been isolated by brain injury. One point of difference is that in our case it is not the very tip of the temporal lobe, but an area slightly posterior.

Now, the application of these phenomena to the work of a music therapist is, I think, rather obvious. The patient whose tape we heard is a good illustration of a fact which is often neglected. Many patients who are essentially cut off from useful communication from other people really have a great starvation for emotional outlets and feeling relationships with others. They may have a potential which is too often neglected and can be utilized to their great benefit, through the utilization of their retained musical abilities.
I think that you have to be aware that it is usually pointless to try and foster any creative activity on the part of the patient so impaired. However, most of us take part in music, not creatively, but by going through again, things that are familiar, and this may include playing an instrument. I don’t think of performing a familiar piece on a musical instrument as in the sphere of creativity. Certainly singing is well-retained with many people, and it is our experience that the relationship that one gets by joining musically with other people is a much more immediately emotionally involving one than one that has to be filtered through speech and the conventions of polite social conversation. So that, we have through music therapy, a short-cut, a very effective one, to the feelings of our patients.

I’m not sure that music therapy with an aphasic patient contributes directly to the improvement of speech. It is possible that it does, because you may have noticed with this tape that at certain points our patient has very little speech, can find words much more easily as he sings along, than is ever possible in ordinary speech. Some aphasic people can sing with words perfectly well articulated when speech without music is completely impossible. More often, they can sing very well, but their word production is not much helped. However, this is much better than no help at all.

But, even though the practice with singing may not directly influence speech in ordinary conversation, it certainly influences it in this way: that the music provides a basis for relationships with other patients. The music therapist provides a morale-boost and a new interest in life. She can make, essentially, the difference between a patient who cannot be reached, is not interested in staying in the treatment situation, and goes home, or goes to a nursing home to vegetate, and one who is an interesting and happy addition to the hospital or to his home.
The term "aphasia" is used to describe a complex language disorder. Briefly stated, the person who has aphasia suffers brain damage which causes an impairment in any or all of the communicative processes. These can include such areas as speech, reading, listening, writing, and several other avenues to communication. A person who has aphasia might know what he wants to say, but can't think of the correct words, or the words might come out incorrectly, or sound like jargon. This inability to speak is not due to muscle paralysis, but the basic difficulty might become even more imposing by the presence of such a paralysis. He might be able to see words, but he might not understand them, or they may tend to run together. Yet his vision may be perfectly normal.

These are but two examples of how a person with aphasia may be affected. He may be, and most frequently is, impaired in several different areas at the same time. In the adult it is understood that these abilities were once present, but have now been disturbed by some damage to the brain. This may be as a result of a stroke, growths, accidents, diseases, and the like. Frequently the person who has aphasia also suffers from a paralysis which affects at least one side of his body.

Speech and language therapy for the aphasic must necessarily be tailored to the individual. It must also be directed to participation in group activities.

About six years ago the Chief of Psychology Service at the New York Veterans Administration Hospital recognized the potential value of incorporating group music, specifically singing, as a therapeutic adjunct in the treatment of the aphasic. A program was instituted at that time with the cooperation of a music therapist of the Hospitalized Veterans Service of the Musicians Emergency Fund. Since its organization this program has been carried out as a joint undertaking between the music therapist and the speech pathologist. The only interruptions in this program have occurred at times when there was no speech pathologist on the staff.

The authors reinstituted this program about one year ago, having one important thing in common: neither of them had any
experience in the utilization of singing as a therapeutic entity for the aphasic. We were fortunate, however, in that we could ask questions of some who had worked in this program in its earlier days.

It is our feeling that a program of this sort is justified for several reasons. Many of our members possess little or no speech when they enter the hospital. Because they tend to perform best in well-known areas, or in areas in which verbalization tends to be somewhat automatic; they could be expected to perform well on songs which are well-known to them, notably the "old favorites."

Following are some of the techniques used in the musical presentation of the songs which have proven most effective with the aphasic in the past, and hold true in our own experience.

First of all, the tempo must be considerably slower than normal, so as to lessen the strain of reading and forming of syllables quickly. The best tempo can easily be determined by watching the patients' reaction closely, and choosing a speed with which they can keep up. This is not to say, of course, that the tempo must be so slow as to not afford some challenge to them. It is well for the therapist to sing along with the patients, clearly enunciating the words, so that they have a good pattern of sound as well as sight to follow. The key of each song must be carefully chosen, so there will be no strain in the actual singing process. We found that, in dealing with male patients, the range should go no higher than middle "C" to be perfectly comfortable for all the patients, and generally the top note is even lower, "B" or "B flat." Obviously, this means that all the songs have to be transposed down from the original.

The best songs to use are those with few words, with the syllables passing at a fairly regular rate and not in "spurts." Generally, each song is done twice so that the patient can try to correct some of his errors immediately.

In truth, it would be difficult to assess whether there is any carry-over from singing to speech, but we have observed some important results. We have known several persons who possessed little or no speech, and appeared to lack motivation because of past failures in the speech attempt. After entering this group some have produced their first words while trying to sing along with the rest of the patients. The fact that they were able to meet with success in one condition showed them that "it can be
done," and this has resulted in an increased positive outlook and motivation in other therapies. Furthermore, a group of this sort has many of the natural advantages inherent in any kind of group work.

Although most of the men were familiar with most of the songs that we started with, they did need some sort of reminder of the words in the form of visual reinforcement. This is a very important consideration for such a group. We knew we had to find a system that could get the maximum amount of output from the patients with the least amount of strain on their part. In essence, our major problem has been in getting the words of the songs before the patients in an effective manner.

We tried several different methods, continually considering new and more efficient ways, adopting a new procedure and then discarding it in favor of a procedure that seemed to be better suited to our purposes. The following is a summary of our own experiences in selecting a method which we thought suited our needs. Although we have not used these devices with other groups (nonaphasics), we feel that our procedures might prove beneficial in working with any small group of handicapped persons.

Our first venture was the use of conventional printed song booklets. This helped, but we ultimately discarded this technique for several reasons. The print was too small. The aphasic who is impaired in reading may not be able to read small print, but he might be able to respond to large print. It was also quite easy for those who could read some words to "lose their place," and could not or would not admit it. Because most of the individuals also had a paralyzed arm, it was rather difficult for them to handle these booklets. Furthermore, it was our feeling that the preoccupation with individual difficulties tended to keep group members from participating in the activity as much as they wanted or were able to do. We also tried mimeographed song sheets, which were discarded for the same reasons for which we discontinued the song booklets.

We tried 5" by 8" cards. These cards had the words for one or two songs mimeographed on each side. The type was large and widely spaced so as to allow for greater ease in reading and handling. This worked considerably better than either of the two previous methods, but it still had shortcomings. The print was still not large enough for some members of our group, and
time was wasted in passing out and collecting these cards. Also, the fact that the attention of the patients was still focused on small cards immediately in front of them tended to keep them from having a "group feeling."

We contemplated the use of a film slide projector. As yet we have not tried this method, though we have spoken with persons who have seen it in operation. It, undoubtedly, has its merits for use with groups, particularly large ones, but it has its shortcomings too. On the positive side, it does manage to keep the attention of the patients focused on one central point, thereby leading to a greater feeling of being a member of a group. This does manage, however, to become a cumbersome procedure. The continuous use and obtaining of a projector as well as a projectionist, can be bothersome. Also, a special room would be needed for this purpose. The constant darkening and relighting of the room for each song is a consideration. We also were told that as soon as the lights were darkened for the projection of a slide, the attention of the group tended to wander. Moreover, it would be increasingly difficult for the leaders of such a group to observe the participation and reactions of the members of the group. Perhaps our criticisms seem unwarranted in view of the fact that we are citing objections to something with which we have no direct contact, but we do seriously question the expenditure of so much effort for such a procedure, particularly for use with a group of modest size.

Our current method employs the use of cards 24" by 36" in dimension. These cards are of Manila tagboard having about the same stiffness as a Manila folder, so that they can be thumbtacked on a board in front of the room. They are permanent, sturdy, and can be used as often as desired, with no deterioration or wastage, as is the case when song sheets are used. One song is imprinted on each side of the card, This is done through the use of a rubber stamp lettering kit such as can be purchased in many stationery stores. The letters are about one inch high, and the capitals are about one and one-half inches, to allow for easy vision from any part of an average-sized room. These sheets were given to us by the Medical Illustration Service at our hospital.¹

¹ For those who have access to federal government supplies, the specific card we use may be purchased from GSA Stores Stock. It is listed as Manila Tagboard, 24" by 36", 9310-752-9094.
This procedure has proved to be better than any other we have tried. It eliminated or decreased all of the difficulties encountered when using the previous methods. Although many of our patients still cannot read too well, the task is made easier for those who can; and they don’t “lose their place” because the words are pointed out by one of the leaders of the group. This technique has minimized the individual difficulties of the members and has resulted in greater participation. We believe there is also a stronger feeling for being members of a group. Our only criticism of this procedure is the length of time it takes to print each song. This can take about three-quarters of an hour, but we believe it is well worth the initial effort when we see the results: a greater degree of participation and a more overt show of friendship and humor than before. The output of many of the group is still limited, but it is better than it was.

Although our experience is limited to aphasic patients, we feel that the system we currently are using can help solve some of the problems encountered in working with other handicapped individuals, particularly those who have limited use of one or both hands.

We are not sure that we have arrived at the best of all possible solutions to important problems, but we do know that we have developed a technique which is considerably better than others we have tried.
PART VII
RESEARCH IN MUSIC THERAPY
THE EFFECT OF CERTAIN ACTION SONGS ON BODY CONCEPT

WANDA LATHOM

INTRODUCTION

The manner in which a young child organizes the reality of his surroundings and himself in relation to things around him has fascinated many people. "The importance of body image to our culture as a whole is obvious in terms of the widespread expenditure of time and effort that is given to altering the body's appearance."¹ This has also been observed by Garma,² Schilder,³ and Critchley.⁴ A problem of such complexity offers many possibilities for research. The primary aspect of the problem that was under consideration in this study was "body-image." Body-image, self-concept, and body-scheme are terms that have been used by many psychologists and psychiatrists. However, these terms often refer to very different concepts. Most of the people who have done research in this area use an operational definition to enable them to clarify that aspect of the concept with which they are concerned. In this study the term "body-image" was used to refer to the S's awareness and knowledge of the physical characteristics of his own body, as indicated by his ability to point to various parts of his body on verbal command, assemble a mannequin, point to various parts of the mannequin on command, and draw a picture of himself.

PROBLEM

The study was concerned with the use of musical action songs and games as a means of increasing the child's ability to identify himself from the rest of his environment and to describe parts of his body. The action songs and games involved indicating a particular part of the body as it was mentioned in the words of

the songs. Machover states that “personality does not develop in a vacuum, but through the movement, feeling, and thinking of a specific body.”

The study was based on the hypothesis that a child must have some organization of his physical appearance before he can begin to relate, in a very meaningful manner, to the people and objects around him; and that as his body-concept increased, he would begin to incorporate the concept of self in relation to space, time, and physical objects and a growing social awareness would also occur. The literature mentions that this very important aspect of maturation may not occur in individuals who, for various reasons, seem to lack the ability to gain adequate knowledge of their body concept. This includes those patients diagnosed as brain damaged, those who are functionally retarded, patients who are exhibiting some form of schizophrenic process, or those physically handicapped individuals who have lacked stimulation due to long periods of hospitalization or inability to move around and explore the environment and relate to others. Ayres noted that:

When a child does not learn through the normal course of development to synthesize impulses into a body scheme, training procedures are based on increasing the flow of sensory impulse, developing a conscious knowledge of the construction and basic movements of the body, and associating the sensation and conscious knowledge through simple gross meaningful motor tasks.

ORIGIN OF PROBLEM

The primary reason that patients similar to the test Ss are referred to music therapy is to stimulate social interaction. However, it seemed that they usually needed therapy for reality orientation to objects, self, and space before they began social interaction. The study originated from a need to determine if music therapy could utilize certain types of songs and musical games to increase body-concept as indicated by performance on the measurement criteria.

RELATED LITERATURE

Strong wrote a dissertation on “A Factor Analytic Study of

6. Ibid.
Several Measures of Self-Concept." He noted that "since the dawn of history, man has been concerned with the concept he holds of himself." Therefore, there is a large body of literature about various aspects of body-concept. This concept has been of interest to people studying learning theory, perception, and the physiological and psychological development of children. However, the literature does not contain information on the effect of action songs on a child's self-concept. Symonds commented on the importance of a realistic body-concept. "The self is the most real thing in our experience and is the frame of reference with which a person perceives, conceives, and evaluates the world around him and toward which he reacts."8

Fisher and Cleveland state that "the more definite an individual's body image boundaries, the greater his capacity to enter into intimate expressive relationships."9 This seems to be in agreement with the hypothesis of this study. However, Schilder notes that "body image is to a considerable degree molded by our interactions with others and to the extent that these interactions are faulty the body image will be inadequately developed."10 Therefore, it seems that social interaction may be affected by the degree of reality orientation that an individual has to self or body boundaries, but that subsequent interaction may also effect the manner in which an individual perceives himself.

Information on how a normal child develops a realistic body-concept provides some of the information on which the study was based. Some related studies that used exceptional children as Ss also provided helpful information, particularly in experimental design and evaluation of data.

**Subjects**

Eight boys and eight girls were chosen for Ss. They were from the age of eight to eleven and were on Adaptive Behavior Levels I, II, and III. Four boys and four girls acted as control Ss and the other eight children were in the music training groups. The eight children in the training groups were matched with the

---

10. Schilder, op. cit.
eight in the control group according to their performance on the initial testing. The two groups were also matched by cottage placement and program, with the exception that the training groups came to music and the control groups did not.

**Procedure**

Individual tests were administered by a clinical psychologist. Wylie noted that "it is a truism that rapport with the experimenter must affect the accuracy and completeness of S's report of his conscious self-concept. However, no one has specifically demonstrated the influence of this factor, and in many studies where data have been taken by group procedures no particular means for establishing rapport have been described."11

The initial testing was used to establish a base line for each S so a difference score could be obtained at the end of the study. It also provided a means of pairing control and training Ss so they were matched on their performance on the measurement criteria rather than less related criteria.

Testing occurred during the week preceding and the week following the training. Training occurred during three 45-minute periods per week for ten weeks between the pre-test and the post-test. In the first test the child was asked to draw a picture of the way he looked. The test was scored according to sixteen reality items12 that corresponded with the parts of the body that the training group identified in the songs. It was felt that ability to manipulate a pencil, short attention span, and lack of self-reference might affect scores on the drawings, so three other tests also were used.

When the S had completed his drawing he was asked to assemble a mannequin. The occupational therapy department had prepared an enlarged copy of the mannequin used in the WAIS. The mannequin was cut into fourteen pieces, and the

---

12. Dr. Henry Leland, Parsons State Hospital and Training Center, has devised a means of scoring the *Draw-a-Person Test* according to 22 reality items, which he separates from functional-efficiency items. Reality items refer to parts of the human body or clothing related to the usual drawing of human figures. Dr. Leland's work is reported in: Jack E. Dye, "An Analysis of Reality Content and Functional Efficiency as Related to Maturation in Human Figure Drawings." Master's Thesis, Kansas State College of Pittsburg, 1962.
facial features, hands, arms, and shoes were painted realistic colors. Clothing was also attached, since the child might derive some clues from the tactile experience of the different textures of clothing. The S received one point for each section of the mannequin that was correctly assembled.

In the third test the S was asked to point to fifteen parts of his body and he received one point for each correct response. These fifteen items corresponded with the fifteen parts of the body that were mentioned in the songs used during the training period.

The fourth test consisted of having the child point to the same fifteen parts on the mannequin when it was correctly assembled. The S received one point for each correct response.

One training group of two boys and two girls was trained by a music therapy aide and the other group was trained by the experimenter. The training groups were trained by two people to see if there would be a similarity in their scores although they were trained by different people. Each group performed the same activities and used copies of the same record.

Fifteen parts of the body were to be identified in the performance of the songs and musical games. Three were circle games. All six songs required the children to either point to parts of the body or move some part of the body. Rhythm and imitation were emphasized in the performance of the songs. The following selections were recorded for use by both training groups:

- Put Your Finger in the Air
- All God's Children
- Watch Your Eyes
- Looby Loo
- Mulberry Bush
- Hokey Pokey

The training Ss learned "Put Your Finger in the Air" first because it could be done while the Ss were seated. These children were quite hyperactive and they were of a pre-group level of socialization. The Ss were taught to come in and sit in chairs that were arranged in a semicircle. After performing the first song, the children were taught to form a circle by holding hands. Polka music was used while Ss learned to hold on to the person next to them and move around the circle. None of the circle games was taught until Ss could make the spatial adjustments to form a circle and had learned to follow instructions to "move" and "stop." The children were seated to perform some of the songs, but active movement was used between these songs since the children were too hyperactive to remain seated very long.
As the Ss learned more songs it was possible to hold their attention for increasing periods of time. At the end of ten weeks they could perform all six songs and could work at goal directed activity for the complete 45-minute period.

The primary question asked in the study was: Did training in the performance of certain songs aid the child in establishing a meaningful organization of body-concept as indicated by higher performance on the measurement criteria? Time and space orientation were also emphasized, although only body orientation was measured. Identification as a group and social interaction also were encouraged.

**Measurement and Results**

As the literature is examined it becomes apparent that "self-concept" and "body-image" constructs have very different meanings to different people. It is difficult to apply objective measures to a concept that is not clearly defined. However, this has occurred throughout a large part of the literature. Results of tests are given, but it is often difficult to determine if the results actually prove the hypothesis, because terms are not defined, and the validity of the measurement device has not been indicated.

The *t* test was applied to determine the significance of the difference in the pre-test and post-test scores of the control and training groups, on each of the four tests. There was not a significant difference in the scores of the training groups as compared with the scores of the control group on any of the four tests. The total scores on the four tests were also combined. The difference between the pre-test and post-test scores was again evaluated by the *t* test. The training group made a 69-point gain, which was significant at the 0.05 level. The control group made a total gain of 54 points, which was not significant at the 0.05 level. The difference between the increase of the two groups was only fifteen points, which was not significant. The scores of the two training groups varied only seven points, which seems to indicate that the study could be repeated by other people with similar results.

When the sign test was applied, every S in both the control and the training groups made an increase in his total score during the ten weeks, although the training groups made a greater increase than the control group.

There are several reasons why the control group made almost
as much increase as the test group. There may have been some communication concerning training procedures between the training Ss and the control Ss, since they lived in the same cottages. Some of the increases may have been from test, re-test effect, although the psychology department believed that this would account for only a small part of the increase. The greatest variable was probably the rest of the program. As the music therapy department talked with others who were involved in the S’s milieu, they also became interested in body-concept and began to work to assist the Ss in gaining a realistic body-image.

**Conclusions and Recommendations**

The lack of a significant difference between the two groups doesn’t necessarily mean that music therapy is not an important part of the milieu that is working to establish increased body-concept.

Many social changes seemed to occur as the Ss in the training groups seemed to get improved orientation to self in relation to objects and other people. These children would usually be prescribed to music therapy for increased social interaction. It might, therefore, seem that songs that deal with body orientation would be a useful place to start socialization for young patients, and music therapy can contribute to the milieu that is working for increased body orientation.

Since this was only a pilot study, it seems that the study should be repeated with these changes: (1) More Ss, (2) more items on each test so that greater increase is possible. Many of the Ss made perfect scores on the assembly task and both pointing tasks, so more items are needed on these tests. (3) The drawing task might be given with chalk so gross movements would be possible. The Ss seemed to be able to draw more of the measured reality items with chalk than they could with pencil and paper. (4) The study should be run with less involvement of other areas of the milieu in specific training to develop body orientation.
REHABILITATION WORK PERFORMANCE AND
THE MUSIC THERAPIST

WALLACE L. KOTTER, GLADYS DOUGLAS-LONGMORE,
AND LEO SHATIN, PH.D.

The growth of music therapy as a profession, its development in numerical strength in the quantity and quality of its training institutions and in the types and varieties of its medical or rehabilitation applications, is sufficiently well known to us not to require any recapitulation.

What, however, are the interests and traits of the "good" music therapist? Can we differentiate between the "good" therapist and the "poor" one? There have been many psychological studies of music teachers and musicians, but to our knowledge there have been no psychological measurements reported for music therapists, i.e., for persons engaged in the application of music as a rehabilitation or treatment method.

The personal qualifications desired of the music therapist have been variously described. Naturally, these lists subsume all of Li'l Abner's qualities plus a few of Mighty Mouse. As is often the case in the absence of sobering and corrective "hard" facts, the aspiration fathered by the wish does far outstrip the level of reasonable expectation. Hence, a musician endowed with all those sterling qualities expected of him would certainly be an unusually great music therapist. For example, he should be businesslike, impartial, healthy, emotionally well balanced and self-controlled, cheerful, objective, disarming, patient, tactful, persistent, inventive, flexible. He should also be well integrated, a leader, and have experience or training in group work. Resourcefulness, punctuality, regularity, self-discipline, organizing ability, honesty, social conformance, and the desire to help people should be sought in his qualifications.

In a less humorous vein, it seems necessary to make some small beginnings toward an objective description of music therapists from the standpoint of their psychological traits and aptitudes.

Pursuant to a plan of investigation designed toward this end, we administered a series of psychological tests to a sample of music therapists available to us for study. The tests were selected to provide some elucidation of the intellectual, occupational-interest, interpersonal, and social characteristics of these music therapists. Ultimately, they will yield a mean profile or pattern of the “typical” therapist of this group, as well as the degree of scatter or deviation from the profile of this fictionally typical therapist. Included within the psychometric test series was a specially prepared inventory which provided information about the job satisfactions of the music therapist and the opinions and attitudes which he held concerning his work.

Basic to this overall project was the need for some external measure or criterion of the “good” versus the “poor” music therapist. How evaluate the music therapist qua therapist? Did we have such an external measurement at hand? If so, we could make careful correlational studies between our psychological test results and the performance competence of the music therapist. In other words, we could etch in much more sharply those psychological traits which differentiate the various levels from “good” to “poor” of competency (or job performance) of the music therapist. The practical merits of such a clearly delineated picture are unquestionable, for thereby we gain more surety in answering those selection and guidance questions which plague our own professional discipline as they do all others.

We propose herewith to present the specific method whereby we developed such an external criterion of adequacy. May we submit that our approach, our own criterion, is but one among (probably) numerous possibilities. It constitutes one attempt at an empirical approach to this whole topic, and herein may well lie its major contribution. Others might choose to move in directions quite different from our own, but these beginnings will have been a success if they but stimulate action toward a more objective clarification of the criteria for judging competency in music therapy.

Our music therapist sample was by no means a stratified sample of the music therapist population as a whole. It may be termed most aptly as “sample of convenience,” and is possibly
a skewed sample. Its nature is urban, perhaps older than the average therapist, and it includes a high proportion of members who had turned to the profession of music therapy relatively late in their careers. Our sample was drawn from music therapists employed by the Musicians Emergency Fund of New York at the time these data were gathered. The therapists worked part or full time in hospitals and rehabilitation settings, where they provided patients with the several forms of therapeutic music under medical prescription. They had received some earlier formal but brief training in music therapy. They had learned primarily on the job, but under continued and careful supervision with concomitant in-service training. They had been subject to a natural and continuous process of qualitative selection over the course of some years. This prior process of selection was based primarily upon the supervisory evaluation of their job performance.

The sample consisted of 30 music therapists: 17 males and 13 females. Their mean age was 42.2 years, S.D. 10.1. They had a mean educational level (including music conservatory or equivalent) of 15.7 years, S.D. 2.4. They had been employed as music therapists for a mean of 6.4 years, S.D. 3.5.

DEVELOPMENT OF THE EXTERNAL CRITERION RATINGS

The criterion rating for music therapists was developed jointly over a three-month period by two executive supervisors of these music therapists, with the consultative assistance of a clinical psychologist. The executive supervisors had each had over five years' experience in the placement, program development, and supervision of music therapists/specialists in a wide gamut of hospital and medical settings. They had made frequent supervisory visits to the institutions where these therapists worked; they had observed them in action; had held discussions with the medical personnel who referred and evaluated patients in music therapy; and had conducted conferences with the medical administrative officers. The participating clinical psychologist had had three years' experience in the training of music therapists for the psychological aspects of their work, and in coordinating intensive rehabilitation programs which included the services of music therapists.

Precipitated out of these extensive supervisory and observational experiences, and ensuing from the joint discussions, was
an array of the several qualities of the "good" therapist, together with a judgment of the relative quantitative significance of the qualities of the "good" music therapist. The relative weightings for these qualities were equivalent to a maximum possible total

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Possible Score</th>
<th>Subject's Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personality:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friendliness</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Responsibility</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Ability to Communicate</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Adaptability</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>55</td>
<td></td>
</tr>
</tbody>
</table>

| Technical Ability:                            |                |                 |
| Initiative                                    | 15             |                 |
| Versatility:                                  |                |                 |
| Piano                                         | 02             |                 |
| Voice                                         | 02             |                 |
| Guitar, accordion, or any other single        | 02             |                 |
| instrument                                    |                |                 |
| Some instruments or groups of instruments     | 01             |                 |
| (brass, string, fretted, etc.)                |                |                 |
| All orch. & band instruments                  | 02             |                 |
| Theory, composition                           | 01             |                 |
| Rhythm groups or other special groups         | 01             |                 |
| (eurhythmics, dancing, etc.)                  |                |                 |
| Music appreciation & ward programs            | 01             |                 |
| Programs and shows                            | 01             |                 |
| Will work with all types of patients          | 02             |                 |
| Total                                         | 30             |                 |

| Other:                                        |                |                 |
| Good health                                   | 10             |                 |
| Good grooming                                 | 05             |                 |
| Total                                         | 15             |                 |

**TOTALS:** 100

Remarks:

Figure 1. Criterion rating scale for music therapists.
score of 100. Each music therapist was then rated according to the schedule. All ratings were then ranked to yield a rank order standing of the therapists from "best" to "poorest." The criterion rating schedule and its explanatory definitions are presented in figure 1. In essence, this criterion was evolved on the basis of those personal and social qualities which were found by experience to be consistently high in therapists who performed well on the job, who were praised for their treatment results by colleagues and medical supervisors, and who were well approved by the administrators of the medical and rehabilitation settings where they worked. The terms in the criterion schedule have been carefully delineated. Their definitions and specifications are presented in the next section of this paper.

**Definitions**

**Friendliness.** Used as a criterion for music therapists, it indicates a musician with a warm, outgoing personality and desire to help his fellow man, able to create a mutually beneficial association with patients, hospital personnel, and others with whom he comes in contact in the course of his work. It implies patience and kindness. The term could also apply in its highest sense to a quality which inspires confidence and ambition in others, a feeling of happiness, and a willingness to cooperate in mutual activities. The negative qualities of this criterion would be reserve, arrogance, egotism, and inconsiderateness of other people's feelings and needs.

**Responsibility.** Stability, perseverance, dedication to work, promptness and regularity, dependability in carrying out scheduled work. This is best illustrated by its opposite: irresponsibility, breaking or disrupting scheduled activities, disappointing patients by missing promised appointments, not notifying the hospital or the employers of changes in schedule, absences, etc.

**Ability to communicate.** To be able to make oneself understood by those with whom the therapist comes in contact; to be able to observe and report well, verbally and in writing. The negative qualities of this criterion are: inadequate observation and reporting, severe language difficulties, inadequate use of the language verbally and/or written.

**Adaptability.** The ability to alter oneself so that one's behavior and attitudes will conform to new or changed circumstances; ability to meet and cope with the new situations or emergencies.
The therapist should keep an open mind and be able to understand another person's point of view. Also, he must be able to work within the schedules and restrictions of hospital rules, adapting his outlook and activities to fit situations encountered in such a way as to obtain maximum results so far as he is able. Negatives of this criterion would be rigidity of thinking and action, and an inability to adapt to the hospital setting.

**Initiative (on the job).** The ability to invent new approaches to work, patients, personnel, and music activities; to use imagination and constructive thinking in dealing with unusual situations or problems. A negative of this criterion is an inability to act without supervision. A therapist with this handicap could not be trusted to set up a music therapy program, nor to carry out his part in one without constant supervision.

**Versatility.** Used as a criterion to measure the therapist's skills in his work. The skills are listed separately and given percentage values to show the value of each skill in relation to music therapy. The degree of musical excellence is not considered here, for the therapist would not have been in the employ of this particular organization were he not a good musician in his chosen specialties. The virtuoso *per se* has little place in music therapy, but a top-ranking therapist would have all the listed skills, or most of them. A broad musical background is necessary to the good music therapist. However, some with limited skills —those who have specialized only in certain musical areas—may have personality qualities which outweigh their limited musical skill. The willingness to work with all types of patients constitutes one aspect of versatility. By restricting his work area, the therapist limits his usefulness to music therapy; by having limited musical skills, the therapist limits his usefulness to his employer and the hospital.

**Good health.** This is an essential characteristic for those in hospital work. They must be able to keep schedules, and not to be absent often because of ill health. The work often is strenuous, the hours long; some hospitals cover a large area and much walking and stair-climbing frequently are necessary. Pianos and numerous instruments continually must be moved. For the protection of the patients, if for nothing else, a therapist should not be in a condition to communicate an illness of his own to patients already ailing. Good mental health is also included here. One
who is unstable or neurotic is not likely to be able to fulfill his duties in a satisfactory manner.

Good grooming. This is self-explanatory. The poorly groomed therapist cannot command the respect of patient, staff, or associates. Cleanliness, neatness, and an appropriate appearance are essential for one using an art as a means of communication in a hospital.

Initial ratings of the 30 music therapists were made jointly by their two supervisors according to the schedule reported above. The ratings were then put aside for a period of one year. At the end of this time, all 30 therapists were re-rated independently by each supervisor. The re-evaluations, based upon continuing supervisory visits and observations, took into account the changes in work attitudes or performance which had occurred among the music therapists in the twelve-month interim.

RESULTS

The reliability of the rating schedule was assessed by a rank order correlation computed between the latter two independent ratings. Inter-observer reliability was demonstrably high: Rho = 0.96, significant at the -0.001 level of probability. When the later independent ratings were correlated with the twelve-months-earlier joint ratings, it was evident that consistency and reliability were quite good, even with the passage of a twelve-month interval. Observer A showed a correlation of Rho = 0.88 (P < 0.01) with the earlier rating; observer B, a correlation of Rho = 0.90 (P < 0.01) with that earlier rating. Hence, the observers (raters) were consistently employing the same rating criteria, and their ratings showed considerable stability despite the passage of a twelve-month interval of time. The qualities of the music therapist which were scrutinized by this scale constituted an enduring and relatively stable cohort of traits.

CONCLUDING REMARKS

We hasten to reiterate that other technical methods, perhaps ultimately more effective than ours, may be employed in the resolution of this matter of criteria. Certainly, other judges might possibly or even probably have included substantive content which we ourselves preferred to omit in the rating schedule just described.

First and foremost, we hope that we have given and will con-
tinue to give impetus to a more quantitative search for the psychological configuration of the music therapist. At the present time we are engaged in the analysis of results obtained in the earlier mentioned battery of psychological tests administered to music therapists, and in correlating therapists' scores on these tests with their own relative adequacy as professional music therapists. Our criterion for adequacy is, of course, the rating scale which has been described herein.
PART VIII
HISTORY OF NAMT
A HISTORICAL STUDY OF THE NATIONAL ASSOCIATION FOR MUSIC THERAPY*

RUTH BOXBERGER, PH.D.

INTRODUCTION

The history of the use of music in therapy goes back to primitive times, yet historical events concerning the use of music as therapy had only an incidental role in the formation of the National Association for Music Therapy. While the musicians engaged in music activities for treatment purposes may have been influenced by the historical background for the use of music in healing, it was the need to make music applicable to the scientific aspects of medicine in the twentieth century that initiated the drive toward an organization based on common goals and purposes. As Sigerist¹ reports in his discussion of civilization and disease, medicine passed through the successive stages of magical, religious, and philosophical interpretations before it reached the scientific stage. This scientific approach to treatment and disease is of relatively recent origin in the history of medicine. The hallmark of twentieth-century medical practice has been the application of the scientific method to all aspects of disease; i.e., the scientific approach has been utilized not only to increase knowledge about disease and illness, but also in the treatment and prevention of disease.

The need for a professional organization became apparent not only to provide stability and direction to the diverse practices that prevailed but also to give assistance in the delineation of music therapy as means of treatment. This need to define and interpret the contribution that music could make in therapy was the paramount aim guiding the formation of the Association as well as its growth and development through the first decade. The achievements of the first ten years of the National Association for Music Therapy (NAMT) reflect the constant interaction between the growth in the structure of the Association and the quest for a professional identity based on the value and potential of music as a therapeutic modality.


The organizational meeting of the National Association for Music Therapy was held on June 2, 1950, in New York City. A committee appointed for this purpose met to elect officers and to adopt a constitution. The first annual meeting was held in conjunction with the Music Teachers National Association in December, 1950, in Washington, D.C. The first decade of the history of the Association closed with the eleventh conference held in San Francisco, in October, 1960.

To assume that the accomplishments of the first decade resulted only from events occurring within this time would be a fallacy based on the belief that the past does not affect the future. On the contrary, it would be more realistic to assume that the events of the years preceding the formation of the Association had a great impact on later developments as shown by the number and significance of the achievements during the first decade.

Music as Therapy from Primitive Times to the End of the Nineteenth Century

Music and the art of healing have been inextricably entwined since the dawn of civilization. To what extent music holds a place in treatment is linked to the socio-cultural environment and the philosophy of disease that prevails at that particular stage of civilization. Sigerist\(^2\) calls attention to the fact that a biological concept of disease is a relatively recent one in terms of the history of civilization. Human institutions have always reckoned with disease in one way or another. Two factors are involved in the genesis of disease: man and his environment. Human life enfolds itself in an environment that is both physical and social. This social and physical environment which is responsible for most disease is in turn shaped by the civilization that has altered man's life.

Music as a social art is not difficult to understand if there is an awareness of art's function in society. Music reflects certain needs of society. To understand and appreciate music as an art, there has to be an understanding of the role of the arts in society at various stages of civilization for "serious art becomes so only

\(^2\) Ibid., pp. 1–5.
if the elements of its content are always some projection of life in its entirety."  

Music and medicine cannot, therefore, be considered other than as part of the social phenomena of civilization. The role of music in therapy is conditioned by the prevailing physical and socio-cultural environment in which it operates and the practice of music therapy is influenced by the prevailing philosophy of the era.  

The victims of illness and disease usually become isolated socially because the individual who is ill is different than those around him. This has generally been true throughout all stages of civilization. Primitive peoples were often more concerned with the socio-economic effects of illness than they were with pain or other distressing physical symptoms. Illness and disease became a great concern for primitive man when he could no longer live the life of the tribe.  

The role of the musician varied in primitive society. Whatever his role for a particular tribe, it was connected with his personality and tribal "image." The musician had considerable importance and power in tribal life. The particular form of healing ritual or healing seance was related to the prevailing philosophy of disease as developed by the tribe. While considerable importance was attached to finding the right song for the healing seance, particularly among those of totemistic culture, the group spirit that was kindled exerted considerable influence for the treatment as well. Music as part of primitive culture had an

important role in the treatment of disease, and this role was intimately related to the magico-religious philosophy of disease held by each tribe.

The primitive man who was sick enjoyed a special position in society; he was the guiltless victim of secret powers which were recognized and warded off by the medicine man. In higher stages of civilization, man was not an innocent victim, but rather one who through suffering had to atone for his sins. In the developing civilizations of the Babylonians and Egyptians, the treatment of disease shifted from magic to religion. All disease came from the gods, and the task of the priest-physician was to discover and interpret the intention of the gods so he could placate them. By the time of the golden age of Greece, a rational system of medicine came into being that attempted to interpret the nature of health and disease. 10

While it is possible to present two contrasting theories of disease in the life of the ancient Greeks, the rational and the mystical (religious), it is apparent that in practice they were intermingled depending upon the philosophy of the individual sufferer and the circumstances of the illness. For the physician who employed rational methods in the treatment of disease, music became an adjunct in the overall course of the treatment. When there was a strong suggestion that music provided a cure for a disease or disorder, it was most often linked to the temple cults or to events where the propitiation of the gods had become important to secure relief from disease. 11

The Middle Ages as an era in the evolution of civilization represents the link between the ancient world and modern times. After the decline of the Roman Empire a new religion, Christianity, came from the East to become the dominating factor in Western civilization for the next ten centuries. Christianity introduced the most revolutionary and decisive change in the attitude of society towards the sick; society assumed the obligation to care for its sick members. However, attitudes that prevailed before the Christian era never were entirely overcome; for this reason disease in many instances was still considered a


punishment and a sin. As Coleman points out, mental illness was associated with demonology. Many of the crude, harsh measures employed for the treatment of the insane were a reflection of the belief that a demon had gained control of the sick person and it had to be exorcised.

The theories of music as therapy derived from antiquity continued to be advocated during the Middle Ages. Religion influenced all phases of life during this time. Music was composed to honor the saints who protected mankind from illness. Whenever persons of high rank became ill, it was the custom for court musicians to write special compositions for them; perhaps it was not so much to help them as to cheer them during their suffering. One of the most unusual examples of music as therapy appeared in contemporary and later accounts of a malady known as “tarantism.” According to popular belief, relief could only be secured through wild dancing to music played for that purpose.

The scientific approach to medicine had its beginnings in the Renaissance with the study of anatomy taking a central position. The pathological method in physiology developed during the eighteenth century and clinical medicine had its development during the early nineteenth century. The one field that was not influenced by a scientific approach was therapy; traditional methods of treatment remained in practice. As a whole, the treatment of disease in the early nineteenth century had not progressed much beyond that of Hippocrates and Galen.

For the physicians of the Renaissance the effect of music on the mind was appreciated in a way peculiar to their profession; music was used as an adjunct in the practice of preventive medicine. It was included among the emotional factors which favored resistance to illness, particularly the great epidemics of the time. Carapetyan states that “these factors, classed under the accidents of the soul,” are as valid today in the light of modern knowledge as they were then. Therefore, anger, excessive sorrow, and worry were to be avoided while hope and a positive attitude were to be encouraged. Medical advice against the plague

15. Sigerist, Civilization and Disease, p. 171.
would, therefore, stress a happy state of mind and the desirability of social recreation and the listening to music.\textsuperscript{16}

The period of musical history termed the Baroque followed the Renaissance well into the middle of the eighteenth century. The musical thought of the Baroque was supplied by the doctrine of affections; the affections were indentified with the content of the music. The scholar, Kircher, is a source for the formulation of the doctrine of temperaments and affections. According to him, melancholy people like grave, solid, and sad harmony; sanguine people prefer dance music because it agitates the blood; choleric people like agitated harmonies because of the vehemence of their swollen gall; while those people of phlegmatic disposition lean towards women's voices because their high-pitched voices have a benevolent effect on the phlegmatic humor.\textsuperscript{17}

The use of music for therapeutic purposes was a natural aspect of the general theory of disease causation: the theory of the four humors. This was the common ground where musical and medical theory met. Yearsley\textsuperscript{18} in a study of the use of music as therapy in the Elizabethan period has collected numerous examples of its use in the literature of that time. If the literature of an era reflects in part the prevailing thought of the times, these examples would provide substantial evidence that the effects of music on behavior and its therapeutic value were accepted as part of the belief of the time.

Medicine in its broadest sense has always been composed of two elements, the craft and the theory. The procedures and practices of surgery and the use of drugs represent the empirical line of development. Gradually, in the late nineteenth and early twentieth century, therapy began to reflect the many discoveries in anatomy, surgery, bacteriology, and biochemistry. Scientific discoveries and methods were incorporated into the treatment of disease. The knowledge in the various areas of medicine no longer sought only to explain the causes of disease—it en-


\textsuperscript{17} Paul Henry Lang, \textit{Music in Western Civilization} (New York: W. W. Norton & Co., 1941), pp. 435-9.

deavored to treat and prevent them. Medicine had made a long journey through magic, religion, and philosophy to reach the scientific stage.\textsuperscript{19}

While the late eighteenth century and the nineteenth century still disclosed an affinity of music and medicine, it was during this time that the divergence of the two fields had its beginning. Not until the middle of the twentieth century was there to develop another philosophy of medical treatment that included the arts in its theory of treatment. This does not mean that music wasn’t used for treatment during this period, but that the use of music as therapy was examined more critically in terms of scientific methods and procedure. The circumstances of its use are usually described in special cases, rather than as representative of a general theory or commonly held belief.

Music Therapy During the Early Twentieth Century

The treatment of disease has been dependent in some manner upon empirical data. Those forms of treatment that have proved beneficial have continued in practice, and the reasons for their efficacy have been interpreted in the light of the prevailing concepts of health and disease. It is not improbable, therefore, that there are therapeutic elements common to all uses of music in treatment throughout history that have been used and adapted by various cultures and civilizations. Those who utilized music for therapeutic purposes applied it in a rational way consistent with the prevailing philosophy of health and disease. Accounts of music as therapy prior to World War I follow the pattern of the nineteenth century. They are individual case histories rather than descriptions of music as part of a larger field of therapy.

With the advent of the phonograph there was more interest shown in the use of music in the hospital setting. Music was used in wards as a diversion during the day and as an aid for sleep at night. Its use was also reported in the operating rooms to mitigate the dread of operations; it was considered effective during local analgesia.\textsuperscript{20, 21}

\textsuperscript{19} Sigerist, op. cit., pp. 229–42.
From reports of the use of music with mental patients, it may be assumed that it had considerably more use in mental hospitals than in general hospitals during this period of time. The actual therapeutic value of the music is not clearly stated since the accounts stress the efficacy of the music and give little or no information about the total treatment situation.22, 23

The National Therapeutic Society of New York City

One of the leading figures advocating the use of music therapy during this time was Eva Vescelius, a musician, who devoted great efforts toward the development of the field. She was the author of numerous articles and a booklet, *Music in Health*. Shortly before her death in 1917, she completed a lengthy manuscript which summarizes much of her work in music therapy.24 She revealed that she relied strongly on vibrations produced by music, saying, "We are organized vibrations. The object of all cures is to change discordant vibrations into harmonious ones."25 She gives specific prescriptions for fevers, insomnia, and other ills. Music is classified as tonic, stimulant, sedative, and narcotic; examples of each type are given from musical literature.26

Vescelius appeared to have had some success in her work at the various hospitals; how much of this was due to the novelty of the experience for the patients, to her own personal enthusiasm, and to the music is difficult to ascertain. She appears to have been quite sensitive to the importance of good interpersonal relationships in the therapeutic situation for she stresses this, although only briefly, in her writings. Much of her understanding of the value of this type of work is obscured by her lyrical expressions and metaphorical allusions to the powers of music. In writing about the need for rapport between the musician and the patients, she says that "we shrink instinctively from all that emanates from one whose person is out of tune with our necessities... there must be perfect harmony between sender and receiver."27 In 1903 she founded the National Therapeutic Soci-

25. Ibid., p. 378.
27. Ibid., p. 383.
ety of New York City and served as its president until her death in 1917. Although Eva Vescelius was almost unknown by the middle of the century, she exerted considerable influence on a number of other individuals who were active in the field of music therapy.

**Columbia University Course in “Musicotherapy”**

In the spring of 1919, Columbia University announced a course in “musicotherapy” to be taught by Margaret Anderton, who had gained experience in this field during her work with wounded servicemen during World War I. The course was to stress an approach based on the needs of the patients: first, in terms of the manner in which music could be administered to neuropsychiatric patients whose difficulties were largely mental; and second, the way music could be used in conjunction with physical medicine to assist patients whose difficulties were largely orthopedic.28

**The National Association for Music in Hospitals**

Isa Maud Ilsen with a background of twenty-six years in hospital work as a nurse, hospital executive, and music director organized the National Association for Music in Hospitals. Its purpose was to introduce music into the hospitals with the cooperation of the medical authorities. She stressed that musicians should be cognizant of hospital routines. Music was to be used as an adjunct to medical treatment without interfering with any hospital procedures or regulations. The aims of the organization emphasized that music had to be appropriate to the needs of the patients and the needs of the situation. Mrs. Ilsen, who served as director of the organization, reported that results had been favorable and that request for an increase in the use of music in hospitals with established programs had been received. There were also a number of requests for the initiation of programs into other hospitals.29

**The National Foundation for Music Therapy**

Another advocate for the use of music for therapeutic purposes was Harriet Ayer Seymour. She had worked with hospitalized veterans during World War I and had become acquainted with

the writings of Eva Vescelius. In 1920, Mrs. Seymour published a guide to the therapeutic use of music, *What Music Can Do For You*. In addition to her career as a pianist and teacher, she continued to work with music as therapy. In June, 1933, she participated in a “practical demonstration” of music therapy for two hundred delegates to the World Congress of the International New Thought Alliance, which was meeting at the Waldorf-Astoria Hotel, New York City. The delegates were asked to concentrate on “power and plenty” while Mrs. Seymour played some Beethoven compositions at the piano. The reactions of the group were described as being positive and several people were cured of headaches and one woman reported improvement in her heart condition.

Mrs. Seymour later became associated with the Federal Music Project of the WPA. She was the Chairman of the Hospital Music Committee of the State Charities Aid Association. In 1938, a report of this work appeared in the *New York Times*. It stated that for the past three years the Federal Music Project had been presenting music activities in seven city hospitals and two women's prisons. It was also reported than an experiment was under way to classify songs on the basis of stimulant, tonic, sedative, and narcotic, so that they could be administered as “specifics” to relieve various types of illnesses. At the same time it was emphasized that the validity of this theory had yet to be proved by means of medical and psychological tests.

In 1941, Mrs. Seymour founded the *National Foundation for Music Therapy*, for which she served as president. At various times she gave courses of instruction in the use of therapeutic music; the last course was given in the spring of 1944 and emphasized the use of music with wounded soldiers.

While the reports of the use of music as therapy increased during the period between the two World Wars, these reports did not indicate any general trend toward the use of music as therapy by the medical profession as a whole. Medical authorities were cautious about making any strong claims for it as a therapy; instead, they stressed its beneficial effects in particular

areas and for special types of cases. Although the term “music therapy” enjoyed a certain vogue prior to World War II, there was no great amount of evidence from the clinical field, with notable exceptions, that merited the claim that it was a professional field of therapy.

**The Emergence of the Music Therapy Movement**

Popular writing about music therapy during and following World War II often referred to it as a “new science.” The emergence of a professional field of music therapy was concomitant with changing concepts in medical treatment—concepts that take into account psychosomatic factors in the etiology and treatment of disease. Menninger points out: “The name ‘psychosomatic medicine’ is an unfortunate one since it implies a duality of body and mind, which is contrary to the conception that the field intends to promote.”

Although the holistic point of view was fairly well established prior to World War II, there were still many who were opposed to it.

In much the same way that World War I established a psychological viewpoint, we find World War II establishing the holistic one. For the incidence of psychogenic disorders in the form of gastrointestinal disturbances (which were the leading medical problem of World War II) as well as the high incidence of mental illness proper finally led to the realization that human behavior adequately approached only in this broad way. And so, at last a framework has been provided for integrating the contributions of all the various correlated research areas into a meaningful picture.

Based on the premise that medicine is basically a social science and that a holistic point of view is prevalent in the treatment aspects of disease, it becomes apparent why music activities increasingly would be utilized for therapeutic purposes. The difficulties that have been encountered in the use of music in treatment were not due to the music itself, but rather to a lack of knowledge about how music may best be applied. Twentieth-century concepts of the treatment of disease have allowed for increased acceptance of the adjunctive therapies, particularly in the mental hospitals.

However, music as a form of therapy has been caught up in a struggle not only to free itself from serving as an adjunct to other activity therapies but also from practices in music therapy that were more often "mystical" than scientific.

The Development of Music in Institutions by Van de Wall

The work of Willem Van de Wall in the development of institutional music programs spanned the period between the two World Wars. He can be considered one of the pioneers in music therapy because his approach to the utilization of music in hospitals and institutions foreshadowed later developments in the field of music therapy. His work was the exception rather than the rule in terms of music in hospitals prior to World War II.

Van de Wall had a professional music career as a harpist that included membership with the Metropolitan Opera House Orchestra, the New York Symphony, and the Marine Band during World War I. In 1919, following his military service he embarked upon a career to utilize music in the treatment and prevention of mental illness. His first experience in the field was at the Central Islip State Hospital, New York. His work attracted the attention of the Russell Sage Foundation, which assisted him in his endeavors to devote his entire time to the social uses of music. The Committee for the Study of Music in Institutions was organized to enable him to continue his work.36, 37

He later became a member of the Bureau of Mental Health, Commonwealth of Pennsylvania, where he was assigned as field representative for music and allied activities. He began his work as part of a statewide program to better conditions in the mental hospitals. His first efforts to develop a hospital music program were made at the Allentown State Hospital for Mental Diseases.38 Between 1925 and 1932, he was granted leave to lecture on music in health and social work at Teachers College, Columbia University, New York City. In 1944, he was named Chairman of the Committee for the Use of Music in Hospitals (ap-

pointed by the National Music Council), which was devoted to furthering the development of music in hospitals.\textsuperscript{39}

\textbf{Music in Hospitals during World War II}

Music was late in coming into use within the military hospitals; this was true of music in the entire military organization as well. However, the military attitude changed, and music and musical organizations were encouraged for morale factors. Doctors had learned that it was much more difficult to keep up the morale of a wounded soldier than a man who was just sick or injured away from the battlefield.\textsuperscript{40}

The hospital recreation workers of the American Red Cross carried on the listening and leisure-time activities in military hospitals. Through cooperation with the Camp and Hospital Councils of the American Red Cross, civilian groups furnished great quantities of musical instruments and supplies to overseas and domestic hospitals and provided entertainment for the wounded men in the hospitals.\textsuperscript{41} The National Federation of Music Clubs was represented on the Camp and Hospital Councils of the American Red Cross in forty-six states. Through the War Service Committee and the Music in Hospitals program, the National Federation of Music Clubs provided musical instruments and volunteer services to the patients in military hospitals. In 1942, under the leadership of Anne M. Gannett, President, the War Service program was started with Ada Holding Miller as Chairman, and Ruth Bradley as Chairman of the Music in Hospitals program. Over two and one-half million pieces of musical equipment were supplied to the Allied troops. It was through the Music in Hospitals program that many of the volunteer services were brought to the military hospitals. In the post-war period the Federation continued to extend its services not only to military hospitals but also to the Veterans Administration hospitals and state hospitals.\textsuperscript{42, 43}

Among the professional music organizations supporting the Music in Hospitals projects were Sigma Alpha Iota, Mu Phi Epsilon, and Delta Omicron. Through their financial support and volunteer services they were able to provide professional music leadership for many hospital music projects. Many of these organizations worked to secure teachers to provide music instruction for the patients. They not only supplied the musical leadership but also sponsored fund-raising projects to provide the equipment and supplies that made many of these music activities possible.44

With the outbreak of World War II, the Musicians Emergency Fund (MEF) turned toward the assistance of the members of the armed forces. One outgrowth of this veterans service was the Hospitalized Veterans Music Service, which has continued to be one of the main projects of the MEF since that time. Through the efforts of Gladys Douglas-Longmore, Director of the Hospitalized Veterans Music Service (HVMS), a program for veterans was developed that included music lessons, auditorium and ward activities, and entertainment by well-known artists. Following the war the services of the HVMS were extended to the VA hospitals and state hospitals upon request from the hospital administrators.45

The objectives of the Music Research Foundation, Inc., founded by Frances Paperte, Director, have been to foster basic research in the use of music in the service of mankind.46 The first project by the Foundation was announced in the New York Times, August, 1944. According to statement by Miss Paperte released by the Office of War Information, a test on the curative effects of music on psychiatric patients was to be conducted at Walter Reed Hospital, Washington, D. C. Musicians were to be organized into an Institute for Applied Music for the purpose of

determining the possibilities of music as an aid to medicine.\textsuperscript{47} The results of this project and some other studies were reported in a book, \textit{Music and Your Emotion},\textsuperscript{48} released by the Foundation in 1952.

\textbf{The Professional Music Associations}

While the music activities developed by the music in hospitals projects of the various music organizations continued to grow, the activities of the professional music associations revealed the deep interest of their members in the use of music as therapy.

In a speech at the Music Teachers National Association at Kansas City, in 1939, Ira M. Altshuler praised the efforts of the WPA Music Program for its cooperation in the music therapy project at Wayne County General Hospital, Eloise, Michigan. He reported that there were more than twenty trained musicians from the WPA Music Program working in units of three (violin, cello, and piano) with more than eight hundred patients divided into small groups. They met with the patients for one-half hour, five days a week. Before they began their work on the wards, they received instruction and training in working with mental patients.\textsuperscript{49}

In 1940, Warren D. Allen, President of the MTNA, appointed Harold Spivacke Chairman of the Committee on Functional Music. At the annual meeting held in Minneapolis, in December, 1941, Captain Howard C. Bronson, Music Officer, Morale Branch, War Department, gave a report of music activities carried on by the military.\textsuperscript{50} Although no annual meeting was held in 1942, the papers were collected and published. Warren D. Allen became Chairman of the Committee for Functional Music. He announced the formation of two subcommittees: Music in Psychotherapy and Music in Industry. The next meeting of the MTNA was held in Cincinnati in 1944. Hughes\textsuperscript{51} reported that

\begin{itemize}
  \item \textsuperscript{47} \textit{New York Times}, August 29, 1944, p. 14.
  \item \textsuperscript{48} \textit{Music and Your Emotions}, prepared by the Music Research Foundation, Inc. (New York: Liveright Publishing Co., 1952).
  \item \textsuperscript{51} Edwin R. Hughes, "War Reactions on Music," \textit{Volume of Proceed-}
\end{itemize}
two important expansions in the use of music were directly attributable to the war—the use of music in industry and the use of music in hospitals. He also reported that as a means of advancing the knowledge of the use of music in hospitals, the National Music Council was conducting a survey of music activities in all important hospitals for mental and nervous diseases throughout the country.

At the annual meeting held in Detroit, in 1946, one of the general sessions was devoted to music therapy; it was conducted at the Wayne County General Hospital with Ira M. Altshuler in charge of the program. It was at this meeting that the case presentation of Horace F. attracted nationwide attention to the field of music therapy. Two changes were made in the standing committees of the MTNA at that meeting. The Functional Music Committee was dissolved and individual committees were formed from the former subcommittees. Roy Underwood was appointed Chairman of the Committee on Music in Therapy.52

In his report at the annual meeting of the MTNA in 1947, Underwood summarized the status of music therapy. He pointed out that there was no organization or controlling body which functioned to eliminate quackery and charlatanism; there was yet much widespread and serious misunderstanding on the part of the music profession about the nature and true function of music in therapy; and there was no publication for the dissemination of worthwhile literature in the field. He recommended first that the members of the committee in the future be appointed with a view of continuity of function and service; second, that the committee be cognizant of the need to inform the membership and others interested in music in therapy about its proper function; third, that steps be taken to set up an editorial body; fourth, that there was a need for guidance in curriculum requirements in music therapy; and fifth, that the establishment of approved

---

52. Members of the Committee on Music in Therapy were: Roy Underwood, Chairman, Michigan State College, East Lansing; Hollowell Davis, M.D., Director of Research, Central Institute of the Deaf, St. Louis; E. Thayer Gaston, University of Kansas, Lawrence; Ray B. Green, Special Services, Veterans Administration, Washington, D. C.
During the annual meeting of the MTNA in 1947, the National Association for Schools of Music (NASM) held concurrent sessions. Two speakers addressed the group on the field of music in therapy. Underwood stated that a great many of the articles appearing in music journals and other publications were very misleading and frequently did more harm than good to the field. This led to prejudice against the use of music in therapy by many physicians and psychiatrists who might have otherwise been interested in the merits of the field. He stressed that this attitude was rapidly changing and that many hospitals were requesting properly qualified musicians for hospital work.

Gaston spoke to the group on what changes had taken place in the field of music in therapy. He pointed out that there was more understanding of the field of music therapy, and a greater realization on the part of students that it is a more complex field than generally supposed to be. Interest on the part of the medical profession could be described as cautious, with a desire to await the results of research in the field.

Although the Music Educators National Conference (MENC) has been concerned for the most part with those developments and objectives related to the field of public school music, it has always been aware of the contributions that music education should make to the public welfare. In the fall of 1944, the first of three articles dealing with the therapeutic aspects of music appeared in the *Music Educators Journal*. Gilliland challenged the music educators to provide music for the hospitals in their areas as requested by the professional staff from these institutions. Yet she cautioned that supervision by medical staff was necessary before the music can be considered as therapy. Gaston stressed the need of all peoples for music; he pointed out

that the reason for the arts throughout the history of mankind has been the resultant mental hygiene benefits. In the last article, Gilliland\textsuperscript{58} again stated that the music educator could make a worthwhile contribution to hospital music by acquiring the experience and training needed for this type of work.

The biennial divisional meetings of the MENC were cancelled in 1945, and consultant’s councils were held in their place. The councils made a number of general recommendations about music therapy; namely, that there was a need for differentiation between the use of music in hospitals and music in therapy, that public school musical organizations should be discouraged from presenting miscellaneous musical programs at hospitals under the misnomer of musical therapy, and that definite steps be taken toward the licensing of those persons who teach or practice musical therapy.\textsuperscript{59} A report by E. Thayer Gaston, Chairman of the Special Committee on Functional Music of the MENC, appeared in the \textit{Music Education Source Book} of 1947.\textsuperscript{60} It reviewed the problems and trends in the field of music in therapy and recommended that prospective workers needed to know about the professional requirements of the field, that well-controlled research was of paramount importance, that there was a need for a publication of some kind, and that information about the use of music in therapy should be made more easily available to music educators.\textsuperscript{61}

The National Music Council was formed in 1940 to meet a need within the field of music. It has served to coordinate the efforts of the various musical groups and organizations and to explore new fields of possible progress in music. As was mentioned previously, the NMC had conducted a survey of the use of music in hospitals in 1944. The objectives of this first national survey had been to collect general information about practices and ideas rather than to secure material for statistical analysis.

The questionnaire used in the survey had been prepared with


the assistance of Willem Van de Wall and Samuel W. Hamilton. It was sent to 341 hospitals and answers were received from 209 institutions. In commenting on the returns from the survey, Dr. Hamilton stated:

The questionnaires returned to the National Music Council have been studied with care. . . . It is easy to see in the careful phrasing of these replies that the men who have been in a position to institute a program of music are sure it was beneficial to their patients. That judgment is made more convincing by the restrained diction of the replies.\(^{62}\)

In his summary on the survey, Van de Wall reported that of the 209 institutions that answered, 192 used music in some form while 14 did not.

The two outstanding practical needs shown by the survey seem to be the medical testing of music as to its therapeutic qualities, and the development of standards and curricula for training of qualified personnel by educational institutions on the basis of careful planning and cooperation with hospitals.\(^{63}\)

In September, 1945, Howard Hanson, President of NMC, announced the formation of a Committee on the Use of Music in Hospitals with Willem Van de Wall as Chairman. Due to the absence of Van de Wall\(^{64}\) from the annual meeting in May of 1946, President Hanson reported that the objectives of the committee were to explore the possibilities for adequate training of workers in the use of music in therapy with the assistance of musicians and psychiatrists.\(^{65}\) The Bulletin of the NMC continued to carry informative articles and news of interest to music therapists. The summary of the survey of music in hospitals was reprinted three times due to the great interest in the field.

**The Period of Formation**

The events prior to the formation of the National Association for Music Therapy were influenced by the various activities as-

---

64. Van de Wall was in Europe as Head of the Adult Education Unit, Public Health and Welfare Branch, United States Office of Military Government for Germany.
associated with the period which has come to be known as the
emergence of the music therapy movement. These were the
activities of the early pioneers working with music in the clinical
setting, the recognition by the armed forces of the value of music
for morale purposes, the musical resources provided by the music
organizations and clubs to the military and civilian hospitals,
and the growth of music in industry. All these developments
led toward the growing utilization of music in the treatment pro-
grams.

The professional music associations had for many years evi-
denced their interest in music in therapy. It became more and
more apparent that if this use of music was to realize fully its
potential as a therapy and to secure the respect of the medical
profession, the music therapy movement needed judicious lead-
ership. It was generally acknowledged by the associations that
one of the paramount requirements for the continued develop-
ment of music therapy as a profession was trained personnel to
carry out the work.

Steps had been taken toward the education of music therapists
as early as 1944, when a degree program for music therapy was
introduced at Michigan State College, East Lansing, Michigan.
Five years later there were five schools offering degree programs;
both undergraduate and graduate, with majors in music therapy.66

By the late 1940's it became apparent that there was a definite
need for some type of organization to promote the professional
growth and development of the use of music in therapy. There
was a need for an organization to assist in the establishment of
standards in the education and certification of music therapists,
to eliminate exaggerated claims and policies of "self-styled ex-
erts"; to provide the means for the exchange and evaluation of
materials and information by the workers; and to move toward
a delineation of the field in order to establish the scope and
limitations of the procedures employed. Probably the most out-
standing need was that of encouraging research so that a body
of knowledge based on scientific methods and evidence would
gradually become available.

Efforts to provide a consistent approach in the application of

66. The other educational institutions were the University of Kansas,
Lawrence; Chicago Musical College; College of the Pacific, Stockton,
Calif.; and Alverno College, Milwaukee. Courses in music therapy
were also given at the Boston School of Occupational Therapy.
music as therapy had long been hampered by the lack of effective communication throughout the field. Descriptive accounts of the use of music in the hospitals appeared periodically in other professional journals, but this type of article did not provide much information that was useful for the professional growth of the musician working in the hospital. In contrast there was a proliferation of articles in the so-called popular magazines purporting to explain the wonders of the "new science" and more often than not making unsupported claims for "cures" attributed to the power of music.

In the fall of 1947, the Executive Committee of the National Music Council invited Ray Green\textsuperscript{67} to become the Acting Chairman of the Committee on the Use of Music in Hospitals. At the annual meeting of the National Music Council held in New York City on May 14, 1948, Green reported on the activities of the Committee from the time he assumed direction of it. First, all correspondence and information concerning the past activities of the Committee were obtained from Guy V. R. Marriner, formerly Acting Chairman. This material was examined and filed after it had been classified. Second, the first issue of the Hospital Music Newsletter (Newsletter) was planned and arrangements for its publication were completed. The first issue of the Newsletter was printed in the National Music Council Bulletin and also published separately for subscribers.\textsuperscript{68}

In the same issue of the Newsletter, Roy Underwood reported on the results of a survey to determine the number of musicians employed in hospitals. It indicated that there were at that time 117 hospitals which employed full-time musicians. The complete list of hospitals was given and of this number 49 were Veterans Administration hospitals.\textsuperscript{69}

The professional and volunteer music organizations continued their hospital music activities during the post-war period. The great contributions of the music volunteers were acknowledged by

\textsuperscript{67} At the time of his appointment Ray Green was Chief of Music, Recreation Service, Special Services, Veterans Administration, Washington, D. C.


\textsuperscript{69} "Hospitals Employing Full-Time Music Specialists," \textit{Hospital Music Newsletter}, May, 1948, pp. 1–2.
Green in a discussion of the use of music in Veterans Administration hospitals. He stated that this contribution enabled all Veterans Administration hospitals to carry on music activities although only 41 out of 126 employed a music specialist. The activities of the music volunteers that began during the war years continued unabated as the need for their services became more apparent not only in Veterans Administration hospitals, but in state institutions and special schools as well.

Conferences and Regional Meetings

The success of the panel meetings and sessions on the use of music in therapy at the annual conferences of the professional associations led to other conferences devoted entirely to music in therapy. Some of these early meetings approached the later Association meetings in size and range of topics.

Eastern Conference on Functional Music.—In 1948, the Conference on Functional Music was held on November 20–21 at the Boston City Club and the Musical Guidance Center, Boston, Massachusetts. Arthur Flagler Fultz, Acting Chairman, Music in Therapy, Eastern Regional, MTNA, was in charge of the arrangements and planned the program. The meeting was planned to bring together full-time hospital musicians for the purpose of discussing common problems; the discussions were carried out in forums and seminars. In a summary report of the meeting a number of problems were listed. One outstanding problem was the lack of research to provide information and knowledge for the hospital musician. Problems were reported that related to methodology and techniques, hospital finances, and working with patients. A desire for a greater exchange of information was expressed. The group discussed future meetings as they agreed that this type of conference was useful and should be held again.

Conference for Hospital Musicians.—The Conference for Hospital Musicians held at the University of Kansas was sponsored by the Department of Music Education. Director of the Conference was E. Thayer Gaston, Chairman of the Department of Music Education. The sessions were conducted in an informal

72. Ibid., p. 8.
manner to allow the greatest exchange of information and ideas. The primary aim was to provide a forum where the exchange of ideas by the participants would lead to further growth and progress in the field of hospital music.\textsuperscript{73}

A survey of the topics and speakers who appeared on the program indicates that not only the hospital music program was discussed but also the future potential of the field of music therapy. After a general discussion of hospital music programs by the registrants, the conference closed with a session on organization for the future.

At this session some tentative dates for future meetings were suggested and the general outline of topics to be discussed was presented. It was suggested that a committee be appointed to work on the proposals with the assumption that the University of Kansas would serve as a clearing house for this project. In response to comments about working with the committees from MTNA and MENG, the consensus of opinion from those present was that future meetings should be for hospital musicians. After a lengthy discussion it was voted to postpone any action on forming an organization for a year. The motion to elect officers for a national organization was tabled until the proposed future meeting. Gaston was asked to name a committee to communicate with hospital musicians and to plan for an organization. He stated to the group that he would be glad to appoint a committee, not to form an organization, but to report back on the feasibility of doing so. The conference closed on this decision.\textsuperscript{74}

Thirty-nine registrants had attended the two-day conference and they included music therapists, music technicians and music specialists, recreation workers in music, music therapy students, music therapy interns, psychologists, psychiatrists, and observers from the Music Education Department at the University of Kan-

\textsuperscript{73} Each participant at the conference received a mimeographed copy of the entire proceedings which had been recorded by a stenographer present at the meetings. The summary of this conference is taken from a copy of the proceedings (in the files of E. Thayer Gaston).

\textsuperscript{74} According to the stenographic notes one reason that there wasn't more accomplished on the formation of an organization was the lack of time. The conference was in its last session and it was felt that there should be communication with other hospital musicians who were not present. There was a strong minority which favored the formation of some type of organization, but the group voted to proceed more slowly and carefully toward the formation of a national organization.
The largest group represented was from the hospitals of the Veterans Administration, and the next largest group of hospital musicians worked in state hospitals. Except for the observers, the meeting was limited to those professionally engaged in some capacity in the use of music in hospitals. The participants came from nine states—Kansas, Iowa, Missouri, Illinois, Indiana, Minnesota, Kentucky, Texas, and Colorado—and Washington, D. C.

North Central Conference on Functional Music.—On March 25–28, 1949, a conference on the use of music in hospitals was held in Chicago, Illinois. The program was designed to interest hospital musicians, occupational and recreational therapists, psychologists, physicians, and teachers of the handicapped in the therapeutic uses of music. The conference committee members were Esther Goetz Gilliland, Chicago Musical College, Chairman; Roy Underwood, Michigan State College; and Beatrice Wade, OTR, University of Illinois. The Chicago Musical College and the Illinois Professional Schools sponsored the conference. The conference featured a series of panel discussions on major areas of interest for those engaged in the use of music for therapeutic purposes.

The participants came from nine states: Illinois, Iowa, Indiana, Michigan, Wisconsin, Minnesota, Missouri, Kansas, and Alabama. There were 30 hospitals and 21 educational institutions represented. Eighteen other organizations in the area of music, recreation, community services, and volunteer groups were also present. Those attending the sessions were physicians, psychologists, teachers, occupational therapists, music therapists, recreational therapists, physical therapists, educational therapists, music teachers and music therapy students, occupational therapy students, social service workers, counselors, volunteers, and research workers.

The Organization of the Association

The Committee on Music in Therapy of the MTNA, Roy Underwood, Chairman, continued to develop programs at various meetings instrumental in bringing music therapy to the attention

76. Abstracts of the papers presented at this conference appeared in subsequent issues of the Newsletter.
of musicians and laymen. During 1949, members of the Committee were Roy Underwood, President-Elect of MTNA; E. Thayer Gaston, Chairman of the Committee on Functional Music of the MENC; Ray Green, Acting Chairman of the Committee on the Use of Music in Hospitals of the NMC; and Mrs. M. L. Price, Occupational Therapy Department, Sheppard-Enoch Pratt Hospital, Towson, Maryland.

A number of sessions on music therapy were held at the Music Teachers National Association in Cleveland, February 28–March 2, 1950. At the request of Roy Underwood, Program Chairman, Ray Green presided at a sectional meeting that was held for the purpose of developing a national organization in the field of music therapy. The group assembled for this meeting elected Green as the chairman of an organizational committee and delegated him to proceed with the formation of a national organization. He was empowered to appoint the members of the committee and to draft a tentative constitution.

As stated previously, Ray Green became the Acting Chairman of the Committee on the Use of Music in Hospitals of the NMC in the fall of 1947. In his annual report to the NMC in May, 1948, he summarized the progress made on the publication of the Newsletter. A fund for publication had been established; at the time of the report $545 had been collected. In his report the following year Green stated that two issues of the Newsletter had been printed in the National Music Council Bulletin. The next issue, which would be in January, 1949, would also be printed separately for the list of subscribers that had been developed during the past year. Beginning with the forthcoming issue the Newsletter would be released three times a year.

At the general meeting of the NMC held in January, 1950,

78. This committee is referred to as a working committee in the minutes of the meeting on organization. References to it in other publications as a subcommittee are erroneous because Ray Green was elected as chairman of a specific committee on organization. The confusion may have arisen because the committee was organized at the MTNA meeting in Cleveland, and because Ray Green was the Acting Chairman of the Committee on the Use of Music in Hospitals of the NMC.

79. Personal Communication from Roy Underwood.


Green reported on the last meeting of the Hospital Music Committee, which was held in January, 1949. Members present had discussed means by which their organizations could participate more fully in the work of the Hospital Music Committee. He also enumerated a number of developments that had taken place during the past year. These included an increase in the number of positions for hospital musicians, an increase in the number of regional conferences and clinics, and initiation of additional training programs in colleges and universities. The Newsletter had been issued three times during the past year and the size was expanded from four pages to eight pages. The number of subscriptions totaled 91. The original sum of money had been exhausted and an additional $525 had been collected for future publications.82

The following June 1, 1950, another report on the activities of the Hospital Music Committee was presented to the annual meeting of the NMC. It contained a summary of the last committee meeting, held in January, 1950. Green also reviewed the events which had taken place at the MTNA meeting held earlier that spring in Cleveland. He stated that a meeting was to be held the following day, June 2, to form an organization in the field of hospital music. It was planned to draft a constitution and elect officers for the coming year. In his report on the Newsletter, Green stated that although there were now 134 subscribers, additional funds would have to be raised to continue the publication. It was estimated that at least 500 subscribers would be needed to make the publication self-supporting.83

The organizational meeting which marked the beginning of the National Association for Music Therapy was held at the invitation of Ray Green, Chairman of the Organizing Committee, at the council room of the American Music Center, 250 West 57th Street, New York City. According to the Minutes of the Founding Meeting,84 Ray Green presided as Chairman Pro Tem and the following individuals were present:

83. "Report of the Committee on Hospital Music," National Music Council Bulletin, May, 1950, pp. 3-4. (Although this was the usual May issue of the publication, it contained both the annual reports for the June meeting and the announcement of the meeting on the formation of the National Association for Music Therapy.)
Alice Joy—Music Research Association of Pasadena and Los Angeles, California
Edwina Eustis (Dick)—Musicians Emergency Fund
Edwin Hughes—National Music Council
Leila Livingston Morse—Nionto Foundation of Los Gatos, California
Arthur Flagler Fultz—Director of Musical Guidance, Boston, Massachusetts
Ira M. Altshuler, M.D.—Wayne County Hospital, Eloise, Michigan
Roy Underwood, Mus. D.—Michigan State University, East Lansing, Michigan
Ada Holding Miller—National Federation of Music Clubs
McFarland—
Mrs. Hartwig Dierks—National Music in Hospitals Chairman, National Federation of Music Clubs
Esther Goetz Gilliland—Director of Music Therapy, Chicago Musical College
Myrtle Fish Thompson—Director of Music Therapy, Essex County Overbrook Hospital, Cedar Grove, New Jersey
Ruth Row Clutcher—Mu Phi Epsilon
Wilma L. West—American Occupational Therapy Association
Beatrice Fields—Presbyterian Hospital
Deane Edwards—Hymn Society of America
Marjorie Fish—Occupational Therapy Department, Columbia University
Ila Bruce Miller—National Arts Foundation
Sister M. Xaveria, O.S.F.—Alverno College
E. E. Garrett—National Foundation of Musical Therapy
Gladys Douglas (Longmore)—Hospitalized Veterans Music Service of the Musicians Emergency Fund.

Chairman Green announced that the purpose of the meeting was to consider a proposed constitution and bylaws for the organization. He explained that a working committee composed of Freida Dierks, Esther Goetz Gilliland, Roy Underwood, Arthur Flagler Fultz, Edwin Hughes, and Ray Green had gathered the previous evening to develop the framework of a con-

stitution that was to be presented at the time. If the proposed constitution were to be adopted, amendments would be in order for the next sixty days. During the discussion that followed the reading of the constitution, Dr. Altshuler suggested that “music in therapy” as given in the proposed name of the organization was a misnomer for it sidestepped the purpose of the organization. In a lengthy discussion that followed after this point was raised, the following questions and comments were offered: were the workers in music sufficiently trained outside of their musical training to be designated “music therapists”; what were the usual practices in regard to titles in the different organizations and hospitals represented at this meeting; and would certain suggestions pertaining to the title limit the scope and purpose of the proposed Association or limit the eligibility of members. Fultz moved and Altshuler seconded that a change be made in the name from “music in therapy” to “music therapy”; this was passed unanimously. The name of the organization was approved as the National Association for Music Therapy.

Following some minor changes in the statement of the aims and objectives, these were also adopted by the group. Before the election of officers, the proposed constitution was adopted; it could be amended anytime within sixty days. The officers elected were: Ray Green, President; Roy Underwood, First Vice-President; Myrtle Fish Thompson, Secretary; and Freida Dierks, Treasurer. The members-at-large of the Executive Committee consisted of Ira M. Altshuler, Kathleen Davison, Samuel W. Hamilton, Francis Heinlen, and Edwin Hughes.

The constitution as adopted provided for one standing committee, the Research Committee, which was elected by the membership. The members of this Committee were: Arthur Flagler Fultz, Chairman, Ira M. Altshuler, E. Thayer Gaston, Jules H. Masserman, and Roy Underwood. The management of the organization according to the original constitution was to be vested in the Executive Committee, which was composed of the officers and the members-at-large. The duties of these officers were not clearly specified; it appeared that the direction of the organization was to be in the hands of an Executive Secretary appointed by the Executive Committee. According to the bylaws this individual would receive all moneys, be custodian of all

85. Ibid.
86. Ibid.
property, be responsible for all records, and for all practical purposes carry on the business of the Association under the direction of the Executive Committee.\textsuperscript{87}

The bylaws provided for the appointment of special committees as deemed necessary. They provided for eight classifications of membership: active, associate, student, contributing, sustaining, life, patron, and honorary life. There was a provision for NAMT to hold membership in the National Music Council. The Newsletter was listed as the official publication of the Association. There were provisions for the affiliation of regional groups provided they fulfilled the objectives and purposes of the Association.\textsuperscript{88}

\textit{First Annual Conference of the Association}

The first conference held by the National Association for Music Therapy was in conjunction with the annual meeting of the Music Teachers National Association in Washington, D. C., December 27–28, 1950. This provided the newly-organized Association an opportunity to hold a conference soon after its formation.

During the conference the Executive Committee met and formulated plans for the future development and growth of the organization. The membership was reported to be 85 at the first business meeting. Physicians were approved for active membership in the Association; the entire matter of membership classification was referred to a committee for further study. Sister M. Xaveria, Alverno College, submitted a design for an emblem. A committee, composed of Ira Altshuler, Sister M. Xaveria, and Samuel Hamilton, was appointed to study the design and make recommendations for its potential use by the Association.\textsuperscript{89}

Although the constitution which had been adopted at the organizational meeting in June stated that the \textit{Newsletter} published by the Hospital Music Committee of the NMC was to become the official publication, the matter of taking over the \textit{Newsletter} was discussed by the Executive Committee during the conference. The decision of the membership at the business meeting was in effect that the members felt that the publication

\textsuperscript{87} NAMT, \textit{Constitution} (1950).

\textsuperscript{88} Ibid.

was very valuable, but the association was not financially ready to print it at this time. The decision was made to appropriate a flat sum to be offered as a portion of the cost of the Newsletter; this sum was to be determined by the Executive Committee, based in part upon the state of the treasury at the time. It was decided to retain the same officers for another year and to have the time and place of the next meeting determined by the Executive Committee. Following a discussion about the Bibliography which was in preparation by the Hospital Music Committee of the NMC, it was decided to make it available as soon as possible and to plan for the release of a definitive and evaluated source book at a later date.

An Executive Committee meeting was held in the office of the American Music Center, May 25, 1951, with Ray Green presiding. Members present were Esther Goetz Gilliland, Second Vice-President; Freida Dierks, Treasurer; Myrtle Fish Thompson, Secretary; and three members of the Executive Committee, Kathleen Davison, Edwin Hughes, and Samuel W. Hamilton. Green reported on a suggestion from the National Music Council that its Hospital Music Committee be discontinued because the Association was now self-sustaining. It was also suggested that the Association could take over the publication of the Newsletter at this time. After a discussion of the matter it was voted unanimously that the Association take over the publication of the Newsletter with the September, 1951, issue. The estimated cost was set at $150 per issue. Myrtle Fish Thompson was instructed to continue with the work on the questionnaire which was in preparation for a second survey of the use of music in hospitals. The Executive Committee accepted the invitation of Esther

---

90. The Constitution (Bylaws, Art. 2, Sec. 1) stated that “the Hospital Music Newsletter published by the Hospital Music Committee of the NMC has been adopted as the official publication of the Association.” There is no record in the minutes of the meeting on June 2 of any discussion of the Newsletter.


92. In his annual report to the National Music Council, Ray Green stated that the Hospital Music Committee had not met during the past year and that the projects undertaken by the Hospital Music Committee were to be carried forward by the National Association for Music Therapy. The members of the NMC voted to dissolve the Hospital Music Committee and transfer the money in the publication fund ($78.21) to the Association. “Report of the Hospital Music Committee,” National Music Council Bulletin, January, 1952, pp. 4–5.
Goetz Gilliland to hold its second conference in Chicago in the fall of 1951. 93

With the plans for the second conference in process, the period of the formation of the National Association for Music Therapy came to a close. The Chicago meeting marked the beginning of a new stage of growth and development not only in the life of the Association but also in the field of music therapy. The future was to show less emphasis on music in hospitals and more on assisting music therapy to find its place as one of the adjunctive therapies in the clinical setting.

The Years of Organization

The events leading to the formation of the National Association for Music Therapy culminated in the first annual conference of NAMT, which was held in conjunction with the annual meeting of the MTNA in Washington, D. C., in December, 1950. If the first conference can be said to climax the struggle to form an organization in the field of music therapy, the second conference held in Chicago in November, 1951, may be considered as the beginning of the structural organization of the Association. While the first conference had been successful in bringing together many different individuals and groups engaged in the use of music in hospitals, the Association now faced the problem of welding these heterogeneous elements into an effective organization able to deal with the demands made on it.

The Second Annual Conference

The second annual conference was held on November 9–11, 1951, in Chicago. The Chicago Musical College was host to the group, and Esther Goetz Gilliland arranged the program. While the two hundred and fifty registrants at the conference attended the sessions and reported them stimulating and inspiring, the Executive Committee had to deal with problems that threatened the stability of the Association itself.

In the absence of President Ray Green, the Vice-President, Roy Underwood, conducted the business meetings and Executive Committee sessions. 94 A number of recommendations were approved

93. Minutes of the Midyear Executive Committee Meeting, May 25, 1951, National Association for Music Therapy, New York City (in the files of the Association).

94. Ray Green was unable to be present because of illness in his immediate family. Roy Underwood secured the necessary papers during
by the Executive Committee and presented at the first business meeting the following day. Roy Underwood requested the passage of an amendment to the constitution to expand the number of members-at-large from five to ten. The slate of officers prepared by the Nominating Committee was then presented to the members; following this, Chairman Underwood asked for a suspension of the rules so that the Association could proceed with matters on which the constitution was at variance with practical procedure.95 The officers elected for the following year were Esther Goetz Gilliland, President; E. Thayer Gaston, First Vice-President; Myrtle Fish Thompson, Second Vice-President; Freida Dierks, Treasurer; and Edwina Eustis, Secretary. Underwood announced a committee would be named to study the constitution and make recommendations for revisions. In the interim a number of recommendations were adopted by the Executive Committee to carry on the business of the Association while the constitution was under revision. Roy Underwood was requested to study the matter of incorporation; this step appeared highly desirable for the protection of the officers and as an aid in securing research grants. A decision on the adoption of the insignia was deferred until the committee made specific recommendations as to who was eligible to wear it. A change was approved to have the members of the Research Committee appointed by the Executive Committee rather than to be elected by the membership as a whole. President Gilliland was delegated the responsibility for the publications; she was empowered to appoint an Editor or to serve in this capacity herself.96 At the final meeting of the Executive Committee, an Education Committee was appointed to make recommendations for the development of educational standards. This Committee, with Roy Underwood as Chairman, was instructed to report back at the conference so that the business of the organization was carried on in the absence of the President.

95. An Executive Secretary had not been appointed as provided in the constitution; therefore, most of the duties had remained with the President. As a result there was some confusion as to the specific duties of the officers. (Minutes of the Second Annual Meeting, Chicago, 1951.)

96. Minutes of the Second Annual Conference, November 9–11, 1951, National Association for Music Therapy, Chicago (in the files of the Association).
next annual meeting." It was also suggested that a Publicity Committee be appointed to assist the President in the preparation of news releases and other public relations duties. Two additional matters were discussed by the Executive Committee. The first concerned the early completion and publication of the Bibliography. The Committee decided additional information should be secured from Ray Green so that it might be published as soon as possible. Myrtle Fish Thompson reported on the progress of the proposed survey of the use of music in hospitals. The questionnaire that was to be used during the survey was ready for consideration by the members of the Executive Committee and the Research Committee.

Membership Growth Following the Chicago Meeting.—During the conference it was proposed that an effort be made to publicize the Association's goals and objectives so that those persons working in this field would have the opportunity of joining the Association. It was stressed that the formation of regional organizations affiliated with the Association not only would help to acquaint prospective members with the Association but also would make a contribution to individual members by providing a means of communication on common problems and objectives.

One of the first actions taken by the membership chairman, Myrtle Fish Thompson, was to divide the states into twenty districts with a chairman in charge of membership for each district. A subchairman was responsible for the membership drive within each state. By May, 1952, the Association had gained over one hundred new members. Every effort was made to maintain high standards for the eligibility of members and to refrain from enrolling members merely to promote the growth

97. During this time Underwood was President-Elect of the MTNA; he accepted the committee appointment with the provision that he have the assistance of E. Thayer Gaston and a person from the medical field. John Anderson, M.D., Superintendent of the Topeka State Hospital, became the third member of the committee.
98. Minutes of the Second Annual Conference, loc. cit.
99. The Bibliography which had been started by Ray Green under the auspices of the Committee on the Use of Music in Hospitals was published as part of the First Book on Proceedings, Music Therapy 1951.
100. Minutes of the Second Annual Conference, loc. cit.
101. Ibid.
of the Association. It soon became apparent that in order to facilitate better communication with the district membership chairmen it was necessary to reduce the original twenty districts to eight regional districts.\(^{103}\)

The Beginning of the Publications.—The Association had assumed the responsibility for the publication of the *Hospital Music Newsletter* from the Hospital Music Committee of the National Music Council at the mid-year Executive Committee meeting held on May 25, 1951, in New York City.\(^{104}\) The only *Hospital Music Newsletter* published by NAMT was the September issue in 1951. At the final Executive Committee meeting at Chicago, E. Thayer Gaston moved that the name of the publication be changed from the *Hospital Music Newsletter* to the *Bulletin of NAMT*; this motion was approved unanimously as being more consistent with the aims of the Association.\(^{105}\)

The first issue of the *Bulletin of NAMT* (*Bulletin*) appeared in January, 1952. With this issue the size of the publication was increased from eight to twelve pages. The editorial policy, as announced by Editor Gilliland, was to publish news and information of general interest to music therapists, reviews of papers presented at conferences, and reports of research in the area of music therapy.\(^{106}\)

The first Book of Proceedings, *Music Therapy 1951*, was published during the year; this was made possible by a loan from the Musicians Emergency Fund of New York City and other interested individuals.\(^{107}\) The President, in addition to her duties with the *Bulletin*, served as Editor of *Music Therapy 1951*.\(^{108}\) The yearbook contained the major papers from the second conference and the *Bibliography*, which was edited by Ray Green with the help of the Research Committee.

---

104. Minutes of the Midyear Executive Committee Meeting, May 25, 1951, *loc. cit.*
107. The original grant from the Musicians Emergency Fund was $750. Freida Dierks, Treasurer, donated $120 to the publication fund; the Chicago Musical College granted funds for postage and provided clerical help.
108. There was no official editorial board; however, the Editor was assisted by Althea Bush, Frances H. Larson, Marjorie Scanlon, and Mrs. Allen Wells. Francis Heinlen served as Business Manager for the publications.
The Third Annual Conference

The third conference was held on October 30–November 1, 1952, in Topeka, Kansas. The main theme of the conference was the emphasis on the theory and philosophy of music therapy, but practical considerations of the use of music in the clinical setting were not neglected. The Topeka Chapter of Music Therapists, Robert Unkefer, President, served as host for the conference; E. Thayer Gaston, First Vice-President, was the program chairman. Approximately 150 registrants from 64 institutions in 22 states attended the session.

Reports to the Executive Committee revealed that much progress had been made during the past year. The working committees had carried on the business of the Association while the Constitution Revisions Committee prepared the changes that were necessary. Roy Underwood, reporting in the absence of Kathleen Davison, Chairman, stated that the old constitution could not be amended without having been submitted to the membership at least sixty days prior to a conference. In view of the large number of changes that were necessary to meet the objectives of the organization, the Committee recommended that it was more practical to adopt a new constitution. After the Executive Committee discussed a number of changes, the new constitution was submitted to the membership for adoption.109

A comparison of the two constitutions reveals a number of major changes in structure and procedure. As in the original constitution, the leadership of the Association remained with the Executive Committee; however, there were important changes. The constitution adopted in Topeka, in 1952, did not contain provisions for an Executive Secretary to carry on the business of the Association.110 Specific duties were delegated to the various officers and committee chairmen and these duties were

110. It was apparent almost immediately after the first constitution was adopted that the Association, which had a membership at that time of slightly over one hundred, would not be able to support a paid Executive Secretary for some time. The delegation of the leadership of the Association to various officers provided not only a method of handling the administrative affairs of the organization, but it also provided a means of gaining the active support of a number of experienced people.
outlined in the bylaws. The new constitution provided for a rotation of the terms of office for the members-at-large so that only one-third of them would be elected each year. Although the number of members-at-large had been increased to ten the year before, the new constitution provided for only nine. There were provisions for two new officers, the Editor and the Corresponding Secretary; they were to be appointed by the President with the approval of the Executive Committee. Amendments to the constitution in the future would have to be presented to the membership at least four weeks before a vote; bylaws could be amended by presentation to the membership twenty-four hours before the election was held. This constitution also provided for five standing committees: auditing, education, editorial, research, and public relations. Further, the constitution provided for the organization and affiliation of local, state, and regional associations or chapters.111

The new constitution stated specifically that there would be a publication, the Bulletin, as the official magazine or journal of the Association. The Editor, Esther Goetz Gilliland, reported to the Executive Committee on the problems encountered in the publication of the yearbook and the Bulletin during the past year. If all copies of the yearbook were sold, the indebtedness on the publications would be resolved. Furthermore, if the interest in the yearbook continued, consideration would have to be given to the possibility of reprinting it.112

The Chairman of the Education Committee, Roy Underwood, presented the core curriculum in Music Therapy to the members of the Executive Committee, and they recommended that it be presented to the membership at the business meeting. During the preparation of this curriculum, the Committee had studied the course offerings of all the institutions that offered work in the field. They had also secured the advice and assistance of hospital administrators, music therapists, directors of clinical training in music therapy, and the teachers of music therapy courses. By this procedure the curriculum was designed to reflect "the ideal program" rather than following any curricula already in existence. The Committee expressed the hope that

111. NAMT, Constitution (1952).
112. Edwina Eustis offered to ask the Musicians Emergency Fund to change the loan to a revolving fund for publications. At a later time $100 of the loan was applied to a life membership for Miss Eustis.
these standards for the education and training of music therapists would lead to the certification of music therapists in the future. The core curriculum was presented to the membership and was approved; later that same month the National Association of Schools of Music also adopted it. The National Association for Music Therapy, however, continued to assume responsibility for the approval of the clinical training programs for interns in music therapy.\textsuperscript{113,114}

The insignia, designed by Sister M. Xaveria, was adopted at this conference, and members of the Education Committee were designated to determine who would be eligible to wear it. Some consideration was given to restricting the use of the insignia to active members. In her report Myrtle Fish Thompson, the membership chairman, emphasized the difficulty in determining the exact number of members because of the lack of contact with delinquent members. She reported that a total of two hundred and seventy-four members were in good standing at that time. Mrs. Thompson stressed that further growth in membership was highly desirable and that the formation of regional organizations appeared to be one of the best methods of achieving solid growth. The success of the Topeka Chapter of Music Therapists in sponsoring a conference underscored the desirability of additional regional associations for the contributions they could make to the field of music therapy.\textsuperscript{115}

Officers elected for the following year were E. Thayer Gaston, President; Lenard Quinto, First Vice-President; Myrtle Fish Thompson, Second Vice-President; Edwina Eustis, Recording Secretary; Freida Dierks, Treasurer. JoAnn Cobb was appointed Corresponding Secretary, and Esther Goetz Gilliland was named Editor.\textsuperscript{116}

The actions initiated at the second conference in Chicago and completed at the third conference in Topeka may be considered as the foundation upon which the structure of the Association developed through the years. While many of the procedures established at the third conference were to be amended or en-

\textsuperscript{113.} Bulletin of NAMT, January, 1953, pp. 2–3.  
\textsuperscript{115.} Minutes of the Third Annual Conference, loc. cit.  
\textsuperscript{116.} Ibid.
larged, the actions taken at Topeka were basic for the future growth of the Association both in membership and in professional standards.

**The Struggle for Growth and Stability**

The close of the third conference in Topeka ushered in a period devoted to the stabilization of the organizational structure of the Association. At this juncture a number of important procedures had been initiated by the Association. First, educational standards were adopted; second, a new constitution designed to meet the practical needs of the Association was approved; third, provisions were made to encourage regional organizations; fourth, two publications were being supported by the Association; and fifth, efforts to encourage research were being made. The potential worth of these developments for the professional growth of music therapy could only be realized by positive action on the part of the Association.

In a realistic appraisal of the situation, President E. Thayer Gaston expressed his views to the members of the Executive Committee; he stressed that public relations were excellent, but that stabilization and standardization, particularly in the area of educational training and clinical practices, would be necessary before recognition by the medical profession would be achieved.¹¹⁷ Shortly before the fourth conference, the President was more explicit in his expressions to the Executive Committee.¹¹⁸ The problems of the organization were summed up briefly in the closing paragraph of an executive letter in the following manner:

I think one of the chief concerns of the Executive Committee at East Lansing will be to systematize various aspects of our Association’s business and procedures. I think there are a number of things which must be stabilized so our chief job is to get our Association in smooth and efficient running order.¹¹⁹

Foremost among the details of business that absorbed the attention of the Executive Committee were the problems attendant to the publication of the *Bulletin* and the annual Books of

¹¹⁷ Executive Letter, E. Thayer Gaston, President, April 15, 1953.
¹¹⁸ At Gaston’s request the time of the first Executive Committee meeting was changed to an earlier hour in order to accommodate the great amount of business.
Proceedings. To support both of these publications was an ambitious undertaking on the part of the recently formed Association. In February, 1953, the President informed the Executive Committee of the offer by Freida Dierks to subsidize in part the publication of *Music Therapy 1952*; the remainder of the funds were to come from the grant by the Musicians Emergency Fund. With the financial arrangement for the publication of *Music Therapy 1952* assured, the Editor, Esther Goetz Gilliland, was able to give her attention to the reprinting of *Music Therapy 1951*.

At the fourth conference in 1953, Esther Goetz Gilliland resigned as Editor. Mariana Bing succeeded Mrs. Gilliland, and Francis Heinlen continued as Business Manager. At this time also, two decisions were made relative to editorial policy for the publications. First, commercial advertising was not to be accepted in either publication; and second, reprints of articles appearing in the publications could not be included in other books on music therapy. However, permission to publish summaries or abstracts of papers presented at the conference was granted to the *Music Journal*. A year later, E. Thayer Gaston was appointed Editor, and Erwin H. Schneider was appointed Editor of the *Bulletin*. Harold Allen of the Allen Press accepted the position of Business Manager for the publications. There were no changes in the editorial staff until the conference in Cincinnati in 1958, when Schneider succeeded Gaston as Editor. The *Bulletin* continued to be published three times a year and

120. Freida Dierks, Treasurer, presented $1,000 in honor of her late husband, the Reverend Hartwig Dierks, a former army chaplain during World War II.

121. The Musicians Emergency Fund through the efforts of Edwina Eustis relieved the Association from the repayment of the original loan by turning it into a revolving fund for publications.

122. North Shore Printer, Chicago, Illinois, was the original printer for the *Music Therapy 1951*. Allen Press received the printing contract for *Music Therapy 1952*; later reprints of *Music Therapy 1951* were also made by the Allen Press.

123. Assistant Director, American Red Cross, Service in VA Hospitals, Washington, D. C.


125. Associate Professor of Music Education, University of Tennessee, Knoxville, Tennessee.

no major changes were made in style or content. In contrast to the Book of Proceedings, which for the most part contained the papers presented at the annual meetings, the Bulletin continued to offer a broad range of topics in the field of music therapy and related fields.

The Fourth Annual Conference

Michigan State College served as host to the fourth conference, which was held at East Lansing, October 19–21, 1953. Lenard Quinto was program chairman, and Roy Underwood was in charge of local arrangements. Officers elected at the conference were Myrtle Fish Thompson, President; Arthur Flagler Fultz, First Vice-President; Freida Dierks, Second Vice-President; Dorothy Brin Crocker, Recording Secretary; and Donald Michel, Treasurer.

In her report on membership at the conference, Myrtle Fish Thompson estimated that approximately 100 new members had been added during the past year, bringing the total to 319 at that time. She attributed a great part of the membership growth to the increasing interest on the regional or district level.127 Related to the growth in membership was the recurring problem of who was to be eligible to wear the NAMT insignia. Having deferred action on this matter at past meetings, the Executive Committee decided at this time that only active members would be qualified to wear the insignia. Student interns in music therapy would also be eligible to wear it if they were identified as students. The first insignia arm patches were presented to Ira M. Altshuler, Chairman of the Committee on Insignia, and Sister M. Xaveria, who prepared the design.128

Growth of the Regional Organizations

The early regional conferences of music therapists and the sessions on music therapy at the meetings of other organizations provided considerable impetus to the formation of the Association. The Executive Committee encouraged continuation of these regional meetings and provided for their affiliation with the Association at the national level.

The first regional meeting of music therapists from the Mid-Atlantic area was held in Milbank Chapel, Teachers College,

127. Ibid.
128. Ibid.
Columbia University, on March 21, 1953, New York City. One hundred and seventy-five individuals were registered, representing music therapy interns, music therapists, recreation therapists (music specialists), recreational directors supervising music, occupational therapists working with music, music volunteers and volunteer directors, physicians, music educators, students, and others. The states represented from the Mid-Atlantic district were New York, New Jersey, Pennsylvania, Maryland, Delaware, and Washington, D. C.; representatives also came from Connecticut, Massachusetts, Virginia, and Michigan. At the close of the first day's meeting the Mid-Atlantic Regional Chapter was organized and the following officers were elected: President, Myrtle Fish Thompson, Overbrook Hospital, New Jersey; First Vice-President, Mariana Bing, American Red Cross, Washington, D. C.; Second Vice-President, Norris Birenbaum, Lyons Veterans Administration Hospital, New Jersey; Secretary, Hermina E. Browne, Marlboro State Hospital, New Jersey; and Treasurer, William Ulrich, Bronx Veterans Administration Hospital, New York City. President Thompson appointed an Advisory Board composed of Edwina Eustis, New York City, Chairman; Virginia Carty, Baltimore; Martha Kalms, Philadelphia; Wallace Kotter, Harriet Cartwright, and Eleanor White of New York City.129 In April, 1953, a request was received by President Gaston from Myrtle Fish Thompson, President of the Mid-Atlantic Regional Chapter, for affiliation with the National Association for Music Therapy. Although other local groups had been organized for a number of years, Mid-Atlantic was the first chapter to request recognition as a regional chapter.130

The Topeka Chapter of Music Therapists was instrumental in the formation of the Mid-Western Regional Chapter, which was organized at a meeting held July 17, 1953, in Topeka, Kansas. It comprised the states of Kansas, Missouri, Arkansas, Oklahoma, Colorado, Nebraska, North Dakota, and South Dakota. Officers elected at that time were President, Robert Unkefer; John Kemm, Vice-President; Linda Sirk, Secretary; and Bessie Eads, Treasurer.131

130. Letter from Myrtle Fish Thompson to E. Thayer Gaston, President of NAMT, April 3, 1953.
131. Personal Communication from Janet Hellbeck.
Early in 1954, the Executive Committee established a number of guidelines for the recognition of regional organizations. First, regional chapters were allowed to adopt regional constitutions, but these constitutions had to meet the approval of the Executive Committee of the NAMT. Second, changes could be made in the geographic districts already established, but these changes must have the approval of the regionals involved and the Executive Committee. Third, membership in a regional organization was to be restricted to residence or job location within the regional boundary; however, invitations could be extended to members in adjacent areas to attend meetings as guests.132

Myrtle Fish Thompson, President of NAMT, announced the recognition of the New England Regional Chapter, which was formed January 30, 1954, in Boston. Boston State Hospital sponsored the organizational meeting. Officers elected were Arthur Flagler Fultz, Musical Guidance Center, President; J. Leslie Cahill, Metropolitan State Hospital, Vice-President; Homer Whitford, McLean Hospital, Boston, Secretary; and Martha Loven, New England Conservatory, Treasurer. The states that were included in the New England Regional followed the district lines; they were Massachusetts, Connecticut, Rhode Island, Vermont, New Hampshire, and Maine.133

The Southern California Chapter of NAMT met on March 16, 1954, for the purpose of organizing a new regional chapter. Among those present at this meeting were music therapists, music educators, music therapy volunteers, and a number of members of the medical profession. Officers elected were Lois A. Benedict, President; A. Clark Adelott, Vice-President; Evelyn Bull, Executive Secretary; and William Richardson, Treasurer.134, 135

Two months later on May 29, 1954, a group of music therapists, volunteers, music educators, and other hospital personnel met at the Veterans Administration Hospital, Murfreesboro,
Tennessee, for a conference to organize the SoutheasternRegional Chapter. States included in this Chapter were North Carolina, South Carolina, Georgia, Florida, Alabama, Mississippi, Kentucky, Tennessee, and Louisiana. Ernest Grisham, Veterans Administration Hospital, Murfreesboro, was elected President; Erwin H. Schneider, University of Tennessee, Vice-President; Olga Pytlar, Eastern State Hospital, Knoxville, Tennessee, Secretary-Treasurer.\textsuperscript{136}

At the College of the Pacific, Stockton, California, the Northern California Music Therapists held an organizational meeting for possible affiliation as a regional chapter. Officers elected at that time were: Wilhelmina Harbert, College of the Pacific, President; Bud DeSylva, Stockton State Hospital, First Vice-President; Christine Otto, Modesto State Hospital, Second Vice-President; Arthur Chaffee, Sonoma State Hospital, Treasurer. The first conference held by this chapter was on January 22, 1955, at Modesto State Hospital. At that time it officially became known as the Northwest Regional Chapter.\textsuperscript{137, 138}

On September 9, 1954, the Great Lakes Regional Chapter was organized at the Dr. Norman M. Beatty Memorial Hospital, Westville, Indiana. Pat Otto, Beatty Memorial Hospital, Westville, was elected President; Allen Wells, Veterans Administration Hospital, Downey, Illinois, Vice-President; Helen Dinklage, Kalamazoo State Hospital, Kalamazoo, Secretary; Leo Muskatovec, Milwaukee County Hospital for Mental Diseases, Treasurer. The states that were included within this regional chapter were Michigan, Indiana, Ohio, Illinois, Minnesota, and Wisconsin.\textsuperscript{139}

The last regional chapter to be formed was the Southwestern; it was organized on January 9, 1956, at the Texas Woman's College, Denton, Texas. It included the states of Texas and New Mexico. Officers elected were Dorothy Brin Crocker, Shady Brook Schools, Richardson, Texas; J. Wilgus Eberly, Texas Woman's College, Denton; Broderick Gordon, North Texas State College, Denton; Joan Moreman, Shady Brook Schools, Secret-


\textsuperscript{137} “Regional Activity,” \textit{Bulletin of NAMT}, September, 1954, p. 5.


tary; and George Bragg, Denton, Texas, Treasurer. With the formation of the Southwestern Regional Chapter, the regional structure of the Association was completed. While a number of minor changes were to take place in the future, the formation of the regionals took place during the four years between the third conference, held at Topeka, Kansas, in 1953, and the seventh conference, also held in Topeka in 1956.

Fifth Annual Conference

New York City was the scene of the fifth conference on October 13–15, 1954. Edwina Eustis of the Musicians Emergency Fund was the local program chairman, while Arthur Flagler Fultz, First Vice-President arranged the program. Officers elected at this meeting were Arthur Flagler Fultz, President; Jules H. Masserman, First Vice-President; Dorothy Brin Crocker, Second Vice-President; Hermina E. Browne, Recording Secretary, and Lenard Quinto, Treasurer.

One of the items of business brought before the members were the proposed changes in the constitution. The Corresponding Secretary and the Chairman of the Public Relations Committee became members of the Executive Committee. The number of standing committees was increased from five to six with the addition of a Budget Committee. The Research Committee was given the specific duty of revising the *Bibliography*. Probably the most important change was the creation of an Honorary Advisory Board of five members appointed annually by the Executive Committee to serve for one year. This Board was created to assist the Executive Committee in formulating major policy, particularly in those areas that would help the Association to develop its educational and training standards and to improve clinical practices. Members of the Board announced by President Fultz the following year included Ira M. Altshuler, M.D., Wayne County Hospital, Eloise, Michigan; Louis L. Cholden, M.D., National Institute of Mental Health, Bethesda, Maryland; Rudolph Dreikurs, M.D., Chicago Medical School; and Charles U. LeTourneau, M.D., Hospital Management Magazine, Chicago; Karl Menninger, M.D., The Menninger Foundation, Topeka, Kansas.

141. NAMT, *Constitution* (1954), Amendments and Bylaws.
On January 14, 1955, the National Association for Music Therapy was officially incorporated under the laws of the state of Michigan as a non-profit organization. The official seal was placed with the Recording Secretary, Hermina E. Browne, and the Certificate of Incorporation was deposited with Roy Underwood as resident agent in the State of Michigan.

One of the first actions taken by Myrtle Fish Thompson, Chairman of the Public Relations Committee, was to develop a pamphlet to meet the growing demand for information about the Association and the field of music therapy. Mrs. Thompson was assisted in preparing a pamphlet, "Music Therapy—What and Why," by members of the Public Relations Committee, the Research Committee, and the Executive Committee.\(^1\)

The changes in the Constitution which placed the Chairman of the Public Relations Committee on the Executive Committee reflected an awareness that as the Association grew in strength, it must be prepared to meet critical attitudes and resistance on the part of other professional fields. Although there appeared to be no particular quarrel with the aims and objectives of the Association, there was a growing criticism voiced at certain practices of music therapists in some of the hospitals. The problem confronting the organization was not so much whether this criticism was justified, but how a policy might be developed whereby adverse comment could be used to bring about an improvement in the work of the music therapists. An outgrowth of this discussion by the Executive Committee was the creation of a Professional Relations Committee with Jules H. Masserman, Chairman.\(^2\)

The Sixth Annual Conference

Other events than those concerned with public relations were to occupy the attention of the Executive Committee at the sixth conference, which was held in Detroit, Michigan, October 6–8, 1955. Ira M. Altshuler was local program chairman and Jules H. Masserman, First Vice-President, was in charge of the program for the conference. Officers elected for the following year were Arthur Flagler Fultz, President; Wayne Ruppenthal, First Vice-President; Mrs. Margaret Masserman, Second Vice-President; John R. Stone, Secretary; and Jules H. Masserman, Treasurer.\(^3\)

---

\(^1\) Minutes of the Sixth Annual Conference, October 6–8, 1955, National Association for Music Therapy, Detroit (in the files of the Association).

\(^2\) Minutes of the Sixth Annual Conference, 1955, loc. cit.
Vice-President; Dorothy Brin Crocker, Second Vice-President; Hermine Browne, Recording Secretary; and Ernest Grisham, Treasurer.

The membership chairman, Dorothy Brin Crocker, reported an increase of approximately 100 members, making a total of 432 at the time of the conference. During the year there had been an effort to strengthen the membership by the formation of regional chapters, by encouraging the organization of state and local chapters, and by attempting to interest high school students in the field of music therapy through attendance at meetings on music therapy.145

Myrtle Fish Thompson reported at the conference that the survey on the uses of music in institutions had been completed. This project had been approved in 1951 at the Midyear Executive Committee meeting upon the recommendation of Ray Green, President, and Arthur Flagler Fultz, Chairman of the Research Committee. During the intervening years, Mrs. Thompson had reported progress on the survey and had been assisted by various committees on the project.146

The purpose of the survey had been to investigate the efficiency of music as an adjuvant rehabilitation, to define broad trends in institutional music programming, and to explore the adequacy of the standards of training and qualification of the music therapists.147 The survey provided considerable information about the current status of music therapy in the hospitals. One finding that provided a challenge for the Association was that job opportunities were increasing, and that there were not enough adequately trained individuals to fill them. The survey revealed a change in viewpoint of the hospital administrators concerning the qualifications of music therapists. Advanced professional training was now expected of music therapists with either music education or music therapy degrees preferred. A broad command of music plus an understanding of the psychological factors encountered in the work was also expected from the musicians working in hospitals.

The survey revealed that there was a need for adequate train-

145. Ibid.
147. Ibid., p. 239.
ing opportunities, professional status, and remuneration approximating other professions requiring comparable experience and training; that adequate space, equipment, personnel, and medical guidance were needed to allow the field to function as a total therapeutic plan; and that more research by scientific methods was needed in order to determine how music therapy functions in the clinical setting.\textsuperscript{148}

The major activities of the Association during the period between the third conference and the seventh conference, both held at Topeka, Kansas, were centered upon building a strong organizational structure for the Association. For the most part, this goal was achieved. The regional organizations were formed, the publications were supported and enlarged, the standing committees had functioned to promote improved business procedures, public relations had been strengthened, and membership had shown a strong yearly increase that provided the impetus for future progress. The Association was now ready to move from the emphasis on organizational structure toward the development of the professional growth of the music therapist.

\textbf{The Development of the Professional Worker}

\textit{The Seventh Annual Conference}

The Topeka Chapter of Music Therapists served as host to the seventh conference, held on October 18-20, 1956. Wayne Ruppenthal, First Vice-President, served as program chairman. Officers elected for the following year were Roy Underwood, President; Dorothy Brin Crocker, First Vice-President; Wilhelmina Harbert, Second Vice-President; Ernest Grisham, Treasurer; and Phyllis King Noble, Recording Secretary.

A review of the conference program indicates an awareness of the problems confronting the music therapist. There was less attention given descriptions of music therapy programs and more attention to the search for answers to the problems confronting the individual music therapist and the Association as a whole. Emerging from the discussions of these problems was a notable concern about the role of the individual music therapist and the function of the music therapy department as one of the adjunctive therapies. It was clear that the Association had made considerable progress in its organizational and administrative affairs.

\textsuperscript{148} \textit{Ibid.}, pp. 266-7.
during the first five years of its existence; at the same time, it was evident that similar gains in professional status were yet to be achieved.

A number of actions were taken at this conference relative to the administration of the Association. A legal agreement between Harold Allen of the Allen Press and the Association was negotiated for the publication of the Books of Proceedings. The proposed Council of Regional Presidents was deferred until the following year. A review of the structure of the Executive Committee indicated that the regional chapters were well represented on a geographic basis. It did not appear to be in the best interest of administrative leadership to add seven additional people to the Executive Committee at this time.149

Membership showed an increase of approximately 100 members during the past year; the total number of members was given as 514. A brief review of the membership growth for past years did not provide as much reassurance about the strength of the Association as the total number of members indicated. Wilhelmina Harbert, the membership chairman, was instructed to give this matter further study and report on possible actions the Association might take to insure a greater stability in membership.150

By the approval of an amendment to the constitution a new standing committee, the Certification Committee, was created. The three members of the Committee elected by membership were E. Thayer Gaston, Chairman; Arthur Flagler Fultz, and Myrtle Fish Thompson.151 According to the bylaws of the constitution the duties of the Committee were:

The Certification Committee shall (1) establish standards and procedures for the certification of Music Therapists, and (2) institute formal approval of training programs. The actions of this Committee shall be subject to the approval of the Executive Committee.152

149. Minutes of the Seventh Annual Conference, October 18–20, 1956, National Association for Music Therapy, Topeka (in the files of the Association).

150. Although at least a hundred new members were reported each year, the membership figures given at the conference did not reflect the membership for the entire fiscal year and did not indicate the consistent turnover in the membership each year.

151. The committee was elected by the membership at the business meetings; the committee selected its own chairman.

152. NAMT, Constitution (1956), Bylaws. Art. 4, Sec. 7.
The Association long had been aware of the need to further develop the professional status of the field of music therapy. Gaston, in his presidential address to the members at the annual conference in Topeka four years earlier, had stressed the value and the need for improvements in education and clinical training requirements. During these early years there had been a continuing effort by the Association to make a distinction between the music activities conducted by music therapists and the many musical activities labeled therapeutic merely because they were taking place in the hospital. Through the work of the Membership Classification Committee there was an attempt to distinguish between those professionally engaged in the field and others working on a part-time or volunteer basis. While this was a move toward a professional distinction among the members, it did little toward solving the problems encountered by the individual workers and the Association in the clinical setting. In some instances, there were musicians working as therapists who were considered as part of another adjunctive therapy because there was no means of distinguishing them from the administrative control under which they functioned.153

The Education Committee had sought to develop a curriculum that would have the approval of the education committees of both the music and the medical professions. While the Association had been successful in securing approval of the core curriculum from NASM, liaison had not yet been established with the medical education committees. In January, 1955, Jules H. Masserman conveyed to E. Thayer Gaston his lack of success in securing any kind of formal liaison between the American Psychiatric Association (APA) and the National Association for Music Therapy. He informed Gaston that according to a communication from Frank J. Curran, M.D., Chairman of the Coordinating Committee of the APA, two other organizations active in music therapy had already approached the Committee on Medical Rehabilitation of the APA about developing liaison with

---
153. As can be seen from a perusal of Civil Service classifications, music therapists may be classified as recreation workers, occupational therapy aides, group workers, etc. For the most part this is an administrative procedure; however, in some cases the music therapist is considered a member of another adjunctive group.
The Committee was under the impression that there were at least four national groups of music therapists in existence. In a letter to Roy Underwood shortly before the annual conference in October, 1956, Gaston reported that there had been no further correspondence with either the AMA or the APA on establishing a liaison with them. He wrote that Dr. Masserman had advised that greater stability in the education and training of the music therapists was needed before approaching the medical groups again.

The Eighth Annual Conference

Michigan State University was host to the Association at the eighth conference, held at East Lansing, Michigan, on October 10–12, 1957. Dorothy Brin Crocker served as program chairman, and Robert Unkefer was local program chairman. Officers elected at this conference were Dorothy Brin Crocker, President; Donald E. Michel, President-Elect; Robert Unkefer, First Vice-President; Wilhelmina K. Harbert, Second Vice-President; Martha Loven, Recording Secretary, and Ernest Grisham, Treasurer.

In his presidential address, Roy Underwood stressed the goals for the future of the Association. He stated that in the process of seeking the recognition that music therapists deserved the registration of music therapists would increase the stature of the profession and increase the status of the Association among other professional groups. The major portion of the business at this conference was devoted to discussions of reports and procedures on the registration of music therapists. The Chairman of the Certification Committee, E. Thayer Gaston, reported to the Executive Committee on a proposed plan

155. Possibly refers to the Musicians Emergency Fund (New York City), the Music Research Foundation (Paperte), and the National Foundation for Music Therapy (Seymour).
156. Letter from E. Thayer Gaston to Roy Underwood, October 9, 1956 (in the files of the Association).
157. This office was created at the eighth conference.
for the registration of music therapists which had been prepared during the past year. Basic to the whole plan was the assumption that eligibility for registration as a music therapist would in the future be dependent on the completion of a college degree that included a period of clinical training. This degree would be based upon the core curriculum adopted in 1952, by NAMT and approved by NASM. After careful consideration by the Executive Committee, the proposed plan as submitted by the Certification Committee was presented to the membership at the business meeting. The plan that was approved called for the registration of all music therapists based upon certain experiential and training determinants valid up to and including December 31, 1960. After this date only music therapists with degrees from schools approved by NASM or those in the process of securing such approval would be eligible for registration. From the time of the adoption of the plan in 1957, until December 31, 1960, the requirements valid for registration were that “all persons actively and for the most part engaged in music therapy would be eligible” and “educators who have directly to do with music therapy either administratively, pedagogically or clinically shall be eligible.”

The plan for registration was published in the annual Books of Proceedings and in the subsequent issues of the Bulletin for the following two years. Forms for registration were sent out early in 1958, to all active and associate members of NAMT. A letter was sent to all hospitals that might employ or did employ therapists to inform the administrators of the procedures for the registration of music therapists.

After the procedures for registration had been established and the process of registering the members was begun, the Certification Committee turned its attention to the problem of developing the degree programs and clinical training facilities. Proposed plans for assisting educational institutions in developing degree programs that would meet NASM approval had been presented to the Executive Committee at East Lansing, in 1957. On November 27, 1957, the Commission on Curricula of the NASM approved a resolution stating that it would serve as the accredit-

ing body for educational institutions granting the music therapy degree.\textsuperscript{160}

A little over a year after the process of registering was begun, the Certification Committee released a list of one hundred and eighty names of music therapists who had become registered during this time; this list appeared in the\textit{Bulletin}, in May, 1959.\textsuperscript{161} The following February, 1960, a report from the Committee on Certification-Registration appeared in the\textit{Bulletin}; it summarized the activities of the Committee for the past three years. In addition, it listed twelve schools and fourteen hospitals which had met the educational qualifications and standards adopted by NASM and NAMT. Other colleges and universities were reported in the process of supplying information to the Committee; as soon as they qualified, their names would be added to the list. Previous to the announcement that appeared in the\textit{Bulletin}, the various schools and institutions had been notified by the Committee of their acceptance.\textsuperscript{162}

\textit{The Ninth Annual Conference}

There was increased regional participation in the program of the Ninth Annual Conference held in Cincinnati, on October 29–November 1, 1958. At a luncheon meeting each regional president or official representative gave a report of regional activities during the past year. Robert Unkefer served as program chairman, while Helen Rosenthal and John H. Reinke, S.J., were local program coordinators.

Wilhelmina Harbert, membership chairman, reported that the membership totaled 630 at this time, as compared to 668 the previous year. The explanation given for this decrease was that it accounted only for those members who had paid their dues by the time of the conference. In her report, Mrs. Harbert also recommended that the existing structure of the regionals be changed to include those states that were not part of any regional chapter. The recommendation was that the Western Regional Chapter include the Islands, Alaska, Utah, and Idaho; and that

\textsuperscript{160.} The Resolution adopted jointly by NASM and NAMT was presented at the NASM meeting by Roy Underwood, a member of the Committee on Curricula of NASM and Past President of NAMT.


the Mid-Western Regional Chapter include the states of Montana, Wyoming, and Iowa and transfer Oklahoma to the Southwestern Chapter.163

The new Western Regional Chapter had been approved earlier in the year by the President, Dorothy Brin Crocker. The previous June, the Southern California Regional Chapter had requested permission to become part of a larger regional chapter. Approval was granted and plans were initiated to combine the Southern California Chapter with the Northwestern Chapter to be called the Western Regional Chapter.164 The first meeting of this Chapter was held the following January 30–31, 1959, at the College of the Pacific, Stockton, California. The officers elected at that meeting were Sara Mae Peterson, President, Stockton; Lois Benedict, First Vice-President, San Jose; Arthur Chaffee, Secretary, Stockton; and Mildred Southall, Treasurer, Los Angeles.165

It was approved by the members at Cincinnati to have the same officers remain for 1958–1959; this action was in accord with an amendment to the constitution approved during the conference that provided for two-year terms of office for all elected officers.166 Erwin H. Schneider succeeded E. Thayer Gaston as Editor, and Melvin R. Zack167 was appointed as Editor of the Bulletin.

In a communication to the Executive Committee in March, 1959, President Dorothy Brin Crocker requested permission to appoint the Chairman of the Certification-Registration Committee, E. Thayer Gaston, as NAMT representative to a meeting of the Joint Committee to Study Paramedical Areas in Relation to Medicine of the AMA.168 Discussion at this meeting, which was held on May 16, 1959, centered on the registration and licensure of paramedical groups. In his report to the Committee, Gaston reviewed the manner in which the Association took care of certification; he explained that the procedure was voluntary; i.e.,

163. Minutes of the Ninth Annual Conference, October 29–November 1, 1958, National Association for Music Therapy, Cincinnati (in the files of the Association).
164. Executive Letter from Dorothy Brin Crocker, President, June 4, 1958.
166. Minutes of the Ninth Annual Conference, 1958, loc. cit.
167. Associate Professor of Music, Los Angeles State College.
registration was not compulsory in order to secure a position as music therapist.\textsuperscript{169} The unofficial liaison with the Council on Medical Education and Hospitals of the AMA was confirmed by a letter from the Assistant Secretary to the Council, John Hinman, M.D., in December, 1959. In his letter to Gaston, he explained that until plans had progressed toward the formation of a committee composed of members of the two groups, Dr. Hinman would serve as the liaison between NAMT and the Council.\textsuperscript{170}

The Tenth Annual Conference

Interest in the Interdisciplinary Study Group was stimulated by the appearance of Donald M. Carmichael, M.D., on the program of the tenth conference held on October 9–11, 1959. Michigan State University, East Lansing, was host to the conference with Robert Unkefer serving as program chairman. Officers elected at the Conference were Donald E. Michel, President; Robert F. Unkefer, President-Elect; Wilhelmina K. Harbert, First Vice-President; Martha A. Loven, Second Vice-President; Mariana Bing, Recording Secretary; and Walter Lancaster, Treasurer.

Donald E. Michel, Chairman of the Committee on Insignia, presented the designs for the official NAMT pin. The membership approved the design that carried the letters NAMT along with the insignia of the Association. Official action was also taken by the Association to specify that the correct designation of a Registered Music Therapist would be RMT and not MTR as had been approved earlier.\textsuperscript{171}

Interdisciplinary Study Group.—The Interdisciplinary Study Group (ISG) was an outgrowth of a pilot study conducted by the American Occupational Therapy Association through a grant from the National Institute of Mental Health on November 13–

\textsuperscript{169} Interview with E. Thayer Gaston, NAMT liaison with the Committee on Allied Health Professions and Services, July 20, 1962. This committee is the same as the earlier Joint Committee to Study Paramedical Areas in Relation to Medicine.

\textsuperscript{170} Letter from John Hinman, M.D., to E. Thayer Gaston, December 2, 1959 (in the files of the Certification–Registration Committee of NAMT).

\textsuperscript{171} Minutes of the Tenth Annual Conference, October 9–11, 1959, National Association for Music Therapy, Inc., East Lansing, Michigan (in the files of the Association).
19, 1956.\textsuperscript{172} The ISG was a study group devoted to the exploration of increased unity and integration of the activity therapies in the hospitals and to the possible formation of a Council of Activities Therapies. Robert Unkefer was named the NAMT representative to the study group.

In his first report to the Executive Committee in 1957, Unkefer stated that some progress had been made toward the aims and objectives of the group.\textsuperscript{173} He reported that at the third meeting of the ISG, Donald M. Carmichael, M.D., the representative from the Committee on Rehabilitation of the APA, advised the group that the plan to form a Council of Activities Therapies at that meeting should be deferred.\textsuperscript{174} The ISG then voted to continue as a study group to work toward further clarification of the purpose and function of the proposed Council. In particular, it was considered desirable that the cooperation and integration of the adjunctive activities be initiated at the local hospital level. At the request of the members of ISG, Col. Robinson continued to serve as moderator and Dr. Carmichael as consultant to the group. The adjunctive or activity therapies represented on the study group were corrective therapy, education therapy, hospital library service, hospital service, hospital recreation, manual arts therapy, music therapy, occupational therapy, and social group work.\textsuperscript{175}

In his report the following year at the ninth conference, Unkefer stated that a number of problems had to be solved before the Council could be organized. He was given approval by the Executive Committee to join the Council, if it were formed during the year.\textsuperscript{176} At the tenth conference in 1959, it appeared that the goals of the ISG were beginning to be achieved, and that action would be taken on the formation of the proposed Council of Activities Therapies.\textsuperscript{177}

\textit{Honorary Life Membership Conferred.}\textemdash The first Honorary Life Membership of the National Association for Music Therapy was conferred on E. Thayer Gaston; he was cited for his “per-

\textsuperscript{173} Report of the ISG Meeting, 1957 (in the files of the Association).
\textsuperscript{174} It was the belief of the representative from the APA that the time was premature and that it was a weak foundation upon which to base future good work (from the Report of the ISG Meeting).
\textsuperscript{175} Report of the ISG Meeting, 1957, \textit{loc. cit.}
\textsuperscript{176} Minutes of the Ninth Annual Conference, 1958, \textit{loc. cit.}
\textsuperscript{177} Minutes of the Tenth Annual Conference, 1959, \textit{loc. cit.}
personal integrity and character, his contributions to the needs and goals of the National Association for Music Therapy, his contributions to the cause of music therapy, and the honor that he has brought to the Association by respect accorded him by other professional associations." The Association presented Dr. Gaston with the first NAMT insignia pin at the time of the citation. The award was conferred during the annual dinner meeting of the Conference.

The major events which marked the development of the professional worker in music therapy occurred during the period between the seventh conference in 1956, and the tenth conference in 1959. The development of the procedures for Registration in NAMT, the designation of educational and clinical training institutions, and the adoption of an insignia pin to differentiate the Registered Music Therapists provided the basis for the future growth of a professional group of music therapists.

THE CLOSE OF THE FIRST DECADE

The eleventh conference was held in San Francisco on October 19–22, 1960; the College of the Pacific was host to the group. Wilhelmina Harbert arranged the program while Betty Isem served as local program chairman. This conference marked the close of the first decade of the Association. In many aspects the program of the conference represented a summary of the first decade; this was a natural consequence of the sense of achievement that pervaded the proceedings. In his presidential address, Donald E. Michel compared the field of music therapy to a person, a patient, and NAMT to a therapist who came on the scene in June, 1950. To carry the analogy further, he proposed that a diagnosis of "schizophrenic reaction" could be derived from the varied and exploratory forms, methods, theories, activities, and the sometimes seemingly erratic approaches to music therapy at the time. Michel did not propose that all the problems had been solved, but rather that the "patient" with the help of NAMT has gained a healthy status so that "he" could devote less time to his own progress and more toward helping others.

It may be said that the conference in San Francisco closed

ten years of organizational and professional growth, culminating in a strong Association; at the same time, it marked the beginning of an even greater drive to discover methods and means to make music therapy a useful modality in the clinical setting and a recognized professional field among the other adjunctive therapies.

The contrast between the programs of the early conferences and the program presented at the eleventh conference, held in San Francisco in October, 1960, provides evidence of the progress made in the field of music therapy as well as in the growth of the Association. Some of the significant differences between the conference in San Francisco and earlier conferences can be summarized as: First, the aims and goals stressed on this program were more specific because of the understanding and knowledge acquired during the past ten years. Second, music therapy as a profession had achieved a state of maturity that was reflected by the differences of opinion concerning theory and practice, presented without disturbing the basic areas of agreement in the field. Third, the guest speakers discussed topics from their own fields in relation to music therapy rather than defining music therapy according to their own views and orientation. Fourth, a majority of the participants on the program of this conference were drawn from the ranks of the music therapists. Fifth, there appeared to be a greater understanding as to what constitutes the theory and philosophy in music therapy—i.e., the theoretical discussion of music therapy—was oriented more realistically to the field. Sixth, there was an increasing recognition that goals and objectives must be developed in special areas; i.e., the goals developed for the use of music with the mentally retarded may not be valid for work with juvenile delinquents. Seventh, there was a growing awareness that while specialization was important, it was also important to try to develop some common approaches to treatment with other adjunctive therapies. Eighth, if music therapy was to progress in the area of clinical practice, it must be able to adapt to the changing concepts of treatment. Ninth, it was apparent that the deficiency of scientific research in music therapy was almost as great as it had been ten years previously. Tenth, one of the most significant developments was the presence of the professional music therapist rather than the musician, the music educator, or the medical
man on the speaker's rostrum, seeking to define the field in which he was actively engaged.

Research in Music Therapy.—The announcement of a sizable grant for basic research by the Sinfonia Foundation\textsuperscript{180} was made at the conference in San Francisco. On the surface this would seem to indicate that considerable progress in research had been made during the first decade. But an examination of the part that the Association played in the field of research in the past reveals little progress and much difficulty. Only a small beginning had been made on the ever-increasing need for basic research in the field of music therapy.

As early as the third conference, speakers were discussing methods and procedures available for research in music therapy. At the same time it became clear that the problems of research were related to the larger problem of evaluation of therapeutic procedures in the field of psychiatry. The rigid controls so necessary for reliable experimental studies were often impossible to secure. Facilities for experimental research, therefore, during these years appeared, for the most part, to be limited to the graduate schools offering work in music therapy or to a limited number of training hospitals which had research programs in other disciplines.

By 1958, a great many objectives in the stabilization of the organization had been attained. At that time the Sinfonia Foundation indicated an interest in supporting research projects in the field of music therapy and the psychology of music. Roy Underwood had been appointed Chairman of the Foundation Committee by President Dorothy Brin Crocker.\textsuperscript{181} During this time President Crocker appointed William Sears as Chairman of the Research Committee.\textsuperscript{182}

In his report to the Executive Committee at the conference in San Francisco, Sears stated that Mu Phi Epsilon had presented $1,500 for the publication of research abstracts that were already in preparation. He also reported that a grant of $1,000 had been received from Phi Mu Alpha and that this money was being

\textsuperscript{180}. Minutes of the Eleventh Annual Conference, October 19–22, 1960, National Association for Music Therapy, San Francisco, Calif. (in the files of the Association).

\textsuperscript{181}. Report from the Foundation Committee. Attached to an Executive Letter from Dorothy Brin Crocker, President, March 15, 1958.

\textsuperscript{182}. Executive Letter, Dorothy Brin Crocker, President, March 15, 1958.
used for the preparation of the research abstracts. In addition to the grants already received, Sears informed the Executive Committee that the first portion of a sizable grant from the Sinfonia Foundation was now available. This latter grant was for basic research and was to be administered by a special committee appointed by President Donald D. Michel and headed by E. Thayer Gaston as Chairman. Among its first projects the committee would develop a number of pilot studies in basic research in the use of music as therapy.

In surveying the progress that has been made in the area of research in music therapy, it appears that the difficulties experienced during this first decade were those that might be attendant upon the efforts of any new organization in such a complex field as music and therapy.

Business Sessions of Eleventh Annual Conference

The business sessions at the eleventh conference provided a review of the progress of the Association during its first decade. Reports from the standing committees revealed the accomplishments of the organization to this time. In his report to the members Gaston summarized the progress of the registration procedures to that time. With the inclusion of the applications in progress, approximately three hundred and fifty music therapists already had been registered. It was approved that all applications must be received by the Committee before the deadline. Although a number of the applications were processed after December 31, 1960, the number of Registered Music Therapists exceeded 400 before the expiration of the deadline.

A number of changes in the publications were proposed by the Editor, Erwin H. Schneider. He stated that the contract with

184. One thousand dollars already had been received to begin the pilot studies.
185. Other members were William Sears, Robert Unkefer, Donald E. Michel, and Erwin H. Schneider.
187. E. Thayer Gaston became ill late in November and Wayne Ruppenthal was appointed Acting Chairman of the Committee on Certification-Registration. With the assistance of Doris Chronister, Secretary to Chairman of Music Education Department, University of Kansas, the committee completed the registration procedures as planned. Ruth Boxberger became the third member of the committee at that time.
Allen Press had expired and that a renewal on the old basis did not appear feasible. The Allen Press had reported that the sale of the yearbooks during the several past years did not warrant a continuation of the old contract. One alternative suggested by the Editor was to include the yearbook as part of the annual membership dues; however, since this would involve a constitutional amendment, it could not be approved at the conference. It was his recommendation that the Association move toward the publication of a journal; this proposed journal should be a professional publication resulting from a merger of the yearbook and the Bulletin.188 The Editor of the Bulletin, William Sears, concurred with these recommendations. He announced that plans were already under way to change to a quarterly publication with a different format in order to facilitate the eventual change to the proposed journal. The Executive Committee approved the proposal to move toward the publication of a journal with the recommendation that the proposed change be well planned in advance and implemented with care.189

In his report to the Association on the progress made by the study group, Robert Unkefer stated that the ISG had reached a plateau in its efforts to form a Council of Activities Therapies. No action had been taken during the past year to form the Council, and there was no indication when the study group might again be active. Unkefer recommended that the Association formalize its own stand before it attempted to take increased leadership in securing the cooperation and integration of the various adjunctive therapies.190

A considerable amount of discussion centered on the persistent problem of how to obtain better regional representation on the Executive Committee. There was general agreement that this was a good policy, but there was a lack of agreement as to how it should be accomplished. A constitutional amendment had been circulated among the members thirty days prior to the eleventh conference in accordance with constitutional requirements. It provided for the election of regional representatives

188. Subsequently the Editorial Committee announced that plans were under way to change to the proposed journal sometime during the fiscal year of 1963–1964. During the intervening years the yearbook was to be included in membership dues according to a constitutional amendment approved by the membership in 1961.
190. Ibid.
to the Executive Committee beginning with the 1960–1961 membership year. As Chairman of the Constitutional Revisions Committee, Robert Unkefer recommended that a vote on this amendment be deferred until a practical plan for putting the amendment into operation was developed with the cooperation of regional chapters.191

One of the most important decisions, in many ways long past due, was the approval of the proposed centralization project. As outlined by President Donald E. Michel, this proposed office would serve as a clearing house to handle routine mail and other Association business. Following the establishment of certain routines in that area, there would be an attempt to integrate duties from the various officers and committee members into one central office. As many routine business duties were to be assigned to this office as time and funds would permit. A part-time secretary was to be employed to work under the direction of E. Thayer Gaston, at Lawrence, Kansas.192 A budget was approved for the first year’s operation of this proposed central office and Gaston was directed to begin the project as soon as possible.193

If the topics presented at the various sessions of the conference program touched more on the achievements of the first decade, the items on the business agenda, in contrast, were devoted to plans for the future growth of the Association in organizational strength and professional stature.

The Summing Up

Accounts of the use of music in medicine date from earliest times, when music was associated with magical beliefs entertained by primitive civilizations. Before reaching the scientific stage, music in medicine passed through the stages of magic, magico-religious, and philosophical interpretations. In the early

191. Ibid.
192. The centralization project as approved at San Francisco was never started, due to the illness of Dr. Gaston a short time following the Conference. During the next summer an extensive proposal for the establishment of a Central Office was outlined by Ruth Boxberger. This proposal (in the files of the Association) was approved at the Conference in Milwaukee in 1961. During 1961–62, selected duties from membership, public relations, certification-registration, and business procedures of the yearbook and Bulletin were integrated into one centralized function. Ruth Boxberger served as Coordinator, E. Thayer Gaston as Consultant, and Ann Branden as Clerk-Secretary.
twentieth century, scientific advances in medicine did not provide for a philosophy of treatment that utilized music; however, individual cases where music was used as a form of treatment were reported.

While the work of Eva Vescelius, Isa Maud Ilser, and Harriet Ayer Seymour created an interest in the therapeutic use of music, the theories which they promoted and the organizations they formed did not survive for any length of time. Although the use of music had not been neglected in mental hospitals and other institutions, it was primarily utilized in conjunction with other therapeutic modalities. The efforts of Willem Van de Wall and Ira M. Altshuler to establish music programs met with considerable success, but too often the lack of trained personnel discouraged the increase of hospital music programs even when administrators were interested in developing them.

With the advent of World War II a new phase of the use of music in medicine was initiated; its primary purpose was to strengthen the morale of the wounded servicemen. The music activities ran the gamut from music for entertainment, for instruction, for recreation, for reconditioning, to music prescribed for therapeutic purposes.

The post-war period saw an increase in the use of music in hospitals. The varied uses of music increased to such a degree that members of the medical staff who might otherwise have been favorably disposed to its use as a therapeutic medium relegated it to a leisure-time activity. Since there had been little or no research done on the value of music as a therapy, proponents of its use expressed the reasons for its efficacy in myriad ways. It was not unusual to hear Biblical quotations, mythological stories, or the number mysticism of early Greek philosophers cited as supporting evidence for its use.

Some efforts were made by the professional music organizations to develop more positive approaches to the field and to counteract unsubstantiated claims for its therapeutic value. As early as 1944, a degree program in music therapy had been instituted at Michigan State College. By the time of the formation of the Association at least five colleges or universities were offering degrees with majors in music therapy.

In 1947, the Committee on the Use of Music in Hospitals (appointed by the National Music Council) began to publish the Hospital Music Newsletter. During the period from 1948
through 1950, regional meetings of music therapists, hospital musicians, and other individuals active in the field were held in Massachusetts, Kansas, and Illinois. Plans for the formation of a national organization were discussed at some of these meetings, but no definite progress was made.

At the annual meeting of the Music Teachers National Association held in Cleveland in March, 1950, a sectional meeting was held to discuss the formation of an organization for music therapy. The assembled group elected Ray Green as chairman of an organizing committee with the power to appoint the other committee members. The meeting which resulted in the formation of the Association was held on June 2, 1950, the day following the annual meeting of the National Music Council.

The events of the first decade of the National Association for Music Therapy indicate two broad trends of development. The first has been the growth of the organizational structure, which has provided the Association with efficient administrative and business procedures. This structural growth of the organization developed to the stage where a central office was established. Other achievements were the formation of regional chapters with representatives elected to the Executive Committee of the Association. During the first decade the Association has published the annual yearbooks and the *Bulletin of NAMT*. Constitutional changes have been approved to provide for a smoother and more efficiently operating organization. NAMT was incorporated in 1955; this action increased its prestige and provided better financial protection for the officers. An insignia was adopted; later, this design was incorporated into an identifying arm band and into a pin to be worn by the Registered Music Therapists. There was a continuing effort to provide useful information about music therapy and the purposes of the organization. The Association has endeavored to maintain good professional relationships with other organizations by sending representatives to their meetings and fostering the exchange of ideas whenever possible.

The second major trend was the drive to increase the professional stature of the musicians working in the clinical setting. The movement for the creation of a more homogeneous group of qualified workers began with the establishment of the core curriculum in music therapy in 1952. In 1956, the Certification Committee was created to devise a plan for the certification or
registration of the music therapists. By the end of 1960, more than four hundred musicians working in the clinical setting had become registered. With the NASM serving as the accrediting agency, a list of schools and hospitals was developed for the education and training of music therapists. The stabilization of the educational and training requirements provided much of the foundation for the unofficial recognition of music therapy as one of the Allied Health Professions and Services of the AMA.

While this study was not designed to analyze the events of the first decade for the purpose of outlining recommendation for future developments, it would seem appropriate to include some considerations of the future of the Association. The events of the future will be based, in part, on the progress made during the past.

One of the primary needs of any organization is leadership. The Association must develop official leadership for the direction of the affairs of the organization, but more important, it must encourage leadership in the development of new insights and concepts of the use of music as therapy. The first type of leadership can be developed at the local and regional level, but the second type must be stimulated by the encouragement of practical and theoretical contributions to the field. The Association has available a number of avenues through which such leadership can be encouraged: first, by means of vital and stimulating programs at the annual conferences; second, by supporting significant research with research grants; and third, by making the proposed journal valuable to the members and interesting to related fields.

Productive research stimulates the professional growth of a field. The research funds that have been received by the Association should be used in such a way that additional funds may be forthcoming from other sources. The Association must strengthen its leadership for research by providing information about areas needing research in music therapy.

In the areas of education, clinical training, and certification standards the Association must keep abreast of the changing concepts in the treatment field. The educational and training requirements should be evaluated periodically to determine if they are valid in terms of the increased use of music with exceptional children, with the aged, as part of outpatient clinics, in psychiatric treatment centers, and in the psychiatric wards of the
NAMT History

general hospitals. Continued growth in the use of music as therapy would indicate that present requirements in education, clinical training, and certification will have to be extended to include training in areas other than the mental hospitals.

At the same time that the Association is furthering the development of professional growth of its members, it must work toward developing a closer relationship with other fields. This is especially true in the field of adjunctive therapies. Some sort of association in the adjunctive field could serve a very useful role as an advisory body to the adjunctive therapy programs at the hospital level. The Association may be favorably situated to take an increased initiative in forming some kind of adjunctive therapy association or council; it lacks the rigid action patterns often so characteristic of organizations with a long history of organization.

If these areas are successfully explored and productive actions are taken by the leadership, many of the problems related to membership will be decreased or will be solved. The Association will have to give more attention to the members who are not part of the active classification. Volunteers should have more guidance to fully utilize their potential worth as musicians in the hospital and as a link for the patients to life outside the hospital or institution.

In conclusion, it can be said that during the first decade the Association has developed primarily within two broad areas: a strong organizational structure and a foundation for professional growth. Future developments will build on these two areas, but the major growth should come in professional stature. This growth will depend upon sound leadership, knowledge based on research, a professional publication, expanded educational and training standards, closer cooperation with other therapies, and a greater utilization of the volunteer musician.
PART IX
REGIONAL SURVEY
MUSIC THERAPY IN THE SOUTHEASTERN UNITED STATES

DONALD E. MICHEL, PH.D.

This report is neither historical nor comprehensive, but only an attempt to present some kind of indication of recent developments in music therapy in the southeastern part of the United States. It is based on a limited survey, conducted as a class project by students majoring in music therapy at Florida State University in the spring of 1961. The survey utilized a postcard questionnaire which could be filled out easily by respondents and mailed back to the class. It was sent out to some 164 institutions selected from a standard list of institutions found in the nine states of the NAMT Southeastern Regional Organization (Kentucky, Tennessee, Louisiana, Mississippi, Alabama, Georgia, North and South Carolina, and Florida). Ninety-one replies (57%) were received from a single mailing; that is, with no follow-up.

The survey investigated four main areas: (1) the nature of music activities in the institution, if any, (2) the number of personnel involved in music activities, and their training, (3) the therapeutic implications or purposes of the music employed, if any, and (4) the plans, if any, for future use of music in therapy at the institution. Generally, the results of the survey showed that many institutions use music informally, such as providing radio, television, record-listening equipment, and musical entertainment, but that relatively few used music as a therapeutic medium in a more formal sense. The most frequently reported activity was that of choral groups of one kind or another, and following this in order of frequency were bands, individual instruction on instruments and in voice, and orchestras. Thirty-four percent of the institutions reporting in the survey described music as being medically prescribed, and most of these employed professional Registered Music Therapists.

Twenty-six percent of the institutions questioned indicated plans to expand their music program in the future and listed their

1. Categories used included: Psychiatric (short- and long-term), Tuberculosis (short- and long-term), Orthopedic (short- and long-term), Children's (short-term), General (long-term), Chronic, Convalescent and Rehabilitation, and Child-Care and Adoption.
main problems in doing so as lack of funds and a lack of professionally trained music therapists. At the least, this may be interpreted as a challenge to all of us in NAMT not only to encourage more students to choose a music therapy career but also to present the story of music therapy and its potential value to many more institutions than now are aware of it. No doubt this is a problem of national scope. Probably, the increase of trained persons goes hand in hand with encouragement of wider usage, for no field can be promoted without persons prepared to apply for openings when or before they exist!

More specifically, the results of the survey can be seen in the following tables.

**Table I—Types of Musical Activity Reported in 91 Southeastern Institutions**

<table>
<thead>
<tr>
<th>Type of Musical Activity Found</th>
<th>Number Reporting</th>
<th>Percent of Total Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>Orchestra</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>Chorus and Choirs</td>
<td>36</td>
<td>39</td>
</tr>
<tr>
<td>Individual instruction (all instruments, voice, etc.)</td>
<td>24</td>
<td>26</td>
</tr>
<tr>
<td>Record-listening (informal and organized)</td>
<td>81</td>
<td>88</td>
</tr>
<tr>
<td>Incidental—recreational radio and television</td>
<td>84</td>
<td>92</td>
</tr>
<tr>
<td>Incidental—live entertainment</td>
<td>78</td>
<td>85</td>
</tr>
</tbody>
</table>

**Table II—Other Types of Musical Activity Reported in 1 to 5 Southeastern Institutions**

<table>
<thead>
<tr>
<th>Type of Activity</th>
<th>Total Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rhythm band</td>
<td>5</td>
</tr>
<tr>
<td>Piped-in music (recorded)</td>
<td>5</td>
</tr>
<tr>
<td>Music appreciation</td>
<td>4</td>
</tr>
<tr>
<td>Folk dancing</td>
<td>4</td>
</tr>
<tr>
<td>Community singing</td>
<td>4</td>
</tr>
<tr>
<td>Music club</td>
<td>2</td>
</tr>
<tr>
<td>Classroom music</td>
<td>2</td>
</tr>
<tr>
<td>String band</td>
<td>2</td>
</tr>
<tr>
<td>Closed-circuit radio</td>
<td>2</td>
</tr>
<tr>
<td>Patient performances and musical shows</td>
<td>3</td>
</tr>
<tr>
<td>Composition, Jazz combos, Eurhythmics, Tap dancing, Ballet, Seasonal plays, Operettas, Dancing, Square dancing, Melody bells, Music theory class (each)</td>
<td>1</td>
</tr>
</tbody>
</table>
While it is obvious from these tables that considerable variety and scope of music activity was found, it was found in relatively few institutions surveyed by this study. Also obvious is the fact that mass media are utilized widely in most of the institutions reporting in the survey, and are considered a source of "music activity."

The survey disclosed that some 42 "trained" music persons were involved in the music activities reported, exclusive of the professional musicians and the amateurs who volunteered, either regularly or sporadically for music activity in the institutions. Somewhat more significant perhaps was the fact that only thirteen of these "trained" musicians were members of NAMT, eight of whom were Registered Music Therapists. These thirteen worked in only eight of the 91 institutions reporting.

Twenty-four of the 91 institutions reporting indicated plans for expanding their present music programs, some with an eye towards more therapeutic applications of music. Nineteen reporting institutions listed additional remarks, ranging from high praise of the program in operation to hopes for future development of a music therapy program.

The survey, completed in the spring of 1961, was quite limited in scope; yet it produced a fairly comprehensive picture of the conditions with regard to music and music therapy in southeastern institutions at that time. A new study is indicated, as a follow-up to the hopes and plans noted at that time. It would seem to be an important challenge not only to the academic institutions in the area offering music therapy training but also to the Southeastern Regional NAMT Organization to make such a follow-up study.

Today, one of the problems of the Southeastern Regional NAMT is like that of other regions. We are scattered over a wide geographic area and it is difficult for us all to spare the time, not to mention the money, required to travel to regional meetings, annually. We have turned reluctantly to a compromise plan of splitting our region into half and alternating annual "workshops" with biennial regional meetings. Perhaps there is some advantage to this in the possibility of encouraging greater development in the subregions, but we also run the risk of dividing our already limited strength.

Nevertheless, progress continues to be made. Since this report was first given, several new programs are known to have devel-
oped, such as the one at the Tuscaloosa, Alabama, Veterans Administration Hospital. In Louisiana and Mississippi in state hospitals and other institutions, such as training schools for the retarded, several thriving music therapy programs are to be found, and the stimulation of the music therapy program at Loyola University in New Orleans is evident. In Georgia, great strides forward in all phases of treatment including music therapy are being made at the Milledgeville State Hospital, one of the largest state hospitals in the country. In Florida, the state training institutions for the retarded continue to operate vital music therapy programs and there is hope for further development in other institutional areas. While Florida State University continues to “export” most of its music therapy graduates to other states like Indiana and Wisconsin, the music therapy program seems to have provided the same kind of stimulation in Florida and Georgia as Loyola University has in its area.

Many things are needed in the Southeast for the further development of music therapy. No doubt they are the same kind of things that are needed in other parts of the country. More scientific research—clinical and laboratory. A better image of the true value of music therapy and its many potential applications. More scholarships to encourage more students to enter music therapy training. More recognition of the good job already being done in many places by increased status, salaries, and expanded departments. Despite this, there is no doubt that music therapy is firmly established in many places in the Southeast, and perhaps what we need most of all is to remind ourselves occasionally of how far we have come—then to get hard at work again. Possibly we need some sort of “creed” to remind us of our purpose, our goals, and why we are committed to this field in these times. Toward this end, and in conclusion, I submit the following as a “Music Therapist’s Creed”:

I believe in Music Therapy because I believe in music as an effective, communicative, therapeutic tool, and as an important and necessary part of every man’s life. I believe in Music Therapy because I believe in therapy—that is, I believe that sick people can and should be helped. I believe in Music Therapy because I believe that the “essence of life” is in what contributions I can make to it, and that my chosen profession provides me with a unique and wonderful means for making such contributions.
APPENDIX
OFFICERS OF THE
NATIONAL ASSOCIATION FOR MUSIC THERAPY 1961–62

Elected Officers

President:
Robert F. Unkefer, Assistant Professor, Department of Music and Department of Psychology, Michigan State University, East Lansing, Michigan.

Immediate Past President:
Donald E. Michel, Ph.D., Associate Professor and Director of the Music Therapy Program, School of Music, Florida State University, Tallahassee, Florida; Past-President, South-eastern Regional Chapter, NAMT.

President-Elect:
Erwin H. Schneider, Ph.D., Professor of Music Education, School of Music, The Ohio State University, Columbus, Ohio; Past-President, Southeastern Regional Chapter, NAMT.

First Vice President and Program Chairman:
Allen Winold, Assistant to the Dean, School of Music, Indiana University, Bloomington, Indiana.

Second Vice President and Membership Chairman:
Betty Isem, Assistant Professor of Music Therapy and Music Education, College of the Pacific, Stockton, California.

Recording Secretary:
Vance Cotter, Department of Music Education, The University of Kansas, Lawrence, Kansas.

Treasurer:
Jack Griffin, Director, Music Therapy Program, Muscatatuck State School, Butlerville, Indiana

Appointed Officers

Editor:
Erwin H. Schneider, Ph.D. (See Elected Officers)

Editor of the Bulletin:
William W. Sears, Ph.D., School of Music, Indiana University, Bloomington, Indiana.
Archivist:
Carol I. Collins, Music Therapist and Supervisor of Clinical Affiliates, Kalamazoo State Hospital, Kalamazoo, Michigan.

Parliamentarian:
Ray Glover, Director of Psychiatric Music Therapy, Larned State Hospital, Larned, Kansas.

Central Office Coordinator:
Ruth Boxberger, Department of Music, Ohio University, Athens, Ohio.

Publisher:
Harold Allen, The Allen Press, Lawrence, Kansas.

ADVISORY COMMITTEE

Jesse F. Casey, M.D., Head, Division of Psychiatry, Veterans Administration, Washington, D.C.


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.
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 $14.00.

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.
Appendix

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.
Appendix

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
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

MUSIC THERAPY 1959

The book of proceedings of the Tenth Annual Conference of NAMT, held in East Lansing, Michigan, October 9–11, 1959, is available from The Allen Press, Box 4, Lawrence, Kansas, for $5.20 postpaid U.S.A.

Part I—Music in Mental Hospitals
Part II—Volunteer Services in Music Therapy
Part III—Music Therapy for Exceptional Children
Part IV—Music Therapy and Music Education
Part V—Music Therapy in Geriatrics
Part VI—Conference Reports
Part VII—Research in Music Therapy
Part VIII—Association Growth
MUSIC THERAPY 1960

The book of proceedings of the Eleventh Annual Conference of NAMT, held in San Francisco, California, October, 1960, is available from the Allen Press, Box 4, Lawrence, Kansas, for $5.20 postpaid U.S.A.

Part I—Current Viewpoints in Music Therapy
Part II—The Education and Function of the Music Therapist
Part III—Music Therapy in Psychiatric Hospitals
Part IV—Music Therapy as Individual Therapy
Part V—Music Therapy for Exceptional Children
Part VI—Research in Music Therapy
Part VII—Association Growth
Part VIII—Addendum: Music Therapy Bibliography
Part IX—Index of Preceding Volumes

MUSIC THERAPY 1961

The book of proceedings of the Twelfth Annual Conference of NAMT, held in Milwaukee, Wisconsin, October 18–21, 1961, is available from the Allen Press, Box 4, Lawrence, Kansas, for $5.20 postpaid, U.S.A.

Part I—Current Viewpoints in Music Therapy
Part II—The Music Therapy Profession
Part III—Music Therapy in Institutions
Part IV—Music Therapy with Specific Syndromes
Part V—Music Therapy with Exceptional Children
Part VI—Historical Bases for Music in Therapy
Part VII—Research in Music Therapy

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 15, 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 15, 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 15, 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.
CONSTITUTION AND BYLAWS OF THE
NATIONAL ASSOCIATION FOR MUSIC THERAPY
Revised, 1962

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, seven representatives elected from Regional organizations, and two Members-at-Large. The terms of the seven Regional Representatives and the two Members-at-Large shall be for three years; no Regional Representative or Member-at-Large may 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 mem-
bership, 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 and the Annual Book of Proceedings.

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 only the associate membership level.

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 fourteen dollars ($14.00), 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 and the Annual Book of Proceedings.

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 the President, President-Elect, 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
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 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 four candidates for the two Members-at-Large positions on the Executive Committee every three years when due. The two 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 October 1st to September 30th.

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.
INDEX

Action Songs, 115
Activities
  Music Therapy, 44, 81, 202
Aims, Music Therapy, 85
Ainlay, George W., 145
Altshuler, Ira M., 147
Alverno College, 152
American Red Cross, 145
Aphasia
  Definition, 103-104, 108
Aphasics
  Appreciation of Music, 103-104
  Case Reports, 104-106
  Production of Music, 103
  Singing Techniques, 109-111
  Song Choice, 109
  Song Presentation, 110-111
  Voice Range, 109
Audio-Analgesia, 7
Ayres, A. Jean, 116
Band, Rhythm, 78-79
Benedict, Lois, 174
Bibliotherapy, 25
Book of Proceedings, 166
Boston School Occupational Therapy, 152
Boxberger, Ruth, 133
Bradford, Gladys D., 145
Bronson, Howard C., 147
Bulletin, 166, 168
Burdick, W. P., 139
Carapetyan, Armen, 138
Carson, Rachel, 12
Cartwright, Dorwin, 50
Central Islip Hospital, 144
Cerebral Palsy, 78, 79
Chace, Marian, 63
Chicago Musical College, 152
Cleveland, S. E., 115, 117
Coleman, James C., 137, 143
College of the Pacific, 152
Combs, A. W., 11
Community and Mental Hospital, 23, 27-28, 63-64
Coordinated Treatment, 17
Cousins, Norman, 11
Creative Arts
Patient Dignity, 24
Critchley, M., 115
Crocker, Dorothy B., 176, 178, 179, 185
Dance Therapy
  Case Reports, 66-67
  Classes, 64-65
  Goals, 65-66
  Individual Sessions, 67
Davidson, Henry A., 23
Day-Care Clinics, 63-64
Delta Omicron, 146
Densmore, Frances, 135
Dierks, Freida, 164, 169, 171, 177
Discipline, Music Therapist, 89, 90
Douglas-Longmore, Gladys, 122
Dreikurs, Rudolf, 50
Eastern Conference on Functional Music, 154
Effects of Music
  Neurological, 6-7
Eichenberger, John F., 50
Eustis, Edwina, 122, 149, 166, 169, 171
Exploitation, Patients, 25
Federal Music Project, 142
Fisher, John H., 84
Fisher, Saul H., 82
Fisher, Seymour, 115, 117
Folkway, Musical Taste, 15
Fowler, William A., 12
Fultz, Arthur F., 50, 154, 176, 180
Functional Music, 76
Garma, H., 115
Gatewood, Esther, 140
German Transcendentalism, 14
Gilliland, Esther G., 122, 149, 150, 164, 166, 168, 171
Goodglass, Harold, 101
Green, Ray, 153, 157, 163
Greenblatt, Milton, 6
Group Dynamics, 96
Hamilton, Samuel W., 151
Hanson, Howard, 151

233
Index

Relationships, Staff, 32, 38
Roles, 43, 58-59
Consultant, 44, 48-49
Group Leader, 44, 48-49
Teacher, 83
Therapist, 44-46
Status, 32
Teacher, 83
Traits, 122, 126-128
Music Therapy
Action Songs, 115
Activities, 44
Recreational, 81
Southeastern U.S., 202
Aphasics, 106-107
Cerebral Palsy, 78, 79
Definition, 25, 87
Effects, Measurement, 31
History
Alverno College, 152
American Red Cross, 145
Boston School, Occupational Therapy, 152
Central Islip Hospital, 144
Chicago Musical College, 152
College of the Pacific, 152
Conference, Hospital Musicians, 154-155
Delta Omicron, 146
Eastern Conference, Functional Music, 154
Federal Music Project, 142
Hospital Music Newsletter, 153
Hospitalized Veterans Music Service, 146
Michigan State College, 152
Mu Phi Epsilon, 146
Music Educators National Conference, 149-150
Music Research Foundation, 146
Music Teachers National Association, 147-149, 153-157
Musician's Emergency Fund, 146
National Association, Music in Hospitals, 141
National Federation, Music Clubs, 145
National Foundation for Music Therapy, 141
National Music Council, 150, 154, 157, 158
National Therapeutic Society, 140
Newsletter, 153
North Central Conference, 156
Sigma Alpha Iota, 146
Twentieth Century, 139-143
University of Kansas, 152
Veterans Administration Hospitals, 151, 156
World War II, 143, 145
Hospital Organization, 28-29
Individual, 90
Mentally Retarded, 76-78
Occupational Therapy, 25, 29, 32, 43
Patients
Group Contagion, 54
Group Standards, 55
Group Unity, 51
Musicians, 57
Programs, 91
Practice, Multiplicity, 14
Primitive Times, 133
Profession, 9
Recreation Therapy, 25, 29, 32, 43
Research Needs, 31
Rhythm Band, 78-79
Rhythmic Approach, 80
Role, 29-30
Sessions
Character of, 86-87
Exploratory, 89
Socialization, 26, 32
Theories, Multiplicity, 14
Values, 91-92
Volunteers, 5
Musicians Emergency Fund, 146
National Association for Music Therapy: History
Book of Proceedings, 166
Bulletin, 166, 168
Central Office, 191
Certification, 180-181, 182-184
Constitution, 160, 167-168, 219
Development, Professional Worker, 179-182
Education Committee, 181-182
Eighth Annual Conference, 182-184
Eleventh Annual Conference, 188-193
Fifth Annual Conference, 176-177
First Annual Conference, 161-162
Fourth Annual Conference, 170-171
Great Lakes Chapter, 175
Growth and Stability, 170-172
Honorary Life Membership, 187-188
Incorporation, 177
Insignia, 169
Interdisciplinary Study Group, 188-187
Mid-Atlantic Chapter, 172-173
Musicians Emergency Fund, 171
National Association, Schools of Music, 169, 183
New England Chapter, 174
Ninth Annual Conference, 184-186
Northwest Chapter, 175
Organization, 158-161
Organizational Meeting, 134
Phi Mu Alpha, 190-191
Publications, Beginnings, 166
Regional Organization, 172-176
Registration, Therapists, 182-183
Research, 190-191
Second Annual Conference, 163-166
Seventh Annual Conference, 179-182
Sixth Annual Conference, 177-179
Southeastern Chapter, 174-175
Southern California Chapter, 174
Survey, 178-179
Tenth Annual Conference, 186-188
Third Annual Meeting, 187-170
Topeka Chapter, 173
National Association, Music in Hospitals, 141
National Federation of Music Clubs, 145
National Foundation for Music Therapy, 141
National Music Council, 150, 153, 157, 158
National Therapeutic Society, 140
Occupational Therapy, 25, 29, 32, 48
Orff, Carl, 74
Outpatient Music Therapy, 82
Paperte, Frances, 146
Patient Behavior, Staff Conflict, 34
Deterioration, 26
Dignity, 23
Group Meetings, 19
Initiative, 24
Programs, 50, 52, 55, 58, 91
Self Respect, 23
Transference, 84
Peter, Darrell, 108
Phi Mu Alpha, 190-191
Polanyi, Michael, 15
Professional Music Therapy, 9
Psychotherapies, 14
Qualifications, Music Therapist, 122-123, 126-128
Radin, Paul, 135
Rapport, Patient, 75-76
Recreational Therapy, 18-19, 25, 29, 32, 43
Rehabilitation Therapies, 49
Research Needs, Music Therapy, 31, 190-191
Response to Music, 31
Rhythm Band, 78-79
Elemental Force, 71
Response, Mentally Retarded, 76-78
Socializing Force, 78
Therapeutic Agent, 71-75
Richman, Sol, 20
Roe, Anne, 15
Roles, Music Therapist, 43, 58-59
Consultant, 4, 48-49