THE EVOLUTION OF MUSIC THERAPY AND ITS PARALLELS TO THE PUBLISHED ARTICLES OF DONALD E. MICHEL

A THESIS

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To the Associate Vice President for Research and Dean of the Graduate School:

I am submitting herewith a thesis written by Teri K. Holmberg entitled "The Evolution of Music Therapy and its Parallels to the Published Articles of Donald E. Michel." I have examined this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Arts, with a major in Music Therapy.

Nancy A. Hadsell
Dr. Nancy A. Hadsell, Major Professor

We have read this thesis
and recommend its acceptance:

Dr. D. Cohen

Richard Talaska

Accepted
Leslie M Thompson
Associate Vice President for Research
and Dean of the Graduate School

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ABSTRACT

AN HISTORICAL STUDY OF THE PUBLISHED ARTICLES OF

DONALD E. MICHEL

Teri K. Holmberg August, 1996

The purposes of this study were: (1) to provide an analysis of the published articles of Donald E. Michel written between 1951 and 1995 and (2) to provide a comparison of observed trends in his writings with those in the music therapy profession. Several published content analyses of journals were examined and used as models for the analysis in this study. Previous historical studies, surveys, newsletters, and relevant articles were examined to determine trends in music therapy. Results were compared to observed trends in Michel's research; parallels and differences were detailed. Results of the analysis indicated that Michel's articles were primarily descriptive in nature and covered a wide variety of topics. Results of the comparison indicated that Michel's research frequently foreshadowed trends in the profession. The researcher concluded that Michel's research revealed him as both a leader and a visionary in the field.

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CHAPTER I

INTRODUCTION AND RELATED LITERATURE

The career of Donald E. Michel has been a long and varied one, involving numerous contributions to the development of the field of music therapy. Having begun his work in music therapy in 1946 at the Topeka Veteran's Administration Hospital with no previous formal academic music therapy training,[1] he went on to establish the music therapy program at Topeka, to develop and head the music therapy department at Florida State University, to serve as president of NAMT, and to further the music therapy program at Texas Woman's University. His published works include over ninety research articles and books, and he continues to contribute to music therapy research, often collaborating with colleagues both in and outside the music therapy field. Despite the wealth of knowledge to be gained by examining his career, very little has been written about him. In 1983, Jim Rowan at the University of Kansas interviewed Dr. Michel about his part in the history of the development of music therapy in the Topeka area from 1946-1954.[2] In her 1991 Master's thesis, Nora Jean

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[1]Donald E. Michel, Interview by Dr. Bill Davis and read by Dr. Kris Chesky, Spring 1993, video recording, Colorado State University, Fort Collins.

Goodreau also interviewed him about his involvement in the music therapy program at Texas Woman's University,[3] and in the same year, Barbara Bastable interviewed him for an oral history of his presidency of NAMT.[4] Finally, in 1993, Dr. Bill Davis at Colorado State University conducted an interview with Dr. Michel in which he asked about Dr. Michel's beginnings in the profession, descriptions of important points or transitions in his career, his memories of the formation of NAMT, his recollections of colleagues, and his present impressions of and recommendations for the direction of the music therapy profession.[5] Although very limited attempts have been made by these few persons to examine some of the contributions of Dr. Michel to the profession, nothing has been written about his research or published works, of which there are a great many. This is one area of his career that is sorely in need of examination. Solomon and Heller support the importance of investigating individual contributions in music therapy, stating:

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[2]Donald E. Michel, Interview by Jim Rowan, January 1983, tape recording, University of Kansas, Lawrence.

[3]Nora Jean Goodreau, "The History of the Texas Woman's University Music Therapy Program from 1957-1977" (Master's thesis, Texas Woman's University, 1991), 71-77.

[4]Donald E. Michel, Interview by Barbara Bastable, 1991, tape recording, Texas Woman's University, Denton.

[5]Donald E. Michel, Interview by Dr. Bill Davis and read by Dr. Kris Chesky, Spring 1993, video recording, Colorado State University, Fort Collins.

> Many early leaders of NAMT and others connected with the profession's development are not well known to the vast majority of practicing therapists. Any body of professional literature which ignores the human element is not only missing important information, but is askew for not taking personal human factors into account. Reading accounts of personal careers can be inspirational and educational for both the novice and the veteran in the field.[6]

However, they add that historical research must have relevance for current practitioners in the music therapy field, and argue:

> Historical research in music therapy must treat questions that concern contemporary practitioners. Some kind of connection or relationship must exist between the study of the past and the practice of the present. A study of the past must reveal some understanding about clients, therapists, students, methods, materials, equipment, facilities, evaluation, administration, and the like. Similarities between past and present practices, purposes, goals, and objectives must not only exist, but must also be described.[7]

Jellison provided justification for historical research by the following statement:

> It is through history that researchers can learn to specify problems, reevaluate evidence, and choose alternatives. The music therapy profession is young but as it matures and creates its own "past," accurate historical documentation may increase to analyze the past in order to interpret the future.[8]

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[6]A. L. Solomon and G. N. Heller, "Historical Research in Music Therapy: An Important Avenue for Studying the Profession," Journal of Music Therapy 19 (Fall 1982): 168.

[7]Ibid., 17.

[8]Judith A. Jellison, "The Frequency and General Mode of Inquiry of Research in Music Therapy, 1952 - 1972," Council of Research in Music Education 35 (1973): 7.

Gfeller defended the examination of bodies of research in general, claiming that "it offers insight into past trends within the profession as well as recommendations for future research efforts."[9]

An examination of Michel's published articles would both provide insight into his personal career and supply current practitioners with relevant connections between past and present music therapy methods, problems, and discoveries. Additional goals might also be accomplished. The study of his writings in relationship to events taking place and trends or changes in the music therapy profession may lend insight into the following question: to what extent are Michel's writings a reflection of professional music therapy, and to what extent is professional music therapy (at the time a particular article was written) a reflection of Michel's writings? In other words, what parallels may be observed between the scope of his published articles and the evolution of music therapy? The answer to this question, if one is attainable, may provide all music therapists with some insight as to how they influence, shape, and are shaped by their profession.

The Purpose of the Study

The purpose of this study is to examine, using both descriptive and historical research methods, (1) Michel's published journal articles, which

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[9]Kate Gfeller, "Music Therapy Theory and Practice as Reflected in Research Literature," Journal of Music Therapy 24 (1987): 193.

address any aspect of music therapy practice or the profession itself and (2) to determine from this examination what parallels might exist between his writings and the development of music therapy. The examination begins with the publication of his Master's thesis in Music Therapy in 1951 and continues with journal articles written up to and including 1995.

The specific descriptive research questions are:

1. About what has he written?
2. Might his articles be categorized into "periods" or some other type of grouping?
3. If so, how should the "periods" or groupings be labeled, and which articles fit into each group?

The specific historical research questions are:

1. What significant events, trends, or changes in music therapy were taking place during the time a particular article was published?
2. How might his writings reflect these factors?
3. How might these factors reflect his writings?

CHAPTER II

METHOD

The method of this study was a combination of descriptive and historical research. The descriptive research provided a content analysis of Michel's published articles from 1951 to 1995 and a discussion of observed trends in his writing. Historical elements of this study included: (1) an analysis of trends in professional development, practice, and research in music therapy from 1950 to 1995 and (2) a comparison of the observed trends between the music therapy profession and Michel's articles, with an emphasis on determining to what extent the trends in one reflect or are reflected by trends in the other. An examination of this relationship was discussed.

Previous content analyses of music therapy journals from the Journal of Music Therapy and Music Therapy Perspectives were examined to provide a model for the content analysis in this study.[10] All of Michel's published articles

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[10]Judith A. Jellison, "The Frequency and General Mode of Inquiry of Research in Music Therapy, 1952 - 1972," Council of Research in Music Education 35 (1973); Janet Perkins Gilbert, "Published Research in Music Therapy, 1973 - 1978: Content, Focus, and Implications for Future Research," Journal of Music Therapy 16 (1979); Mark R. James, "Sources of Articles Published in the Journal of Music Therapy: The First Twenty Years, 1964-1983," Journal of Music Therapy 22 (1985): 87; Peggy A. Codding, "A Content Analysis

written within the time frame of this study were also reviewed. Included in the examination were collaborative writings, articles pertaining to all aspects of music therapy practice, development, and professional issues, and all methods of research. Excluded from review were books, chapters in edited books, grant reports, book reviews, speeches, or any other unpublished writings.

Previous historical studies of the profession and the National Association for Music Therapy (NAMT) by Boxberger, Shreve, and Solomon[11] were examined to determine trends in professional development. Events reported in NAMT Notes from 1985 to 1995 were also reviewed in order to complete the analysis. Other published articles which indicated the direction of the profession were examined as well.

Results of previous content analyses of music therapy research were examined in order to develop a comprehensive summary of trends in research

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of the Journal of Music Therapy, 1977 - 1985," Journal of Music Therapy 24 (1987); Anthony Decuir, "Readings for Music Therapy Students: An Analysis of Clinical and Research Literature from the Journal of Music Therapy," in Perspectives on Music Therapy Education and Training, eds. Cheryl D. Maranto and K. E. Bruscia (Philadelphia: Temple University, 1987); Barbara L. Wheeler, "An Analysis of Literature from Selected Music Therapy Journals," Music Therapy Perspectives (1988): 96.

[11]Ruth Boxberger, "A Historical Study of the National Association for Music Therapy," Music Therapy (1962); Helen Simmons Shreve, "Music Therapy: An Historical Overview to 1976" (Master's thesis, Boston University, 1977); Alan L. Solomon, "An Historical Study of the National Association for Music Therapy, 1960 - 1980" (Ph.D. diss., The University of Kansas, 1985).

within the profession. Solomon's study on the history of the Journal of Music Therapy[12] was also reviewed for contributions to this summary. In order to complete the picture, the current author conducted a survey of articles published in the Journal of Music Therapy and Music Therapy Perspectives from 1988 to 1995, using elements of some of the content analyses examined in this paper as a model.

Several studies which discussed various aspects of music therapy practice were examined to determine trends in this area. In addition, a variety of articles that described clinical practices were studied to determine trends in practice. Finally, articles which detailed specific therapeutic approaches were reviewed for their contributions to music therapy practice.

Observed trends in professional development, research, and practice were compared to observed trends in Michel's research. Observations were discussed, as with all other discussion of trends in this study, in the context of approximate ten-year periods: (1) 1950- 1959, (2) 1960-1974, (3) 1975-1984, and (4) 1985-1995. Conclusions about the relationship between Michel's writings and the profession were proposed.

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[12]Alan L. Solomon, "A History of the Journal of Music Therapy: The First Decade (1964 - 1973)," Journal of Music Therapy 30 (Summer, 1993).

CHAPTER III

ANALYSIS OF MICHEL'S PUBLISHED ARTICLES

This chapter provides an analysis of Michel's published research articles based on the methods used by Jellison, Gilbert, Codding, Decuir, and Wheeler[13] in similar studies. Articles in this study were examined for the following information:

A. Total number of articles.

B. "Type" of articles written, i.e. research, position paper or clinical,[14] and number of each.

Gilbert defined the aforementioned "types" of articles as the following:

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[13]Judith A. Jellison, "The Frequency and General Mode of Inquiry of Research in Music Therapy, 1952 - 1972," Council of Research in Music Education 35 (1973); Janet Perkins Gilbert, "Published Research in Music Therapy, 1973 - 1978: Content, Focus, and Implications for Future Research," Journal of Music Therapy 16 (1979); Peggy A. Codding, "A Content Analysis of the Journal of Music Therapy, 1977 - 1985," Journal of Music Therapy 24 (1987); Anthony Decuir, "Readings for Music Therapy Students: An Analysis of Clinical and Research Literature from the Journal of Music Therapy," in Perspectives on Music Therapy Education and Training, eds. Cheryl D. Maranto and K. E. Bruscia (Philadelphia: Temple University, 1987); Barbara L. Wheeler, "An Analysis of Literature from Selected Music Therapy Journals," Music Therapy Perspectives (1988): 96.

[14]Gilbert, 104.

1. Research. Articles characterized by: a) objectivity, b) a structured mode of action, and c) evaluation for future action.
2. Position paper. General presentations or opinions delineating current needs of the profession.
3. Clinical. Prescriptions of current clinical programs in terms of techniques and activities rather than in terms of systematic, objective program analysis or data collection.[15]

C. Mode of inquiry used, i.e. philosophical, historical, descriptive, or experimental, and number of each.

Jellison provided the following description of the modes of inquiry:

1. Philosophical: articles of a nature dealing with analysis, criticism, and/or speculation of ideas or theories in relation to music therapy.
2. Historical: articles of a nature relating information from the past.
3. Descriptive: articles of a nature relating the current status of music therapy through surveys, case studies, and comparative or correlation studies of individuals, groups, events, and stimuli: articles descriptive of the growth of the profession, programs, activities, groups or individuals; articles analyzing developments in relation to specific attributes and possible future growth.
4. Experimental: articles of a nature relating to the manipulation of a variable through definition or structure of an experimental design.[16]

D. Research setting, i.e. clinical, university, or other,[17] and number of each.

Codding defined the preceding research setting classifications as follows:

1. Clinical: studies and articles pertaining to settings traditional to music therapy application including educational, rehabilitative, and health facilities, and clients receiving related services. Public school settings, when observed, were considered clinical settings.

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[15]Ibid.

[16]Jellison, 3.

[17]Codding, 197- 98.

2. University. Studies and articles whose focus is the university setting and whose clientele comprise traditional graduate and/or undergraduate students.
3. Other. Studies and articles whose focus or subject population meets criteria other than those cited in the clinical and university definitions.[18]

E. Population focus or topic of each articles and number of each.

The following population focus or topic categories developed by Decuir were used in this analysis:

1. Special Education and Childhood Exceptionality
2. Speech and Communication Disorders
3. Adult Psychiatric
4. Psychology of Music/Influence of Music on Behavior
5. Group Psychotherapy
6. About Music Therapy
7. Behavioral Approaches
8. Music Therapy in the General Hospital
9. Education and Training of Music Therapists
10. Evaluation in Music Therapy.[19]

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[18]Ibid.

[19]Decuir, 58.

One category developed by Wheeler, "Offender," was also used in this study.[20] An additional category was included by the author; articles were also examined for possible classification in the category of "Theoretical Applications and Music Therapy." Articles which discussed the use of music therapy based upon a specific therapeutic approach were placed in this category.

Results

Forty-three articles met the criteria for this study. This section classifies these articles according to topic or population focus. Within each classification, the following information for each article is provided: (1) subject/dependent variable, (2) article "type" (Research (R), Position Paper (PP), or Clinical (C)), (3) mode of inquiry used (Experimental (E), Discriptive (D), Philosophical (P), or Historical (H)), (4) setting (Clinical (C), University (U), or Other (O)), (5) year published, and (6) name of publication in which the article appeared. Subjects/dependent variables with an asterisk (*) indicates their appearance in more than one category. Also included is an analysis of the number and percentage of articles within the categories of: (1) article "type," (2) mode of inquiry, and (3) setting.

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[20]Barbara L. Wheeler, "An Analysis of Literature from Selected Music Therapy Journals," Music Therapy Perspectives (1988): 96.

Table 1. -- Special Education and Childhood Exceptionality

Subject/Dependent Variable	Type	Mode of Inquiry	Setting	Year	Publication
*Self-Esteem/ Attentiveness	R	E	C	1970	Journal of Music Therapy; Journal of Research in Music Education
*Disadvantaged Children/Learning	R	D	C	1971	Books of Proceedings, Music Therapy
Remedial Reading	R	E	C	1981 1982	College Division Research Reports; Journal of Music Therapy
*Handicapped Children in Public Schools	R	D	C	1984	College Division Research Reports
*Role of Music Therapy in Special Education	PP	D	O	1977	Musicoterapi Nytt

Table 2. -- Speech and Communication Disorders

Subject/Dependent Variable	Type	Mode of Inquiry	Setting	Year	Publication
Cleft Palate Disorders	C	D	C	1960	Books of Proceedings, Music Therapy
Cleft Palate Disorders	C	D	C	1961	Books of Proceedings, Music Therapy
*Speech and Language Disorders	R	D	C	1974	Journal of Music Therapy

Subject/Dependent Variable	Type	Mode of Inquiry	Setting	Year	Publication
Procedures in Speech and Hearing Problems	R	D	C	1974	Yugoslavian Association of Music Therapy

Table 3. -- Adult Psychiatric

Subject/Dependent Variable	Type	Mode of Inquiry	Setting	Year	Publication
*Patient Case Records	C	D	C	1952	Books of Proceedings, Music Therapy; Journal of Research in Music Education
Case Study	C	D	C	1953	Books of Proceedings, Music Therapy
*Group Therapy	C	D	C	1954	Books of Proceedings, Music Therapy
Survey of Cases	C	D	C	1958	Books of Proceedings, Music Therapy
Survey of Cases	C	D	C	1959	Books of Proceedings, Music Therapy
*Sedative Effects of Music on Acutely Disturbed	R	D	C	1951	Books of Proceedings, Music Therapy

Table 4. -- Psychology of Music/Influence of Music on Behavior

Subject/Dependent Variable	Type	Mode of Inquiry	Setting	Year	Publication
*Sedative Effects on Mental Patients	R	D	C	1951	Books of Proceedings, Music Therapy

Subject/Dependent Variable	Type	Mode of Inquiry	Setting	Year	Publication
Self-esteem	R	D	C	1969	Newsletter of the Florida Division of Mental Health
*Defensive Breathing / Relocation for Children with Asthma	R	E	C	1983	College Division Research Reports
*Stress	R	D	C	1983	Congres Mondial de Musictherapy

Table 5. -- Group Psychotherapy

Subject/Dependent Variable	Type	Mode of Inquiry	Setting	Year	Publication
*Applications/Methods	C	D	C	1954	Books of Proceedings, Music Therapy

Table 6. -- About Music Therapy

Subject/Dependent Variable	Type	Mode of Inquiry	Setting	Year	Publication
Contemporary Research in Progress	R	D	C	1953	Books of Proceedings, Music Therapy
Satisfaction in Music Therapy	PP	P	O	1954	Books of Proceedings, Music Therapy
Research Related to Music Therapy	R	D	O	1955	Books of Proceedings, Music Therapy
Professional Growth	PP	P	O	1956	Books of Proceedings, Music Therapy
Directing a Music Therapy Dept.	PP	D	U	1956	Bulletin of NAMT

Subject/Dependent Variable	Type	Mode of Inquiry	Setting	Year	Publication
Practices in Music Therapy	C	D	C	1957	Books of Proceedings, Music Therapy
Professional Development	PP	D	O	1958	Bulletin of NAMT
Professional Development	PP	D	O	1960	Books of Proceedings, Music Therapy
Professional Development	PP	D	O	1961	Books of Proceedings, Music Therapy
Music Therapy in the Southeastern U.S.	R	D	C	1962	Books of Proceedings, Music Therapy
Clinical Practice	R	D	C	1965	Journal of Music Therapy
International Music Therapy	R	D	O	1971	Journal of Music Therapy
Career Description	PP	D	O	1977	American Music Teacher
Music Therapist Role Changes	R	H	O	1982	College Division Research Reports
International Music Therapy	R	D	O	1990	Music Therapy Perspectives
Research Methods	PP	D	O	1976	Soundingboard
Professional Development	PP	D	O	1978	Soundingboard
Frank E. Knight - Tribute	R	D	O	1983	Music Therapy Perspectives

Table 7. -- Education and Training

Subject/Dependent Variable	Type	Mode of Inquiry	Setting	Year	Publication
Education and Training in U. S.	R	D	U	1971	Stitchting voor Muziektherapie-Nederlands, Journal of Research in Music Education
Research in Undergraduate Education	R	D	U	1969	Journal of Music Therapy
Curriculum Standards	PP	D	U	1959	Books of Proceedings, Music Therapy
Guidance into Training	PP	D	U	1956	Books of Proceedings, Music Therapy

Table 8. -- Offenders

Subject/Dependent Variable	Type	Mode of Inquiry	Setting	Year	Publication
Music Therapy in a Correctional Institution	R	D	C	1957	Books of Proceedings, Music Therapy

Table 9. -- Behavioral Approaches

Subject/Dependent Variable	Type	Mode of Inquiry	Setting	Year	Publication
*Increased attentiveness/Self-Esteem	R	E	C	1970	Journal of Music Therapy; Journal of Research in Music Education

Subject/Dependent Variable	Type	Mode of Inquiry	Setting	Year	Publication
*Disadvantaged Children/Learning	R	D	C	1971	Books of Proceedings, Music Therapy
*Speech and Language Disorders	R	D	C	1974	Journal of Music Therapy
*Defensive Breathing/Relaxation for Children with Asthma	R	E	C	1983	College Division Research Reports
*Role of Music Therapy in Special Education	PP	D	O	1977	Musicoterapi Nytt

Table 10. -- Evaluation in Music Therapy

Subject/Dependent Variable	Type	Mode of Inquiry	Setting	Year	Publication
*Patient Case Records	C	D	C	1952	Books of Proceedings, Music Therapy
*Stress	R	D	C	1983	Congres Mondial de Musictherapy
*Handicapped Children in Public Schools	R	D	C	1984	College Division Research Reports
*Developmental Skills Model	R	P	C	1985	Australian Music Therapy Association

Table 11. -- Music Therapy in the General Hospital

Subject/Dependent Variable	Type	Mode of Inquiry	Setting	Year	Publication
*Defensive Breathing/Relaxation for Children w/Asthma	R	E	C	1983	College Division Research Reports
*Music Vibration Table™ and Pain Relief	R	E	C	1991	Music Therapy Perspectives

Table 12. -- Theoretical Applications and Music Therapy

Subject/Dependent Variable	Type	Mode of Inquiry	Setting	Year	Publication
*Developmental Skills Model	R	P	C	1985	Australian Music Therapy Association

Table 13. -- Number and Percentage of Article Type

Type	Number	Percentage
Research	25	58%
Position Paper	12	28%
Clinical	6	14%
Total	43	

Table 14. -- Number and Percentage of Mode of Inquiry

Mode	Number	Percentage
Descriptive	33	77%
Philosophical	5	12%
Experimental	4	9%
Historical	1	2%
Total	43	

Table 15. -- Number and Percentage of Article Setting

Type	Number	Percentage
Clinical	25	58%
Other	13	30%
University	5	12%
Total	43	

Analysis of Michel's published articles indicated coverage of a wide variety of topics, populations, and settings. It also revealed a fairly even distribution of articles among the topic or population focus categories, with the exception of the "About Music Therapy" category (Table 6). This category yielded 18 articles; the next more frequently addressed category was "Adult Psychiatric," with six articles (Table 3). A wide range of subject foci existed within the "About Music Therapy" category. Subjects ranged from individual practitioners to all

practitioners within the National Association for Music Therapy (NAMT), and from regional practices to international practices. Half of the articles written in this category were "Position Papers," most of which were published in the Books of Proceedings, Music Therapy, prior to 1962.

All other categories addressed by Michel yielded five or fewer articles. "Special Education and Childhood Exceptionality" (Table 1) and "Behavioral Approaches" (Table 9) each contained five articles. Three of the special education articles were also listed in the behavioral category. The categories of "Speech and Communication"(Table 2), "Psychology of Music/Influence of Music on Behavior" (Table 4), "Education and Training" (Table 7), and "Evaluation in Music Therapy" (Table 10) each had four articles. Two articles appeared in the "Music Therapy in the General Hospital" category (Table 11), while "Group Psychotherapy" (Table 5), "Offenders" (Table 8), and "Theoretical Applications and Music Therapy" (Table 12) contained one article each.

A majority of articles (58%) were classified as "research" with regard to article type (Table 13). Likewise, most articles (77%) also used a descriptive mode of inquiry (Table 14). Only four articles (9%) reported statistical data. The most frequently addressed setting was "clinical," accounting for 58% of all articles (Table 15).

It appears from this analysis that the bulk of Michel's articles were

descriptive in nature, often dealing with subjects relating to various areas of clinical practice. He also seemed intent upon describing every aspect of the profession itself, as evidenced by the variety of subject matter in the "About Music Therapy" category. In particular, he frequently focused his writings upon the status, needs, or possible directions of the music therapy profession. However, his focus did not remain entirely on these endeavors; the representation of many other topics within his research indicates his interest in and knowledge of the far-reaching possibilities of the profession.

CHAPTER IV

THE EVOLUTION OF MUSIC THERAPY AND ITS PARALLELS TO THE PUBLISHED ARTICLES OF DONALD E. MICHEL

Although it is commonly accepted that music has been used as a therapeutic agent for centuries, it is not until this century that the employment of music for healing purposes has become a profession: organized, systematic, with a set of recognized and agreed-upon premises, and a name -- music therapy. The emergence of music therapy as a recognized profession and the organization of its practitioners in the United States was largely due to the efforts of "hospital musicians" working in military hospitals during World War II and in post-war Veteran's Administration and state hospitals. Boxberger refers to this time as the period of "the emergence of the music therapy movement."[21] She states that the recognition by the military and doctors of music's effectiveness in improving morale, the support of music organizations and clubs for the therapeutic use of music in hospitals, and the growth of music in industry led to a greater acceptance of the work of hospital musicians and of the use of music as

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[21]Ruth Boxberger, "A Historical Study of the National Association For Music Therapy," Music Therapy (1962): 152.

a viable therapy.[22] Despite the increases in acceptance and employment, early music therapists recognized several areas of need that had to be addressed if the profession were to progress. Boxberger enumerated several of these needs, as stated by past NAMT President Roy Underwood, in her dissertation, "A Historical Study of the National Association for Music Therapy:" (1) respect from the medical profession, (2) strong leadership within the profession, (3) trained personnel to provide music therapy services, (4) organization to promote professional growth, communication to those outside the field, development of the use of music in therapy, standards in education and certification, exchange of information, and delineation of practice, and (5) development of a body of knowledge based on scientific research.[23] She provided a 1947 statement from Roy Underwood, a pioneer in the establishment of music therapy and NAMT, which "summarized the status of music therapy" stating:

> 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

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[22]Ibid.

[23]Ibid., 143-197 passim.

> 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 scientific procedures was needed in music in therapy.[24]

It was the recognition of these needs that led to the founding of the National Association for Music Therapy (NAMT) in 1950. Since then, music therapists have worked together for more than 45 years to insure the survival of the profession by striving to promote growth in professional development, advances in practice, and greater understanding through research. Each of these areas has experienced many changes during the course of this relatively young profession. Significant examples of their evolution will be examined in this chapter.

Professional Development

Over the course of the past four-and-a-half decades since the establishment of NAMT, music therapists have continued to pursue several primary goals for the advancement of their profession: first, to inform the public and other professionals about what they do; second, to define for themselves more clearly the parameters and requirements of music therapy and its

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[24]Roy Underwood, "Report of the Committee on Music in Therapy," Volume of Proceedings, MTNA, ed. Theodore M. Finney (Pittsburgh: Arthur Rippl, 1948), 319, quoted in R. Boxberger, "A Historical Study of the National Association For Music Therapy," Music Therapy (1962): 148-49.

practitioners; third, to ensure the survival of music therapy by the creation of ever-increasing opportunities for employment. Although these goals have not changed, their scope has expanded with each passing decade. Efforts to inform the public have progressed from the occasional descriptive account of the use of music therapy in hospitals, published in various professional medical and health care journals and popular magazines in the late 1940's -- early 1950's,[25] to coverage within a wide range of professions and in every area of the media in the 1990's. Early leaders of NAMT debated such questions as: "music in therapy" versus "music therapy" for the name of their profession, qualifications of professional music therapists and for membership in NAMT, and the training requirements for new music therapists.[26] Current practitioners discuss original theoretical approaches of music therapy and their application to a wide variety of settings. NAMT's efforts in the 1950's were focused on expanding music therapy from the hospital setting to the clinical setting as an adjunctive therapy.[27] The profession now strives to gain equal status as a therapy "in its own right" -- a therapy capable not only of providing healing for many different types of clientele, but also of providing effective preventative services. The original goals

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[25]Boxberger, 153.

[26]Boxberger, 160-65.

[27]Boxberger, 163.

for professional development have not changed as of yet -- only the focus of objectives has been altered as gains have been realized. The following sections will highlight these objectives for professional development in approximate 10-year periods.

1950 - 1959

By far the most significant event in the area of professional development for music therapy during this period was the establishment of NAMT in 1950. It may be said that the founding of this organization was the cornerstone of all subsequent advances in the profession. Dorothy Brin Crocker, when describing the early efforts of the members of NAMT, says:

> We have been laying foundations which we considered strong and solid. We have been building a sound national organization devoted to the progressive development of Music Therapy with the hope that we would ultimately attain professional status deserving of respect.[28]

Likewise, Boxberger describes the major accomplishments of NAMT in its first 10 years in existence as developing "a strong organizational structure and a foundation for professional growth."[29] The main focus for music therapy during this period was to establish and stabilize its new organization in order to advance

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[28]Dorothy Brin Crocker, "Significant Factors in the Advancement of Music Therapy," Music Therapy (1958): 15.

[29]Boxberger, 197.

the profession. They saw many areas of need that had to be addressed for advancement to occur, and many of these needs were resolved.

NAMT Accomplishments

Some major accomplishments in the area of professional development during the early years of NAMT were: (1) the decision (after much philosophical debate) to designate the profession as "music therapy" rather than "music in therapy", (2) the determination of eligibility for membership in NAMT, (3) the establishment of regional districts, (4) the publishing of the Book of Proceedings, Music Therapy, which reported the major papers presented at each NAMT conference, (5) the adoption of the insignia, used to identify members of NAMT, (6) the creation of a certification committee, which "established standards and procedures for the certification of Music Therapists, and instituted formal approval of training programs," (7) the adoption of a core curriculum for universities offering degrees in music therapy, (8) the designation of "Registered Music Therapist" for those persons who qualified, (9) the listing of approved colleges and universities which met the educational standards of NAMT, (10) the formation of an unofficial liaison with the American Medical Association (AMA), and (11) participation in the Interdisciplinary Study Group (ISG), which sought to increase unity and integration between adjunctive and activity therapies.[30]

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[30]Boxberger, 160-197 passim; Esther Goetz Gilliland, "Our First Decade," Music Therapy (1960): 173-75.

Areas of Need

Although the pioneer members of NAMT made great strides in the development of their profession, they noted several deficiencies that had to be met for music therapy to progress. Expanded training was deemed necessary in order to enable music therapists to work with clientele outside the hospital setting.[31] The need for a professional journal that was not only valuable to music therapists, but of interest to professionals in related fields, was also identified.[32] Regarded as the greatest deficiency of the profession during this period was the lack of and need for valid scientific research. In 1958, Crocker stated in The Book of Proceedings, Music Therapy, that "research is, and will always be, one of the most significant and certainly one of the most challenging goals in the advancement of Music Therapy."[33] Many thought at this time that the establishment of a solid base of empirical research would serve to advance the profession more than anything else. They believed it would give music therapists a greater understanding of their work and would garner the respect of other professionals, especially in the fields of medicine and psychiatry. The benefits of engaging in the particularly difficult task of scientifically measuring

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[31]Boxberger, 196-97.

[32]Ibid., 152.

[33]Crocker, 16.

such a subjective medium -- music -- would be to give "scientific validity to many techniques we have found to be effective, confirm or deny some of our suppositions, and eventually open the door to greater understanding concerning the influence of music on behavior."[34] Having established a solid organizational base, it was with plans for meeting the changing needs of a growing profession that NAMT graduated to its second decade.

1960 - 1974

Music therapy did indeed face a great many changes during this period, partly due to its own increased knowledge about itself, and partly as a result of the evolving society in which it functioned. In 1960, E. Thayer Gaston predicted some of the changes that would occur in that decade as the profession matured. Included in these predictions were: (1) greater rapport would be developed between music therapy and medicine, psychiatry, and other adjunctive therapies, (2) education, including graduate training, would become more solidified and strengthened, (3) a more uniform clinical experience would be established, (4) music therapists would make more money, have greater job stability, and be better known, and (5) research would become more stringent.[35] Some of these

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[34]Ibid.

[35]E. Thayer Gaston, "Our Second Decade," Music Therapy (1960): 178-79.

predictions were already becoming realized at the beginning of the decade. For example, in her address, "Our First Decade," Gilliland reported that thousands of the NAMT pamphlets, "Music Therapy as a Career" had been distributed, and she provided a long list of other organizations which had begun to schedule sessions on music therapy at their conferences.[36] Boxberger as well noted the changes that had already taken place in the profession by contrasting the programs of the early NAMT conferences with that of the eleventh conference held in 1960. In her comparison she noted ten specific examples of growth in the music therapy profession:

> 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

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[36]Gilliland, 175.

> 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.[37]

Legislation and Environmental Changes

However, as music therapists were rapidly increasing their knowledge about themselves, many of the environments in which they worked were changing just as quickly, requiring them to reevaluate their positions in those environments. Alan Solomon, in his dissertation, "A Historical Study of the NAMT, 1960 - 1980," attributes changes in music therapy practice to shifts in the political climate. He stated that, "increasingly, external activities, specifically federal legislation, were influencing the clinical practice of music therapy."[38] One of the most significant pieces of legislation to affect music therapy was the passage of Public Law 88-164: the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, which gave federal funds to

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[37]Boxberger, 189-90.

[38]Alan L. Solomon, "A Historical Study of the National Association for Music therapy, 1960-1980" (Ph.D. diss., The University of Kansas, 1985), 160.

states for construction of community mental health centers.[39] This law signaled the beginning of a dramatic shift in perception about persons in need of psychiatric treatment, how they should be treated and to what end, and where and for how long they should receive treatment.

General Changes in Attitudes

As the focus of treatment setting moved from large state hospitals to smaller community centers, the focus of treatment became more personal and individualized. Shreve characterized the change of focus by pointing out a general attitude shift as evidenced by the use of new terminology (e.g., "mental health center" replaced "psychiatric center," "counseling" was given instead of "psychotherapy," and "client" replaced "patient").[40] Therapists also began to examine the social environment when treating clients, as well as relevant biological and psychological factors, thus focusing treatment on the "whole" person. It became important to assist clients in adapting to their environments -- a much more functional view of treatment.[41]

General Changes in Mode of Treatment

Mode of treatment in the new community facilities reflected the shift to the

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[39]Helen Simmons Shreve, "Music Therapy: An Historical Overview to 1976" (Master's Thesis, Boston University, 1977), 185.

[40]Ibid., 174.

[41]Ibid., 186-87.

more functional goals of treatment. Due to the rapid growth of outpatient clinics, greater emphasis was placed on short-term goals and "behavior modification" in order to accommodate therapists' shorter duration of involvement with their clients. Family and group therapies also saw their advent during this period, as well as early intervention and preventive treatment.[42]

Implications for Music Therapy

The radical changes taking place in the facilities and treatment of persons with mental illness also had a profound effect on music therapy and its role in treatment. For a number of reasons, including the loss of psychiatrists to private practice, higher costs of treatment, and increased demands for treatment, other professionals, including music therapists, began to take on more responsibility for treatment.[43] As a result, music therapists were required to develop a wider base of knowledge, especially in sociology and psychotherapeutic theories. Because of the added accountability given to members of the "support therapies," their interaction with each other changed. Euper stated that "the "team" approach of yesterday has become the "interdisciplinary" approach of today.... This forces each staff member to lead groups and activities that are

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[42]Ibid., 184-86.

[43]Ibid., 175-80.

designed for psychotherapy."[44] Music therapy had begun its move away from an "adjunctive" service that depended primarily on psychiatrists to dictate needs and goals for clients to a therapy that was capable of assessing clients' needs, prescribing treatment, and supervising services. Loberg stated that music therapists had begun to be:

> ...scientifically accountable for their treatment. This new need for accountability will require music therapists to re-evaluate and strengthen their methods for choosing specific therapeutic techniques.[45]

Solomon summarized the implications of Public Law 88-164 for the role of music therapy within the new mental health setting:

> 1) a "wide variety of innovative approaches which are both stimulating and a bit threatening" were called for which placed "a higher level of responsibility" on music therapists and called for "resources which many music therapists have not developed"... (2) the need for "a triangulate sociological-psychological-cultural orientation for all mental health workers"...and (3) a change in the attitudes toward non-medical treatment personnel with the development of the interdisciplinary treatment team in which a sharing of knowledge and responsibility among staff members of different disciplines occurred. The emphasis on team approach created a "great blurring of traditionally defined roles" and required a "strong background in psychology and sociology" for music therapists.[46]

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[44]J. A. Euper, "Contemporary Trends in Mental Health Work," Journal of Music Therapy (Spring 1970): 20.

[45]David E. Loberg, "What Kind of Therapy," Journal of Music Therapy (Spring 1973): 18.

[46]Solomon, 170.

General Developments in Music Therapy

There are several accomplishments of note which took place in music therapy during its second and early third decades as an "organized" profession. One of the most significant was the initial publication of the Journal of Music Therapy in March, 1964, replacing The Books of Proceedings, Music Therapy and the Bulletin of NAMT. Solomon declared this "the single most important activity in which they [NAMT] had engaged since the founding of the Association," and that it "would do more to establish credibility and respect for music therapy than perhaps any other single endeavor in which the Association would engage."[47] Also important were the products of two grants received by the University of Kansas in 1964. One grant, titled, "An Analysis, Evaluation, and Selection of Clinical Uses of Music in Therapy," resulted in the publication of the first music therapy textbook, Music in Therapy.[48] The second grant, "Pilot Training and Evaluation Project," provided advanced training in clinical music therapy and research and trained scholars in music therapy.[49] Also established in 1966 was the NAMT Central Office in Lawrence, Kansas, where it would remain until 1982; Margaret Sears was appointed as coordinating secretary at

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[47]Ibid., 160; 234-35.

[48]Ibid., 234-35.

[49]Ibid., 235.

that time and later became executive director in 1974.[50] The formation of the Central Office was viewed as an indicator that NAMT had grown professionally to the point that it was a national contender among professional organizations. Solomon stated that "it [NAMT] was preparing itself to assume its position on the national scene."[51]

Summary

In the midst of a period in which ideas about therapy seemed to be in a constant state of change, music therapy hastened to adapt. Despite its uncertain role in the ever-evolving methods and environments for client treatment, the profession managed to not only endure, but to garner a more significant role for itself in the clinical setting. The next decade would see the music therapy profession adapting further in its theories, training, and methods to meet its increased responsibility.

1975 - 1984

The period between the mid-1970's and mid-1980's may be described as a time of increasing diversification and expansion for the music therapy profession. By 1975, music therapy was employed in a wider variety of settings than ever

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[50]Ibid., 286; 362.

[51]Ibid., 286.

before. Music therapists had the luxury of making choices about the type of setting and clientele with whom they wanted to work. There was more discussion within the profession about the need for specialization to serve specific populations more effectively. Priestly described the variety of settings from which music therapists could choose to work (e.g., state institutions, day centers, special schools, private practice, and community centers), as well as the client populations (e.g., "severely subnormal," physically handicapped, maladjusted and autistic children, psychiatric patients, and geriatric patients). She also supported the possibility for specialization by music therapists, arguing that it would better serve the needs of both the therapist and the client.[52] Because of the wide range of possibilities that were faced, prospective music therapists were encouraged to examine their own desires and/or needs when deciding upon a population with which to work. She also wrote that music therapists should understand their own needs in order to find the proper work setting.[53] In so doing, more effective treatment for the client and greater job satisfaction for the therapist were assured. Shreve summarized the state of the profession in 1976 by saying:

> The role and function of the music therapist appears to be in a

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[52]Mary Priestly, Music Therapy in Action (New York: St. Martin's Press, 1975), 40-45.

[53]Ibid., 45.

> continual state of flux. This is partly due to the emergence of community mental health centers. New demands are being placed on the therapist, and new techniques of therapy called for. Therapists need to have a clearer understanding of their own needs and strengths so as to be as effective as possible. The sudden responsibility of the music therapist for the clients' total therapeutic process calls for more strictly supervised clinical training and educational changes. The need for high level musical ability and performance is now being questioned. The trend in music therapy seems to center more around psychotherapeutic and social rehabilitation techniques than musical preparation. Perhaps the music therapist of the future will not be a musician at all.[54]

In reference to the last statement made by Shreve, a battle continued during the '60's and '70's concerning the level of importance of music and musical skill in therapy; an issue that will be further discussed in the "Practice" section of this chapter. In addition to the diversification of music therapy, its sphere of influence in treatment continued to expand. The increased responsibility placed upon music and other support therapists as the result of the shift to short-term, out-patient, and community based care only continued to grow. Rubin reported that within the community setting, music therapists were required to plan programs and to supervise care for clients throughout their entire treatment. He stated that for the first time, music therapists were functioning as "primary therapists," responsible for almost all aspects of treatment and serving as group co-leaders

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[54]Shreve, 202.

in group psychotherapy sessions.[55] Music therapy was gaining the greatest amount of independence it had seen to date. Events which took place in the area of professional development for music therapy during this decade served to further it along the paths of diversification, expansion of influence, and independence.

Legislation

With the passage of Public Law 94-142 -- the Education for All Handicapped Children Act -- in 1975, music therapy was assured of a more significant role in special education. The Act provided for "a free appropriate public education which emphasizes special education and related services designed to meet their unique needs...," and further defined "related services" to include music therapy; this was the first time music therapy had been mandated in federal legislation.[56] Music therapy's increased involvement in the special education setting sparked a controversy in which the need for a separate degree in "special music education" was debated. Involved in the discussion were the relationships among music therapy, music education, and special education. A distinction was made that music therapists are the leaders in working with handicapped individuals, while music educators, although caring for

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[55]Beverly Rubin, "Music Therapy in Community Mental Health Programs," Journal of Music Therapy (Summer 1975): 60.

[56]Solomon, 395-96.

children are not, by education and training, concerned with nonmusical problems, and that the Association should show leadership in the use of music for the handicapped.[57] Despite the efforts of music therapists to show their leadership, they would encounter difficulty establishing significant gains in opportunities within this setting. Solomon suggested that economic barriers and "perhaps the inability of music therapists to convince others that music therapy services were required to assist a handicapped child to benefit from special education had a limiting effect."[58] In regard to federal legislation in general, there was a marked increase in NAMT interest and involvement beginning in the late 1970's. Solomon described this as an area that "would assume primary importance" during the years between 1977 and 1980.[59] Steps were taken to establish a lobbying fund, to hire a legislative consultant, and to provide training to teach grantsmanship.[60] NAMT was kept apprised of new legislation and grant availability by Donald Hawkins, a hired legislative consultant. Much of the Association's initial efforts was focused on learning how to obtain grant money through various agencies. These efforts were rewarded in 1979 when NAMT

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[57]Ibid., 423.

[58]Ibid., 396.

[59]Ibid., 434.

[60]Ibid., 470-74.

received a grant titled "A National In-Service Training Model for Educational Personnel Providing Music Education/Therapy to Severely/Profoundly Handicapped Children" from the Bureau of Education for the Handicapped of the United States Department of Health, Education, and Welfare.[61] One of the most significant outcomes of increased interest by NAMT in participating in federal legislation was the relocation of the National Office to Washington, D.C. Research was undertaken concerning the move in 1978, and in 1979 it was determined that "if NAMT is to have an effective voice in government legislation and standards, then a Washington area location is a necessity."[62] The final decision was made to move in 1980, and relocation took place in 1982.

Other Developments

The period between 1975 and 1984 saw many other significant developments within the profession. Two of the most crucial were the decisions by NAMT in 1980 to apply for affiliate membership in the National Commission for Health Certifying Agencies (NCHCA) and to develop a national certification examination. These steps were taken with the belief that they were necessary in order for music therapists to achieve the credibility they desired in relation to

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[61]Ibid., 495.

[62]Ibid., 489.

other health care professionals, as well as health insurance providers."[63] This attitude was echoed by NAMT President Frederick Tims in the "Presidential Perspectives" section of NAMT Notes in 1984. With the first certification exam scheduled for November at that time (it would later be postponed to 1985), Tims justified the exam by stating, "competence-based credentialing is a clear prerequisite for advancement of a professional group."[64] Another very important accomplishment was the development of the Standards of Clinical Practice in 1979. This document contained a definition of music therapy, delineated the populations with whom music therapists worked, and provided guidelines for referral and acceptance, assessment and evaluation, program planning, implementation, documentation, and discharge.[65] Also significant were the development of a Code of Ethics in 1977, the publications of the Music Therapy Index in 1977 and the Music Psychology Index in 1978, the approval for publication of what would later be called Music Therapy Perspectives in 1978 and its first publication in 1982, an invitation to represent music therapy at a creative arts therapy conference sponsored by the American Psychological Association (APA) in 1979, and the establishment of new standards for graduate

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[63]Ibid., 531.

[64]Frederick Tims, "Presidential Perspectives," NAMT Notes (January-February 1984): 2.

[65]Solomon, 492.

level music therapy programs in 1980.[66] Through the efforts of its members during that decade, the music therapy profession defined itself more precisely and made its first significant steps towards acquiring national influence. The early attempts to become involved in legislation marked the beginning of a trend which would achieve prominence during the next decade.

1985 - 1995

Due to the lack of research on professional development during the past decade, this researcher will outline significant events and issues that were discussed in NAMT Notes between 1985 and 1995. As mentioned previously, increased involvement in federal and state legislation had become a priority during this decade. Also, the music therapy profession continued to seek alliances with other organizations, but these alliances became more equal. Less emphasis was placed on seeking validation or increased credibility for music therapy from other members of the alliance; rather, music therapy sought to determine how the organizations could mutually benefit one another. It became more common for other professionals to explore how music therapy might enhance and apply to their work instead of the opposite (as was usually the case in previous decades). One specific application of music therapy also emerged

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[66]Ibid., 532.

as a major topic of discussion -- i.e.. the connection between music and medicine and/or healing. Developments in each of these three areas will be examined separately in this section. General developments within the profession will also be discussed.

Legislative Involvement

In 1985, NAMT began including the "Government Relations Report" as a regular section in the newsletter, NAMT Notes. Updates on impending legislation and NAMT's involvement in it were reported in each issue by Kate Gfeller, the Government Relations Committee chair. Eventually written by Andrea Farbman, first as NAMT director of government and public relations and then as executive director, this report continued to be included regularly in the newsletter. Articles written in this section have informed its readers about many issues over the past eleven years, but have primarily focused on a few main areas: (1) NAMT's status with various accrediting agencies, (2) instructions for becoming involved in federal and state legislative decision-making, (3) status of inclusion of music therapy in legislation, (4) instruction on acquisition of grants, and (5) information about insurance reimbursement. However, two pieces of legislation passed during this period greatly impacted the development of music therapy as a profession and require a more thorough examination here. The first was the passage of the Americans with Disabilities Act (ADA) on June 26, 1990,

which "would provide people with disabilities with expanded opportunities and protections..."[67] The passage of this act led to the formation of a Senate "work group" on disability which examined national policy in the areas of education, employment, health care, and housing.[68] This allowed music therapists the opportunity to inform the Senate about the value of music therapy with this population and to provide suggestions for policies concerning educational and social services.[69] The second, and most significant piece of legislation for music therapy was the passage of the Older Americans Act Amendments of 1992 (OAA). The September-October issue of NAMT Notes summarizes the impact of this law upon music therapy:

> With the stroke of a pen, hundreds of programs for elderly persons were authorized. For the first time, however, music therapy is an integral part of the legislation. We now have a statutory definition of music therapy. And, along with other services, music therapy is now listed as a preventive and supportive service.
>
> Undoubtedly the most exciting part is that the law authorizes music therapy education and training, and research and demonstration projects. Because of this legislation, music therapy programs and services for the most disabled elderly persons will be available.
>
> In a year when appropriations have been beyond difficult to obtain, we have managed to get language authorizing funds for music therapy programs. Now that the President has signed the appropriations bill, $825,000 will be available for music and other

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[67]NAMT Notes (May-June 1990): 3.

[68]NAMT Notes (September-October 1990): 4.

[69]Ibid.

creative arts therapies, programs under the OAA.[70]

Many of these gains were accomplished due to NAMT's participation in the Senate hearing, "Forever Young: Music and Aging," in August of 1991. Cathy Knoll reported in the September-October 1991 issue of NAMT Notes that "because the sharing record contains testimony from numerous experts and 'real people' about the efficacy of music therapy as a health care service with older individuals and other populations, we are now in a position to impact legislation and regulations involving music therapy services."[71] Her predictions were realized the following year, and several benefits have resulted from both events, including the "Rhythm for Life" project, increased job opportunities for music therapists in the geriatric setting, and many research grant awards from the Administration on Aging (AOA).

Relationship Development with Other Associations

NAMT formed many alliances with other professional organizations and accrediting agencies during this period as it continued its pursuit of acknowledgment; music therapists wanted recognition equal to other, more "established" professions. Some alliances went further. In several instances,

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[70]NAMT Notes (September-October 1992): 1.

[71]Cathy Knoll, "And What a Day it Was! Highlights from the Senate Special Agency Committee Hearing on Agency and Music," NAMT Notes (September-October 1991): 3.

liaisons were formed with NAMT because of the perceived benefits music therapy could bring to other professions. Decuir stated very succinctly the reasons behind this shift to a more equal relationship between music therapy and other professions:

> Our government relations representatives tell us that successful competition for jobs and recognition depends on the professional publics' perception of the "uniqueness of our services" and "task specificity." More succinctly, what do music therapists add to the clinical setting that no other professional does? The obvious answer is the music! In our attempts to gain credibility, we have opted to become "junior" psychotherapists, sports and activities specialists. All of which are fine, but for the past forty years our raison d'etre has been the use of music to bring about acceptable changes in behavior. I believe a return to the music has to be coupled with a public relations effort in which we re-educate and educate the professional and general public.[72]

One significant alliance was developed at this time with the American Dance Therapy Association, the American Association for Music Therapy, and the National Association for Drama Therapy. These four groups joined together to form the National Coalition of Arts Therapy Associations (NCATA). The coalition's purposes were to:

> 1) strengthen education and professional bonds between art, music, dance and drama therapies; 2) further the growth and development of the creative arts therapies; and 3) foster a greater understanding of each discipline among the human service professions and general

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[72]Anthony A. Decuir, "Presidential Perspectives," NAMT Notes (May-June 1986): 4.

public.[73]

NCATA also worked to have music therapy and other creative arts therapies included in the 1986 Joint Commission on the Accreditation of Hospitals' (JCAHs') Accreditation Manual for Hospitals. Gibbons described the benefits of this accomplishment by saying:

> These efforts secured jobs for over 650 creative arts therapists who are employed in rehabilitation programs at JCAH approved hospitals. Without regulations which include them, creative arts therapists' jobs are extremely vulnerable to bureaucratic budget cuts.[74]

NAMT also continued to gain acceptance from the APA. In May of 1986, several music therapists conducted a presentation, upon APA's invitation, at their 139th annual conference. The 1986 July-August edition of NAMT Notes reports that "the psychiatrists' response to the presentation entitled "Music Therapy: Through the Sound Barrier" and to music therapy itself was overwhelmingly favorable.[75] In 1987, NAMT was invited by the Committee on Accreditation of Rehabilitation Facilities (CARF), to participate in a revision of their standards. As a result, the published standards for treatment "include language that is very positive for music therapists;" music therapy is included as a service that "should

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[73]NAMT Notes (January-February 1985): 1.

[74]Ibid., 6.

[75]NAMT Notes (July-August 1986): 3.

be utilized depending upon the needs of persons served."[76] Due to the work of NAMT with the Accreditation Council on Services for People with Developmental Disabilities (ACDD), music therapists became eligible to qualify as Qualified Mental Retardation Professionals (QMRP) in 1988. Also in 1988, NCATA became a "formal member of a coalition of rehabilitation therapies with occupational therapy and recreational therapy." As such, it gained formal status with JCAH and was able to participate in all JCAH activities.[77] In 1989, music therapists were asked to participate in a project developed by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), called, "Agenda for Change." NAMT Notes described its participation as "a unique, proactive opportunity to influence the accreditation process."[78] Music therapists also formed alliances among their own ranks. In 1993, NAMT, AAMT, and CAMT held their first North American music therapy conference in Toronto, entitled, "Music Therapy: Crossing Borders -- Joining Forces."[79] This was not to be the extent of the collaboration between music therapy associations, however.

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[76]Kate Gfeller, "Government Relations Report," NAMT Notes (September-October 1987): 2.

[77]David Read Johnson, "News from NCATA," NAMT Notes (May-June 1988): 2.

[78]NAMT Notes (March-April 1989): 4.

[79]NAMT Notes (April-May-June 1993): 1.

The July-September 1994 issue of NAMT Notes reported the results of a study comparing NAMT and AAMT in three main areas: (1) organizational structure, (2) educational requirements, and (3) clinical preparation.[80] By this time, a dialogue had begun concerning the unification of the two organizations, and the same issue of NAMT Notes also published the Memorandum of Unification Agreement proposed by the presidents of AAMT and NAMT. They agreed that "the best way to advance the profession of music therapy was with one unified association.[81] A revised agreement was published in the Summer 1995 edition of NAMT Notes. This agreement was approved by the Assembly of Delegates, the Executive Board of NAMT, and the membership the following winter. In the future, music therapists in the United States will belong to one organization, the American Music Therapy Association (AMTA), and will have one entry-level credential: MT-BC.[82]

Music and Medicine

As the use of alternative medicine became increasingly more accepted in the fourth decade of music therapy's "organized" existence, so too did the use of "non-traditional" therapies, separately or in conjunction with traditional medicine,

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[80]NAMT Notes (July-August-September 1994): 6.

[81]Ibid., 9.

[82]NAMT Notes (Summer 1995): 5.

to bring about healing. Various workshops and seminars upon the subject were reported in NAMT Notes. Such a summer workshop (called "Music and Medicine") was offered at Southern Methodist University in which participants would "explore recent treatment innovations in Music Therapy, Behavioral Medicine, Biofeedback, and Family Systems." [83] These workshops came to be known as "The Arts of Health" seminars, and offered subjects each year concerning the connection between music and health care. Frequently, doctors and other "traditional" health care professionals led the seminars. In 1988, an organization called the International Arts-Medicine Association (IAMA) invited music therapists to apply for membership. The November-December issue of NAMT Notes published their goals:

1) To provide a forum for communication for professionals in the arts and health
2) To provide for those artists having physiological or psychological therapeutic needs a referral to appropriate treatment facilities
3) To provide health professionals an educational resource that will enhance their skills in supplying such therapeutic services
4) To promote scientific research which explores and develops the relationships among aesthetics, artistic activities, the creative process, and human health.
5) To establish a library for arts and health professionals
6) To widen the public consciousness of arts-medicine and its practitioners
7) To encourage and provide a forum for physicians and other health professionals who are themselves avocational artists
8) To enlist the support and consultation of artists to enhance the artistic and creative skills of health professionals

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[83] NAMT Notes (March-April 1986): 4.

9) To strive to prevent dysfunction among practitioners of the arts...[84]

In the March-April 1989 issue of NAMT Notes, NAMT President Cheryl Maranto spoke about the importance of moving ahead in the field of "medical music therapy:"

> ...I have appointed a music/medicine task force composed of physicians and music therapists to consider these issues and make recommendations regarding: deficiencies in the research base, future medical applications of music, education, training, and continuing education needed to meet the demands of emerging medical areas, and future ways to enhance collaboration between the two professions.[85]

The Fall 1990 issue of the Journal of Music Therapy contained articles which were "devoted to the topic of music, medicine and medical applications of music therapy."[86] A book entitled, "Applications of Music in Medicine," published by NAMT and edited by Maranto, was made available in 1991.[87] The National Institutes of Health (NIH) Office of Alternative Medicine awarded a grant in 1993 to a study involving music therapy and brain injury. The project involved "a new team of neuropsychological and music therapy specialists [combining] the

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[84]NAMT Notes (November-December 1988): 3.

[85]Cheryl D. Maranto, "Presidential Perspectives," NAMT Notes (March-April 1989): 4.

[86]NAMT Notes (March-April 1989): 4.

[87]NAMT Notes (September-October 1991): 7.

scientific study of human behavior with the medium of music to improve the altered socio-emotional abilities of brain injured persons."[88] In 1994, NAMT began raising funds to produce a "documentary training program and supporting materials about the value and efficacy of music therapy," which would "be aimed specifically at the medical community, i.e., doctors, nurses, health care administrators, etc."[89] Filming began on this video in 1995.

General Development

Three events occurred during this period which were significant in development of professional music therapy. First, in 1985, the Certification Board for Music Therapists (CBMT) administered its first examination for the credential, Music Therapist -- Board Certified. Second, NAMT offered continuing education courses approved by CBMT at its 40th annual conference in 1989. These courses became a requirement for all board certified music therapists in order to keep their certification, and thus "assure the public of the continued competency of the Music Therapist -- Board Certified."[90] Third, increased media attention was focused on professional music therapy. Articles were written in many major newspapers, and music therapists were interviewed on the news

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[88]NAMT Notes (September-December 1993): 14.

[89]NAMT Notes (July-September 1994): 1.

[90]NAMT Notes (January-February 1985): 2.

and featured on television shows such as "48 Hours." Celebrities began advocating music therapy, sponsoring benefits, and allying themselves with NAMT. In 1995, NAMT representatives were invited to the Grammy Awards. Each of these three events served to further music therapy's aim to become a respected and recognized profession.

Summary

The music therapy profession has come far in the pursuit of its goals during the past forty-five years. It has informed the public and other professions through the establishment of professional journals, the development of liaisons with other organizations, and communication with all areas of the media. It has also clearly defined the role of its practitioners by adopting standards of practice, a code of ethics, curriculum standards, a means of certification, and provisions for continuing education. Finally, it has ensured increasing opportunities for employment through its involvement in legislation and its discovery of new applications through continued research.

Research

From the beginnings of organized music therapy, research has always been recognized as the "life-blood" of the profession. Its significance is noted for a number of reasons. First, research is necessary for effective clinical practice.

In the early years of the profession, this was especially important. Music therapists were just beginning to explore the possibilities of music as a therapeutic tool, and they were still establishing theories about its uses. Solomon noted that "the Association's leaders understood that the dissemination of research findings was essential to establish a foundation of knowledge upon which to build clinical treatment theories."[91] Research has continued to be a necessary agent for effective clinical practice. Jellison supports this idea by stating that "philosophically, research in music therapy has been verbally recognized by NAMT as an approach that will convey information for application by the therapist to accomplish therapeutic goals."[92] Nicholas and Gilbert also concur, saying that "clinical techniques and approaches continue to be dependent upon the published research efforts of practitioners."[93] Second, the publication of music therapy research provides greater credibility for the profession and promotes understanding and respect from other professions. The presentation of objective, scientifically-valid research in the place of

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[91]Alan L. Solomon, "A History of the Journal of Music Therapy: The First Decade (1964-1973)," Journal of Music Therapy 30 (Summer 1993): 4.

[92]Judith A. Jellison, "The Frequency and General Mode of Inquiry of Research in Music Therapy, 1952-1972," Council of Research in Music Education 35 (1973): 2.

[93]Mary J. Nicholas and Janet Perkins Gilbert, "Research in Music Therapy: A Survey of Music Therapists' Attitudes and Knowledge," Journal of Music Therapy 17 (1980): 207.

unsupported testimonials as to music's healing properties played a significant role in the acceptance of music therapy as a viable treatment option. Solomon observed that "the Association's [NAMT's] publications would be the medium through which other professions would view and judge music therapy," and that "the Journal of Music Therapy is often responsible for the increased awareness, respect, and credibility that music therapy enjoys in the eyes of other health professionals as well as the general public."[94] Finally, research allows a fuller understanding of the properties and effects of music upon humankind, and of new ways to use music with special populations. As an example, Shreve discussed the profession's lack of understanding about why music affects mood: "Why music has an effect on mood is still not clearly understood. What factors in music produce certain effects in certain people is also in question. If and when these questions are answered, music therapy will have made a great breakthrough in its development." In reference to the use of music with new populations; "There are gaps of information in much of the research. This is a need to be overcome in the future. As therapists become more research-oriented and students start publishing investigations, these gaps may be filled."[95] However, in order for research to be useful, one must be aware of it and know

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[94]Solomon, "A History of the Journal of Music Therapy," 31.

[95]Shreve, 240-242.

how to use it.[96] Knowledge of past and current research literature in one's field not only aids effectiveness in practice, but also "eliminates the expensive waste of foolish reduplication and spurious floundering."[97] To this end, several analyses have been made of different music therapy journals; these analyses categorize the contents of each journal according to mode of inquiry, population focus, "general focus," i.e. "research," "position paper," or "clinical,"[98] and in some cases, research setting, author gender, and author credentials. This chapter will present a comprehensive account of the findings of these analyses -- first of content analysis, then of observed trends. This paper will complete the analysis of two of the journals, thus updating the data to 1995. This author will also summarize the findings of this analysis and note any long-term evolutionary trends in the research. Journals to be examined include the Books of Proceedings: Music Therapy, the Journal of Music Therapy, Music Therapy Perspectives, Music Therapy: Journal of the American Association for Music

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[96]A. F. Fultz, "The NAMT Long Range Design for Music Therapy Research," Music Therapy (1952): 13, quoted in A. Decuir, "Readings for Music Therapy Students: An Analysis of Clinical and Research Literature from the Journal of Music Therapy," in Perspectives on Music Therapy Education and Training, eds. Cheryl D. Maranto and K. E. Bruscia (Philadelphia: Temple University, 1987) 57.

[97]Ibid.

[98]Janet Perkins Gilbert, "Published Research in Music Therapy, 1973-1978: Content, Focus, and Implications for Future Research," Journal of Music Therapy 16 (1974): 107-8.

Therapy, and The Arts in Psychotherapy.

Content Analysis

Jellison, in an article titled, "The Frequency and General Mode of Inquiry of Research in Music Therapy, 1952-1972," provided an analysis of articles in the Music Therapy Annual Books of Proceedings (1952 - 1963) and the Journal of Music Therapy (1964 - 1972). Four hundred eighty-five articles were classified according to mode of inquiry: philosophical, historical, descriptive, or experimental. Experimental articles were further identified as having either a statistical or a behavioral design. Also examined was the number of descriptive and experimental research articles that reported data. She categorized the data into seven, three-year periods. The following conclusions were drawn from her analysis:

1. A general decrease has occurred in the total number of published articles.
2. A general increase has occurred in the total number of articles reporting data.
3. The frequency of articles as to mode of inquiry can be rank ordered: (1) descriptive, (2) philosophical, (3) experimental, and (4) historical.
4. Although a decrease has occurred in the frequency of descriptive articles, a gradual increase is apparent in the number of descriptive studies reporting data.
5. Philosophical research has decreased.
6. There are only a few examples of historical research.
7. Experimental research has gradually increased and has recently expanded to include experimental behavioral research as well as

statistical research.

8. Behavioral techniques have been reported in experimental descriptive, and philosophical research during the last seven years.[99]

Gilbert continued this analysis in her article, "Published Research in Music Therapy, 1973 - 1978: Content, Focus, and Implications for Future Research," with a more in-depth examination of articles from the Journal of Music Therapy during the following six years. Gilbert included the categories of "general focus," research setting, "bases for research," -- i.e., "physical perceptual," "psychological," and "pedagogical" -- and clientele focus. Twenty-one settings were uncovered in the clientele focus category, and research setting was limited to "clinical" or "university." Results of the analysis yielded the following information:

1. The total number of articles published per 3-year period has continued the decline noted by Jellison.
2. Within the last 3 years, the percentage of hard research papers has increased relative to the proportion of position papers and strict clinical descriptions. At the same time, a balance is noted between clinical and university settings for research.
3. Published research during the last 6 years, categorized according to mode of inquiry, revealed the following ranking for frequency: descriptive, experimental, philosophical, and historical research. The proportion of descriptive and experimental studies has increased during the last 6 years, concomitant with a decrease in the proportion of philosophical and historical studies.
4. The proportion of studies focusing upon pedagogical and physical/perceptual bases for music research has increased in

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[99]Jellison, 6.

the last 3 years; the comparative focus on psychological aspects of musical behavior has decreased within the last 3 years.

5. An increasing percentage of studies focus on mentally retarded clients, university students, and normal children, when comparing the last 3-year publication period to the 3 previous years. A decrease in focus on psychiatric clientele is noted; additionally the diversity of clientele focused upon by (sic) published research has decreased.[100]

Data from this study revealed that experimental research, formerly ranked third in frequency for mode inquiry in the Jellison study, had overtaken philosophical research to become the second most frequently used mode of inquiry.

An article by James titled, "Sources of Articles Published in the Journal of Music Therapy: The First Twenty Years, 1964-1983," focused its analysis on different areas of classification: (1) year of publication, (2) affiliation of the author, i.e., "agency" or "university," (3) gender of the author, and (4) credentials of the author. His justification for this research was the following:

> Very little documented information exists about the sources of scholarly productivity in music therapy, or the location of academic institutions where outstanding progress and leadership in the profession are occurring. Such information would provide historical insight into the status of research in the profession, and would help delineate current trends in music therapy research.[101]

Data also included the names of the universities and geographical regions which

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[100]Gilbert, 107-8.

[101]Mark R. James, "Sources of Articles Published in the Journal of Music Therapy: The First Twenty Years, 1964-1983," Journal of Music Therapy 22 (1985): 87.

produced the most research. James reached the following conclusions from his analysis:

1. The vast majority of recent (1974-83) articles have originated from university settings.
2. The general frequency of articles published in the Journal of Music Therapy has remained stable in its first 20 years.
3. The Florida State University, The University of Kansas, and Loyola University have established themselves as leaders in the profession with respect to scholarly productivity, producing 25.1% of the professional literature.
4. General parity exists between men and women authors, with a recent trend for more articles to be authored by women.
5. Information concerning author credentials is severely limited. Consistent editorial policies could be used to document both academic and professional credentials.[102]

He also determined that unlike Gilbert and Jellison's findings, the number of published articles during the scope of this analysis remained stable.

Codding continued the work begun by Jellison and Gilbert in her article, "A Content Analysis of the Journal of Music Therapy, 1977-85." Like the two previous researchers, Codding reported her data in three-year periods, and used several of the same categories. However, she added "other" as an option for research setting because of "the frequency of non-research articles appearing for specified years."[103] Findings of the research were summarized as follows:

1. The total number of published articles has remained constant for

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[102]Ibid., 93.

[103]Peggy A. Codding, "A Content Analysis of the Journal of Music Therapy, 1977-85," Journal of Music Therapy 24 (1987): 198.

the 3-year periods from 1977-85, indicating a recovery from the continual declines noted by Jellison and Gilbert.
2. Within the last 9 years, the percentage of research studies has remained high relative to the proportion of position papers and clinical articles, corroborating the findings of Gilbert.
3. Analysis of research by mode of inquiry indicates the following prevalence ranking: (a) experimental, (b) descriptive, (c) historical, and (d) philosophical research. Results suggest an increase in the number of experimental studies.
4. Few examples of historical and philosophical research exist in the recent music therapy literature.
5. During these years, more studies have been conducted in clinical than in university settings. Research in the public schools is increasing.
6. Statistical designs are more prevalent than are behavioral designs in experimental research.[104]

The results of this analysis indicated that experimental research had overtaken descriptive research for the first time, and that philosophical research had dropped to the least frequently used mode of inquiry. Also, unlike in the Gilbert study, it was determined that there were more clinical than research studies.

Decuir provided a comprehensive analysis of "specific areas of music therapy research and clinical writing according to disability areas studied"[105] in the book, Perspectives on Music Therapy Education and Training. In chapter seven, titled, "Readings for Music Therapy Students: An Analysis of Clinical and Research Literature from the "Journal of Music Therapy," Decuir classified articles from the journal between 1964-1986 into 19 categories. He also

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[104]Ibid., 202.

[105]Decuir, "Readings for Music Therapy Students," 58.

provided the subject/dependent variable, "mode" of technique -- i.e., "research" or "clinical" -- and the year, volume, and number of each article. The purpose of this analysis "was to examine the availability of clinical and research literature in music therapy."[106] Results indicated a lack of research in the areas of learning disabilities, speech and communication disorders, substance abuse, community mental health, gerontology, visual and auditory impairment, physical disability, autism, and vocational rehabilitation. Child and adult psychiatric literature was determined to be out of date. The categories with the most literature were "Psychology of Music/Influence of Music on Behavior," "Mental Retardation/Developmental Disability," "Behavioral Approaches," and "About Music Therapy," respectively.

Wheeler expanded on the Decuir study; she provided a similar analysis of articles in Music Therapy Perspectives (1982 - 1987), Music Therapy: Journal of the American Association for Music Therapy (1981-1987), and The Arts in Psychotherapy (1973-1987, music therapy articles only). In addition to the information provided in the Decuir analysis, she added authors' names, name of journal, and a comparison of the number of articles in a particular category in the Journal of Music Therapy with the journals examined in this study. She also added new classifications and dropped or changed some that had appeared in

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[106]Ibid., 69.

the Decuir study. Wheeler found a more even distribution of articles, both in regard to "mode," (research, general, or clinical), and classification. She indicated the former existed because it "reflects the purposes of the journals; all of the journals in the current study have clinical work as an important focus while the Journal of Music Therapy focuses on research."[107] As for the latter, she qualified her findings by stating, "this should not be taken as an indication that the amount written in any area is adequate for the profession of music therapy."[108] Wheeler noted from her research a distinct lack of research studies involving childhood, adolescent, and adult psychiatry. Although she did report an increase in the number of articles concerning substance abuse, again these articles were clinical rather than research-oriented.

This author has conducted a survey of articles in the following journals: the Journal of Music Therapy (1988-1995) and Music Therapy Perspectives (1988-1995). The analysis included papers appearing in the "articles" section of each journal; book reviews, editorials, commentary, indices, etc., were excluded. Content was analyzed using categorizations similar to those of previously examined studies: mode of inquiry, article focus, and population focus. Classifications for population focus were derived from the Decuir and Wheeler

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[107]Barbara L. Wheeler, "An Analysis of Literature from Selected Music Therapy Journals," Music Therapy Perspectives (1988): 100.

[108]Ibid.

studies, with the exception of "Theoretical Approach and Music Therapy," which was added by the author due to the large number of articles which included a specific theoretical approach in the title.

Results of the author's survey of Music Therapy Perspectives (1988-1995) and the Journal of Music Therapy (1988-1995) yielded data concerning frequency and percentage of mode of inquiry (experimental, descriptive, historical, philosophical), article focus (research, position paper, clinical) and population focus. One hundred twenty articles from the Journal of Music Therapy and 107 from Music Therapy Perspectives, a total of 227 articles, were analyzed. Results of data on mode of inquiry were as follows: 50% of articles in the Journal of Music Therapy and 3% in Music Therapy Perspectives were experimental research articles. The total percentage of experimental articles was 28%. The extreme difference of percentage between the two journals can most likely be accounted for due to the different stated purpose of each journal. Wheeler noted in her study that "each journal has its own purpose, and that purpose is largely reflected in the contents of the journal."[109] She reported that the objectives of Music Therapy Perspectives are "to speak to the immediate client service needs of the practicing music therapist" and "to include articles

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[109]Ibid., 96.

which deal primarily with implications for music therapy practice."[110] Thus, articles in this journal are more likely to be descriptive than experimental in nature. Conversely, the Journal of Music Therapy is intended to include reports of original investigations and theoretical papers pertaining to music therapy --"[111] in other words, primarily research studies. Still, descriptive studies accounted for 45% of articles in the Journal of Music Therapy; however, as article foci data revealed, very few of these were clinical in nature. Predictably, 93% of the articles in Music Therapy Perspectives were descriptive. Descriptive articles totaled 68% of the total articles. Results of analysis for historical and philosophical articles mirrored those of studies previously discussed in this section. Each of these modes of inquiry accounted for only 2% of the total number of articles, indicating that researchers continue to avoid these types of research despite the obvious need for their representation in current music therapy journals. An examination of article foci revealed that 86% of those in the Journal of Music Therapy and 45% of those in Music Therapy Perspectives were research-based, for a total representation of 66%. Clinical focus accounted for only 10% of articles in the Journal of Music Therapy , while 41% were clinical in nature in Music Therapy Perspectives. This data reflects the aforementioned

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[110]Ibid.

[111]Ibid., 99.

statements by Wheeler concerning the stated purpose of each journal. The total percentage of clinical articles was 25%. "Position paper" was the focus of 4% of articles in the Journal of Music Therapy and 14% in Music Therapy Perspectives, for a total of 9%. Analysis of population focus yielded interesting results. Both journals contained articles representing 17 different areas, both with similar percentages of representation between the areas. Two exceptions to this were in the areas of "Influence of Music on Behavior/Psychology of Music," and "Theoretical Applications of Music Therapy." In the former category, Music Therapy Perspectives contained only four articles in this area while the Journal of Music Therapy yielded 29. The latter category was represented by 22 articles in Music Therapy Perspectives, but only 5 in the Journal of Music Therapy. Again, these results can probably be accounted for by the purpose of the journals. Investigations into physiological and/or psychological responses to music are primarily experimental in nature. Although one might presume theoretical articles would appear more in the Journal of Music Therapy, the ones represented in this study focused mainly on clinical applications, thus appearing more appropriately in Music Therapy Perspectives. The categories with the most total article representation were: "Special Education/Childhood Exceptionality" (37 articles), "Gerontology" (27 articles), "Theoretical Applications and Music Therapy (27 articles), "Influence on Behavior/Psychology of Music"

(33 articles), and "Dental/General Hospital" (18 articles).

Summary of Trends and Conclusions

Jellison noted in her analysis that, although descriptive studies occurred most frequently, the amount of experimental research and research reporting data had increased significantly over the span of her study. She stated that "there is a trend in music therapy toward the advancement of knowledge of experimental research methods and a growing recognition of this mode of inquiry as a research process significant to growth and development."[112] She also indicated a reason for the observed decline in the number of philosophical research articles in the latter years of her study:

> While philosophical research is imperative to the identification of needs and concerns in music therapy and is imperative to the identification of possible directions for the advancement of therapeutic practice, a decrease in articles of this mode of inquiry does not necessarily indicate a process of decline in valuable ideas and theories. It would only appear that philosophy has indeed identified areas and directions and the demand now is for precise examination of those ideas and theories.[113]

Her analysis of trends seems to reflect the trends that occurred in professional development at that time: a) the profession was aging and needed fewer articles describing music therapy as people became more familiar with it, b) music

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[112]Jellison, 7.

[113]Ibid.

therapists saw clients for shorter periods of time and had to focus on short-term, behaviorally oriented goals, and c) music therapists were becoming more accountable for treatment and needed scientifically valid procedures. Her study supported this idea by stating:

> Research in music therapy is more than an "idea" and is a major activity of the profession. However, with the rapid advancement of the profession as a behavioral science and its growing demand for and application of scientific procedures in research, the idea of "quality" [scientific] research becomes crucial.[114]

The results of the Gilbert study realized Jellison's predictions to some degree. Experimental research became the second most frequently- occurring type of research, overtaking philosophical research. She also noticed an increase in physiological and perceptual studies, thus indicating an increased interest in how music affects human behavior. Also noted were the changes in numbers of articles concerning specific populations.[115] Decreases in articles focusing on psychiatric patients and increases of those focusing on mentally retarded clients reflected the shift in job placements for music therapists at that time. Mental health care was moving away from institutions and into community services, while Public Law 94-124 brought music therapists into the public school/special education setting.

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[114]Ibid.

[115]Gilbert, 105-7.

Codding's study acknowledged a continuation of this trend by noting an increase in research conducted in the public school setting.[116] It was during the period of her study that experimental research became the most frequently used mode of inquiry, especially those with statistical rather than behavioral designs.[117] It may have been that music therapists finally began to heed decades of pleas for greater amounts of scientifically valid research. Perhaps the higher profile of the profession, i.e., its beginning involvement in national legislation and recognition from other organizations, may have played a part in the increase. The pressures for accountability and documentation of tangible results from insurance payers may also have been influential.

The most noticeable trend from the Decuir analysis is that over the course of twenty years, music therapy services have greatly expanded from their "hospital music" beginnings. However, in so doing, the research produced by its practitioners has been spread rather thin, with an inadequate number of studies being conducted for most populations.[118] Wheeler's study yielded the same results, even though different journals were examined. She concluded, "when considered together, the four journals [3 from Wheeler, 1 from Decuir] studied

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[116]Codding, 202.

[117]Ibid.

[118]Decuir, 70.

cover a variety of topics and do so in a relatively balanced manner. There is, nonetheless, a need for more literature in almost every area of music therapy.[119]

The results of this author's study, in regard to frequency of population focus, reflected the trends in professional development. Legislation concerning handicapped children (Public Law 94-142) and the elderly (OAA) were creating the opportunity for more involvement with clients in these populations, thus producing an increase in reported research. The renewed interest of music therapy's applicability in the medical setting provided increased research in this area as well. Larger numbers of practitioners in these settings provided more opportunity for the reporting of research and clinical practices. Like the Decuir study, the author's analysis yielded a large number of studies in the area "psychology of music/influence of music on behavior" (located almost entirely in the Journal of Music Therapy). This may indicate the attitude held by most music therapists that the influence of music on the psyche and the body is still not fully understood; the large amount of research in this area reflects our continuing attempt to understand our therapeutic tool more fully. It may also be related to the large number of articles addressing specific theoretical approaches. The studies may also have been undertaken in order to provide bases for these approaches. However, since the majority of articles in the area

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[119]Wheeler, 101.

of "Theoretical Approaches and Music Therapy" appeared in Music Therapy Perspectives, they are more likely based on the findings of mature clinical practices rather than experimental research. It appears from the current author's study that music therapy has begun to focus less on its outward growth into more areas of practice and more on its internal development of therapeutic techniques based on established practice.

Practice

As the music therapy profession and its research have evolved, so too has the actual practice of music therapy. It would be virtually impossible to determine a causal relationship for the changes that have taken place in these three areas -- one would have a difficult time proving whether the needs of practice led to discoveries in research or if research breakthroughs shaped changes in course of practice, for example. Without a doubt, a correlational state exists between them. All three areas have affected each other and are inextricably related. Therefore, it quickly becomes apparent upon examination that the changes observed in music therapy practice are closely linked with the professional climate and research developments at any particular point in time. This section will examine the evolution of music therapy practice over the course of this study, and will note the corresponding events in professional development

and/or research that may relate to those changes. Significant trends in music therapy practice will be examined in approximate 10-year periods.

1950 - 1959

Music therapy practices during this period reflected its status at the time. Its practitioners were employed primarily in V. A. hospitals or mental institutions, working with persons in a psychiatric setting. Music therapists were frequently subject in their practices to the dictates of physicians and/or psychiatrists. Shreve describes a 1955 study of music therapy at Winter V. A. Hospital in Topeka, Kansas, where "the physician suggested long-term and management goals for the patient, and a carefully planned set of activities was set up and followed."[120] She also described a 1954 study in which the necessity for the music therapist to have any knowledge of psychotherapeutic technique was questioned. According to the author of the study, the psychiatrist was the "boss" and "clinical supervision by psychiatrists is far more important."[121] Therefore, music therapists were somewhat limited in the scope of their practice. However,

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[120]Richard Gray, "The Prescription of Music Therapy of Winter V.A. Hospital, Topeka, Kansas," Music Therapy (1955): 170-171; quoted in H. Shreve, "Music Therapy: An Historical Overview to 1976" (Master's Thesis, Boston University, 1977), 132.

[121]Robert Johnson, "Clinical Interpretation in Music Therapy," Music Therapy (1954): 68-74, quoted in Shreve, 131.

some programs sought to elevate the music therapist's place in the treatment team to one of more equal standing. The V. A. Hospital in Utah reported in 1955 that "the music therapist and war physician discuss and decide what activities would be helpful for each patient."[122] Reports of specific practices were often limited to the unique needs of psychiatric patients, such as providing music to alleviate anxiety during insulin coma therapy and electroshock therapy, or playing music that would "sedate" hyperactive or violent patients.[123] However, for the first time, music therapy was recognized as a legitimate profession, and its services were applied on a larger scale than ever before. The field was open to unlimited possibilities, and many practitioners took advantage of the opportunity. Ruppenthal encouraged music therapists to find new ways in which music could be used therapeutically,[124] and indeed they did. A wide variety of innovative approaches were reported during this time. Among those reported were the effects of "leisure activities," such as group sing-alongs, musicals, "day-hall" concerts, and handbell groups. Other reports examined the effects of specific types of music on patient mood and behavior and applications of music

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[122]Wallace Gudgell, "Prescribed Music at the V.A. Hospital, Salt Lake City, Utah," Music Therapy (1955): 130-140, quoted in Shreve, 132.

[123]Shreve, 127-60 passim.

[124]Wayne W. Ruppenthal, "The Use of Music with Group Psychotherapy," Music Therapy (1956): 54-57, quoted in Shreve, 133.

to elicit behavioral changes. Group rhythm activities were used with schizophrenic clients to encourage non-verbal communication and reality orientation, and to alleviate feelings of "aloneness." Ways in which music could be used to promote relaxation, ease pain, and lessen anxiety in surgery were also explored.[125] In addition to the burgeoning interest in the role of music as a therapeutic agent, there was much discussion among music therapists about their role in treatment, especially with regard to how they functioned as "therapists." Ruppenthal did not believe that the prescription of music for such procedures as electroshock therapy was actual therapy. He contended that the music therapist's role in treatment should be much more active.[126] Some studies emphasized the importance of establishing rapport with clients; they considered the therapeutic relationship to be as important or more important than the music.[127] Others purported the music itself to be the foundation of the relationship and the source of rapport.[128] The definition of "therapy" as it applied to music therapy remained largely unresolved during this period. In 1959,

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[125]Shreve, 127-60 passim.

[126]Ruppenthal, 54-57, quoted in Shreve, 133.

[127]E. Thayer Gaston, "Functions of a Music Therapist," Music Therapy (1953): 28-29.

[128]Donald Blair, T. A. Werner, and Mair Brooking, "The Value of Individual Music Therapy as an Aid to Individual Psychotherapy," Music Therapy (1959): 169.

Braswell wrote about the confusion concerning what constituted "therapy" in music therapy.[129] The duality of the music therapist's role -- that of musician and of therapist -- had yet to be resolved. Practitioners did have ideas about where they needed to go, though. Braswell suggested the need for goal-directed programs which would help to validate the efforts of the music therapist.[130] There was a general consensus (among music therapists) that additional training in psychology and medicine was needed.[131] Ruppenthal emphasized the importance of focusing on the needs of the patient rather than the quality of musical performance.[132] Also noted by many music therapists during this time was the need for scientific research that would test the effectiveness of current practices and pave the way for new ones.[133] Music therapy practice, like professional development at this time, was defining itself, its role in the treatment of clients, its capabilities, its limitations, and its possibilities.

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[129]Charles Braswell, "The Goal Directed Hospital Program," Music Therapy (1959): 47-53 passim.

[130]Ibid.

[131]Shreve, 145.

[132]Wayne W. Ruppenthal, "Objectivity in Clinical Practice," Music Therapy (1957): 81-84.

[133]Shreve, 149-160 passim.

1960 - 1974

Music therapy practice continued to focus largely on its applications in the mental health setting during this period, but its scope expanded. Legislation and changes in attitude about effective treatment for psychiatric patients caused music therapists to re-evaluate their role and methods with this population. Schorsch described the development of music therapy practice as "in process," modified by changes in treatment setting, concept of treatment, understanding of patients and illnesses, and trends in related disciplines and health care.[134] With the move to community-based services in place of long-term institutional treatment, music therapists adapted their techniques to the demands of the new setting. Shorter duration of treatment required the development of short-term goals and objectives. Higher client to staff ratio demanded the use of group therapy techniques in place of those for individual therapy. Much of the discussion about the general aims of treatment and client needs centered around a central theme: social adaptation. Commonly stated areas of need were interpersonal relationships, functional skills for living in a changing society, appropriate social skills, and skills for coping with environmental stress.[135]

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[134]Sr. Josepha Schorsch, "Music Therapy: In Process," Journal of Music Therapy 8 (Summer 1971): 41.

[135]Warren G. Phillips, "Community Mental Health -- A New Challenge!" Journal of Music Therapy (March 1965): 16-18; Lester G. Glick, "Music as Therapy in Community Agencies," Journal of Music Therapy

Addressing these needs required eliciting changes in behavior; therefore music therapy techniques focused on behavior modification. A large number of music therapists reported ways in which music and/or music therapy could change behavior. For example, Madsen, Cotter, and Madsen described music therapy as having the potential for "behavioral manipulation" and described several techniques in which this might be accomplished -- uses of music for desensitization, hypnosis, specific conditioning, as a reward and as a contingency for desired behaviors.[136] They even went so far as to suggest that "a re-definition of music therapy along behavioral lines should be investigated."[137] Solomon acknowledged the influence of behaviorist theory and techniques upon music therapy practices. He stated that during the 1960's and 1970's, "the adoption of behavior modification techniques continued to increase, reaching new heights in 1974,"[138] the evidence of which could be seen in the

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(December 1966): 120; Charles Braswell, "Social Facility and Mental Illness," in Music in Therapy, ed. E. Thayer Gaston (New York: MacMillan, 1968) 382-387; Nancy Hadsell, "A Sociological Theory and Approach to Music Therapy with Adult Psychiatric Patients," Journal of Music Therapy (Fall 1974): 113-124 passim.

[136]Clifford K. Madsen, Vance Cotter, and Charles H. Madsen, Jr., "A Behavioral Approach to Music Therapy," Journal of Music Therapy (September 1968): 69-71.

[137]Ibid., 70.

[138]Solomon, "A Historical Study of the National Association for Music Therapy," 374.

research literature of the time; terms such as "contingent," "stimulus fading," "schedule learning," and "reinforcer" were included in the titles of research appearing in the Journal of Music Therapy.[139] Group therapy techniques also served to accomplish social adaptation goals; music in a group setting was viewed as a facilitator for increasing nonverbal communication, a developer of leisure skills, an aid to functioning within social structure, an enhancer of self-esteem, and an aid to vocational rehabilitation.[140] Activities used to achieve these goals usually involved group music performance, such a group singing or choral activities, bands, or group guitar playing.[141] Others suggested different ways in which music could be employed. Baumel described a group music therapy setting in which the members brought instruments and music to be played for the group to foster group closeness, trust, and cohesiveness. He also claimed that music selected as a background by the music therapist could be

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[139]Ibid., 375.

[140]Christine Christian, "Family Group Therapy: Implications for Music Therapy," Journal of Music Therapy (September 1967): 100-105; Phillip M. Margolis, "Community Mental Health: Harmony or Cacaphony?" Journal of Music Therapy (Fall 1972): 126; Herbert Gerwitz, "Music Therapy as a Form of Supportive Psychotherapy with Children," Journal of Music Therapy (June 1974): 61-65; Hadsell, 113-124 passim.

[141]Becky Butler, "Music Group Psychotherapy," Journal of Music Therapy (June 1966): 53-56; Gerwitz, 61-65.

used to set mood and facilitate interaction.[142] Caplan and Butler suggested the use of songs applicable to clients' needs to be played for group discussion and lyric analysis.[143] Despite the expansion during this time in applications of music to achieve therapeutic aims, discussion continued to rage among music therapists concerning the importance of music and the musical skill level of the therapist, in particular, in treatment. Madsen down-played performance abilities of music therapists in favor of increased proficiency in the areas of clinical psychology, experimental research, and physiology.[144] Gaston and Marker disagreed strongly, both contending that skilled musicianship was an essential component of effective music therapy and a basic requirement for the professional music therapist.[145] Moreno agreed with Madsen's position that high musical performance level was non-essential in achieving therapeutic goals; he even went so far as to suggest that future music therapists might be psychology

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[142]Lee N. Baumel, "Psychiatrist as Music Therapist," Journal of Music Therapy (Summer 1973): 83-85.

[143]Butler, 62.

[144]Clifford K. Madsen, "A New Music therapy Curriculum," Journal of Music Therapy (September 1965): 85.

[145]E. Thayer Gaston, "Letters and Announcements," Journal of Music Therapy (June 1966): 80.

students who have an interest in music.[146] Music therapy practices during this period were characterized by their adaptation to changing attitudes, theoretical orientations, and practices within the settings in which they worked. Out of this adaptation came innovative techniques which would shape future music therapy practice.

1975 - 1984

Several surveys were conducted during this period which attempted to define more clearly the role and function of music therapists. The current author suggests that these studies were undertaken because the wide diversity of clientele served and employment settings, a primary characteristic of this era in music therapy practice, made it increasingly difficult to describe the functions of its practitioners in all-encompassing terms. The surveys were able instead to define some general parameters and common denominators among music therapists within an ever-widening sphere of employment. This section will report the findings of the following surveys: (1) "A Survey of Clinical Practice in Music Therapy Part I: The Institutions in Which Music therapists Work and Personal Data," by Braswell, Maranto, and Decuir, (2) "A Survey of Clinical Practice in Music therapy Part II: Clinical Practice, Educational, and Clinical

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[146]Joseph Moreno, "The Identity of the Music Therapist," Journal of Music Therapy (Spring 1969): 21.

Training," by the same authors as above, (3) "Survey of Duties and Responsibilities of Current Music Therapy Positions," by McGinty, and (4) "Survey of Current Functions of a Music Therapist," by Lathom.[147] Results will be discussed in terms of observed trends in practice over the course of this period, with any observed correlations to professional development and/or research noted. Data from "Music Therapy Theory and Practice as Reflected in Research Literature," by Gfeller will also be examined.[148]

One trend that can be observed from the surveys conducted is the increase in variety of populations with which music therapists worked. Although the Braswell, Maranto, and Decuir survey determined that the largest number of practitioners worked in the area of psychiatry, many other populations were represented from their respondents.[149] These included clients with mental

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[147]Charles Braswell, Cheryl Dileo Maranto, and Anthony Decuir, "A Survey of Clinical Practice in Music Therapy Part I: The Institutions in Which Music Therapists Work and Personal Data," Journal of Music Therapy 16 (1979): 3; C. Braswell, C. D. Maranto, and A. Decuir, "A Survey of Clinical Practice in Music Therapy Part II: Clinical Practice, Educational, and Clinical Training," Journal of Music Therapy 16 (1979): 52; Judith Koch McGinty, "Survey of Duties and Responsibilities of Current Music Therapy Positions," Journal of Music Therapy 17 (1980): 153-55; Wanda B. Lathom, "Survey of Current Functions of a Music Therapist," Journal of Music Therapy 19 (1982): 3.

[148]Kate Gfeller, "Music Therapy Theory and Practice as Reflected in Research Literature," Journal of Music Therapy 24 (1987): 189.

[149]Charles Braswell, Cheryl Dileo Maranto, and Anthony Decuir, "A Survey of Clinical Practice in Music Therapy Part I: The Institutions in Which Music Therapists Work and Personal Data," Journal of Music Therapy 16 (1979):

retardation, learning disabilities, emotional disturbances, or physical handicaps, elderly clients, elderly clients with psychological diagnoses or mental retardation, adolescent clients with emotional or behavioral problems, and clients with substance abuse addictions; some respondents reported unspecified private practice, and public school employees reported working with mentally retarded, learning disabled, emotionally handicapped, physically handicapped, and multiply handicapped clients.[150] The Lathom study reported similar findings, but in terms of the following settings: (1) nursing homes or geriatric facilities, (2) private practice, (3) psychiatric practice, (4) rehabilitation or habilitation centers, (5) community-based facilities, (6) university or college, and (7) children's facilities.[151] She stated that "the most frequently reported health problem of music therapy clients was mental illness," and that "the next most frequent area was developmental disabilities."[152] The variety of settings in which music therapists were employed was reflected in the Standards of Clinical Practice adopted by NAMT in 1979; the preamble defined music therapy as "the specialized use of music in service of persons with needs in mental health,

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[150]Ibid., 5.

[151]Wanda B. Lathom, "Survey of Current Functions of a Music Therapist," Journal of Music Therapy 19 (1982): 3.

[152]Ibid., 7-8.

physical health, habilitation, rehabilitation, or special education."[153] Obviously, by this period of music therapy's history, it was widely accepted among its practitioners that their profession could be applied effectively outside the area of psychiatry.

Another observed trend from the surveys was the increased responsibility and accountability given to music therapists. McGinty reported that 78.7% of her respondents designed sessions alone with no input from other staff; 93.7% were responsible, either alone or with a team, for setting and evaluating treatment plans; and about half (46.5%) were serving as "primary therapists" for their clients.[154] Braswell, et. al., reported 78% of their respondents' music therapy activities were "on an accountability (goals, objectives) basis,"[155] and 83.67% wrote individual treatment plans and progress reports for their clients.[156] Also, 80.92% of music therapists responded either "very often" or "often" to a question concerning requests whether they were to give verbal patient progress reports

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[153]Solomon, "A Historical Study of the National Association for Music Therapy," 492.

[154]Judith Koch McGinty, "Survey of Duties and Responsibilities of Current Music Therapy Positions," Journal of Music Therapy 17 (1980): 153-55.

[155]C. Braswell, C. D. Maranto, and A. Decuir, "A Survey of Clinical Practice in Music Therapy Part II: Clinical Practice, Educational, and Clinical Training," Journal of Music Therapy 16 (1979): 52.

[156]Ibid., 54.

during staff meetings.[157] These results bear witness to the perceived gains in status and independence for the profession during this period and support the claim made by Rubin that music therapists were becoming "primary therapists."[158]

The types of tasks and activities in which music therapists engaged with their clients during this time were revealed in the Lathom survey. 80% of respondents reported that they evaluated every client and that a wide variety of items were included in client interviews, observations, and assessment in order to determine treatment.[159] Assessments included observation of behaviors in the areas of communication, socialization, cognition, motor ability, and music interests and/or knowledge.[160] The most frequent tasks subsequent to evaluation were to "maintain documentation of progress in music therapy" (74.7%), and to "prepare music therapy goals based on results" (66.7%).[161] Respondents reported engaging in a variety of tasks to accomplish certain goals; the most common centered on eliciting successful participation, appropriate

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[157]Ibid., 57.

[158]Rubin, 60.

[159]Lathom, 8; 16-17.

[160]Ibid., 17.

[161]Ibid., 18.

social behavior, and communication.[162] The three most commonly used musical vehicles for these tasks were portable accompanying instruments (72%), vocal skills (67.6%), and percussion instruments (54.5%).[163]

The final observed trend is the shift of focus from the psychiatric setting to the special education setting as a lucrative avenue for music therapy practice. With the passage of Public Law 94-142 and its provision for music therapy services, practitioners anticipated much greater involvement in the public school setting. Some surveys reflected the increased attention upon this area. Although only 6.81% of their respondents reported working in the public school setting, Braswell, et. al., provided a specific question in their survey concerning the populations served within this setting.[164] This indicates either anticipation of a larger number of respondents in this setting or a desire to note the beginning of a perceived trend in this area. Lathom reported the percentage of facilities which employed music therapists as consultants (22%), and suggested that this percentage would increase "as more music therapists are employed by public schools."[165] McGinty categorized different positions held by music therapists into

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[162]Ibid., 22.

[163]Ibid.

[164]Braswell, Maranto, and Decuir, "A Survey of Clinical Practice in Music Therapy Part I," 5.

[165]Ibid.

three "levels," with level 3 holding the highest prestige (salary and responsibility). Included in the level 3 classification was the "special education consultant."[166] This reflected the status already gained by music therapists practicing in this setting and the general positive attitude about its potential. The perceived potential for growth in this area influenced the research as well. Solomon stated that during the mid and late 1970's, "music therapists were becoming interested in special education applications and behavior modification techniques, which assumed increasing importance and attention in the music therapy literature."[167] This may be observed in the Gfeller study which tracked the percentage of articles concerned with emotional disturbance compared with those regarding mental retardation. Although a majority of music therapists continued to work in the psychiatric setting during this period, there were equal numbers of articles discussing each of these two areas between 1976 - 1978, and from 1979 - 1984 clients with mental retardation surpassed clients with emotional disabilities as the most frequently discussed population in music therapy research.[168] It seems evident that the smaller percentage of music therapists working with this

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[166]McGinty, 160.

[167]Solomon, "A Historical Study of the National Association for Music Therapy," 433.

[168]Kate Gfeller, "Music Therapy Theory and Practice as Reflected in Research Literature," Journal of Music Therapy 24 (1987): 189.

population saw great potential for its development and sought to enhance this area of practice with a solid body of research.

This period of music therapy practice was one of increased opportunity, accountability, and responsibility. Music therapists were called upon to assess clients, to implement treatment with measurable goals and objectives, and to evaluate the effectiveness of their work. They were frequently called upon to do these things independently, without input or mandates from other professionals. The result was a noticeable gain of status for this profession which would only increase in the next decade.

1985 - 1995

Music therapy practice in the past decade has seen developments in specific settings and with specific methods to the point that areas of specialization had been created within the profession. Although music therapy continues to be widely used with psychiatric populations, three other areas realized particular growth during this period: music therapy in the special education setting, in the medical setting, and in geriatrics/gerontology settings. It is the practices within these three areas that will be discussed in this section. Also of interest are the large number of music therapists who began to adapt either established therapeutic techniques or independently created theoretical

principles into unique methods of music therapy practice. Several examples of these new techniques will be examined as well. Correlations in professional development and/or research in these areas will also be discussed.

Music Therapy and Special Education

The passage of Public Law 94-142 did eventually provide a growing practice for music therapists in the public school setting, especially within special education programs. Since special education classes often contain students with a wide variety of diagnoses, e.g., autism, visual/hearing impairment, language delays, developmental disabilities and physical disabilities, music therapists must often focus on a broad variety of objectives. A study conducted by Hughes, Robbins, and King reported several "skill areas" addressed by music therapists working in the Leon County Schools' Exceptional Student Education program in Tallahassee, Florida. These skill areas were: (1) social, (2) self-esteem, (3) academic, (4) auditory, (5) visual, (6) motor, (7) social integration ("mainstreaming"), and (8) arts performance.[169] Often the objectives addressed in music therapy within this setting were the result of discussion with members of each child's Individual Education Plan (IEP) team -- i.e., a physical, occupational, or speech therapist, a special education teacher, a counselor, etc. -- and the

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[169]Jane E. Hughes, Brenda J. Robbins, and Raymond J. King, "A Survey of Perception and Attitudes of Exceptional Student Educators Toward Music Therapy Services in a County-Wide School District," Journal of Music Therapy 25 (1988): 220.

results of a music therapy assessment. Davis described this process in an article titled, "A Model for the Integration of Music Therapy within Preschool Classrooms for Children with Physical Disabilities or Language Delays." She stated:

> Music therapy goals and objectives are discussed with other team members and taken from the music therapy assessment. Broad areas such as increasing verbal social interaction, visual attending, or expressive communication skills, serve as annual or long-term goals. Items within these categories, such as initiating verbalizations with peers, maintaining eye contact with a person or task, or answering "Wh" questions (what, who, where, etc.) become objectives when a criterion for mastery is added. All music therapy goals and objectives are written and reviewed, revised, or updated on each child's Individual Education Plan (IEP).[170]

The professionals contributing to each child's IEP may suggest specific methods or procedures that complement the unique methods of music therapy, thus combining the offering of each profession to create the most effective treatment. Davis explained this process with the following:

> Specific methods and procedures, mentioned in the IEP, include whether the child is seen for individual or group music therapy, when and how to reinforce behaviors; when to provide a model or give verbal, gestural, or pointing prompts, or physical assistance; what to do if a child does not respond; and what to do when the desired level of performance has been attained. Materials utilized, such as instruments and visual aides, are also briefly mentioned in this IEP

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[170]Ronna K. Davis, "A Model for the Integration of Music Therapy Within Preschool Classrooms for Children with Physical Disabilities or Language Delays," Music Therapy Perspectives (1990): 82.

section.[171]

She also described activities commonly used in music therapy sessions:

> Music experiences include singing and chanting, playing instruments, moving, listening, creating new lyrics, and reading simple notation. Weekly classroom themes, such as foods, seasons, friends, and community helpers, are incorporated into music selection.[172]

Although its value has been the subject of much discussion,[173] the "mainstreaming" of exceptional children into regular classrooms is an area that continues to occupy music therapists. Gunsberg described the use of "Improvised Musical Play" (IMP), "a novel teaching application of music with developmentally delayed and nondelayed young children in the classroom setting,[174] to foster social play between the two groups. The goal of the integrated play was to create an opportunity for social learning, especially for the children with developmental delays. The therapist, with the use of a guitar and a few rhythm instruments, would act as "mediator" in constructing a four-stage play format. Almost all of the work of the music therapist involved observing the

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[171]Ibid., 83.

[172]Ibid.

[173]Cynthia M. Colwell, "Adapting Music Therapy Instruction for Elementary Students with Special Needs: A Pilot," Music Therapy Perspectives (1995): 97.

[174]Andrew Gursberg, "Improvised Musical Play: A Strategy for Fostering Social Play Between Developmentally Delayed and Nondelayed Preschool Children," Journal of Music Therapy 25 (1988): 179.

children's activities and improvising lyrics to describe them while playing a steady rhythmic pattern. The improvisation would eventually become repetitive and structured as the children became aware of each other's actions and engaged in unified play. He provided an update for this method with specific application suggestions in 1991. Colwell reported the benefits of adapted music instruction for special needs students in a regular music class as: (1) more on-task behavior, (2) greater success of music tasks, (3) and increased social interaction with peers.[175] Because music teachers' focus and training is only on the instruction of musical skills to "normal" students, effective mainstreaming requires consultative services from persons knowledgeable about the unique needs and characteristics of exceptional students. Music therapists frequently function in this capacity. Colwell described the consultative relationship with the following:

> A music therapist is the professional trained to use music-based assessments to determine the strengths and needs of individuals with special needs. A music educator is knowledgeable of what music skills need to be learned and what prerequisites are necessary to successfully participate in a specific activity. Through these assessments and the music therapist's knowledge of adaptations and characteristics common to certain disabilities, this musical achievement can become a reality for all students.[176]

She further characterized the consulting music therapist as "a liaison with the

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[175]Colwell, 97.

[176]Ibid., 102.

special education or support personnel..."[177] Therefore, in addition to providing direct services to students in the public school setting, music therapists help to ensure student success in the classroom through consultative services.

Gerontology

The field of gerontology has greatly expanded over the past decade, and the use of music therapy with this population has increased as well. As the number of elderly persons continues to increase in this country and people are living for longer periods of time, more interest has been taken in examining the unique needs of the elderly. Professionals who serve their needs look for ways to improve quality of life, to maintain or improve physical health, and to address emotional issues. However, "the elderly" obviously do not comprise one homogeneous group. Smith and Lipe reported several different specific sub-populations of elderly persons and geriatric settings in which music therapists worked: (1) nursing homes, (2) "locked wards" (for clients with Alzheimer's disease), (3) retirement communities, (4) adult day care centers, (5) medical centers, (6) psychiatric facilities, (7) domiciliary care centers, (8) general long- and short-term hospitals, (9) rehabilitation, and (10) assisted living.[178] One may easily glean from this information that a wide variety of needs are represented

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[177]Ibid.

[178]David S. Smith and Ann W. Lipe, "Music Therapy Practices in Gerontology," Journal of Music Therapy 28 (1991): 207.

within this population, and broad range of opportunities exists for music therapists. Indeed, during this period music therapy in gerontology had the third largest group of practitioners in the profession.[179] Despite the range and differences in needs within this population, Smith and Lipe determined some common areas for all practitioners -- i.e., assessment of clients and treatment goals addressed in sessions. Common areas of assessment included social skills, "level of functioning," cognitive skills, motor skills, affective responses, preference for musical styles, and musical background/training.[180] Treatment goals included increasing/maintaining socialization skills, sensory stimulation, increasing/maintaining cognitive skills, expression of feelings, increasing/maintaining physical functioning, increasing relaxation/reducing anxiety, creative expression, reducing problem behaviors, and spiritual affirmation; the first three goals were the ones most often used.[181] Similar materials/instruments were used as well; record/tape collections, cassette recorders, sheet music, rhythm instruments, piano, guitar, and record players were used in sessions by most music therapists.[182] Although no current studies

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[179]Ibid., 194.

[180]Ibid., 203.

[181]Ibid., 209.

[182]Ibid., 205.

have been undertaken to determine recent trends in music therapy practice with the elderly, an examination of recent literature suggests a focus on the uses of music therapy specifically with Alzheimer's clients. From 1992-1995, of the 11 articles written regarding music therapy with the elderly (two in Music Therapy Perspectives and eight in the Journal of Music Therapy, nine concerned the treatment or assessment of Alzheimer's clients. Suggested benefits of music therapy included decreased wandering, increased group participation, and increased appropriate social behavior.

Music Therapy and Medicine

The use of music therapy in the field of medicine encompasses a wide variety of settings in which clients may have very different needs. However, the general focus for music therapists is the same: to facilitate healing and/or wellness in persons regardless of specific medical condition. Music therapists have had to adapt to changes in this setting, though. In 1988, Clark and Ficken reported on the status of music therapy in the health care environment. In spite of drastic program cutbacks due to "severe economic crisis,"[183] they suggested several ways in which music therapists could survive in the field: (1) promoting their "cost-effectiveness," (2) focusing on "wellness" programs, (3) using short-term assessments and treatment, (4) utilizing large group activities, and (5)

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[183]Michael F. Clark and Carl T. Ficken, "Music Therapy in the New Health Care Environment," Music Therapy Perspectives (1988): 23.

emphasizing assessment and treatment not easily accessed by other disciplines.[184] A review of literature concerning music therapy in the health care setting reveals many different treatment areas. These areas include the use of anxiolytic music in anesthesia, AIDS, obstetrics, management and alleviation of chronic pain, surgery, stimulation or relaxation of premature infants, brain injury rehabilitation, gynecology, chemotherapy, alleviation of preoperative anxiety, physical rehabilitation, and cardiac rehabilitation. Many music therapists reported using client-preferred music to reduce perceived pain, anxiety and tension, and to promote relaxation during procedures such as surgery, childbirth, gynecological procedures, and chemotherapy. One study used music listening to reduce anxiety and its resulting negative side-effects prior to surgery.[185] Others described techniques for rehabilitative treatment. With chronic pain patients, lyric analysis was used to challenge irrational beliefs; music was also paired with training in self-regulation skills (progressive muscle relaxation, autogenics, biofeedback, guided imagery) and was employed as a vehicle for emotional expression and mood shaping through the use of the iso-principle.[186]

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[184]Ibid., 23-27 passim.

[185]Sheri L. Robb and others, "The Effects of Music Assisted Relaxation on Preoperative Anxiety," Journal of Music Therapy 32 (Spring 1995): 2.

[186]Mark E. Selm, "Chronic Pain: Three Issues in Treatment and Implications for Music Therapy," Music Therapy Perspectives (1991): 91-94.

Group music (song writing, singing) and art activities were used with persons with traumatic brain injury to promote socialization and to provide an emotional outlet for personal issues.[187] Preferred music was also used to improve participation and mood in persons participating in a cardiac rehabilitation exercise program.[188] Music was used to reduce stress and to provide pacification or stimulation for premature infants, as well as to mask aversive isolette sounds in premature infants.[189] Imagery and music were paired prior to delivery to uncover "unfinished business" in expectant mothers,[190] and during surgery to reduce anxiety.[191] The focus of music practice in the health care arena appears to be twofold: (1) to prevent the negative side-effects that inhibit treatment and recovery, and (2) to maximize the benefits of rehabilitation.

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[187]Vicki L. Barker and Betsey Brunk, "The Role of a Creative Arts Group in the Treatment of Clients with Traumatic Brain Injury," Music Therapy Perspectives (1991): 29-30.

[188]Sterling K. MacNay, "The Influence of Preferred Music on Perceived Exertion, Mood, and Time Estimation Scores of Patients Participating in a Cardiac Rehabilitation Exercise Program," Music Therapy Perspectives (1995): 91.

[189]Jayne M. Standley, "The Role of Music in Pacification/Stimulation of Premature Infants with Low Birthweights," Music Therapy Perspectives (1991): 23-24.

[190]Cathy H. McKinney, "Music Therapy in Obstetrics: A. Review," Music Therapy Perspectives (1990): 57-58.

[191]Diane Snyder Cowan, "Music Therapy in the Surgical Arena," Music Therapy Perspectives (1991): 42.

Theoretical Approaches and Music Therapy

An important aspect of music therapy practice in the last decade is the large number of unique therapeutic applications of music therapy based upon either established psychotherapeutic techniques or independently created theories. Gfeller stated that from the results of her study which found no single theory central to music therapy practice, "those in the music therapy profession might question whether the theoretical foundations of music therapy practice have been defined adequately."[192] When one considers the primary events taking place in the development of the profession during this period, the apparent lack of a recognized central theory of music therapy seems at odds with its increased prominence. Music therapy was receiving more national attention than ever before -- in legislation, in the media, in the music industry, and from other national organizations. NAMT and AAMT prepared to merge in order to unite all members of the profession. It would seem that a unified, central theory of music therapy would be desirable, as it would be more easily explainable to the public and understandable to its own and other professions. However, from the reports of clinical practice given by music therapists during this decade, this does not appear to be the case. In fact, one might argue that music therapists are questioning the necessity and/or possibility of having such a

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[192]Gfeller, "Music Therapy Theory and Practice," 192.

theory central to all music therapy practice. A review of articles appearing in the Journal of Music Therapy and Music Therapy Perspectives during the past decade yielded the following therapeutic approaches applied in music therapy practice: multimodal therapy, Gestalt therapy, cognitive and Rational-Emotive therapy, shamanism, cognitive-linguistic approach, quantum theory, and Jungian therapy. There have also been reports of independent theoretical approaches to music therapy practice. Because these theories are unique to music therapy practice, they will be examined in greater detail. This section will describe three of these original theories: (1) Kenny's model, known as "the field of play," (2) Bonny's Guided Imagery and Music (GIM), and (3) Moreno's multicultural music therapy.

The Field of Play

Kenny explained her motivation for developing the "field of play" model. She observed a need for a "new language" in which to describe the music therapy experience; one that would "accurately reflect the music therapy process, yet which can be understood and used by professionals in other fields.[193] Her model is based on "constants" she has observed from "direct experiences" in music therapy practice. Based on these "constants," she developed three "primary fields" and four "secondary fields" into which the client

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[193]Carolyn Kenny, The Field of Play: A Guide to the Theory and Practice of Music Therapy (Atascadero, CA: Ridgeview Press, 1989), 7.

and therapist enter by means of non-verbal, usually improvisatory music activity. The creation of the music itself promotes healing; thus, "the process is the product."[194]

Guided Imagery and Music

Although Guided Imagery and Music (GIM) was developed in the 1970's, this specialized form of music therapy had just "come of age" in the late 1980's, according to Bonny.[195] She claimed that "in recent years, [GIM] has generated interest for music therapy practitioners in clinical practice.[196] Her reason for this recent interest in and acceptance of her method was the following:

> Further changes within music therapy practice have taken a healthy broadening turn from exclusive reliance on behavioral principles to a willingness to brave the cold waters of uncertainty in search of music therapy theoretical paradigms.[197]

Her technique is used with clients in psychiatric populations and is usually administered in a one-on-one, private practice setting with a prescribed number of sessions. Bonny describes the GIM process as:

> ...a process that focuses on the conscious use of imagery which arises in response to a formalized program of relaxation and music to

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[194]Ibid., 89.

[195]Helen Lindquist Bonny, "Sound as Symbol: Guided Imagery and Music in Clinical Practice," Music Therapy Perspectives (1989): 7.

[196]Ibid.

[197]Ibid.

> effect self-understanding and personal growth processes in the person. Used one-to-one with a trained guide, GIM may be a powerful uncovering process in exploring levels of consciousness not usually available to normal awareness. Music selections chosen to facilitate elements of instrumental timbre, vocal color, rhythm, dynamics of pitch, intensity, and harmony contribute subtly and powerfully to mood, emotional involvement and insightful introspection. A progression of musical selections, or a profile (Bonny, 1978), chosen on the basis of ability to initiate and extend a mood or experiential state, insures continuity and provides for a secure milieu. In a GIM session, as the client becomes more immersed in his/her inner world of imagery and feeling, early life experiences emerge as real; a flood of repressed emotions may irresistibly pour forth; juxtapositions of unlikely images may bring insight and creative problem-solving. Catharsis, insight, problem-solving -- all valuable clinical goals -- are experienced.[198]

This method is one of the few that requires additional training to administer; training is post-graduate and takes three or more years to complete.[199]

Multicultural Music Therapy.

The multicultural approach, while not a fully-formed theoretical model like the Kenny or Bonny techniques, still presents its applications based upon therapeutically valid premises. Multicultural issues have come to the forefront during the past decade, and Moreno points out that "the American music therapist inevitably will be dealing with clients from a wide diversity of backgrounds." He further states that "to enhance the possibility of establishing

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[198]Ibid.

[199]Helen Lindquist Bonny, "Twenty-one Years Later: A GIM Update," Music Therapy Perspectives (1994): 72.

musical communication with clients from varying cultural backgrounds, the music therapist should have a basic working knowledge of a wide variety of representative world music genres."[200] He provides other therapeutically valid reasons for attaining such knowledge: (1) unfamiliar music might motivate unresponsive "mainstream" clients to participate and (2) music with no previous or extra-musical associations may elicit spontaneous musical and emotional responses.[201] Three specific genres of music are suggested, largely due to their accessibility to therapists and clients: Indian and African music, which are based on the oral tradition and thus require no musical training,[202] and Indonesian Samalan music, which uses instruments very similar to Orff instruments.[203] All three provide the opportunity for "immediate and successful musical participation."[204] The Indian music activity is based on a group creation of instrumental melody and drone, vocal melody, and movement. The Indonesian activity is also group-oriented, involving the playing of "repeated, easily memorized cyclic melodic patterns and repeated entrances at the same place in

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[200]Joseph Moreno, "Multicultural Music Therapy: The World Music Connection," Journal of Music Therapy 25 (1988): 17.

[201]Ibid., 20.

[202]Ibid., 22-25.

[203]Ibid., 24.

[204]Ibid., 25.

the cycle...;"[205] traditional Orff barred instruments may be used. Independent rhythmic patterns played by each member of the group on drums or other percussion provides the basis for the African music activity. Moreno concludes his argument for this approach by saying, "the music may reach the client on the deepest possible level of culture and values and a shared world view."[206]

Summary

Music therapy practice in the current decade has expanded in a different way from that of the previous ones. The past decade strove to bring music therapy to a wider variety of populations, thus expanding the practice of music therapy externally. The current decade's practitioners seek to widen the repertoire of music therapy practice through the development of new theories and techniques of clinical practice, thus expanding the practice of music therapy internally. Perhaps in the future, music therapists, like psychologists and doctors, will be highly-trained specialists in various specific techniques of clinical practice.

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[205]Ibid., 24.

[206]Ibid., 27.

Comparison of Michel's Articles and Observed Trends in Professional Development, Research, and Practice in Music Therapy

This section will compare observed trends in Michel's articles with those in the previously discussed areas of professional development, research, and practice in music therapy. Similarities and differences between his writings and these three essential components of music therapy will be examined; comparisons will be made in general, in isolated periods of time, and in single instances. Representative articles from Michel's work will be discussed in detail to illustrate those comparisons. The examination will progress chronologically in approximate ten-year periods.

1950 - 1959

Many similarities may be observed between Michel's research and significant trends occurring in the three areas of music therapy examined during this period. In the area of professional development, it was previously stated that the primary goals of the profession were to inform the public and other professionals, to define the parameters and requirements of music therapy and its practitioners, and to create opportunities for employment. Evidence of attention to each of these areas is evident in his writing. An article titled, "Purpose and Methods of Keeping Patient Case Records" is an example of his

contribution to defining the requirements of music therapists as treatment professionals. In this article, he explains how client records kept by the attending music therapist can aid treatment and provide a means of communicating with physicians who refer patients to music therapy. He implies that this practice might increase the "legitimacy" of the profession by stating, "as music therapy continues its growth as a profession, and as music therapists grow individually, maintaining efficient, usable patient case records in the music therapy department becomes an increasingly important matter."[207] The article, "Real Bases of Satisfaction in Music Therapy," described personality traits and attitudes of music therapists who find satisfaction in their work. His description provided a further accounting of what is required of an effective music therapist. When these traits are assimilated, the music therapist "can gain the utmost pleasure in being able to free himself from himself in the helping of others...."[208] Michel also wrote of the importance of informing physicians and psychiatrists of the possibilities of music therapy as a viable treatment option. In the article, "Considerations Toward the Professional Growth of Music Therapy," Michel observed:

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[207]Donald E. Michel, "Purpose and Methods of Keeping Patient Case Records," Music Therapy (1952): 82.

[208]Donald E. Michel, "Real Bases of Satisfaction in Music Therapy," Music Therapy (1954): 168.

> the effectiveness of music therapy often depends upon a state of their [psychiatrists'] confidence in its potential application and in the potential effectiveness of music therapists...where there has been a real, cooperative effort by psychologists to learn about the possibilities of music therapy and an interest exhibited in working with music therapists there has been the most effective use of it made.[209]

He even went so far as to suggest that the psychiatrist receive training about the uses of music therapy in order to "prescribe it intelligently for his patients."[210] In regard to creating employment opportunities, Michel directed a 1957 study to determine the possibility of providing music therapy services to prison inmates. The results were reported in the article, "A Study to Determine Potential Music Therapy Needs in a Federal Correctional Institution," which concluded that the study "seems to indicate a positive need for development of music therapy activities at this particular institution."[211] Like his colleagues, Michel was very outspoken about the need for valid scientific research within the profession. In 1953, he examined current studies which addressed the "Nature of Music Therapy" or the "Aims of Music Therapy" in the article, "Contemporary Research Projects in Progress within the Long Range Design Framework -- A Review of

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[209]Donald E. Michel, "Considerations Toward the Professional Growth of Music Therapy," Music Therapy (1956): 86.

[210]Ibid., 87.

[211]Donald E. Michel, "A Study to Determine Potential Music Therapy Needs in a Federal Correctional Institution," Music Therapy (1957): 209.

Trends." He compared the benefits of developing a base of scientific research to the acceptance enjoyed by the field of psychotherapy:

> ...music therapy may look forward to procedures based on scientific knowledge about the medium and about the processes operating therewith, just as psychotherapy is based on psychological knowledge gained from scientific research and sometimes on psychoanalytic knowledge gained from objective reporting of accumulated experience. Music therapy must always be based on such knowledge as is already available in these broader fields of therapy in which it operates, but it should also look forward to a fund of knowledge based on research in its own operations.[212]

He encouraged music therapists to cultivate an attitude of "research-mindedness" and to report even "amateurish" research because "amateur explorers and researchers have made important discoveries in the past, and in some cases have provided fuel to experimental ideas which have proven stimulating bases for further research by professionals."[213] He recommended the study of research in related professions, claiming that the music therapist would "find it profitable in his own work in this field which yet remains largely experimental."[214]

Some of Michel's descriptions of clinical practice reflected the general

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[212]Donald E. Michel, "Contemporary Research Projects in Progress within the Long-range Design Framework," Music Therapy (1953): 228-29.

[213]Donald E. Michel, "Other Research Literature Related to Music Therapy," Music Therapy (1955): 202.

[214]Ibid.

practices of the time rather closely. He described the use of music for sedative purposes in, "A Study of the Sedative Effects of Music for Acutely Disturbed Patients in a Mental Hospital." He provided suggestions for music selection in terms of "functional" aspects, such as dynamics, tempo, etc., and concluded that, "music, carefully selected on the basis of functional music criteria, can be used with predictable success for general sedative purposes with a group of disturbed mental patients."[215] Of interest is the fact that the data collected for this research was completed at the Winter V. A. Hospital in Topeka, Kansas, in 1947.[216] Other reports of the use of music for sedative purposes in mental hospitals were made in the 1950's; the application of music in this way was fairly common. The fact that Michel's research predates these reports may suggest that his research set a precedent for this method of treatment. Other clinical practice articles give evidence of his forward thinking. In the article, "A Survey of 375 Cases in Music Therapy at a Mental Hospital," (1958) and its concluding report (1959), Michel made several progressive observations regarding treatment and the role of the music therapist. For example, although the case studies were of patients in a long-term mental health care facility, Michel discovered that the average duration of participation in music therapy services

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[215]Donald E. Michel, "A Study of the Sedative Effects of Music for Acutely Disturbed Patients in a Mental Hospital," Music Therapy (1951): 54.

[216]Ibid., i.

was only 4.4 months.[217] Based upon this finding, he determined:

> There appears to be a need for further adaptation and development of musical media and musical materials which can be useful in the study of music and in music therapy procedures for short-term patients who are often musical beginners.[218]

He also again made a plea for scientific research, particularly in the area of evaluating treatment results of music therapy.[219] The article, "Some Applications of Group Therapy Methods with Music Therapy" anticipated the shift to this treatment modality in the mid 1960's, especially in regard to the rationale behind it. He suggested that the benefits of this approach center around increasing socialization skills. Isolated clients had begun to relate to each other, drawing a sense of identity from each other, and receiving support through shared problems.[220] Music could be used to influence the mood of the group and in activities to encourage group participation.[221] These statements are the precise arguments used to support group therapy in the 1970's.

Michel's articles during this period contained elements of both the

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[217]Donald E. Michel, "A Survey of 375 Case Records in Music Therapy," Music Therapy (1958): 174.

[218]Ibid., 175.

[219]Ibid.

[220]Donald E. Michel, "Some Applications of Group Therapy with Music Therapy," Music Therapy (1954): 205-6.

[221]Ibid., 206.

establishment and the pioneer. The subject matter of many of his articles were directly related to the settings in which he practiced at the time each article was written. Until 1954, Michel was Director of Music Therapy at the Winter V. A. Hospital in Topeka, Kansas. This setting was common to many practitioners during this period, and the foci of his articles reflected this trend. After 1954, Michel was establishing the music therapy program at Florida State University and his role as a music therapist was altered from direct service provider to educator and spokesperson, hence, a large number of his articles reflected the profession's desire to inform members outside the profession about music therapy and to define the profession for its practitioners. However, some articles explored the possibilities of music therapy and made predictions for the future. One observation must be noted about Michel's writings in this period. Although he argued for the need for scientific research in several articles, none of his own contain any statistical data. Like most literature from this period, all of his articles were descriptive or philosophical in nature.

1960 - 1974

Michel's articles between 1960 and 1974 focused on three areas: (1) reporting and describing various aspects of music therapy, (2) the use of music therapy with speech disorders, and (3) music therapy in the school setting with

"problem" or "disadvantaged" children. In regard to the first area, two factors probably contributed to his attention to it. First, as NAMT president from 1959 - 1961, it was his duty to address the members regarding the progress and status of the profession. He did so in two articles: "...And the Patient Gets Well," and "Music Therapy in Troubled Times." In the first article, he cited NAMT's membership in the International Study Group and the AMA's committee on allied health professions as evidence that music therapy was approaching "the achievement of an equal, respected place among older, more established therapies."[222] This sentiment was most certainly reflected by developments in the profession during the decade which followed this statement. As discussed in the "Professional Development" section of this study, music therapists were given more responsibility and had more accountability in the treatment of clients. The second article touched on a subject which would be hotly debated over the next decade -- and beyond. In a discussion of the "internal" and "external" problems of the music therapy profession, he stated:

> A final problem, which is neither altogether external nor internal to NAMT, is that of the uniqueness of training demanded of the music therapy. To find persons who can specialize literally in two fields -- music and therapy -- without becoming schizophrenic, is no small

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[222]Donald E. Michel, "...And the Patient Gets Well," Music Therapy (1960): 7.

problem![223]

This statement reflects the unresolved position in the profession about the degree of importance of music and therapy in treatment. The second contributing factor was the fact that music therapy had been "organized" for ten years; it was somewhat established and was growing rapidly. There was a great deal of information to report. As a long-standing member of NAMT and a seasoned practitioner, Michel was in a position to do the reporting. His contributions in this area included a regional report, a survey of the clinical practices of NAMT members, a report on the use of research in music therapy education, and a description of music therapy practices around the world.[224]

His attention to music therapy with speech disorders was basically an exploration of uncharted territory. In 1960, he stated, "A search of the literature reveals very little information on music therapy with speech therapy and almost

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[223]Donald E. Michel, "Music Therapy in Troubled Times," Music Therapy (1961): 8.

[224]Donald E. Michel, "Music Therapy in the Southeastern United States," Music Therapy (1952): 201-4; "Professional Profile: The NAMT Member and His Clinical Practices in Music Therapy," Journal of Music Therapy II (December 1965): 124-129; D. E. Michel and C. K. Madsen, "Examples of Research in Music Therapy as a Function of Undergraduate Education," Journal of Music Therapy 6 (Spring 1969): 22-25; D. E. Michel, "Music Therapy: An Idea Whose Time Has Arrived Around the World," Journal of Music Therapy 8 (Fall 1971): 90-95.

no references to music in speech therapy with cleft palate children."[225] He published two reports on the use of music therapy with "cleft palate children" at Florida State University in 1960 and 1961. The first study did not attempt to use a scientific approach, but simply wanted to "explore more specific therapy applications through music in various group and individual situations while working closely with and under the guidance of speech therapists..."[226] The second report in 1961 was more directed. The activities used "attempted to make a direct application of their work in music to the individual speech problems of the children in accordance with the speech therapy goals set up by the Speech and Hearing Clinic."[227] Although this "primary" goal was deemed successfully met in helping the children to improve their speech, also noted were the "side" benefits of improved social skills and increased self-confidence through group music participation.[228] This report echoes Michel's earlier statements about the benefits of group music therapy -- statements that would be repeated by others in the decade to come. In an article titled "The

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[225]Donald E. Michel, "Music Therapy in Cleft Palate Disorders," Music Therapy (1960): 126.

[226]Ibid., 127

[227]Donald E. Michel, "Music Therapy in Cleft Palate Disorders (II)," Music Therapy (1961): 111.

[228]Ibid., 114.

Development of Music Therapy Procedures with Speech and Language Disorders" Michel and May examined the studies conducted with this population to date. The results revealed growth in the use of music therapy in conjunction with speech therapy. They also suggested that "perhaps future research and development will eventually lead to a special technology, useful to both speech therapists and music therapists."[229] Michel's involvement with this population at Florida State University most certainly contributed to the growth of music therapy applications in this area.

Michel's writings in the third area were primarily concerned with music therapy in the special education setting (although they were not specified as such). The article "Music and Self-Esteem Research with Disadvantaged, Problem Boys in an Elementary School" was significant for several reasons. First, it reported its findings based on statistical data. This was the first of Michel's published articles that did so. As noted in the "Research" section of this study, Jellison reported an increase in experimental research articles in the late 1960's and early 1970's. Michel could have been following this trend. Also of significance was the use of a "behavioral research model...to assess the

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[229]Donald E. Michel and Nancy Hudgens May, "The Development of Music Therapy Procedures with Speech and Language Disorders," Journal of Music Therapy II (Summer 1974): 74.

generalization of the effects of music therapy to the classroom."[230] The use of this model paralleled common music therapy practice during this period and its focus on behavior modification techniques. Lastly, the focus on children with "learning and behavior problems"[231] in the classroom setting was significant. The goals of this study were to promote self-esteem in children with a "failure-set" and to increase attending through administration of contingent music.[232] Although this article predated Public Law 94-142 and any large-scale involvement in the special education setting on the part of music therapists, these types of goals would become common as the use of music therapy in public schools increased. During the time this article was written, Michel was Director of Music Therapy at Florida State University; this program was well known for its behaviorist approach to music therapy instruction and applications. Perhaps Michel anticipated the possibilities of behavioral methods with children in the special education setting.

Michel's articles during this period reveal him as a leader in the music therapy profession. His articles sought to inform members of the profession

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[230]Donald E. Michel and Dorothea Martin, "Music and Self-Esteem Research with Disadvantaged Problem Boys in an Elementary School," Journal of Music Therapy 7 (Winter 1970): 124-25.

[231]Ibid., 124.

[232]Ibid., 127.

about developments in their field. They also predicted possible directions. His articles gave evidence of a desire to explore the possibilities of music therapy applications. As trends within the profession moved away from the psychiatric setting and explored new areas, so too did his writings.

1975 - 1984

Michel continued in his leadership role through the writings during this period. His article, "Music Therapy as a Career" described the functions of music as a therapeutic tool, the role of the music therapist, the goals of music therapy, the persons with whom it is used and why, job possibilities, and the training requirements for music therapists.[233] The goal of this article was obviously to inform the lay-person about music therapy -- a task necessary to increase the visibility and acceptance of the profession. Music therapy at this time was gaining in national recognition, and it was important to inform the public to ensure continued recognition. Michel undertook that responsibility with the writing of this article. He also continued to inform members of the profession about music therapy. In the article, "Music Therapist Role Changes in the USA since 1946," Michel characterized the current status of music therapy as a field

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[233]Donald E. Michel, "Music Therapy as a Career," The American Music Teacher (1977): 18-20.

gaining responsibility in many areas of treatment.[234] He also predicted the music therapy roles which were likely to realize increased emphasis in the future: (1) direct-care giver, (2) entrepreneur, salesman, public relations, etc., (3) college educator, (4) special educator, (5) researcher, (6) composer/arranger, (7) counselor, (8) consultant, and (9) assessor.[235] Certainly, many of his predictions have been realized. Music therapists have become responsible for all areas of treatment as direct-care givers. They assess, develop and implement plans for treatment, and evaluate results. They strive in their communities, states, and on the national level to increase recognition and employment opportunities. They are employed in ever-increasing numbers in the public school/special education setting as both direct-care givers and consultants. More music therapists are engaging in experimental research with each passing decade. It appears that Michel's vision of the future for music therapy was quite accurate.

Michel also continued his research in the area of special education during this period. This is not surprising, since Public Law 94-142 had just been passed and music therapists were very optimistic about possible applications in this setting. Another possible reason for his continued interest with this population was his location during this period. Michel was Professor and Coordinator of

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[234]Donald E. Michel, "Music Therapist Role Changes in the USA Since 1946," College Division Research Reports (1982): 10.

[235]Ibid., 16-17.

Music Therapy at Texas Woman's University in Denton, Texas, and music therapy in the public schools, both for direct service and for student practicums, was becoming more widely accepted in this area. In addition, research concerning special education and childhood exceptionality increased significantly in the mid-1970's and 1980's, as evidenced by the surveys discussed in the "Research" section of this paper. Michel made several significant contributions to this treatment area in his writings. His article, "Music, Music Education, Music Therapy -- What are their Roles in Special Education?" delineated the role of the music therapist in special education as distinct from those of the music performer and the music educator based upon the difference in focus on goals and training. He stated:

> These needs and goals [of the client] are the first consideration in therapy, and very often determine a quite different approach than is customarily made if the activity is simply performance or is being taught (often toward performance goals). Music therapy makes use of performance, and of music education techniques, but requires a fundamentally different approach, as well as a very different background of knowledge than is necessary for performance or education. This is the basic answer to the question of what music in special education should be. It should not be entertainment (or performance) alone; it should not be music education alone; with today's level of development in the field, it should be music therapy.[236]

As music therapists began providing services in this setting in larger numbers, Michel realized the need to clarify their function apart from other music-related

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[236]Donald E. Michel, "Music, Music Education, Music Therapy -- What are Their Roles in Special Education?" Musikoterapi-Nytt (April 1977): 29.

services, thus providing a "rationale for the use of music therapy in special education, rather than music entertainment or music education."[237] This article is an additional example of Michel's leadership through his writings. Another article sought possible applications of music therapy with children having reading difficulties.[238] It investigated ways in which children process verbal information, focusing especially on hemispheric processing, by pairing music with words in one hemisphere, in both hemispheres, and using words alone. Statistical data were reported in this study, and although data concerning hemispheric processing were inconclusive, it was determined that music paired with words in general enabled more retention of definitions than the presentation of words alone.[239] Michel suggested that further research be conducted to create "concrete applications...to aid in therapeutic work with handicapped children exhibiting reading difficulties."[240] Research efforts concerning the "psychology of music" and the "influence of music on behavior" were increasing during this period, most likely as a means to determine possible clinical applications.

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[237]Ibid.

[238]Donald E. Michel and others, "Music Therapy and Remedial Reading: Six Studies Testing Specialized Hemispheric Processing," Journal of Music Therapy 19 (1982): 219-229.

[239]Ibid., 228.

[240]Ibid., 229.

Michel's article was a good example of this type of research. Finally, at the end of this period, Michel provided a review of student research conducted in the special education setting since 1975, including a more detailed examination of four recent studies. The article, "Recent Research in Music Therapy Applicable to the Handicapped in Schools" reported this research because the studies were largely unpublished, but had applications in school settings.[241] Included in the report were "handbooks" for music therapists, studies on speech training, integration of special education students, assessments, and case-study examples. Michel's study provided a description of the variety of ways in which music therapy could be used in the special education setting. A description of this sort was probably very beneficial and timely. As Public Law 94-142 had been in place for nearly a decade, music therapy practice in this area was established, and more music therapists were entering the field. The reporting of new and ground-breaking research was necessary to insure the growth of music therapy within this setting.

Michel continued his leadership role during this period through articles designed to inform the public, to recruit new members into the profession, and to keep current practitioners up-to-date. He did not hesitate to offer his opinions

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[241]Donald E. Michel, "Recent Research in Music Therapy Applicable to the Handicapped in Schools," College Division Research Reports (1984): 1.

about needs in the profession or his philosophy concerning particular aspects of music therapy. His writings in the area of special education reflected this attitude, as did his articles "about music therapy." His research efforts of this period followed the general research trends of the period, but they did not follow in content -- they led.

1985 - 1995

Although Michel continued to contribute to the profession throughout the latest decade, much of his work concentrated on lectures, conference presentations, assessments, and a book translation, all of which are not included in the scope of this study. However, two significant pieces of research written during this period will be examined in this section.

An article titled, "Growing Together Through Music: Music Therapy in a Life-span Developmental Skills Model" provided a comprehensive description of how music therapy might be employed at all stages of life. He did this in terms of the specific developmental needs encountered during each stage in the areas of motor skills, cognition, social/emotional skills, and communication skills. He explained his philosophy about how problems may occur, thus creating the need for intervention:

> Stress, when it becomes Distress, is at the origin of most human problems. The result of prolonged distress may take the form of

> Disease, Disorder, or DISABILITY. The problems resulting from them, in turn, are reflected in the loss, lack of, or distortion of developmental skills, in the major areas just mentioned [motor, *communication, social/emotional, and cognitive skills*].[242]

In effect, Michel described the culmination of music therapy practice as it had become: a mode of treatment that was applicable to all areas of life. With this article, Michel provided his own "comprehensive theory of music therapy."[243] This article is very much in keeping with the research trend of the time, as noted by the current author in the "Research" section of this study. Unique theoretical applications of music therapy were reported in significant numbers during the mid-1980's to the present; these contributed to the internal development of the field. Michel's article also made a contribution in this way.

The final article to be examined is one that relates to the increased interest regarding music therapy applications in the field of medicine during this period. The connection of music and medicine was a subject that was given particular attention in the Dallas and Denton, Texas, areas, specifically through the "Arts of Health" seminars given at Southern Methodist University in Dallas, and the discussion at the University of North Texas in Denton concerning the development of a music and medicine department. Michel's proximity to these

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[242]Donald E. Michel, "Growing Together Through Music: Music Therapy in a Life-Span Developmental Skills Model," Proceedings of the Australian Music Therapy Association 5 (1985): 1.

[243]Ibid., 1.

programs might have influenced his interest in this area, particularly in regard to the use of music in pain relief. Although several studies had been conducted concerning the use of music in pain relief, Michel and Chesky's study, "The Music Vibration Table (MVT™): Developing a Technology and Conceptual Model for Pain Relief," paired music and vibration for the relief of pain in a controlled environment. As stated by the researchers, "with the MVT, precise measurement and control of music vibration can be made since the MVT is designed to measure frequencies and amplitudes of vibrations as they have an impact on the subject's body."[244] The results of several pilot studies were reported; all subjects experienced a perceived reduction in pain after treatment on the MVT (based upon pain perception questionnaire scores). Based upon their results, the researchers suggested several questions for future research, such as: "How will different types of music affect pain? How will different kinds of pain patients react to the treatment? Will music preference have an effect on pain relief?"[245] They proposed that the use of music in the treatment of pain should be pursued because "it impacts upon so many areas of disability,

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[244]Kris S. Chesky and Donald E. Michel, "The Music Vibration Table (MVT™): Developing a Conceptual Model for Pain Relief," Music Therapy Perspectives (1991): 32.

[245]Ibid., 37.

disease, and disorder,"[246] and that music therapists had the potential to become "recognized experts in the treatment of pain."[247] Again, Michel was an innovator with a current music therapy trend.

Summary

A comparison of trends and developments in the profession, practice, and research in music therapy with representative examples of Michel's articles throughout the 45 years of "organized" music therapy yield several conclusions. First, Michel was aware of these trends and developments -- he had his "finger on the pulse" of music therapy. Furthermore, he was a contributor to them through his participation in and reporting of innovative studies. Lastly, he was (and continues to be) a leader in the field. Through his articles he freely expressed personal views, philosophies, and predictions for the direction of music therapy. People with this kind of vision are necessary to insure not only the health, but the growth of a profession in any field. Through the contributions of his research, Michel has demonstrated his leadership role and visionary status within the music therapy profession.

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[246]Ibid.

[247]Ibid.

CHAPTER V

SUMMARY AND CONCLUSIONS

A content analysis of the research articles written by Michel during the course of his career provided insight into his contributions to the profession. First, he personally provided it with a large body of research. Next, he endeavored to describe the profession within a wide variety of contexts for practitioners and laypersons alike. He also explored the possibilities of music therapy practice within a considerable diversity of settings. Finally, he frequently declared his position on the status, needs, and direction of the profession.

An examination of trends in professional development described the evolution of music therapy from its "hospital music" beginnings. Early practitioners were employed primarily in Veteran's Administration or mental hospitals, and their work was closely supervised by physicians or psychiatrists. With changes in mental health care came added responsibility and increased independence for music therapists. As the profession became more established, the settings in which music therapists worked became more diverse. Practitioners explored possible applications for new populations, thus expanding their spheres of opportunity and influence as a viable therapy. Legislation

played a significant role in the development of the profession. Changes created by P.L. 88-164 -- the Mental Retardation Facilities and Community Mental Health Centers Construction Act -- in 1963, and P.L. 94-142 -- the Education for All Handicapped Children Act -- in 1975 helped to provide a place for music therapy among other the adjunct therapies. Later, music therapists became directly involved in legislation, such as with the Older Americans Act Amendments in 1992, that might impact them. NAMT ensured the validity of the profession and the respect of other professions by establishing standards of practice, curriculum and training standards, a code of ethics, a certification examination, professional journals, and liaisons with other organizations. The music therapy profession currently enjoys recognition by a wide variety of established professions. It receives attention from all areas of the media and from the music industry. Furthermore, its official organization, NAMT, has gained influence on the national level in legislation and in its dealings with other organizations.

Music therapists recognized the need for valid research early in the profession's history. In the beginning, research was necessary to build a foundation for clinical treatment and theory and to establish credibility. The effectiveness of music therapy had to be proven through scientifically-valid research. As a young profession, music therapy depended on research to define what its practitioners were doing. Early research primarily consisted of

philosophical and descriptive articles. Practitioners identified a need to debate the nature and underlying theories of music therapy, as is typical within any young profession, and music therapists might not have had the training necessary to conduct experimental research at this point. As the profession progressed, fewer philosophical articles were written, and greater numbers of descriptive articles appeared. Expansion of treatment settings created the opportunity for larger numbers of articles describing clinical treatment practices. However, increased responsibility and accountability for music therapists created a greater necessity for statistical research. By the 1980's experimental research was the most frequently-occurring mode of inquiry in the Journal of Music Therapy; philosophical articles occurred least frequently. During the past ten years, a shift of focus has taken place in music therapy research. The variety of populations and/or topics discussed in articles has remained relatively stable. Instead, music therapists are reporting specific therapeutic applications upon established populations. Current research indicates an increase in original theories of clinical practice and a trend toward specialization within specific populations.

Music therapy practice initially focused on the treatment of clients with mental illness. Music therapists frequently used music to "sedate" clients or to alleviate anxiety during procedures such as shock therapy. With the advent of

community-based treatment came group music therapy and short-term therapy techniques. Social and environmental adaptation became the focus of treatment. As more music therapists entered the special education setting, behavior modification techniques were frequently used in clinical practice. By the late 1970's the NAMT included persons with needs in mental or physical health, habilitation, rehabilitation, or special education in its definition of those who receive music therapy services. By 1980, music therapists often functioned a "primary therapists;" they were responsible for client assessment, treatment implementation, and evaluation. Current music therapy practice indicates a trend toward specialization within specific settings, with noticeable growth in the areas of special education, gerontology, and medicine. Finally, of particular note is the seemingly unresolved debate among practitioners (which has taken place for at least as long as NAMT has been in existence) concerning the importance of music versus the importance of the therapeutic relationship in music therapy treatment.

A comparison of trends in Michel's writing with professional development, research, and practice trends in music therapy revealed many parallels; it also showed Michel to be a leader and visionary in the music therapy profession. His early writings often focused on practices within the psychiatric setting, and were primarily descriptive or philosophical in nature. However, he explored new

techniques, such as group therapy; he suggested innovative treatment methods, such as adapting treatment to accommodate short-term goals; and he researched possible areas for expansion of music therapy services, such as in correctional institutions. Articles in the 1960's further reflected his leadership role in the profession. He frequently reported on the status, needs, or direction of music therapy; his research at this time described a wide variety of topics related to all aspects of the profession. He also continued to explore new territory for music therapy applications, such as in the treatment of children with speech and language disorders. His writings about the use of music therapy in the special education setting pre-dated P.L. 94-142, indicating that he recognized the possibilities of behavior modification techniques in the setting. Michel continued to research the use of music therapy in the special education setting throughout the 1970's and 1980's, and his writings revealed his visionary status. He described the role of music therapy in special education as a treatment separate and distinct from music performance and music education, thus providing the profession with a justification for its use in this setting. He also predicted areas of music therapy which would gain increased emphasis in the 1990's -- most of his predictions have since been realized. Articles written by Michel during the past ten years parallel the current focus of music therapy research. His "life-span developmental skills" model, which proposed a unique

method of treatment for persons within a variety of settings at all stages of life, is very much in keeping with current research trends. Likewise, his study on the use of music in pain management reflects the current interest in music therapy applications in the medical setting. Again, both of these articles were original in their approach. The body of Michel's articles, when compared to the evolution of the music therapy profession, showed him to be an innovator and a visionary in the profession.

This research has clearly shown how the contributions of one person, particularly through research, can influence the direction of a profession. The current researcher hopes that two benefits might be gained from this study: first, that others might realize the importance of research and be encouraged to contribute in this way to the profession; and second, that the importance of historical research, in particular, might be better understood so that more persons will pursue this mode of inquiry. Now is the time to take advantage of a unique opportunity in historical research -- to conduct it while persons who helped shape the profession from its beginnings are still alive. Similar studies might create a clearer picture of the development of music therapy. A greater understanding of the profession could contribute to the success of all music therapists.

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APPENDIX

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DONALD E. MICHEL

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