

CHAPTER I



Music Therapy: An Overview

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Music therapy is one of the most beautiful of professions. To nourish and enhance the healthy essences of the human being through the creative, therapeutic use of music is a profoundly enriching life's work. To receive the benefits of this therapy is a profoundly enriching experience.

INTRODUCTION

Historical Perspective

Viewed historically, music as therapy is both ancient and young; its roots deep and its branches ever growing. The development of music therapy as a profession has been in process since the power of music as a mode of expression was first experienced. This power lies in its inherent nature and its congruence with human feelings, emotions, and states of being.

The concept of the power of music is found in literature ranging from that of the Egyptians and Greeks to that of the present day. Thousands of years before the advent of the profession of music therapy, the shaman or medicine man of many cultures was aware of the curative power of music and used it directly in healing. This power was also known to the healing cult of Asklepios, an actual or mythical priest-physician who was worshipped as a demigod in Greece and later as Aesculapius, the god of medicine, in Rome. In classical Greece, Pythagoras prescribed specific musical intervals and modes to promote health, and Plato linked music to the moral welfare of the nation in *Laws*, a work that contains a poetic description of music and movement as a means of restoring the being to health and harmony (Meinecke, 1948). Among the biblical tales of the restorative effects of music, we learn that David, by playing his harp, eased the afflictions of Saul.

Over the centuries, there has been a search for methods of using music for mental disorders. As milieu therapy began to be introduced into psychiatric hospitals (Jones, 1953), the seeds of a new therapy were being planted.

In an attempt to bring some joy into the lives of hospitalized persons, professional musicians began to perform, conduct bands and choral groups, and encourage patients to begin or resume the study of instruments.

It was not, however, until veterans of World War II began to fill hospitals to overflowing that these same musicians became aware of the need for knowledge and understanding of the many psychopathological as well as physical health issues that plagued war victims. It was no longer possible merely to entertain or engage them in activities. It had become imperative to give service of a therapeutic nature through music. That it would mean preparation of a new and different kind to deliver such service was recognized by hospital personnel, psychiatrists, and music educators alike. The first academic program to train music therapists was developed and instituted at Michigan State University in 1944.

As the field branched out, there emerged a need to develop standards for the education and training of music therapists. As a result, in 1950—the year that marks the beginning of the profession of music therapy—a group comprising psychiatrists, professional musicians, and music educators, originating at the Menninger Clinic in Topeka, Kansas, met in New York City for the purpose of founding a national organization named the National Association for Music Therapy (NAMT). By 1953, minimal education and clinical training requirements leading to a baccalaureate degree and registration as a music therapist were instituted in several college and university music therapy programs.

In 1971, another national organization, the American Association for Music Therapy (AAMT),¹ came into being. This organization was founded by music therapy practitioners, music educators, and psychiatrists to meet the needs of an expanding field and the growing diversity of client populations, especially those in large urban centers (as indicated by its original name, the Urban Federation for Music Therapists). Based in metropolitan New York, this organization approved its first music therapy program at New York University.

In the spirit of working together toward a united front for music therapy, both organizations joined forces in 1998 to create the American Music Therapy Association (AMTA). Instead of two separate governing bodies, the music therapy profession is represented by one executive board

1. Until 1998, NAMT and AAMT was legally authorized to grant registration and certification to the music therapist as a Registered Music Therapist (R.M.T.) and a Certified Music Therapist (C.M.T.), respectively.

that works to further the practice of music therapy throughout the United States. Board certification, maintained by the Certification Board for Music Therapists (CBMT), is now required; music therapists no longer receive registration or certification, but must pass the national board certification exam and maintain the credential, Music Therapist-Board Certified (MT-BC), to practice.

It is from these mythical and historical roots that the discipline of music therapy has sprung.

Academic and Clinical Training of the Music Therapist

The education of the music therapist requires multidisciplinary study including courses in musicianship, behavioral sciences, and theories of psychiatry and psychotherapy, as well as clinical experience as a music therapy intern. The separate approaches to curriculum planning of the NAMT and AAMT were combined as part of the unification process. Colleges and universities offering baccalaureate degrees in music therapy must adapt to the changes in academic and clinical training set forth by AMTA by March 2006.

Curricula, reflecting the educational structure and using the unique resources of the institution, are based on the following competencies in areas considered essential to music therapy practice. AMTA-approved programs must not only be comprised of these following areas, but must show evidence of a competency-based approach²:

- Musical Foundations
 - Music theory and history
 - Composition and arranging skills
 - Major performance medium skills
 - Keyboard, voice, and guitar skills
 - Nonsymphonic instrumental skills
 - Improvisational skills (instrument and vocal)
 - Conducting skills
 - Movement skills

2. Adapted from “Essential Competencies for the Practice of Music Therapy,” by K. E. Bruscia, B. Hesser, and E. H. Boxill, 1981, *Music Therapy*, 1(1), pp. 43–49.

- Clinical Foundations
 - Exceptionality
 - Principles of therapy
 - The therapeutic relationship
- Music Therapy
 - Foundations and principles
 - Client assessment
 - Treatment planning
 - Therapy implementation
 - Therapy evaluation
 - Documentation
 - Termination /discharge planning
 - Professional role/ethics
 - Interdisciplinary collaboration
 - Supervision and administration
 - Research methods
- General Education
- Electives

(AMTA, 2003)

A minimum of 180 hours of preinternship field training is required to gain diverse field experience prior to the internship. This phase of training introduces and orients students to a variety of client populations, institutional settings, treatment approaches, and music therapy methods and defines the role of a music therapist in various clinical environments. The internship (a minimum of 1020 hours) is the culminating experience in the student's program and is considered a crucial period in the training process. Students may apply for an internship position from the National Roster list of AMTA-approved internship sites up to one year prior to their coursework completion. In addition, students have the option of obtaining a university-affiliated internship in which the academic institution contracts with a facility that does not have a National Roster internship program, but does have the means to train a music therapy student.

Once students have completed their coursework and internship, they must pass the national board certification exam. The CBMT grants the credential MT-BC, which must be maintained by means of continuing education hours or exam recompletion on a five-year cycle. For those wishing advanced education, graduate degrees at both the master's and doctoral levels are offered by several universities.

THE PRACTICE OF MUSIC THERAPY

Music Therapy Defined

Music—a universal human phenomenon—is structured tonal sound moving in time and space. From its origins in the primitive imitation of nature's sounds—songs of birds, calls of animals, and waves of the ocean—music has evolved into organized forms that have varied in style and idiom from century to century and culture to culture. “Sound is an ordinary natural phenomenon: Music on the other hand is the result of man's conscious development of sound into an art and science” (Rowley, 1978, p. 9). The basic elements of music—designated throughout this book as the components—are rhythm, melody, harmony, pitch, tempo, dynamics, timbre, and, referentially, the text of song (included as a component because of its fundamental importance to music therapy). These components embody qualities and attributes that have an impact singly, in different combinations, and as a gestalt (Clendenin, 1965).

Therapy, from the Greek *therapeia*, is fundamentally the rendering of a health-giving service. When the term *therapy* is applied to the treatment of mental, psychological, and behavioral disorders, it becomes interchangeable with the term *psychotherapy* and covers a variety of modern therapeutic and psychotherapeutic approaches (Binder, Binder, & Rimland, 1976). Music therapy can be considered a psychotherapeutic process inasmuch as it is “a form of treatment . . . in which a trained person deliberately establishes a professional relationship with the object of removing, modifying, or retarding existing symptoms, of mediating disturbed patterns of behavior, and of promoting positive personality growth and development” (Wolberg, 1954, p. 8). As the approach to music therapy in this text demonstrates, the methods, theories, and techniques of modern therapies and psychotherapies are adapted and incorporated into the practice.

Music therapy is an amalgam of music and therapy. When music, as an agent of change, is used to establish a therapeutic relationship, to nurture a person's growth and development, to assist in self-actualization, the process is music therapy. In this process, music is consciously used for the enhancement of living, being, and becoming. Broadly defined, music therapy is the use of music as a therapeutic tool for the restoration, maintenance, and improvement of psychological, mental, and physiological health and for the habilitation, rehabilitation, and maintenance of behavioral, developmental, physical, and social skills—all within the context of a client—

therapist relationship. A nonverbal treatment modality that is applicable to both the verbal and nonverbal person, it serves those of a wide age range and with a wide diversity of disorders. It can be a diagnostic aid (Nordoff & Robbins, 1971, 1977) and can reinforce other treatment modalities.

Fundamental reasons for the efficacy of using music as a therapeutic agent are as follows:

- It is a cross-cultural mode of expression.
- Its nonverbal nature makes it a universal means of communication.
- As a sound stimulus it is unique in its power to penetrate the mind and body directly, whatever the individual's level of intelligence or health need. As such, it stimulates the senses, evokes feelings and emotions, elicits physiological and mental responses, and energizes the mind and body.
- Its intrinsic structure and qualities have the potential for self-organization of the individual and organization of the group.
- It influences musical and nonmusical behavior.
- It facilitates learning and the acquisition of skills.
- It is an eminently functional, adaptable, and aesthetic modality applicable to all client populations.

The overall goals of treatment through the therapeutic use of music are (a) to effect personal change, (b) to facilitate interpersonal relations, (c) to nourish growth and development, (d) to contribute to the attainment of self-actualization, and (e) to assist the individual's entry into society.

Music therapy is both an art and a science. Art and science are acts of discovery, imagination, and inspiration that give rise, on one hand, to symbolic and aesthetic expression and, on the other, to verifiable and investigative expression. "Both ... give a fresh world view, reslice the universe in a different way, and both are human creations" (Gerard, 1958, p. 1).

As an art, music therapy has two aspects: First, the medium of therapy, music, is an art form; second, the process of therapy becomes an art as the medium is shaped by the music therapist. The talented therapist, who is fully engaged with the client and who applies clinical skills creatively in dealing with the whole person, is practicing the art of music therapy.

The science of music therapy also has two aspects to be considered. First, in looking at the scientific application of established methods, the therapist experiments, explores, investigates, and discovers what works or does not work, what the efficacy of a particular technique is, and whether or not it has broad application. Further questions are asked, such as: Why

does this strategy work or not work? When does it work or not work? What variables cause it to work or not work? What effect does the practitioner, as the instrument of the therapeutic relationship, have on the results? Is the music suitable? Is it applied in a purposeful way? In examining and evaluating therapeutic outcomes, the data offer guidelines for theory, practice, and research. Conversely, research supplies guidelines that the music therapist applies to practice.

Gaston (1968), one of the founders of music therapy, stated that the therapeutic use of music is a means of influencing human behavior and closely related music therapy to behavioral sciences. This relationship is most fitting as music therapy concerns itself with the effects of the functional use of music on human behavior (Disereus, 1926).

Music therapy is rooted in participation, in actively making music, whether repeating a rhythmic pattern on a drum or playing a Bach fugue, singing isolated words of a song or performing a Verdi aria, blowing one note on a flutophone or weaving a Gluck melody on a flute. To understand the immediacy of the multisensory effect of music on the organism is to understand the fundamental meaning and beauty of this mode of treatment (Alvin, 1966). In the very act of making music and responding to musical stimuli, a person experiences instantaneous psychological and physiological sensations on many levels. The concrete reality of sensing auditorily, visually, tactually, kinesthetically, and emotionally brings the person into the present and has immediate results (Anderson, 1977). Because of mental, physical, or psychological dysfunction, however, experiencing is sometimes on a subliminal, or unconscious, level. Through music therapy strategies and techniques, the therapist aims to bring this experiencing to consciousness, to open up lines of communication, in the broadest sense, by awakening, heightening, and expanding awareness (Boxill, 1981).

The dynamic process is a continuum of therapeutically oriented musical experiences flexibly and creatively generated to attain long-term goals and short-term objectives. Those goals and objectives are part of a music therapy treatment plan formulated by the music therapist in consultation with other professional staff or an interdisciplinary treatment team. The plan is based on findings of music therapy assessment in such areas as awareness of self, others, and the environment; general characteristics; motor, communication, cognitive, affective, and social domains; creativity and self-expression; and specific musical behaviors. Methodology is based in three categories of music—composed music, clinically improvised music, and adapted music—and in three modes of therapeutic music activities—singing/chanting, instrument playing, and music–movement.

The province of the music therapist is knowledge of a special kind: a profound understanding of the influence of music on a person's total being. This understanding is deepened through the study of the aesthetics and psychology of music as well as the theoretical foundations of the discipline. And, although it is basic to understand the power of music, being able to communicate that power is vital. Apart from professional training, it is this capacity that makes the difference between practicing creative music therapy and therapy that is perfunctory.

Settings and Client Populations

From the initial programs, which were limited to psychiatric units for veterans or to general hospitals serving adults only, the practice of this treatment modality has grown to encompass a variety of settings with diverse client populations. The following list indicates that variety:

- psychiatric centers and hospitals for children, adolescents, and adults with disorders ranging from emotional disturbance to severe psychosis; hospital outpatient centers for patients with psychiatric disorders; treatment programs in community rehabilitation centers and halfway houses for posthospitalized patients with psychiatric disorders;
- general hospitals for patients in acute care;
- specialty hospitals for patients in acute care, including individuals with physical disabilities;
- nursing and day care centers for older adults;
- developmental centers, hostels, group homes, and intermediate care facilities for persons with developmental disabilities;
- special public and private school, after-school programs for exceptional children, including those with emotional issues;
- community and private clinics for people with psychosocial issues, including adolescents with behavior disorders; and
- clinical treatment centers and halfway houses for persons with alcohol and drug use issues.

Professionals in such disciplines as psychiatry, medicine, and nursing in a variety of treatment settings have corroborated the findings of music therapists that the therapeutic use of music can motivate people in ways that other therapies often cannot. And there is widespread acceptance that music therapy has evolved into a treatment modality that is suitable and

effective for almost all dysfunctions—psychological, physiological, developmental, psychosocial—and for all ages, as demonstrated by the preceding list. Because the therapeutic agent, music, bridges the gap between people of different cultures, different ages, and different mental and physical health issues, the music therapy process is a leveler, an organizer, a unifier. The four vignettes presented here illustrate these points. They offer a kaleidoscopic view of treatment in a number of different kinds of settings. The first deals with a young man with developmental disabilities who is a resident in a developmental center; the second, with a group of pre-adolescents drawn from a special education class of a day treatment center for children with emotional issues; the third, with a child in a private school for exceptional children; and the fourth, with a young woman in a psychiatric hospital.



Vignette 1

Toby, a resident in a developmental center, was a young man, 25 years old with multiple disabilities at the time of our therapy sessions. He was on his back in a “cripple cart.” Diagnosis: moderate mental retardation; quadriplegia. When I first saw him, he appeared to be immobile, incapable of moving his limbs. His head was the only part of his body he could move, and that in a limited, sideways fashion. He stared intently at me, his lips forming words that were inaudible. Toby sensed I had come to him to make music, and he vibrated with excitement. As I leaned over him, I saw that his mouth was quivering. When I sang, “Hello, Toby, yes indeed, yes indeed, yes indeed. Hello, Toby, yes indeed, yes indeed, my darling,” his quivering smile burst into O-shaped silent laughter. He attempted to sing with me, mouthing, with the beginning traces of phonation, “Yes indeed, yes indeed, yes indeed.” I repeated “Hello, Toby” slowly, very deliberately articulating, “Y-e-s i-n-d-e-e-d, y-e-ss i-n-d-e-e-d, y-e-s i-n-d-e-e-d, my d-a-r-l-i-n-g.” Intensely, Toby followed my lip movements as he attempted to sing with me.

Later in the session, when I sang, “Sing” (Raposo, 1971), Toby matched some of the words and tones immediately. Perhaps it was a tune that was familiar to him. He became very excited, and when I finished singing the song he attempted to sing it on his own, as if asking me to repeat it with him. It became *Our Contact Song* (see Chapter 4).

Once this contact was established, I sang this song repeatedly, seeking ways to have Toby participate in as physical a manner as possible. Perhaps the musical stimulation of a song he loved could motivate him

to transcend his bodily limitations. Using a hand-over-hand technique, I slipped a drum mallet into his right hand, which was his preferred hand. His eyes gave me the signal that he was very pleased with what I was doing, his hand moving ever so perceptibly to grasp the mallet. I then placed a timpani drum (the legs of which had been removed) on the cart, maneuvering it within his reach. Toby became more and more excited. I sang, accompanying myself on the Autoharp®, while a music therapy intern guided Toby's right hand toward the drumhead. A tenuous, unsteady beat floated from the drum. I caught it and merged my singing and playing with it. His fingers tightened their grasp on the mallet, and his arm began to move spastically but more firmly. My delight at bringing him out of his isolation and providing him with a means of contact reached a peak when he began to articulate the words of the song audibly and tonally. I leaned over, singing and playing in synchrony with him. Toby's face lit up in ecstasy. Our relationship started on this note and contained the joyous, health-producing ingredients that are a therapist's dream.



Vignette 2

The music therapy room was set up for the arrival of six preadolescents who were in a special education class of a day treatment center for children with emotional issues. Chairs were arranged in a semicircle near the piano. Conga drums, a timpani drum, bongos, a large cymbal on a stand, a metallophone, claves, a pair of maracas, a tambourine, and a marimba were all within reach.

Three of these young people had histories of violent acting-out behavior. One experienced school phobia; another was diagnosed as having a schizoid personality and another, as having unsocialized aggressive reaction of childhood. The music therapist, knowing the need for structure and positive outlets that would redirect their disruptive behavior, hostility, or withdrawal, immediately matched the expressed and unexpressed intensity that pervaded the group by engaging them in vigorous hand clapping to familiar rock music. The uproar that had prevailed as they entered the room was quickly and nonverbally dealt with by focusing their energy on a stimulating music activity that reached them on many levels. The entire group, aggressive or withdrawn, experienced a common connection with the music and the therapist who “spoke their language” and was thereby able to gain their trust.

Once the scattered group of individuals became unified, instruments were distributed with the therapist's assurance that there would

be an opportunity to exchange or take turns on the various instruments. There was also a firm but kindly reminder that the instruments were to be handled with care and played appropriately.

The musical stimuli and instruments provided both a socially acceptable channel for negative feelings and release from withdrawal. In creating therapeutically purposeful music activities suitable for their ages, health needs, and individual as well as collective interests, the therapist was able to direct their behaviors and feelings into positive, creative expression.

It was many months into therapy when the session just described took place—many months of exploration and discovery, of peaks and valleys.



Vignette 3

At the time of my relationship with her, Madeline was 7 years old. She was diagnosed as having withdrawing reaction of childhood/overanxious reaction of childhood. On admission to a school for exceptional children, she was described as having a symbiotic relationship with her mother, who infantilized her. The description indicated that she spoke in monosyllables, had poor motor coordination, did not engage in spontaneous play, was extremely inhibited, and had marked variability in functioning.

In our initial sessions Madeline's hands flew to cover her ears every time the dynamic level of the music or my voice intensified. When I played or sang softly, she smiled and shyly whispered, "I like that. That's pretty. You sing nice." Her sessions were cloaked in a kind of mistiness. She seemed to be confluent with the environment. When she moved to music, she seemed to fade into the corners of the room. I wondered about her inability to tolerate sound that exceeded a moderate level of intensity. A report of her early childhood mentioned elective mutism. Was there any correlation?

As she grew to trust me, I experimented with different dynamic levels, seeking to discover the key to this extreme sensitivity, which was isolating her from peers as well as adults. At one session I thought she might be ready to accept an increase in the volume of my singing and instrumental accompaniment. Instantaneously, she clamped her hands over her ears. Her face was engulfed in anguish. "Don't scream! Don't scream! My mother screams at me all the time!" Then she pounded on

a drum with all the strength she could muster. After this outburst, her body crumpled as if deflated. She was completely spent.

Over a period of time, with cautious yet deliberate changes in dynamics and kinds of music, our sessions took on a new dimension. A world of sound began to open up to Madeline. It became fun to pound on the drum and make loud sounds. She could make soft or loud sounds on the xylophone, whichever she felt like doing. She even asked for “that loud song.” Dropping passive-aggressive, fearful behaviors, she began to be assertive and direct. Her speech and entire bodily expression revealed a high-spirited little girl who was beginning to come out of hiding and play with the other children she had previously considered “too noisy.” That no longer bothered Madeline as it had before she experienced music therapy.



Vignette 4

Highly intelligent, boyish, Helene was 18 years old at the start of treatment. Diagnosis: anorexia nervosa and borderline personality disorder. Symptoms of anorexia nervosa developed over a period of 2 years, resulting in two psychiatric hospitalizations. As her health worsened, she exhibited increasing signs of self-destructive behavior with classic anorectic and bulimic episodes. After she graduated from high school, her work history was sporadic. As the symptoms became intolerable, she was unable to sustain work and was hospitalized. Typical of the syndrome, she experienced extreme swings from hyperactivity to lethargy, hostility to amiability, aggression to passivity.

When she became completely resistant to verbal psychotherapy, threatening to flee from the hospital, the psychiatrist recommended one-to-one music therapy sessions as a possible means of reaching her and staving off a situation fraught with disaster. Having witnessed the benefits of music therapy in this psychiatric hospital, the staff made the referral.

At first, her oppositional behavior carried over to the music therapist. She threw up a wall to protect herself from any intrusion into her familiar, hopeless, frantic world. “No one is going to make me do anything or feel any way!” she would spit out defiantly.

After several brief, exploratory music therapy encounters, a discovery was made. Helene could strum a few chords on the guitar to accompany herself while singing. This was a possible path to establishing rapport and building a relationship, and, indeed, it happened. She began to relax her

impenetrable stance and allow the therapist to share musical experiences that fed her emotionally and broke through her alienation and terror.

It was not a smooth path that therapist and patient were treading together. Helene constantly manifested erratic behavior. She had to be right. She had to play without making mistakes. She had to be perfect. “Why am I always wrong? Why do I always spoil everything? I’m a mess!” she would spew out. And herein lay the challenge: to free her from the obsession in which she was trapped, to liberate her from the vicious cycle of rigid expectations and intense disappointments that consumed her bodily, mentally, and emotionally.

With the therapist’s acceptance of her, Helene was gradually able to receive support from this gentle guidance and nonjudgmental attitude. Specific music therapy strategies and techniques were used to encourage freewheeling, free-from-failure musical improvisations on the guitar and percussion instruments, as well as vocally. Helene responded to the warm, safe environment that the therapist created. The music therapist addressed her strengths, her need for freedom within the structure of musical forms, and her cry for release from the tensions of having to be “good” and “right” and “perfect” instead of being “bad” and “wrong” and “nothing” (in her distorted opinion of herself). In doing so, the therapist helped Helene to gain a measure of emotional stability and a feeling of self-worth. The swings of mood diminished in severity as her sense of being capable of gratifying her hungers in a pleasurable and socially acceptable way became more reliable.

And when she played and sang for other patients on the unit, it was all right with her if she struck a wrong chord on the guitar. What of it! She was having a great time, and the others loved it!

CONCLUSION

Since its beginnings as an ancillary therapy in psychiatric and veterans’ hospitals (Ludwig, 1977), music therapy has come of age as an autonomous treatment modality. Increasingly, it is regarded as an integral component of institutional, community, and private treatment programs. Music therapy has become an integral part of allied mental health and health

professional organizations (for example, as a Special Interest Group of the American Association on Mental Deficiency). Currently, more than 3,500 music therapists practicing in the United States maintain AMTA professional membership and hold national board certification through CBMT. Students interested in the field of music therapy have more than 70 college and university training programs in the United States from which to choose, including numerous master's degree programs and the first doctorate in music therapy. Through advocacy and governmental relations work, music therapy is more visible and recognizable in all aspects of the health care industry.

The growth of music therapy is not limited to the United States; music therapy programs have been introduced in health care institutions all over the world. As a result, national music therapy organizations have been formed in many countries. Beginning in the late 1970s, international congresses highlighted the growth of the profession and the beginning of international music therapy collaborations. In 1979, music therapists from many countries met in Europe to share knowledge and concerns about the profession. In 1981, music therapy was represented at an international conference held at the United Nations in support of the International Year of Disabled Persons. International symposiums, such as the one held at New York University in 1982, fostered these new connections, culminating with the formation of the World Federation of Music Therapy at the 5th International World Congress in Genoa, Italy.

In addition to the World Congresses, music therapists worldwide may continue to foster relationships via the internet; *Voices*, an online world forum for music therapy, contains quarterly newsletters featuring articles and essays by music therapists from various countries.

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