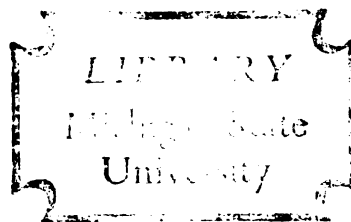


SOME EFFECTS OF PREFERRED RECORD LISTENING
ON THE FREQUENCY OF SPONTANEOUS
VERBALIZATIONS OF LOW-VERBALIZING, CHRONIC
CLIENTS IN A DISCUSSION GROUP THERAPY SETTING

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ABSTRACT

SOME EFFECTS OF PREFERRED RECORD LISTENING ON THE FREQUENCY OF SPONTANEOUS VERBALIZATIONS OF LOW-VERBALIZING, CHRONIC CLIENTS IN A DISCUSSION GROUP THERAPY SETTING

By

Christina Marie Lucia, R.M.T.

The purpose of this study was to investigate some effects of preferred record listening on the frequency of spontaneous verbalizations of low-verbalizing, chronic clients in a discussion therapy setting. It was an attempt to provide quantifiable data to support the use of this music therapy technique in the treatment of mentally ill geriatric patients.

A sample of six nursing home residents, all diagnosed as low-verbalizers with a chronic psychiatric illness, met with the therapist for 18 discussion therapy sessions. Prior to the first session, subjects were tested to determine their music preferences from among these categories of vocal music: Country/Western; Pop (Top 40's); Blues; Musicals/Soundtracks; Inspirational; and Easy Listening Favorites. The music preferences of subjects determined the selection of records available throughout the course of the study.

The subjects were tested for increases in verbal spontaneity during alternating cells of "Music" and "No Music" condition. A standardized set of discussion topics was designated prior to the onset of the study.

At the beginning of the 50 minute sessions, the therapist announced the topic for discussion. During the "Music" condition, the lyric content from records selected by subjects was used to facilitate discussion.

During the "No Music" condition, only verbal techniques were used to facilitate discussion.

Verbal data were analyzed for frequencies of spontaneous verbal output by both subjects and therapist. Measures of correlation provided evidence to suggest that the therapist's spontaneous verbal output was not a significant factor in determining the high or low frequencies of subject verbal spontaneity. A one way analysis of variance produced no statistical evidence to support the use of preferred record listening rather than verbal techniques only during discussion group therapy. Missing data caused by subject absences made more refined statistical analyses illadvised. However, inspection of subjects' raw score verbal frequencies suggests some internal interaction patterns occurring among subjects.

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CHAPTER I

INTRODUCTION

The Problem

This current research attempted to provide evidence to support the use of music therapy as a preferred treatment modality with some mentally ill persons. It was an outgrowth of a pilot study conducted while the researcher was engaged in music therapy clinical practice with adult psychiatric clients at a Midwestern community mental health center. It was a further attempt to quantify the extent to which the frequency of spontaneous verbalizations of low-verbalizing, chronic clients could be increased as the result of preferred record listening introduced into a discussion group therapy setting. An awareness of the following problems provided the impetus for this study: (1) the traditional methods of verbal therapy used with chronic, mentally ill clients emphasize the inadequate verbal skill level characteristic of the illness; and (2) the therapist responsible for the direction of care may be severely limited in that capacity as the result of an incomplete or misrepresented view of the client's needs as depicted solely by information elicited and obtained through verbal expression. Further, it had been observed that low-verbalizing, chronic clients seemed to relate more verbal information during those discussion therapy sessions that involved record listening than during comparative discussion therapy sessions where only verbal techniques were employed.

Significance of the Problem

The ability to effectively communicate one's thoughts, feelings, problems, or opinions is of significance to all persons. The need for communication skills on at least a functional level is considered desirable, if not necessary, for maintaining a healthful and productive interdependent societal role. Although nonverbal messages comprise additional communication cues, the spoken word remains the most direct form of message relaying from one individual to another.

The degree to which a person develops this highly prized skill of effective verbal communication can depend on one or more of several contributing factors. Such factors include the following: intelligence, adaptive learning, adequate modeling, opportunity for practice of the desired skill, and confounding by physical or psychological impairments. The area of psychological impairment was the focus for this research.

To determine an adequate model of psychological impairment, an assessment was made of the dichotomous facets of mental health as they differ from the dynamics of mental illness. Garner presents five considerations of the meaning of mental health as purported by Jahoda:

1. Ability to perceive reality and ability to maintain sufficient degree of contact with reality for appropriate orientation to person, place, and time;
2. Ability to develop, maintain, and sustain healthy relationships with people;
3. Ability to communicate effectively with people;
4. Availability of efficient and appropriate defense mechanisms;
5. Ability to use sound judgements and make decisions.¹

¹Grayce Cynthia Scott Garner, "Qualitative and Quantitative Analyses of Schizophrenic Verbal and Non-Verbal Acts Related to Selected Kinds of Music" (Unpublished Ed.D. dissertation, Columbia University, 1973), pp. 9-10.

Mental health and mental illness may, then, be described as a series of regression and approach experiences through time with regard for the above cited considerations.

It is the function of the therapist in the therapist/client interaction to facilitate the approach process toward these desired aspects of positive mental health. Des Lauriers states:

. . . the effort at therapy with a mentally ill individual is an attempt, not at changing his problems or conflicts, but rather at giving him more adequate and more sound means of dealing and coping with them.²

The therapeutic process itself can involve an individual encounter between the therapist and the client or may involve the client in a group process with the therapist. Michel presents a perspective on the group advantage:

. . . some of the benefits are: the group presents a medium for stimulation of socialization; the group helps the isolated person to begin to relate to others; . . . the interaction of a group discussion may help to generalize problems which have previously been thought of as specifically and peculiarly those of the individual.³

Further, Greenblatt, York, and Brown suggest that progressive desocialization is symptomatic of mental illness and, as such, the hospital environment should promote resocialization by presenting to the individual a rich assortment of socializing possibilities suited to his

²Austin Des Lauriers, "Psychiatric Concepts of Music Therapy," Music Therapy 1956, Sixth Book of Proceedings of the National Association for Music Therapy (Lawrence, Kansas: NAMT, 1957), pp. 32-33.

³Donald E. Michel, "Some Applications of Group Therapy with Music Therapy," Music Therapy 1954, Fourth Book of Proceedings of the National Association for Music Therapy (Lawrence, Kansas: NAMT, 1955), pp. 205-8.

needs and toward invoking his own social motivation.⁴ The music therapist can provide for such treatment objectives in the therapy encounter.

The use of music within the therapy group has been cited in the literature for several of its attributes. Cholden emphasizes the value of music as an expediter of group communication and feeling:

. . . in the listening experience there is a community of feeling that becomes more readily observable in the discussion of the musical experience. The patient may feel himself belonging to a group in which his place is clear.⁵

The social character of music described by Dreikurs relates to the need of the mentally ill person for social readjustment. The use of music as both a stimulator and expressor of emotions can serve to integrate each within the context of the group.⁶

Music can also become a structured reality, an organizational tool for the thinking that precludes verbal expression. Accordingly, Des Lauriers states:

Music is a medium which by its very structural requirements allows feelings to be expressed in a rational way. . . . Exposed to such an experience, the mentally ill patient has the opportunity to let flow for himself what he cherishes most, and what he is most afraid to lose and derive gratification from, in an atmosphere of

⁴Milton Greenblatt, Richard H. York, and Esther Lucille Brown, From Custodial to Therapeutic Patient Care in Mental Hospitals (New York: Russell Sage Foundation, 1955), pp. 106-7.

⁵Louis Cholden, "Psychiatric Concepts of Music Therapy," Music Therapy 1952, Second Book of Proceedings of the National Association for Music Therapy (Lawrence, Kansas: NAMT, 1953), pp. 27-31.

⁶Rudolf Dreikurs, "The Dynamics of Music Therapy," Music Therapy 1953, Third Book of Proceedings of the National Association for Music Therapy (Lawrence, Kansas: NAMT, 1954), pp. 15-23.

order, of organization, of rationality.⁷

The music therapy group, then, can be regarded as a safe atmosphere for resocialization and the communication skill building process. Both promote the mentally ill person in his approach toward a more satisfying level of mentally healthy functioning. Within the music therapy group, the mentally ill person can rely on both the music and the therapist to support his efforts toward more effective interaction within the group setting. The therapist and the tool of music employed service the group as catalyst, facilitator, and motivator for the communication and resocialization process. Yet, it is the client himself and his degree of comfortableness allowing for spontaneous expression that determines the effectiveness of the relearning over a period of time. Reusch emphasizes this as follows:

Therapeutic communication relies upon spontaneous expression. . . . The inner experience of a patient can only be approached by studying the spontaneous expressions of the patient. The therapist who relies upon the patient's habitual ways of communicating will quickly detect whether the patient's means of expression are inadequate.⁸

In retrospect, the significance of this research stemmed from an awareness of the mentally ill person's need for acquiring verbal skills that indicate healthy functioning. Further, such healthy functioning precludes a need for spontaneous expression within the group setting. The group music experience can provide a structure highly suitable for therapeutic movement toward such goals.

⁷Des Lauriers, op. cit., pp. 32-33.

⁸Jurgen Reusch, Therapeutic Communication (New York: W. W. Norton and Company, Inc., 1973), pp. 36-37.

Purpose of the Study

It was the purpose of this study to investigate some effects of preferred record listening on the frequency of spontaneous verbalizations of low-verbalizing, chronic clients during discussion group therapy. It was an attempt to provide quantifiable data to support the choice of music therapy as a preferred treatment modality for some clients who seek psychiatric treatment. The following was the hypothesis tested:

The frequency of spontaneous verbalizations of low-verbalizing, chronic clients in discussion group therapy will increase significantly during those sessions which employ preferred record listening as a verbalizing agent as compared to those sessions which utilize only verbal techniques.

Limitations of the Study

The scope of this research was limited to selected residents of a Miswestern nursing home facility. Each subject had been previously assessed as a low-verbalizer with a chronic psychiatric illness characterized by withdrawn and asocial behavior. Although the subjects were within the age limits of the normal geriatric population, they were selected for inclusion in this study with specific regard for their psychiatric dynamics. Accordingly, this research may suggest similar trends for younger psychiatric clients displaying the same behavioral characteristics. Because of the small sample tested, however, the reader is cautioned when generalizing these results to other geriatric or adult psychiatric treatments in similar settings.

Also acknowledged at the onset of this research was the possible contamination of results due to the novelty element generated by both the music therapy treatment and the music therapist. However, the field

application rather than the laboratory nature of this research provides information regarding the practical and realistic application of this music therapy technique with the geriatric mentally ill person.

Definition of Terms

1. Low-verbalizer: that client assessed by an attending psychiatric nurse as having deficit verbal skills. This deficit was determined by a minimal output of verbal material with secondary regard for the quality of the content.
2. Chronic client: that client with a documented psychiatric diagnosis of a chronic nature.
3. Preferred record listening: individual client selection of songs from a collection of record albums containing representative samples of the group's preferences as determined by a music preference pre-test.
4. Spontaneous verbalization: a verbal expression that is independently initiated or in response to an open-ended question or statement.
5. Discussion group therapy: treatment designed to encourage a verbal exchange among group members.

Methodology

In this study, one group of six subjects met for a period of nine weeks for discussion group therapy as a scheduled portion of their treatment at a nursing home facility. This group utilized a predetermined set of topics as the basis for discussions. Half of the sessions employed preferred record listening as a verbalizing agent. The other sessions were structured to begin with twenty minutes of topic discussion

followed by thirty minutes of unstructured record listening. Data with regard for the occurrences of spontaneous verbalizations were collected from twenty minute segments of tapes made during each session. From these data, an analysis of variance and measurements of correlation provided the basis for a statistical interpretation and discussion of the results.

Overview of Procedure

Chapter II presents a selected review of the literature pertinent to the use of music with the mentally ill and the geriatric client. Included is a presentation of the pilot study and a descriptive analysis of the results which shaped the direction for this current study. A rationale for the use of preferred record choice determined by subjects is also included. Chapter III describes the methodology: the scope of the study, the subjects, the setting, the determination of a music preference test, the procedures, and the methods of analyzing the data. The findings and interpretations of the data are presented in Chapter IV. Chapter V provides a summary, a critical review of the findings, and recommendations for further research. The Appendix includes those forms used for the jury selections of music, the pretest form, those records used throughout the course of this research, and verbatim samples from the research sessions.

CHAPTER II

REVIEW OF SELECTED LITERATURE

Accounts of the use of music as a means toward a psychotherapeutic end have pervaded the literature for decades. Yet, published studies providing quantifiable support for purported hypotheses relating to the effects of music on group interaction are of limited quantity and present incongruous results.

During the late 1950's, Sommer¹ and Dollins² investigated some effects of background music on verbal output of psychiatric clients during psychotherapeutic group sessions. Their results were supported by Shatin and Zimet, who concluded that stimulative music generates more verbal interaction than either sedative music or no music.³ In 1963, Garner provided qualitative and quantitative analyses of schizophrenic verbal and nonverbal acts related to selected kinds of music. She

¹Dorothy Twente Sommer, "The Effect of Background Music on Frequency of Interaction in Group Psychotherapy," Music Therapy 1957, Seventh Book of Proceedings of the National Association for Music Therapy (Lawrence, Kansas: NAMT, 1958), pp. 167-8.

²Curtis N. Dollins, "The Use of Background Music in a Psychiatric Hospital to Increase Group Conversation Frequency," Music Therapy 1956, Sixth Book of Proceedings of the National Association for Music Therapy (Lawrence, Kansas: NAMT, 1957), pp. 229-30.

³Leo Shatin and Carl Zimet, "Influence of Music upon Verbal Participation in Group Psychotherapy," Diseases of the Nervous System, 19 (February, 1958), 66-72.

substantiated the theory that subjects will verbalize more frequently following the playing of recorded music.⁴

Contrastingly, however a 1965 study by Bonny, Cistrunk, Makuch, Stevens, and Tally concluded that background music of a stimulative and/or sedative type did not significantly influence verbal interaction of peer interaction study.⁵ Traub suggested further that a music listening activity of either a sedative or stimulative nature will not significantly alter the initiation of verbal behavior of low-verbalizing, regressed mentally ill subjects.⁶

Studies of the use of music activity with the elderly client were noticeably scant throughout the literature. General observation points to the value of music activities to stimulate minds and uplift the spirits of geriatric persons (Hall⁷). In a descriptive report, Hart more specifically suggests:

Group listening was always well received. . . . The music recalled memories of past times; this conversation was stimulated. The latter was especially valuable to the residents, because topics of conversation and contributions by the members had been stereotyped for almost as long as each had been living there in the

⁴Garner, op. cit., p. 126.

⁵Helen L. Bonny; Martha Cistrunk; Rebecca Makuch; Emily Stevens; and Junotte Tally, "Some Effects of Music on Verbal Interaction in Groups," Journal of Music Therapy, II (1965), 61-63.

⁶Carol Traub, "The Relation of Music to Speech of Low Verbalizing Subjects in a Music Listening Activity," Journal of Music Therapy, X (Winter, 1969), 105-7.

⁷Dorothy Hall, "Music Activity for the Older Patient," Music Therapy 1956, Sixth Book of Proceedings of the National Association for Music Therapy (Lawrence, Kansas: NAMT, 1957), pp. 115-118.

convalescent home.⁸

Bright also commented on the associative quality of music:

Because elderly people tend to dwell in the past too much, it may seem unwise to accentuate this by calling up the past still more by music. The aim, however, should be to encourage discussion, relating one person's memories of a particular period of time with those of others in the group, to talk about the past in relation to the present . . .⁹

Noticeably lacking, however, was any statistical evidence supporting the above cited observations. Only Cotter submitted a review of any quantitative relevance:

. . . physical and verbal behavior were considered appropriate when the patient took part in any of the music activities, held realistic verbal conversation with other patients or observers and performed any physical act which observers thought appropriate. . . . Both observation and statistical treatment showed significant changes in the physical and verbal activities of the patients as a group.¹⁰

Of concern was the awareness that little research regarding musical influences upon the behavior of geriatric or adult mentally ill persons has been conducted since the late 1950's - early 1960's. Further, this early research emphasized the use of music as a background stimulus with the therapist's role primarily that of a responder to group-initiated interaction.

This current research differed from the literature reviewed

⁸Ann Hart, "The Development of a Music Therapy Program in a Convalescent Home," Music Therapy 1959, Ninth Book of Proceedings of the National Association for Music Therapy (Lawrence, Kansas: NAMT, 1960), pp. 116-120.

⁹Ruth Bright, Music in Geriatric Care (New York: St. Martin's Press, Inc., 1972), p. 6.

¹⁰Vance Cotter, "The Influence of Music on Geriatric Patients - Physical and Verbal Activity," Music Therapy 1957, Seventh Book of Proceedings of the National Association for Music Therapy (Lawrence, Kansas: NAMT, 1958), p. 162.

according to these basic assumptions:

1. Subjects actively determined the music used during research sessions;
2. The music listening was a directed task rather than a background stimulus;
3. The therapist was an active participant in the group interaction;
4. Only music with lyrics was available for selection.

Basic Assumptions

Determination of music selection. It was observed in the preceding studies that music selections introduced as the research variable were categorized by panels of judges of varying expertise. However, no regard for the musical preferences of the subjects tested was acknowledged. Dreikurs cites musical taste as a factor in the individual's responsiveness to the medium:

There can be no doubt that music constitutes a "language." Each culture apparently has its own musical language, which may break up into separate dialects. We witness on our American scene the co-existence of various musical dialects, which are understood only by those familiar with each. Jazz, popular, classical, modern, and atonal music use completely different forms of expression; some people are familiar only with one or the other and may reject all other forms . . . Therefore, it seems unwarranted to assume a correlation between an individual's personality and his preference for a type of music or composer. While certain personality factors may enter the picture, musical preference is probably more affected by social contacts, through identification with people who have a definite taste or affinity for certain musical dialects and styles, used by certain composers.¹¹

¹¹Dreikurs, op. cit., pp. 15-23.

In a study by Meadows, such factors as socioeconomic status, race, musical experience, and geographic location were found to be statistically significant in determining music preferences.¹²

More pointedly, Bright describes the use of music in the reactivation of the withdrawn or psychotic geriatric patient:

The initial contact with patients must be through music which is likely to be familiar. We can thus penetrate the outer shell of indifference and gain some response. Having done this, we can go on to rebuild patient's self-respect by asking them to choose songs . . . by making it clear that it is their requests for music which are of paramount importance . . .¹³

Prior to the onset of this research, then, the musical preferences of subjects were determined. The group's preference served as the criterion for the selection of record albums available during the research sessions.

Music listening as a directed task. A second difference in this research as compared to those previously reviewed was the focus for the music presented. In contrast to those studies which used music as a background stimulus, this research emphasized the subjects' focused attention on the music for the duration of each selection played.

The music therapist as an active participant. The literature reviewed depicted the therapist in varying levels of group involvement. Some studies had no therapist present in the group with data collection compiled from tapes of sessions or through one-way mirrors. Other studies collected data by placing observer-recorders in the group as

¹²Eddie Spencer Meadows, "The Relationship of Music Preference to Certain Cultural Determiners" (Unpublished Ph. D. dissertation, Michigan State University, 1970), pp. 161-64.

¹³Bright, op. cit., p. 103.

silent members. Butler¹⁴ and Shatin and Zimet¹⁵ emphasize the involvement of a therapist as an active group member.

This latter model was adapted for the purposes of this research based on the assumption that any realistic psychotherapeutic treatment involves therapist interaction.

Exclusivity of vocal music. Prior to the onset of this study, the frequency of spontaneous verbal output of subjects was determined as the desired behavior for shaping. As such, it is assumed that vocal music provides a directly useable model for such behavior. The subject can initiate a response related to the lyrics he has just heard. Further, the musical context affords a nonthreatening medium through which the lyric content can be presented. Butler concurs as follows:

. . . using the lyrics as a basis, a patient may interpret and verbalize freely, projecting his own feelings into the discussion. . . . A patient can verbalize and project his own personality into the discussion more easily by using the lyrics of the song as the object of discussion.¹⁶

The normal geriatric patient versus the mentally ill geriatric patient. The process of aging carries with it specific adjustment reactions. Physical decline and retirement accompany family structural shifts that may jeopardize ego strengths and a sense of continuing life fulfillment. Although the precipitating events may vary considerably from person to person, core emotional stresses typify the aging population. Bright cites loneliness, grief, and loss as the central concerns

¹⁴Becky Butler, "Music Group Psychotherapy," Journal of Music Therapy, III (June, 1966), 53-66.

¹⁵Shatin and Zimet, op. cit., p. 66-72.

¹⁶Butler, op. cit., pp. 53-56.

of the elderly.¹⁷ In a longitudinal study comparing men without disease or previous psychiatric illness to healthy young men, Libow substantiates: "Mild reactive depression constituted the most common single diagnosis."¹⁸

In contrast, the mentally ill geriatric patient more probably has manifested a chronic psychiatric illness with an onset much earlier in life. In a study of the differential diagnosis model for psychiatric assessment of the aged, Varner and Calvert clearly separate the mental state of depression associated with the "normal" stresses of growing old from the dynamics of chronic mental illness. This latter group is termed the "recurrent functional" group and is characterized as follows:

These persons have clearly defined mental illness which began earlier in life. . . . Chronic schizophrenia as well as major affective disorders occur in this group. Frequently we find that there has been a long history of mental hospitalization, and regular to infrequent use of psychotropic medication over the years. The usual mental health center serving mainly younger adults would probably identify this group as "aftercare." We have found, not too surprisingly, that many such elderly persons prove to be suitable for traditional kinds of intensive psychotherapy as part of the total therapeutic plan and that even the "long-term mental case" can benefit from therapy quite late in life.¹⁹

The subjects chosen for participation in this study dynamically represent the preceeding description of the recurrent functional patient. As we suggested in the literature, it is reasonable to parallel both

¹⁷Bright, op. cit., p. 10.

¹⁸Leslie S. Libow, "Interaction of Medical, Biologic, and Behavioral Factors on Aging, Adaptation, and Survival. An 11-year Longitudinal Study," Geriatrics, 29 (November, 1974), 75-88.

¹⁹Roy V. Varner, and W. R. Calvert, "Psychiatric Assessment of the Aged: A Differential Model for Diagnosis," Journal of the American Geriatrics Society, XXII (June, 1974), 273-277.

treatment and its outcome for this geriatric population with that of the younger, aftercare sector of the mentally ill population. It is, therefore, a basic assumption of this research that when this music therapy technique is applied during discussion therapy sessions of younger, aftercare clientele, similar results are likely to occur.

The Pilot Study

The purpose of the pilot study which served as the basis for this current research was to determine some effects of using record listening as an adjunctive approach for group aftercare follow-up in the treatment of adult psychiatric clients at a Midwestern community mental health center. The null hypothesis was established as follows:

There is no significant difference in the effectiveness of a "music listening" aftercare group as compared to a "verbal only" aftercare group when the following variables are measured:

1. attendance for treatment;
2. frequency of spontaneous client verbalizations;
3. frequency of interdependent socializations among group members outside the treatment session.

The subjects were selected from the general population of Team A aftercare clientele at the Midtown Community Mental Health Center, Indianapolis, Indiana. Aftercare treatment was defined as a meeting between the therapist and client wherein the client was assessed for current mental status and medication evaluation. The subjects were chosen without regard for age, sex, or diagnostic consideration; with regard for the assessment of chronically ill status, unemployed or sheltered workshop employment, and a prior attendance figure of having kept four of their last six scheduled appointments (this attendance figure was established as an average attendance figure of aftercare clientele

for a six month period prior to the onset of the pilot study).

Subjects were randomly assigned to one of four subgroups of eight subjects each. Two subgroups composed the control group, Group A, and two subgroups were designated as the experimental group, Group B. The control group received treatment administered by Therapist I, who utilized only verbal cues in the group sessions. The experimental group received treatment administered by Therapist II, who utilized both verbal cues and record listening cues in the group session. Each subgroup met on a regularly scheduled monthly basis for five consecutive months in a designated conference room. Sessions were of an hour and a half duration. The only distinction in equipment present was for Group B which utilized a portable stereo record player and assorted record albums. All sessions were recorded with a Sony cassette tape recorder for the first 45 minutes of each treatment session.

The content areas available for verbal initiation by both Therapist I and Therapist II were standardized as follows: (1) psychiatric medication review and related information, (2) leisure time usage and personal time management, (3) affective responses, and (4) situational changes since the preceeding treatment session. Therapist II in Group B treatment sessions incorporated the use of record listening as well as verbal cues during the experimental sessions. To distinguish from record listening as a background stimulus, it should be noted that for the duration of the playing of the recorded music, the subjects' attention was directed to the listening task. Specific songs were chosen by the subjects and/or Therapist II following a verbal directive given by the therapist to define a discussion topic shaped from one of the permissible content areas outlined above.

1. 在 1949 年以前，中国是一个半殖民地半封建国家，政治、经济、文化各方面都受到外国势力的控制。1949 年 10 月 1 日，中华人民共和国成立，标志着中国结束了半殖民地半封建的历史，实现了民族独立和人民解放。

2. 新中国成立后，中国进入了社会主义革命和建设时期。1956 年，中国完成了对农业、手工业和资本主义工商业的社会主义改造，确立了社会主义制度。

3. 在社会主义建设时期，中国取得了巨大的成就。1964 年，中国成功爆炸了第一颗原子弹，成为世界上第五个拥有核武器的国家。1970 年，中国成功发射了第一颗人造地球卫星“东方红一号”。

4. 1978 年 12 月，中国共产党十一届三中全会召开，作出了把党和国家的工作重心转移到经济建设上来，实行改革开放的伟大决策。

5. 改革开放以来，中国经济飞速发展，人民生活水平显著提高。中国已经成为世界第二大经济体，对世界经济增长的贡献率超过 30%。

6. 在文化领域，中国也取得了长足的进步。中国优秀传统文化得到了传承和弘扬，同时也不断吸收借鉴外来文化，形成了具有中国特色的社会主义文化。

7. 中国在国际事务中发挥着越来越重要的作用。中国坚持独立自主的和平外交政策，维护世界和平，促进共同发展。

8. 进入 21 世纪，中国进入了全面建设社会主义现代化国家的新征程。中国将继续坚持改革开放，推动高质量发展，实现中华民族伟大复兴的中国梦。

Procedures for notification of subjects and follow-up reminders were standardized for both Group A and Group B. The two therapists conjointly reviewed all tapes to alleviate possible bias of interpretation. The manner of data collection was a tallying procedure from the tapes recorded during each subgroup session. One mark indicated one spontaneous verbal attempt of a subject. There was no attempt made to quantify either the content or the duration of responses. Attendance figures were also recorded for each subject.

It is worthy to note that although the original sample populations for both Group A and Group B were set at $N=16$, extraneous factors occurring after the determination of the sample populations required the elimination of some subjects from consideration for analysis in the results of this study. These factors were as follows: (1) the subject failed to respond to a request to participate as indicated by a nonattendance from the onset of the study; (2) the subject moved out of the geographical area serviced by the treatment facility prior to the termination of the study; or (3) the subject was terminated from the research groups by the attending therapist with the assessment that the subject's status required an alternate treatment regime.

Due to the degree of mortality generated over the five month course of the study, a statistical treatment was not applied as the results would be unrepresentative of the sample. Therefore, the null hypothesis was accepted.

Both Therapist I and Therapist II did, however, concur as to certain trends that seemed to appear during the course of the study. From an inspection of graphs recording the spontaneous verbalizations of these subjects present at various times during the study, it appeared

that more subjects in the experimental group evidenced a positive trend of increased verbal spontaneity than did those subjects in the control group. Of those subjects completing the study, the attendance figures were as follows: for Group A, the control group, 34 visits out of a possible 35 visits, or 97 per cent; for Group B, the experimental group, 50 visits out of a possible 55 visits, or 90 per cent. Both these figures suggest a more valued sense for the group experience than that evidenced by the individual aftercare attendance figure which had been previously determined as approximately 70 per cent. Both therapists agreed that the study was not of sufficient duration to suggest any evidence with regard to the development of interdependent socializations among subjects outside of the treatment session.

From the pilot study, these recommendations for further research were generated:

1. include in the criteria for subject selection those who regard music as a positive experience;
2. conduct the study over a shorter duration of time and decrease the time interval between sessions;
3. identify a residential treatment facility as the research setting to reduce the mortality potential;
4. standardize more closely the discussion topics for each research session;
5. determine a more refined tool of measurement of research data.

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CHAPTER III

METHODOLOGY

Setting

The Barton House of Indianapolis, Indiana, was the site for this present research. The 110 bed facility is an accredited nursing home which receives referrals from numerous community agencies. Besides the typical geriatric population, the Barton House accepts referrals from a nearby state hospital for the mentally ill. Once referred, residents usually remain as life placements within the facility. Permission for running the study was obtained from the administrative staff of Barton House.

The Barton House is staffed by a medical team of doctors, nurses and aids. Activity personnel provide a limited number of recreational programs such as bingo and craft projects. No planned music activity was available to residents prior to this project with the exception of the singing of hymns during the weekly church services.

All research sessions were held in an enclosed dining room area which also served as the craft and recreation room. Subjects were seated around a table without regard for seating arrangement. The researcher was the group discussion facilitator with no additional personnel present during the research sessions. Equipment present during all sessions were a Sony cassette tape recorder, a Lyons Band portable phonograph, and 20 assorted record albums.

Subjects

Nine subjects were initially selected for inclusion in this study upon the recommendations of two psychiatric nurses employed by the Barton House. Subjects were chosen with regard for these criteria:

1. The subject indicated a prior interest in music.
2. The subject carried a diagnosis of chronic mental illness and displayed a low verbal output.
3. The subject had the mental capability to comprehend simple directions, questions, or statements.

Of the nine subjects originally selected, one subject required more extensive treatment and was transferred from the Barton House during the week between the music preference test and the first experimental session. A second subject refused to attend after the first experimental session. An additional subject terminated from the study following the second experimental session. It is worthy to note that the latter two subjects were new residents of the Barton House at the time of their referral to the discussion group. It may be speculated that an incomplete adjustment to the nursing home setting contributed to their expressed disinterest in continuing with the study.

Of the remaining six subjects, all had been residents of the Barton House for approximately two and one-half years. Ages ranged from 67-87 years. Five subjects were diagnosed as chronic schizophrenic, the sixth with a manic-depressive illness. All subjects regularly received major psychotropic medications. The subjects were also similar in their lack of social awareness and infrequent participation in the planned recreation activities at Barton House.

Determination of Music Preference

An initial compilation of vocal album selections was categorized by a panel of radio disc jockeys according to these classifications: Country/Western, Pop (Top 40's), Blues, Musicals/Soundtracks, Inspirational, and Easy Listening Favorites. See Appendix A for a listing of the album selections categorized. An artist/album combination was regarded as indicative of one of the above stated categories if it was reported as such by three out of four of the panel members. From this categorized collection, representative samples of each were used for the music preference test administered to the research subjects prior to the first experimental session.

The music preference test followed the method of paired comparisons.¹ This method was chosen because of its relative simplicity of administering and ease of obtaining subject responses. Due to the nature of some mental illnesses, it was decided that the subjects would find most ease in responding to a test with a limited choice indicator and one which did not involve an extended concentration for each item examined. Therefore, the test was a listening comparison of 15 matched items, examples from each category paired once with examples from every other category. Appendix B lists those selections included in the test. Each of the items paired was of a 45 second duration. The subjects were to circle their preferences on a form sheet (see Appendix C) according to these instructions:

¹Ray Robert Welch, "The Development of an Instrument to Assess the Musical Preferences in College Music Appreciation Classes" (Unpublished Ed.D. dissertation, Indiana University, 1974), p. 20.

The purpose of this music listening test is to aid the therapist in understanding your likes and dislikes in choosing music. She can then provide a selection of the music you like best for those discussion sessions that will include the use of records. Your task now is to listen to the following tape. You will hear 15 paired items. For each of these items, you will hear parts of two different songs. You are to circle on this form the letter A if you prefer the first example or circle letter B if you prefer the second example. You are to circle only one response for each item. Please answer all items - there are no right or wrong responses.

Following the preference test, each subject's test was scored to determine the number of times each category was selected as the preferred choice. These raw scores were compiled for all subjects to produce the total number of times each category was preferred for the group as a whole (see Appendix D). Percentage scores were determined which represented the number of times the subjects chose a style of music in comparison to the number of times they could have chosen that style. The group's percentage scores for each category were as follows: Country/Western: 19%; Pop (Top 40's): 21%; Blues: 14%; Musicals/Soundtracks: 11%; Inspirational: 14%; and Easy Listening Favorites: 21%.

A new categorization of albums for research sessions was necessary due to the researcher's relocation and a shift in the availability of albums since the making of the music preference test. Albums were this time categorized by four area music therapists, again requiring a three out of four vote agreement to be considered indicative of a category style. Although the categorizations of music were judged by two different panels of experts, a 91% agreement was reached for items appearing on both tests. See Appendix E for the categorization of music by music therapists.

A total of 20 albums was available for each session. Of these 20, the following indicates the breakdown according to preferred categories:

Country/Western - 4 albums; Pop (Top 40's) - 4 albums; Blues - 3 albums; Musicals/Soundtracks - 2 albums; Inspirational - 3 albums; and Easy Listening - 4 albums. The same groupings of albums were used for six consecutive sessions. This allowed subjects to become sufficiently familiar with the selections available and also provided the consistency of using the same albums under both the experimental and control conditions. See Appendix F for a list of record groupings used.

Procedures

This study was comprised of 18 discussion group therapy sessions. One week prior to the initial session, an introductory meeting of subjects was held for the purpose of explaining the procedures of the following sessions and to administer the music preference test. Subjects also signed release forms to allow the necessary taping of therapy sessions. The group met on a regularly scheduled, twice a week basis for the next nine consecutive weeks. The 50 minute sessions were held each Wednesday at 3:00 P. M. and each Saturday at 10:00 A. M.

The design implemented was a version of the Equivalent Time Samples Design described by Stanley and Campbell.² It included an alternation of experimental and control cells that followed a patterned topic series. The design can be realized according to this representation:

Week I Introductory Session - Music Preference Testing

Week II	Session I	Session II
	Music - Topic 1	Music - Topic 2

²Donald T. Campbell and Julian C. Stanley, Experimental and Quasi-Experimental Designs for Research (Chicago, Illinois: Rand McNally College Publishing Company, 1963), pp. 43-46.

Week III	Session I Music - Topic 3	Session II No Music - Topic 4
Week IV	Session I No Music - Topic 5	Session II No Music - Topic 6
Week V	Session I Music - Topic 7	Session II Music - Topic 8
Week VI	Session I Music - Topic 9	Session II No Music - Topic 1
Week VII	Session I No Music - Topic 2	Session II No Music - Topic 3
Week VIII	Session I Music - Topic 4	Session II Music - Topic 5
Week IX	Session I Music - Topic 6	Session II No Music - Topic 7
Week X	Session I No Music - Topic 8	Session II No Music - Topic 9

Those sessions identified above as "Music" sessions refer to those sessions which actively used preferred record listening throughout the 50 minute session. At the beginning of those sessions, the therapist announced the topic for group discussion, following which subjects were directed to choose a song from the albums available to aid them in beginning the discussion. The lyric content was used as the catalyst for group discussion. See Appendix G for an example of a "Music" condition session.

Those sessions identified as "No Music" refer to sessions not using preferred record listening to facilitate topic discussion. These sessions began with the announcement of the discussion topic followed by 20 minutes of talk time with no verbalizing agent present other than the subjects and the therapist. Following the 20 minutes of talk time, the subjects were allowed to choose any music desired for the remainder of the session. In contrast to the "Music" sessions, this record listening

time was unstructured in that no topic was identified and no directed discussion of the lyrics was maintained. See Appendix H for an example of a "No Music" condition session.

The topics for discussion were adapted from Analysis of Music Therapy Group Procedures by Wolfe, Burns, Stoll, and Wickmann³ as follows:

Topic 1 - People I admire

Topic 2 - Something I've got going for me is . . .

Topic 3 - If I were to change something about myself, this is what it would be

Topic 4 - What do I do when I'm feeling down?

Topic 5 - Anger - What's it all about for me?

Topic 6 - Confidence - How do I get it and keep it?

Topic 7 - Leisure time, hobbies, and finding fun

Topic 8 - Looking back a happy time of the past

Topic 9 - These are the gifts of life

Each of the topics was presented twice, once each for the condition of "No Music" and the condition of "Music". The order, initially chosen with some regard for continuity from one session to the next, remained stable.

Collection of Data

Verbal data were collected from tape recordings made of each session. From these tapes, two trained recorders independently analyzed twenty minute segments of each session. For those sessions using music, the

³David E. Wolfe; Sally Burns; Mary Stoll; and Karen Wickmann, Analysis of Music Therapy Group Procedures (Minneapolis, Minnesota: Golden Valley Health Center, 1975), pp. 23-49.

recorders did not include the time spent in record listening when determining the twenty minute segment for analysis.

The recorders tallied the spontaneous verbal responses made by each subject. A tally was recorded for each spontaneous verbalization of undetermined length. However, a second tally was recorded if the flow of an initial response was interrupted by a question, comment, or statement of another group member and then carried to completion. A new tally period followed a three second silence. A separate collection was made of the spontaneous verbal comments made by the therapist.

From each session, the spontaneous verbal responses collected for analysis were as follows: 1.) individual subject responses, 2.) group total responses, and 3.) therapist responses.

Analyses of Data

The Spearman rank order measurement of correlation was used to establish reliability between recorders for the collection of data. The Pearson product moment correlation measure was used to assess the influence of the therapist's spontaneous verbal frequency on subject frequencies of verbal spontaneity. A confidence interval was set to establish a range for therapist's frequency of verbal spontaneity for both "Music" and "No Music" conditions.

An analysis of variance was applied to compare group total responses per session between the "Music" and "No Music" conditions. The researcher had anticipated conducting an internal analysis of variance for repeated measures to determine the following interactions: 1.) individual subject responses by "Music" or "No Music" condition; 2.) individual subject responses by topic condition; and 3.) individual subject

responses by "Music" or "No Music" condition by topic condition. However, an incomplete set of data caused by subject absences made statistical treatment illadvised. Therefore, a descriptive analysis of raw scores by subject for the conditions of "Music" and "No Music" is presented for the reader's inspection. Finally, Mann-Whitney U tests were applied to determine any significant differences for topics presented during the "Music" or "No Music" conditions.

CHAPTER IV

FINDINGS AND INTERPRETATIONS OF RESULTS

Reliability Between Recorders

The measuring instrument for data collection was an independent tallying procedure by two recorders. To determine reliability between their calculations, the Spearman rank order test of correlation was applied. A $\rho = .61$ was obtained. From inspection of Klugh's Table R for Critical Values of the Correlation Coefficient,¹ the $\rho = .61$ is accepted at the .01 level of significance. From the above results, it is unlikely that a significant margin exists between the two recorders' reports of spontaneous verbal interaction.

Therapist's Effects on Subject Responses

The active participant role of the therapist in this research poses two questions regarding influences on subject responses. These questions are: 1.) To what extent does the therapist's frequency of verbal spontaneity influence the group's frequency of verbal spontaneity? 2.) Is the therapist more verbal during the research condition of "Music" than during the "No Music" condition?

The Pearson product moment correlation measure was used to determine the degree of relationship between the therapist's and the

¹Henry E. Klugh, Statistics: The Essentials for Research (New York: John Wiley and Sons, Inc., 1974), p. 403.

group's verbal spontaneity. An $r = .42$ was obtained. At the .05 level of significance, no clear pattern can be established between frequencies of spontaneous verbal output of therapist and subjects. Thus, question one posed above is answered. No significant relationship exists to suggest that a high or low spontaneous verbal output by the therapist will effect a similar output by the subjects.

Question two asks: "Is the therapist more verbal during the research condition of 'Music' or 'No Music'?" To compare the therapist's frequency of verbal output between the "Music" and "No Music" conditions, a confidence interval across both conditions was established at the 95% level. For raw scores ranging from 94 to 170 with $\bar{X} = 134.55$, confidence limits were set at 93.28 and 175.82. An inspection of Table 1 below reveals the frequencies of the therapist's verbal spontaneity between these limits for all research sessions.

TABLE 1. FREQUENCY OF THERAPIST'S SPONTANEOUS VERBAL OUTPUT DURING "MUSIC" AND "NO MUSIC" CONDITIONS LISTED BY TOPIC

CONDITION	TOPIC								
	1	2	3	4	5	6	7	8	9
MUSIC	104	157	135	132	161	167	94	121	117
NO MUSIC	136	119	145	105	170	137	137	139	146

Question two is, therefore, answered. With a 95% confidence level, the therapist verbalized within the same limits for both the "Music and "No Music" conditions.

The "Music" versus "No Music" Condition

A null hypothesis was specified for statistical analysis as follows:

There is no significant difference in the frequency of spontaneous verbalizations of low-verbalizing, chronic clients during those sessions which employ preferred record listening than during those sessions which utilize only verbal techniques.

A one way analysis of variance was applied to determine the significance of the interaction between the "Music" and "No Music" conditions. The area of rejection for the null hypothesis was set at $\alpha \leq .05$ level of significance. Table 2 provides a summary of the analysis producing an F ratio of $F = 1.007$, $df = 1/16$, $p > .05$.

TABLE 2. ANALYSIS OF VARIANCE FOR "MUSIC" VERSUS "NO MUSIC" CONDITIONS

Source of Variation	SS	df	MS	F
Between conditions	256.88	1	256.88	1.007 N.S.
Within conditions	<u>4079.12</u>	<u>16</u>	254.95	
Total	4336.00	17		

At the .05 level of significance, the data failed to reject the null hypothesis. No statistical evidence was obtained to support the use of preferred record listening rather than verbal techniques only during discussion group therapy with low-verbalizing, chronic clients.

Individual Subject Responses by Condition

The researcher had anticipated conducting an analysis of variance for repeated measures for these internal interactions: 1.) individual subject responses by "Music" or "No Music" condition; 2.) individual

subject responses by topic condition; and 3.) individual subject responses by "Music" or "No Music" condition by topic condition. However, subject absences produced missing data across the treatment conditions. Such incomplete data produced the effect of unequal and different groups thereby making statistical treatment impossible.

A descriptive analysis is offered to account for some of the variation observed among verbal output of individual subjects. The raw scores are presented in Table 3 according to "Music" or "No Music" condition and arranged in order of topic presentation.

From inspection of Table 3 an obvious disparity is observed between the verbal frequency range for Subjects A, B, and C as compared to Subjects D, E, and F. All subjects were initially selected by two attending psychiatric nurses according to the criteria for low verbalizers with a chronic psychiatric illness. However, it appears that the potential for verbal spontaneity differed widely among subjects.

Subject B was observed as the most frequent verbalizer across both conditions. Worthy to note was the shift in participation among other subjects during those sessions when Subject B was absent. All other subjects produced their highest individual raw score during Subject B's absence. Most notable are Subjects A and C.

Subject A presented a range of raw scores from 16 obtained during Subject B's presence to 56 obtained in her absence. The mean scores for Subject A varied as follows: 1.) during Subject B's presence, $\bar{X} = 24.2$; 2.) during Subject B's absence, $\bar{X} = 40.5$.

Similarly, Subject C presented a range of raw scores from 10 obtained during Subject B's presence to 54 obtained in her absence. The mean scores for Subject C varied accordingly: 1.) during Subject B's

TABLE 3. FREQUENCY OF INDIVIDUAL SUBJECT'S SPONTANEOUS VERBAL OUTPUT DURING "MUSIC" AND "NO MUSIC" CONDITIONS LISTED BY TOPIC

		Subject	TOPIC								
			1	2	3	4	5	6	7	8	9
C O N D I T I O N S	M U S I C	A	21	23	56	35	16	24	21	25	34
		B	27	35	-	-	50	44	32	39	42
		C	13	16	47	30	19	19	18	21	21
		D	0	12	-	8	6	6	3	-	2
		E	1	1	4	3	1	0	2	2	5
		F	<u>0</u>	<u>0</u>	<u>2</u>	<u>0</u>	<u>0</u>	<u>4</u>	<u>0</u>	<u>0</u>	<u>1</u>
		Totals	62	87	109	76	92	97	76	87	105
I N D I V I D U A L	N O M U S I C	A	33	26	21	42	36	41	27	30	22
		B	-	45	27	-	-	-	55	60	50
		C	28	21	24	54	40	-	10	17	24
		D	6	8	11	11	27	22	5	7	0
		E	3	3	3	3	1	6	3	2	0
		F	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>1</u>	<u>1</u>	<u>3</u>
		Totals	70	103	86	110	104	69	101	117	99

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presence, $\bar{X} = 18.6$; 2.) during Subject B's absence, $\bar{X} = 39.8$.

It is acknowledged that the interaction patterns attributed to Subject B's presence or absence in the group are only contributory elements in the total interaction spectrum. However, the limits of the measuring instrument and the process for subject selection do not allow for a more refined sociometric analysis of the group's interaction. Thus, the observations are offered for the reader's speculation.

Topic Presentation During "Music" or "No Music" Condition

To determine any significant differences existing for topics presented during one or the other of the research conditions, Mann-Whitney U tests were applied. The reason for this analysis was due to the missing data reported in Table 3. These missing data prohibited the use of a two way ANOVA for repeated measures.

A $p \leq .05$ level of significance was set. Results are presented in Table 4. At the $p \leq .05$ level of significance, all U scores are non-significant. Thus, the element of topic can be considered an unlikely influence on the results obtained during either the "Music" or "No Music" condition.

TABLE 4. U TEST RESULTS FOR TOPIC COMPARISON DURING "MUSIC" AND "NO MUSIC" CONDITIONS

TOPIC	U TEST RESULTS		
1	$U = 12$	$N = 11$	$P = .331, p > .05$
2	$U = 17$	$N = 12$	$p = .469, p > .05$
3	$U = 8$	$N = 10$	$p = .238, p > .05$
4	$U = 10$	$N = 10$	$p = .345, p > .05$
5	$U = 13$	$N = 11$	$p = .396, p > .05$
6	$U = 12$	$N = 10$	$p = .545, p > .05$
7	$U = 10.5$	$N = 12$	$p = .138, p > .05$
8	$U = 14.5$	$N = 11$	$p = .500, p > .05$
9	$U = 13$	$N = 12$	$p = .242, p > .05$

CHAPTER V

SUMMARY, CRITICAL REVIEW, AND RECOMMENDATIONS FOR FURTHER STUDY

Summary of Purpose

The acquisition of functional verbal skills is a therapeutic goal for many mentally ill persons. Verbal communication that is spontaneously initiated is one indicator of movement toward such a goal. The group music experience can provide a structure highly suitable for facilitating this therapeutic movement.

It was the purpose of this research to investigate some effects of preferred record listening on the frequency of spontaneous verbalizations of low-verbalizing, chronic clients during discussion group therapy. It was an attempt to provide quantifiable data to support the choice of music therapy as a preferred treatment modality for some clients who seek psychiatric treatment. The research hypothesis was stated as follows:

The frequency of spontaneous verbalizations of low-verbalizing chronic clients in discussion group therapy will increase significantly during those sessions which employ preferred record listening as a verbalizing agent as compared to those sessions which utilize only verbal techniques.

Summary of Procedures

A sample of six chronic, low-verbalizing nursing home residents met with the therapist for nine weeks for discussion group therapy. Prior to the first meeting, subjects were tested to determine their music

preferences from among these categories of vocal music: Country/Western, Pop (Top 40's), Blues, Musicals/Soundtracks, Inspirational, and Easy Listening. The results of the music preference test determined the selection of records available to subjects during the course of the study.

The subjects were tested during alternating cells of "Music" and "No Music" conditions. Each cell consisted of three consecutive sessions. A total of 18 research sessions were held. A standardized set of discussion topics was designated prior to the onset of the study. Each topic was presented under both conditions.

At the beginning of the 50 minute sessions, the therapist announced the topic for discussion. During the "Music" condition, the lyric content from records selected by the subjects was used to facilitate discussion. During the "No Music" condition, only verbal techniques were used to facilitate discussion.

The spontaneous verbal output of subjects and therapist were collected by tape for each session. Two recorders independently tallied the responses from twenty minute segments of each tape. Analyses of spontaneous verbal output formed the basis for the interpretation of results.

Findings and Discussion

The frequency of spontaneous verbal output of chronic, low-verbalizing subjects did not significantly change for the course of the study. The conditions of "Music" and "No Music" generated no substantial differences when comparing group scores. As a result, the research hypothesis was not accepted. Further, the element of topic was determined to be a nonsignificant factor in eliciting spontaneous verbal output of subjects.

A descriptive inspection of the interaction among individual

subjects suggested a trend related to the absence of Subject B. The raw score frequencies of all subjects were higher during Subject B's absence, with particular influences on Subjects A and C. This trend may reflect an interpersonal conflict between Subject B and other group members that produced an atmosphere of discomfort in the treatment setting. It is also reasonable to consider that the high verbal output by Subject B was time consuming and decreased the opportunity available for others to contribute spontaneously to the discussion. Further, Subject B's high verbal output may have influenced the other subjects' sense of responsibility for maintaining the flow of discussion. Such speculations are offered for the reader's consideration with the acknowledgment that a more refined criteria for subject selection and the measuring instrument could have contributed more conclusive results.

A Critical Review

Of initial consideration for review was the criteria for subject selection. The obvious disparity in the range of verbal spontaneity produced among subjects suggests a question regarding their comparable potential for verbal output. It may be speculated from the consistently high level of verbal output of Subject B from the onset of the study that she was not really a low-verbalizer at the time of subject selection. More specific guidelines should have been provided for defining the dimension of "low-verbalizer". Also, a personality inventory could have been useful to match subjects according to particular dynamic components.

The problems manifested by broad subject selection criteria were further compounded by the small sample studied. The sample was not large enough to incorporate the diversity of incoming verbal potential of

subjects.

A further problem was in the isolation of a nursing home population. The nursing home setting was originally chosen by the researcher to reduce the potential for absences or withdrawal from the study. However, prevalent was the fact that once referred to the nursing home, residents were generally life placements within the facility. This permanency may have had some effect on the motivation of these residents as compared to other mentally ill geriatric patients who have greater opportunity for independent living. The reader is reminded that while the use of preferred record listening to promote spontaneous verbal output was not substantiated for the sample of nursing home residents studied, these results can not be generalized to other geriatric or mentally ill populations.

The variable for study chosen to indicate more healthy verbal functioning was that of increased spontaneous verbal output. A more complex sociometric instrument would have allowed more detailed observations of the internal subject interaction. While spontaneous output is one measure of healthy verbal functioning, contributory elements such as appropriate gestures, eye contact, and direction of responses among group members are also available for observation. A measure to determine growth in duration of subject responses would have also added an additional dimension to the variable of spontaneous verbal output.

Some question may have been aroused by the reader regarding experimental bias since the researcher served as the group facilitator. The significantly low statistical correlation between the frequencies of therapist and subjects' verbal spontaneity suggests no pattern of

influence during the "Music" versus the "No Music" condition. Further, when comparing therapist verbal frequencies during both conditions, all session scores were within the limits of the 95% confidence level.

Recommendations for Further Study

The small sample studied provides little basis for generalization of results to other groups of chronic, low-verbalizing, mentally ill persons. For future attempts in determining the effects of preferred record listening on the frequency of spontaneous verbal output, the following recommendations are offered:

1. Refine the criteria for subject selection. A personality inventory revealing interpersonal characteristics is suggested as well as more specific guidelines for determining a range of frequencies for the "low-verbalizer" definition.
2. Include a sociometric measure to aid in the interpretation of subjects' and therapist interactions.
3. A pretest and posttest design may be considered to measure growth of the subjects over time. Such a measure could alleviate the problem of incomplete data related to occasional subject absences.
4. A younger adult sample of low-verbalizing mentally ill subjects may be considered for study.
5. The nature of chronicity in the major mental illness studied may require a much longer duration of study for change occurring to be quantitatively measured.

APPENDICES

APPENDIX A

CATEGORIZATION OF SELECTED VOCAL MUSIC FOR THE MUSIC PREFERENCE TEST

Panel of experts: Radio disc jockeys

Directions: Please categorize the following artist(s)/albums, choosing only one of the categories listed below:

- | | |
|--------------------|-----------------------------|
| A. Country/Western | D. Musicals/Sountracks |
| B. Pop (Top 40's) | E. Inspirational |
| C. Blues | F. Easy Listening Favorites |

(The letter designation signifies at least a three out of four panel member agreement on the classification style. A blank represents those examples for which less than a three out of four agreement was established.)

1. F Ray Charles Singers, "Moods of Love"
2. A Tammy Wynette, "Another Lonely Song"
3. D "My Fair Lady"
4. E Mormon Tabernacle Choir, "Onward Christian Soldiers"
5. B Cher, "Dark Lady"
6. B Olivia Newton-Hohn, "Have You Never Been Mellow"
7. B The Ozark Mountain Dare Devils, "It'll Shine When It Shines"
8. B Linda Ronstadt, "Heart Like a Wheel"
9. B Poco, "Cantanamous"
10. C Elmore James, "Southside Blues"
11. B Rolling Stones, "Let It Bleed"
12. D "Godspell"
13. F Tony Bennett, "All-Time Hall of Fame Hits"

14. _____ Jerry Lee Lewis, "Southern Roots"
15. _____ Nitty Gritty Dirt Band, "Will the Circle Be Unbroken?"
16. B Spinners, "New and Improved"
17. F Barbra Streisand, "Greatest Hits"
18. _____ Ray Charles, "Crying Time"
19. B Cat Stevens, "Teaser and the Firecat"
20. B John Denver, "An Evening with John Denver"
21. E Robert Shaw Chorale, "What Wondrous Love"
22. B Neil Young, "Harvest"
23. _____ Louisiana Red, "Louisiana Red Sings the Blues"
24. B Moody Blues, "A Question of Balance"
25. B Jim Croce, "Life and Times"
26. C B. B. King, "Guess Who"
27. A Charley Pride, "A Sunshiny Day"
28. D "The Sound of Music"
29. F Frank Sinatra, "Adventures of the Heart"
30. _____ Charlie Daniels Band, "Fire on the Mountain"
31. A Porter Wagoner, "Blue Moon of Kentucky"
32. A Merle Haggard, "If We Make it Through December"
33. D "Fiddler on the Roof"
34. F Andy Williams, "Days of Wine and Roses"
35. B Stevie Wonder, "Fullfillingness"
36. E Jim Nabors, "The Lord's Prayer"
37. B Judy Collins, "Colors of the Day"
38. B Bob Dylan, "Greatest Hits, Volume II"
39. B Elvis Presley, "Good Times"
40. B Barry White, "Can't Get Enough"

41. E Mahalia Jackson, "I Believe"
42. C Memphis Slim, "Blues Memphis"
43. B America, "Holiday"
44. A Donna Fargo, "The Happiest Girl in the Whole USA"
45. E The Staple Singers, "The Staple Singers Pray On"
46. Goosecreek Symphony, "Words of Earnest"
47. B Simon and Garfunkel, "Bridge Over Troubled Water"
48. Glen Campbell, "Greatest Hits"
49. D "Funny Girl"
50. F Perry Como, "Dream Along With Me"
51. B Carole King, "Tapestry"
52. A Charlie Rich, "Behind Closed Doors"
53. Gordon Lightfoot, "If You Could Read My Mind"
54. B Pure Prairie League, "Two Land Highway"
55. Marian Anderson, "Spirituals"
56. Leadbelly, "Leadbelly Legacy - Number One (Take This Hammer)"
57. B The 5th Dimension, "Age of Aquarius"
58. B Steve Miller Band, "The Joker"
59. C Muddy Waters and Howlin' Wolf, "London Revisited"
60. The Dillards, "Roots and Branches"
61. B Gladys Knight and the Pips, "All I Need Is Time"
62. D "Lost Horizon"
63. F Judy Garland, "Very Best of Judy Garland"
64. B Helen Reddy, "Free and Easy"
65. B The Impressions, "Finally Got Myself Together"
66. New Riders of the Purple Sage, "Gypsy Cowboy"
67. B Janis Joplin, "Joplin in Concert"

- 68. E Tennessee Ernie Ford, "We Gather Together"
- 69. A Johnny Cash, "Any Old Wind that Blows"
- 70. A Loretta Lynn, "Love is the Foundation"
- 71. F John Gary, "John Gary Sings Especially for You"
- 72. B Aretha Franklin, "Let Me in Your Life"
- 73. B Stylistics, "Let's Put It All Together"
- 74. C Mike Bloomfield and Paul Butterfield, "Steelyard Blues"
- 75. Don Fogelberg, "Souvenirs"
- 76. F Kate Smith, "Here and Now"
- 77. B Kris Kristofferson and Rita Coolidge, "Full Moon"
- 78. B Neil Diamond, "Jonathan Livingston Seagull"

APPENDIX B

MUSIC EXAMPLES USED ON THE MUSIC PREFERENCE TEST

ITEM	CATEGORY	ARTIST	ALBUM/SELECTION	SELECTION
1. A	Pop	Cat Stevens	<u>Teaser and the Firecat</u>	"Moonshadow"
B	Country/ Western	Charlie Rich	<u>Behind Closed Doors</u>	"The Most Beautiful Girl"
2. A	Easy Listening	Frank Sinatra	<u>Adventures of the Heart</u>	"It's Only a Paper Moon"
B	Musicals/ Soundtracks		<u>Fiddler on the Roof</u>	"If I Were a Rich Man"
3. A	Country/ Western	Porter Wagner	<u>Blue Moon of Kentucky</u>	"Green Green Grass of Home"
B	Blues	Elmore James	<u>Southside Blues</u>	"Do You Want Me to Cry?"
4. A	Blues	Maria Muldaur	<u>Steelyard Blues</u>	"Lonesome Star Blues"

APPENDIX B (continued)

B	Pop	Olivia Newton-John	<u>Have You Never Been Mellow</u>	"Have You Never Been Mellow"
5. A	Musicals/ Soundtracks		<u>Funny Girl</u>	"I'd Rather Be Blue"
B	Country/ Western	Loretta Lynn	<u>Love is the Foundation</u>	"I Gave Everything"
6. A	Blues	B. B. King	<u>Guess Who</u>	"Neighborhood Affair"
B	Musicals/ Soundtracks		<u>Godspell</u>	"Day by Day"
7. A	Blues	Muddy Waters	<u>London Revisited</u>	"Lovin' Man"
B	Easy Listening	Tony Bennett	<u>All-Time Hall of Fame Hits</u>	"Rags to Riches"
8. A	Country/ Western	Donna Fargo	<u>The Happiest Girl in the Whole U.S.A.</u>	"The Happiest Girl in The Whole U.S.A."
B	Easy Listening	Kate Smith	<u>Here and Now</u>	"I'll Take Care of Your Cares"
9. A	Musicals/ Soundtracks		<u>Lost Horizon</u>	"Living Together, Growing Together"
B	Inspirational	Mormon Tabernacle Choir	<u>Onward Christian Soldiers</u>	"Onward Christian Soldiers"

APPENDIX B (continued)

10. A	Musicals/ Soundtracks		<u>Sound of Music</u>	"Do Re Mi"
B	Pop	Carole King	<u>Tapestry</u>	"I Feel the Earth Move"
11. A	Inspirational	Tennessee Ernie Ford	<u>We Gather Together</u>	"We Gather Together"
B	Country/ Western	Merle Haggard	<u>If We Make It Through December</u>	"If We Make It Through December"
12. A	Inspirational	Jim Nabors	<u>The Lord's Prayer</u>	"Just A Closer Walk With Thee"
B	Blues	Memphis Slim	<u>Blues Memphis</u>	"Feel Like Screaming and Crying"
13. A	Inspirational	Robert Shaw Chorale	<u>What Wondrous Love</u>	"Amazing Grace"
B	Pop	Simon and Garfunkel	<u>Bridge Over Troubled Water</u>	"Bridge Over Troubled Water"
14. A	Inspirational	Staple Singers	<u>The Staple Singers Pray On</u>	"How Great Thou Art"
B	Easy Listening	Judy Garland	<u>Very Best of Judy Garland</u>	"Somewhere Over the Rainbow"
15. A	Pop	America	<u>Holiday</u>	"Tin Man"
B	Easy Listening	Ray Charles Singers	<u>Moods of Love</u>	"Misty"

APPENDIX C

MUSIC PREFERENCE TEST

"The purpose of this music listening test is to aid the therapist in understanding your likes and dislikes in choosing music. She can then provide a selection of the music you like best for those discussion sessions that will include the use of records."

Directions: Your task now is to listen to the following tape. You will hear 15 paired items. For each of these items, you will hear parts of two different songs. You are to circle on this form the letter A if you prefer the first example or circle the letter B if you prefer the second example. You are to circle only one response for each item. Please answer all items - there are no right or wrong responses. We will now begin.

1. A B
2. A B
3. A B
4. A B
5. A B
6. A B
7. A B
8. A B
9. A B
10. A B
11. A B
12. A B
13. A B
14. A B
15. A B

APPENDIX D

TABLE 5. FREQUENCIES OF INDIVIDUAL SUBJECT AND TOTAL GROUP MUSIC PREFERENCES BY MUSIC STYLE

MUSIC STYLE	FREQUENCY OF INDIVIDUAL SUBJECT PREFERENCES						TOTAL GROUP PREFERENCES
	A	B	C	D	E	F	
COUNTRY/WESTERN	4	1	2	4	3	2	16
POP (TOP 40's)	1	4	2	5	4	3	19
BLUES	0	2	0	3	4	3	13
MUSICALS/SOUNDTRACKS	2	1	3	0	2	2	10
INSPIRATIONAL	4	3	3	1	1	1	13
EASY LISTENING	4	4	5	2	1	3	19

APPENDIX E

CATEGORIZATION OF SELECTED VOCAL MUSIC FOR RESEARCH SESSIONS

Panel of experts: Registered Music Therapists

Directions: Please categorize the following artist(s)/albums, choosing only one of the following.

- | | |
|--------------------|-------------------------|
| A. Country/Western | D. Musicals/Soundtracks |
| B. Pop (Top 40's) | E. Inspirational |
| C. Blues | F. Easy Listening |

(The letter designation signifies at least a three out of four panel member agreement on the classification style. A blank represents those examples for which less than a three out of four agreement was established.)

1. C Charlie McCoy, "Harpin' the Blues"
2. E Jim Nabors, "The Lord's Prayer"
3. D "My Fair Lady"
4. Glen Campbell, "Greatest Hits"
5. B Helen Reddy, "Love Song for Jeffrey"
6. Ray Price, "She's Got to be a Saint"
7. D "Godspell"
8. F Johnny Mathis, "I'm Coming Home"
9. E Anita Bryant, "Abide With Me"
10. B Simon and Garfunkel, "Bridge Over Troubled Water"
11. A Charley Pride, "In Person"
12. C B. B. King, "King Size"

13. F Norman Luboff Choir, "Side By Side"
14. F Vicki Carr, "Ms. America"
15. B Gordon Lightfoot, "Summertime Dream"
16. C Ray Charles, "Crying Time"
17. D "The Sound of Music"
18. Mahalia Jackson, "In Concert"
19. C Elmore James, "Southside Blues"
20. E Johnny Mann Singers, "The Church's One Foundation"
21. A Johnny Cash, "Any Old Wind That Blows"
22. F Judy Garland, "Greatest Hits"
23. A Donna Fargo, "The Happiest Girl in the Whole U.S.A."
24. C Memphis Slim, "Raining the Blues"
25. F Frank Sinatra, "Some Nice Things I've Missed"
26. B Cat Stevens, "Teaser and the Firecat"
27. A Charlie Rich, "Behind Closed Doors"
28. E Roy Clark, "Sings Gospel"
29. D "Funny Girl"
30. C Bessie Smith, "Nobody's Blues But Mine"
31. A Tammy Wynette, "Til I Can Make It On My Own"
32. B Carpenter's, "The Singles"
33. F Andy Williams, "The Other Side of Me"
34. Lou Rawls, "You're the One"
35. A Marty Robbins, "Have I Told You Lately That I Love You"
36. B Mac Davis, "All the Love in the World"
37. D "Camelot"
38. A Loretta Lynn, "Somebody Somewhere"
39. E Tennessee Ernie Ford, "Faith of Our Fathers"

40. _____ Linda Ronstadt, "Greatest Hits"
41. B Carol King, "Tapestry"
42. F Jack Jones, "...Sings Michel Legrand"
43. _____ Elvis Presley, "Good Times"
44. _____ Charlie McCoy, "Good Time Charlie"
45. D "Fiddler on the Roof"
46. E The Staple Singers, "Great Day"
47. A Merle Haggard, "If We Make It Through December"
48. B Chicago, "Chicago VI"
49. F Ray Charles Singers, "Moods of Love"
50. A Lynn Anderson, "All the King's Horses"
51. C John Hurt, "The Immortal John Hurt"
52. B Stevie Wonder, "Songs in the Key of Life"
53. F Kate Smith, "Here and Now"
54. D "West Side Story"
55. E Mormon Tabernacle Choir, "The Lord is My Shepard"
56. C Louisiana Red, "Louisiana Red Sings the Blues"
57. B Cher, "Dark Lady"
58. A Connie Smith, "I Got A Lot of Hurtin' Done Today"
59. B Jim Croce, "Life and Times"
60. F Perry Como, "Hello, Young Lovers"
61. B Spinners, "Happiness Is ..."
62. C Leadbelly, "Leadbelly Legacy - Number One"
63. C Mike Bloomfield/Paul Butterfield, "Steelyard Blues"
64. D "Lost Horizon"
65. E Don Shirley, "The Gospel According to . . ."
66. _____ George Jones, "Alone Again"

- 67. B America, "Holiday"
- 68. F Barbara Streisand, "Greatest Hits"
- 69. A Porter Wagoner, "Blue Moon of Kentucky"
- 70. F Anita Kerr Singers, "Walk A Little Slower"
- 71. A Kris Kristofferson/Rita Coolidge, "Full Moon"
- 72. F Paul Williams, "A Little Bit of Love"
- 73. F Tony Bennett, "All Time Hall of Fame Hits"
- 74. F Nancy Wilson, "All in Love is Fair"
- 75. B Olivia Newton-John, "Have You Never Been Mellow"
- 76. E Mormon Tabernacle Choir, "Sheep May Safely Graze"
- 77. A Roy Clark, "Classic Clark"
- 78. A The Marshall Tucker Band, "Long Hard Ride"
- 79. Engelbert Humperdinck, "My Love"
- 80. E Tennessee Ernie Ford, "Sings About Jesus"

APPENDIX F

RECORD ALBUMS AVAILABLE DURING RESEARCH SESSIONS

SESSIONS 1 - 6

Country/Western

Porter Wagoner, "Blue Moon of Kentucky"
Marty Robbins, "Have I Told You Lately That I Love You?"
Lynn Anderson, "All the Kings Horses"
Loretta Lynn, "Somebody, Somewhere"

Pop (Top 40's)

Carole King, "Tapestry"
Carpenters, "The Singles"
Mac Davis, "All the Love in the World"
Jim Croce, "Life and Times"

Blues

B. B. King, "King Size"
Charlie McCoy, "Harpin' the Blues"
Memphis Slim, "Raining the Blues"

Musicals/Soundtracks

"Fiddler on the Roof"
"West Side Story"

Inspirational

Jim Nabors, "The Lord's Prayer"
Mormon Tabernacle Choir, "Sheep May Safely Graze"
Anita Bryant, "Abide With Me"

Easy Listening Favorites

Perry Como, "Hello, Young Lovers"
 Johnny Mathis, "I'm Coming Home"
 Judy Garland, "Greatest Hits"
 Vicki Carr, "Ms. America"

SESSIONS 7 - 12

Country/Western

Donna Fargo, "The Happiest Girl in the Whole U.S.A."
 Charlie Rich, "Behind Closed Doors"
 Marshall Tucker, "Long Hard Ride"
 Charley Pride, "In Person"

Pop (Top 40's)

Olivia Newton-John, "Have You Never Been Mellow"
 Stevie Wonder, "Songs in the Key of Life"
 America, "Holiday"
 Helen Reddy, "Love Song for Jeffrey"

Blues

Ray Charles, "Cryin' Time"
 Bessie Smith, "Nobody's Blues But Mine"
 Elmore James, "Southside Blues"

Musicals/Soundtracks

"The Sound of Music"
 "Godspell"

Inspirational

Roy Clark, "The Gospel According to Roy Clark"
 Johnny Mann Singers, "The Church's One Foundation"
 The Staple Singers, "Great Day"

Easy Listening Favorites

Andy Williams, "The Other Side of Me"
 Kate Smith, "Here and Now"
 Barbara Streisand, "Greatest Hits"
 Tony Bennett, "All-Time Hall of Fame Hits"

SESSIONS 13 - 18

Country/Western

Merle Haggard, "If We Make it Through December"
Tammy Wynette, "'Til I Can Make it on My Own"
Johnny Cash, "Any Old Wind That Blows"
Connie Smith, "I Got A Lot of Hurtin' Done Today"

Pop (Top 40's)

Simon and Garfunkel, "Bridge Over Troubled Water"
Gordon Lightfoot, "Summertime Dream"
Spinners, "Happiness Is . . ."
Cher, "Dark Lady"

Blues

Leadbelly, "Leadbelly Legacy - Number One"
John Hurt, "The Immortal John Hurt"
Louisiana Red, "Louisiana Red Sings the Blues"

Musicals/Soundtracks

"Funny Girl"
"Camelot"

Inspirational

Don Shirley, "The Gospel According to Don Shirley"
Anita Kerr Singers, "Walk a Little Slower"
Tennessee Ernie Ford, "Sings About Jesus"

Easy Listening Favorites

Norman Luboff Choir, "Side By Side"
Ray Charles Singers, "Moods of Love"
Frank Sinatra, "Some Nice Things I've Missed Along the Way"
Nancy Wilson, "All in Love is Fair"

APPENDIX G

VERBATIM DISCUSSION FROM A "MUSIC" CONDITION SESSION

(This segment is from SESSION # 13, TOPIC # 4.)

Therapist: Today we'll be using the records to help us with our discussion. We'll play a song, then talk awhile about what we hear, then play another song and talk some more. Our topic for today is "what's it like for you when you get down in the dumps?" I wonder if you can find a song that tells us what gets you feeling down, or what you do to help pick up your spirits when you're down. When you play the song, I'll ask you if it's a song to help pick up your spirits or one that describes feeling down for you.

Take a few minutes now to look through the records and find one that will help you get started in the discussion.

(PAUSE)

Subject A: "Walk A Little Slower".

Therapist: Okay. Now, is this a song for when you're feeling down or when you're trying to cheer yourself up?

Subject A: Trying to cheer myself up.

Therapist: Okay. Let's all listen to John's song to decide if it's a "cheer him up" song. This is a song called "Walk A Little Slower" by the Anita Kerr Singers.

(song is played)

Therapist: Well, what do you all think? Is that a song that makes you feel more down in the dumps or one that helps pick up your spirits?

Subject C: I don't know.

Subject A: Picks up your spirits.

Therapist: Pick up your spirits you say?

Subject A: Yeah.

Therapist: What words did you hear in that song that go along with that idea of picking up your spirits?

Subject A: Well, it's hard to do.

Therapist: Hard to pick up your spirits?

Subject A: Yeah, it is.

Therapist: Anybody else find that to be true?

Subject C: I think it's kind of hard to do.

Therapist: Well, in the song they gave a couple of suggestions. They suggested we walk a little slower and take a look at the world around us, the flowers that were blooming.

Subject A: Yeah.

Therapist: . . . and the sun that's shining. Take a look at some of the . . .

Subject A: reality.

Therapist: . . . Yeah, some of reality and also signs of hope and better times.

Subject A: Yeah.

Therapist: Do you think this is a season (Spring) that we could look around us?

Subject A: Yeah.

Therapist: What is it that makes you sad? What kind of thoughts do you have that make you sad?

(PAUSE)

Subject A: Well, being penned in.

Subject C: Helen might have taken a walk.

Therapist: Uh-huh. Are you concerned about her?

Subject C: Oh, I think she's alright. She just went somewhere.

Therapist: You'll have to tell her you missed her - that you're sorry she's not here.

Subject C: Uh-huh.

Therapist: John was saying that he feels down in the dumps when he's penned in. Does anybody else have that feeling?

(PAUSE)

Therapist: When you say you're feeling penned in, John, are there other words that go along with it that describe that feeling for you?

Subject A: Uh.

Therapist: I wondered if you feel like you don't have much control over what happens in your life.

Subject A: I have more control when I'm penned in.

Therapist: What are some things you have control over in your life?

(PAUSE)

Subject A: Well, I don't know. . . (laughter) . . .I can't figure it out. It's confusing.

Therapist: A confusing question?

Subject A: Yeah.

Therapist: Okay. Should we go on and hear another song?

Subject A: Yeah.

Subject C: I've got one here.

Therapist: Okay. Which one was yours?

Subject C: Well, I believe that first one there, or "You Are the Sunshine of My Life." Either one's alright with me.

Therapist: Okay. Why don't you decide then?

Subject C: Can you find this one? "You Are the Sunshine of My Life" - I like that.

Therapist: Let's listen to the words of this one now. When it's over, we'll decide if it was a peppy song - a cheerful song, or one that's more down in the dumps.

(song is played)

Subject C: Thank you. I liked that.

Therapist: So, is that a down in the dumps song or a cheery song?

Subject C: Cheery one.

Therapist: What did anyone else think?

Subject A: Cheery song.

Subject C: (garbled comment)

Therapist: Un-huh. Allie, how about for you? Was that a cheery song or a down in the dumps song?

Subject D: Cheery.

Therapist: He was singing a song about his favorite person.

Subject C: Uh-huh.

Therapist: He was singing the song to the "sunshine" of his life.

Subject A: Yeah. To his girlfriend.

Therapist: Maybe his girlfriend . . . or whoever helps him feel good.

Subject A: Yeah.

Therapist: Anybody have a favorite person who is the sunshine of your life? Helps pick up your spirits?

Subject A: Yeah.

Therapist: Who's that for you, John?

Subject A: Pearl.

Therapist: Tell us about Pearl.

Subject C: Pearl _____ . Do you mean her?

Subject A: Yeah.

Subject C: Yeah, she's pretty nice.

Therapist: How does she help pick up your spirits, John?

Subject A: Well, we go down to White Castle and get a hamburger and a hot chocolate once in awhile. Then I don't feel so lonesome.

Therapist: Good for you! . . . How about anybody else? Does anybody else have a "sunshine of your life" who helps pick up your spirits?

(PAUSE)

Subject C: I think my daughter helps pick my spirits up. We don't go out very often, but once in awhile. . . I'm going to try and find out when Mother's Day is and go out that day.

Therapist: Oh, let's see . . .

Subject C: I can't find it out on the calendar. It's not on my calendar.

Therapist: It isn't?

Subject C: No it isn't. I looked twice.

Therapist: But it is in May.

Subject C: It's in May but I don't know just when. I'll ask the beauty shop lady. I'm going to get my hair done tomorrow and I'll ask her then.

Therapist: Well, what about that? Getting your hair done - does that make a brighter day for you?

Subject C: It makes me feel better.

Therapist: Uh-huh.

Subject C: I have a cold, though. I hate to get it done, but I guess it won't make me worse.

Therapist: I bet it'll make you feel prettier.

Subject C: Uh-huh. It's so short, she can't do much with it.

Therapist: ~~Mmm~~ . . . Is it true for anyone else that your spirits pick up when you take care of how you look?

Subject A: Yeah, they do.

Therapist: I noticed you've been shaving quite regularly, John.

Subject A: Yeah, I have . . .

Subject C: (simultaneously) Yeah, he has.

Therapist: You been feeling a little better these days?

Subject A: Yeah, I've been feeling a little better.

APPENDIX H

VERBATIM DISCUSSION FROM A "NO MUSIC" CONDITION SESSION

(This segment is from SESSION # 5, TOPIC # 5.)

Therapist: Again, like on Saturday, we'll have our talk time for the first twenty minutes, then go into music at the end of the session. So - today our topic - something we can get started talking about - is what it's like for us when we get angry. I think we all get mad from time to time, and I wonder what experiences you've had being angry - and what you've done about it.

(PAUSE)

Subject C: It's been a long time since I've been angry.

Therapist: Has it?

Subject C: Yeah. I can't remember . . .

Subject A: I haven't been angry for a long time.

(PAUSE)

Therapist: Well, thinking back . . . what kinds of experiences do you remember that used to cause some anger for you?

Subject C: I don't remember any. Do you? Do you remember any times you was angry?

Subject A: Well, if somebody tells a story about you, and it wasn't true . . . or something like that.

Therapist: Yeah, that would make me mad, too.

(PAUSE)

Therapist: How do we get over feelings of being angry? How do you think you shifted, Edna, from having things bother you to now when things don't bother you so much?

Subject C: Well . . .

Subject A: I go to my room.

Therapist: How does that help, John?

Subject A: Well, I try to figure out why - who was right and who was wrong . . . Meditate . . . I meditate.

Therapist: After you've figured out who's right and who's wrong, then what?

Subject A: Oh, next time I see that person, I tell him whether he was wrong or right.

Therapist: So you tell that person your feelings about it?

Subject A: Yeah . . . if they was wrong . . . if they was right, I apologize. If they was wrong, I tell them.

Therapist: That's a pretty healthy way to handle it.

(PAUSE)

Therapist: Allie, can you remember a time when you've been angry?

Subject D: Yes, I can remember that. It's been a long time ago, though . . . Sometimes it makes me mad when we don't get waited on right (laugh).

Therapist: Ah . . . that's something that happens here?

Subject D: Yes.

Subject C: Waited on at the table you mean?

Subject D: Well, sometimes she leaves our coffee 'til last - to pour it, you know.

Subject C: Hmmm.

Subject D: I think she ought to pour it first.

Therapist: And that makes you a little mad.

Subject D: Yeah.

Therapist: What do you think you could do about feeling mad when that happens?

Subject C: Ask her to . . . (cut off)

Subject D: Well, I usually pass it off.

Therapist: That's one way. The only problem with that is you probably stay mad every time it happens. . . . Did you hear Edna's

suggestion?

Subject D: No, I didn't hear it.

Therapist: (to Edna) You said to ask her to pour it first.

Subject C: Oh, yeah. But she wouldn't do it, would she?

Subject D: No.

Subject C: They always pour it last.

Therapist: Is that the procedure here?

Subject C: (garbled response) . . . (to Allie) You sit right over there - over there at the last table. I sit there at the next to the last table.

Therapist: Do you have assigned places where you're supposed to sit?

Subject C: Yes, uh-huh. When you come in, you take your same place.

Therapist: Do you mind that?

Subject C: No.

Therapist: Anybody mind that?

Subject E: Mind what?

Therapist: Having the same place for dinner every night?

Subject E: NO.

Therapist: Do you ever wish you could mix around with other people?

Subject C: No, I'm satisfied.

Therapist: Huh.

Subject A: I'm satisfied.

(PAUSE)

Therapist: You know, when we think about the word "angry", it sometimes sounds like a pretty strong word. There are also some other words that describe not liking what's going on. Anybody have any idea what other feeling words go a long with being mad?

Subject A: I think you get moody.

Therapist: Uh-huh. Get moody. Ever get frustrated?

Subject A: Frustrated.

Therapist: Do you know what frustrated is all about?

Subject A: I don't know the definition of it.

Therapist: You know, Allie, that's kind of what fits your situation. You get frustrated in a situation where you don't like what's going on but you probably can't do much to change it.

Subject C: Oh, I didn't know that.

Subject D: When you don't say a whole lot.

Therapist: When you don't have much power to change the situation, a lot of times you end up feeling frustrated.

Subject A: What does frustrated mean?

Therapist: Well, it means you wish you could make a change happen, but you can't, so you're stuck with the anger just sitting in your stomach.

Subject A: Uh-huh.

Therapist: Have you ever felt that way about anything?

Subject A: Yeah, I've felt that way.

Therapist: Can you remember anything that caused you to be frustrated while you were doing it?

(PAUSE)

Oh, I know an example. Do you two (Edna and John) remember when you were making those rugs - just learning how - and having gotten stuck, not knowing just what to do next?

Subject A: Yeah.

Therapist: That's a frustrating situation. You just don't know how to get out of it.

Subject C: Uh-huh.

Therapist: You just don't know how to get out of it.

Subject A: Frustration.

Subject D: Not really angry, but frustrated.

Therapist: Uh-huh . . . Yeah.

Subject D: Sometimes I don't allow myself to get angry. I used to get

angry quick - you know, about anything.

Therapist: Uh-huh.

Subject D: After I got saved, I was better.

Therapist: You were more patient?

Subject D: Yes. I had more patience then.

(PAUSE)

Therapist: Are there any people that live here that you just think "they're mad all the time!" Can you picture anyone around here who looks mad all the time?

Subject A: Some of them.

Subject C: Think some of them are?

Subject A: I don't know about all of them, but some of them are.

Subject C: A few.

Therapist: What do people look like when they're mad? Do people have certain expressions on their faces, or . . .

Subject D: They have a frown on their face.

Subject A: Do I look like I'm mad all the time?

Subject C: Uh-uh.

Therapist: Not to me. Why do you ask that?

Subject A: I thought maybe you were referring to me - I don't know.

Therapist: Were you referring to him Allie?

Subject D: NO.

Therapist: I didn't think so.

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