A STUDY OF THE PROCESS AND OUTCOMES OF RELATED ARTS THERAPY WITH THE ADULT SCHIZOPHRENIC PATIENT

Thesis for the Degree of Ph. D.

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Betty J. Keem

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By

Betty J. Keem

AN ABSTRACT OF A THESIS

Submitted to
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ABSTRACT

A STUDY OF THE PROCESS AND OUTCOMES OF RELATED ARTS THERAPY WITH THE ADULT SCHIZOPHRENIC PATIENT

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The central purpose of this study was to report findings of an investigation to study the process and outcomes of related arts therapy with adult schizophrenic patients confined in three Michigan psychiatric hospitals. The study was designed so that the outcomes would provide answers to questions raised about the effectiveness of related arts therapy. The study was basically concerned with uncovering factors which interact and produce beneficial results, and just as important, factors which do not interact and do not produce beneficial results, thereby determining the effectiveness of related arts therapy. This kind of knowledge is of value to hsopital milieu treatment teams when making decisions regarding treatment as it relates to the needs of the adult schizophrenic patient.

A total population of sixty subjects for this study was selected by stratified random sampling from the IBM card file in each of the three hospitals--thirty males and thirty females. The male and female populations were then randomly divided into two subgroups, experimental and control. A comparison of the two groups was made in accordance with the objectives of the study. The data analysis varied due to availability of statistical models.

The findings revealed that the two groups were dissimilar in their CQ-set personality profiles after therapy. Sex was not a factor. The patients in the experimental group exhibited a significant personality

improvement. This improvement appeared to move the experimental schizophrenic personality profile closer to that of the optimally adjusted personality profile. The personality profile of the patients in the control group remained as it was before the study was initiated.

From the data collected about ward status changes it was possible to determine that the majority of experimental patients exhibited a move toward a more open environment--open ward or out patient basis. The control group remained in the same environment after therapy as it was before therapy.

The findings also indicated that the personality of the therapist was a factor in measuring the effectiveness of the related arts therapy treatment. Therapists whose patients received the most beneficial results from therapy scored higher in (1) original thinking, (2) personal relations, (3) emotional stability, and lower in (1) cautiousness, (2) vigor, (3) sociability than therapist whose patients received fewer beneficial results from therapy.

It was also uncovered by the findings that related arts therapy had little or no effect on the actual illness itself--the psychotic syndromes and morbidity patterns. During the three month therapy period, there was a significant improvement in the psychotic syndromes and morbidity patterns, which could be attributed only to the hospital milieu therapy treatment.

Further, the findings revealed that related arts therapy seemed to produce an adverse effect on the hospital adjustment of the experimental group.

It was found, in this study, that although related arts therapy did not have an effect on the psychotic illness, it did have an effect

on reorganizing the personality of the adult schizophrenic patient. Further, the personality reorganization seemed to promote the adult schizophrenic patient closer to the ultimate treatment goal--release from psychiatric treatment.

This study represents an effort to identify and measure factors of related arts therapy which interact and produce beneficial results, when applied as part of the milieu therapy treatment presribed for the adult schizophrenic patient. It is hoped that additional studies will eventually produce a body of knowledge which will give those concerned with prescribing treatment for mental health a clearer picture of related arts therapy effectiveness. Only when this picture is completed, through additional research, will related arts be able to function at a maximum level in order to meet the needs of humanity beseiged with mental health problems.

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The writer wishes to express her gratitude and appreciation to Dr. Harold J. Dillon, Chairman of her Guidance Committee, for his encouragement and guidance during the planning and preparation of this thesis. Appreciation is also extended to other members of the Guidance Committee: Dr. John Howell, Dr. Clyde M. Campbell, and Dr. Max S. Smith who provided the conceptual and organizational insights necessary for the completion of the project.

The author also wishes to acknowledge her special indebtedness to Dr. Curtis W. Page--Traverse City State Hospital, Dr. Clemens H. Fitzgerald--Wayne County Psychiatric Unit, and Dr. John Hsu--Pontiac State Hospital who made the resources of their respective hospitals available to the writer. Also, special mention must be made of the clinical psychologist, registered nurses, and therapists who so capably assisted in the testing and collection of behavior reports from which the data of this study were derived.

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CHAPTER I

INTRODUCTION

Reason for this Study

In this century research has become more and more an outstanding characteristic of our cultural development. Scientific method of inquiry has spurred on the advancement of medicine.[1] The effects of music to some extent defy objective investigation,[2] because music is communication of a nonverbal and nonlogical nature. Aesthetic feeling, highly subjective, tends to resist scientific inquiry. Defense of this use of music in therapy, however, rests in the ability of musicians, therapists, and psychiatrists to scientifically examine and revaluate the assumed values of music in therapy.

This research study is one of the first in the field of interaction in related arts therapy, using music as a basis, for the mentally ill. Prior to World War II musicians had applauded the use of music as a therapy for the ill but most claims were merely unscientific recitals of personal observations. Further, within the related disciplines little scientific attention had been paid to the subject. There were, of course, a few exceptions to this, notably reports from Van de Wall.

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[1]Dorothy M. Schullian and Max Schoen (eds.), Music and Medicine (New York: Henry Schuman, Inc., 1948).

[2]Carlos Chavez, Musical Thought (Cambridge: Harvard University Press, 1961), pp. 19-34.

After World War II a number of research projects concerned with understanding the various aspects of the effects of music therapy in psychiatric disorder came into existence. Some gave emphasis to the significance of the "intra" psychology movement, and some to the "inter" psychology influence. Only recently has the interaction of multi disciplines in therapy been scientifically investigated.

An upsurge of interest in mental illness was undoubtedly influenced by the war.[3] The reasons were manifold. Some were diffuse and part of the general shaking up experienced by people everywhere; some reflected greater awareness of the severe emotional problems confronting mankind in a changing society. Another factor was the apparently high prevalence of psychiatric disorder found in the course of selection for military service. Moreover, psychiatrists, in caring for the health of military units rather than individuals only, noticed striking differences evidently due to conditions of living, battle and morale and were confronted with the problems of rehabilitating those who had been psychiatrically disturbed. More recently, the late President Kennedy focused national attention on mental illness when he stated:

> I propose a national mental health program to assist in the inauguration of a wholly new emphasis and approach to the care of the mentally ill. Government at every level--federal, state, and local--private foundations, and individual citizens must all face up to their responsibilities in this area.[4]

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[3]Leo Srol, et. al., Mental Health in the Metropolis (New York: McGraw Hill and Company, 1962), p. VII-VIII.

[4]U.S., President, 1961-63 (J. F. Kennedy), Message from the President of the United States Relative to Mental Health and Mental Retardation, 88th Congress, 1st Session, February 5, 1963. House Document No. 58, p. 2.

After the President's mandate was delivered psychiatry and its adjunctive therapies were plunged into a major revolution.[5] First order of the revolution was a national mental health survey.[6] It brought to light the following pertinent facts about mental illness.

1. At least 1 person in every 10--19,000,000 peoples in all--has some form of mental or emotional disturbance (from mild to severe) that needs psychiatric treatment.
2. Mental illness is known to be an important factor in many physical illnesses, even heart disease and tuberculosis.
3. At least 50% of all the millions of medical and surgical cases treated by private doctors and hospitals have a mental illness complication.
4. There are more people in hospitals with mental illness, at any one time, than with all other diseases combined, including cancer, heart disease, tuberculosis, and every other killing and crippling disease.
5. Illnesses and ages of mental hospital patients fall principally into the following diagnoses and approximate age groups:
   (a) Schizophrenia--about 23% of new patients are schizophrenics; most of these fall between ages 15 and 34. They make up about 50% of all the resident population of mental hospitals, because of their youth on admission and long-term hospitalization.
   (b) Senile brain disease and cerebral arteriosclerosis--these psychosis account for about 23% of new admissions, usually over the age of 60. Because of high death rates among these patients, they represent only about 14% of the hospital population.
   (c) Involutional psychosis--about 4.2% of new patients admitted to mental hospitals; usually between the ages of 45 and 60.
   (d) Manic-depressive and psychotic depressive reactions--about 3.5% of new admissions; usually between 35 and 50.
   (e) Alcohol intoxication and addition--about 12% of new admissions; usually between 25 to 55.
   (f) Personality disorders other than alcoholism--about 7% of new admissions; between 15 and 35.
   (g) Other disorders make up almost 28% of new admissions, each of low incidence.[7]

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[5] George A. Stanford, "Orchestration of the New Mental Hospital Theme," Journal of Music Therapy, Vol. I., No. 4 (December 1965), pp. 124-128.

[6] D. W. Martin, M.D., The Mentally Ill Do Get Well (Pontiac, Michigan: Pontiac State Hospital, 1963), pp. 7-10.

[7] Ibid.

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Over half a million children in the United States are classified as psychotic or borderline cases. Most of these children are suffering from childhood schizophrenia. Only a small percentage are receiving any kind of psychiatric care. About 18,300 children and young people, with serious mental disorders, are admitted as patients to public mental hospitals each year. Three thousand are under 15 years of age and 15,300 are between 15 and 24 years of age. Conservatively estimated, an additional 241,000 children under 18 are treated at psychiatric clinics each year, for less severe mental disorders.[8]

There are approximately 72,000 hospital beds in Michigan and over half of these beds are occupied by the mentally ill.[9] Mental health appears to be not only a real medical problem but also a gigantic social problem. Broader medical and social concepts are needed for the treatment of the mentally ill. Broader programs in research are in demand. The impending forces have motivated many new research projects. Implicit is the need for appropriate targets for investigation. Milieu therapy[10] is currently, in Michigan, a concern of a large number of persons engaged in the prevention of mental illness--namely teachers, particularly teachers in urban centers. The field is broad and many scientific studies are needed to refine, define, and describe desirable directions. The research project reported in this dissertation was designed to study a small but vital segment of the whole. Results of this study combined with results of similar studies with other types of subjects provide a

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[8] Ibid.

[9] Ibid., p. 2.

[10] Kenneth Artiss, Lt. Col., Milieu Therapy in Schizophrenia (New York: Grune and Stratton, 1962).

necessary link in establishing psychiatric adjunctive therapeutic programs for both curative and preventative purposes.

Statement of Purpose

It is the purpose of this dissertation to report findings of an investigation to study the process and outcomes of related arts therapy with certain psychotic patients, selected at random and confined in three Michigan psychiatric hospitals. To do this the therapy sessions were recorded and the process of therapy was described through the use of meaningful categories of behavior as measured by the recorded typescripts. The outcomes of therapy were studied through the use of objective measures of personal level of functioning before and after a three months therapy period.

Several converging lines of theory and research are involved in this study. First, the study addresses itself to the lawfulness of behavior in therapy. Second, the study questions the interaction of related arts, therapist, and patients. Third, it raises the question of the kind of personality reorganization to be postulated as a result of the interaction of related arts therapy.

As a point of departure for category construction and hypothesis formulation this study accepted the conceptions of interpersonal relations suggested by Ruesch,[11] Menninger,[12] Maslow,[13] and Bennis.[14] According to

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[11]Jurgen Ruesch, Psychiatric Care (New York: Grune and Stratton, 1964).

[12]Karl Menniger, Vital Balance: The Life Process in Mental Health and Illness (New York: Viking Press, 1963).

[13]Abraham H. Maslow, "Some Basic Propositions of a Growth and Self-actualization Psychology," in Perceiving, Behaving, and Becoming, 1962 ASCD Yearbook, ed. Arthur Combs (Washington D.C.: ASCD, 1962).

[14]W. G. Bennis, et. al., Interpersonal Dynamics (Homewood, Illinois: The Dorsey Press, 1964).

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these conceptions, interpersonal relationships are carried on in terms of persistent patterns of attitudes toward self and others. The nature of these relationships as a consequence of therapy can be specified. The sample used in this study was limited to mental patients of the psychotic group. Both the descriptive constructs and predictions have been formulated with this in mind.

The Hypothesis

This thesis, an analysis of related arts therapy with adult psychotic patients, was specifically designed to determine:

1. the actual value of the interaction between this type of therapy and the behavior of the adult psychotic patient,
2. the effectiveness of related arts therapy on the psychotic syndromes and morbidity patterns of the adult psychotic patient,
3. the actual value of this type of therapy as it relates to the personality of the adult psychotic patient,
4. the actual value of the related arts therapist personality as the therapist interacts with the adult psychotic patient,
5. the identification of factors and interactions that are most conducive to the success of related arts therapy with adult psychotic patients.

The general or collective hypothesis to be proved by this study is that related arts therapy, although apparently effective by consensus of those practicing the art, can be objectively proved to be an effective therapy. Further, its potentialities can be insured by correctly identifying those factors which enhance and support its effectiveness.

Principle Features of the Following Chapters

A frame of reference for examining this research project is given in Part One, chapters II and III. Chapter II is richly woven with the history of music therapy, and chapter III traces the development of research in the field from its emergence to current trends leading up to a definition of related arts therapy demonstrated with clinical examples. To establish this frame of reference data were collected from: historical records of the National Association of Music Therapy as reported in the Volumes of Proceedings, "A Historical Study of the National Association for Music Therapy," unpublished doctoral dissertation by Ruth Boxberger on file at the University of Kansas, Department of Education; literature pertinent to the use of music in healing; related psychiatric and psychological literature; and a review of current music therapy and related therapies practices reported in published articles. In addition to the above, data were collected from personal interviews with directors of music therapy programs in higher education. These included Robert K. Unkefer, Michigan State University, East Lansing, Michigan; Erwin H. Schneider, Ohio State University, Columbus, Ohio; William W. Sears, Indiana State University, Bloomington, Indiana; directors of education and research in psychiatric hospitals: Clemens F. Fitzgerald, M.D., Wayne County General Hospital, Psychiatric Unit, Eloise, Michigan; John Hsu, M.D., Pontiac State Hospital, Pontiac, Michigan; and Curtis W. Page, Ph.D., Traverse City State Hospital, Traverse City, Michigan; and clinical director, Arthur M. Dundon, M.D., Traverse City State Hospital, Traverse City, Michigan. A final source of material was gathered from experiences of the following practicing music therapists: Ruth Vancil, Pontiac State Hospital, Pontiac, Michigan, Christine Smith, Wayne County General

Hospital, Psychiatric Unit, Eloise, Michigan, and Betty J. Keem, Traverse City State Hospital, Traverse City, Michigan.

Part II includes chapters IV, V, & VI. Chapter IV outlines the design and procedure of this research project "A Study of the Process and Outcomes of Related Arts Therapy with Certain Psychotic Patients." The presentation and analysis of data with case studies is reported in chapter V. The final chapter, chapter VI, a summary, includes conclusions and recommendations.

PART ONE

CHAPTER II

HISTORICAL BACKGROUND

Origins of Music

The origin of music is not understood. Diserens and Fine[1] have reviewed the following theories about the origin of music. Darwin claimed that music played a role supplementing the process of natural selection whereby the male or female progenitor of mankind acquired musical tones and rhythm for the sake of charming the opposite sex. Knight has objected to this idea on the grounds that many songs of primitive peoples are songs of war, exploit, and lamentation. Spencer thought that music originated from impassioned speech. Stumpf also thought the vocal element was important and assigned the beginnings of music to early signal calls.

The concept that music is a potent and effective agent is not new. Music and the art of healing have been inextricably entwined since the dawn of civilization. Many ancient mythological figures were the gods of both music and healing.[2] To what extent music has a place in treatment of a disease is linked to the socio-cultural environment and the philosophy that prevails at a particular stage of civilization.

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[1]Charles M. Diserens and Harry Fine, Psychology of Music (Cincinnati: College of Music, 1939), p. 19-44.

[2]Ruth Boxberger, "A Historical Study of the National Association for Music Therapy," (unpublished doctoral dissertation, Department of Education, University of Kansas, 1963), p. 8.

Sigerist[3] calls attention to the fact that human life unfolds itself in an environment that is both physical and social. The social physical environment, responsible for most disease, is in turn shaped by the civilization that has altered man's life.

> Religion, philosophy, education, social and economic conditions--whatever determines a man's attitude toward life--will also exert great influence on his individual disposition to diseases and the important of these cultural factors is still more evident when we consider the environmental causes of disease.[4]

Music as a social art is not difficult to understand if there is an awareness of art's function in society. To understand and appreciate music as an art, there has to be an understanding of the role of the arts in society at various stages of civilization, for "serious art becomes so only if the elements of its content are always some projection of life in its entirety."[5]

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

Music and Medicine in Primitive Cultures

Victims of illness and disease usually become isolated socially, because the individual who is ill is different from those around him. Primitive peoples were often more concerned with the socio-economic effects

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[3]Henry Sigerist, Civilization and Disease (Ithaca, New York: Cornell University Press, 1944), pp. 1-5.

[4]Ibid., p. 3.

[5]Paul Henry Lang, "The Role Music Plays Among the Arts," Music Quarterly, XXXV (October, 1949), p. 603.

of illnesses than they were with the pain or other distressing physical symptoms. Illness and disease became a great concern for primitive man when he could no longer live the life of the tribe.[6, 7, 8]

Sigerest[9] considers primitive medicine to have been related primarily to magical practices, although it contained a few religious elements. Rational treatment was applied as part of ritual. The incantation pronounced over the drug provided the power to cure disease and alleviate suffering. Magical religious and empirical elements are blended in primitive music by the catalystic qualities of magic. Schneider,[10] from analyzing primitive music, believes that many of the supposed nonsensical syllables have a magic quality and have the power to evoke a spirit or frighten it away. Schneider[11] also points out that primitive music and dancing created a movement which apparently generated something that is more than the original movement itself. As primitive man sang and danced he seemed to discover in himself an intense liberating healing power unknown in everyday life.

Music permeated every aspect of primitive society. Thus it is difficult to differentiate between the style of music used specifically

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[6]Paul Radin, "Music and Medicine Among Primitive Peoples," Music and Medicine, ed. Dorothy M. Schullian and Max Schoen (New York: Henry Schuman, Inc., 1948), pp. 3-24.

[7]Sigerist, op. cit., pp. 131-146.

[8]Frances Densmore, "The Use of Music in the Treatment of the Sick by the American Indians," Music and Medicine, ed. Dorothy M. Schullian and Max Schoen (New York: Henry Schuman, Inc., 1948), pp. 24-45.

[9]Sigerist, op. cit., pp. 131-147.

[10]Marious Schneider, "Primitive Music," The New Oxford History of Music, Vol. I: Ancient and Oriental Music, ed. Egon Wellesz(London: Oxford University Press, 1957), p. 2-4

[11]Ibid., p. 4.

as part of the healing process and music as practiced in other areas of community life.

> The relation between the musical style and the content of the song (i.e., words) lies not in the external occasion (rain, war) but in the prevailing psychological tension. If the witch doctor implores the spirit of disease to release his patients, the song will be friendly; if he fights it with his spear the song will be warlike; yet both will be medicine songs.[12]

The musician, who may be called a medicine man, priest-practitioner, priest-magician, or shamon, had considerable importance in tribal life.[13, 14] While all members took part in musical activities, a differentiation can be made between certain individuals who have special powers or privileges and the other participating musicians.

> In general the musician is highly esteemed while practicing his art, because he is regarded as the possessor of a higher power. But he is also feared or despised. He is honoured in public but avoided in private. That he is able to traffic with the world of the spirits makes him a somewhat sinister figure, and the more intensely a community feels his power the more it tries to keep him at arm's length.[15]

In setting up the healing ritual or seance, primitive tribes assigned to the musician-priest not only the task of discovering which spirit was responsible for the illness, but to use the right healing song to entice the spirit from the patient's body. While considerable importance was attached by many tribes to find the right song for the healing seance, the importance of the group to the rituals must not be overlooked. Radin[16] and Densmore[17] both describe healing seances where

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[12] Ibid., p. 39.

[13] Edward Sapir, Culture, Language and Personality, ed. David G. Mandelbaum (Berkeley: University of California Press, 1958), p. 137.

[14] Frank Boas, Primitive Art (Cambridge: Harvard University Press, 1927), p. 9.

[15] Schneider, op. cit., p. 41.

[16] Radin, op. cit., pp. 14-23.

[17] Densmore, op. cit.

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[15] Schneider, op. cit., p. 41.

[16] Radin, op. cit., pp. 14-23.

[17] Densmore, op. cit.

a chorus of sorts functions to help heighten the patient's desire to get well. It was expected that the participation of the sick man's friends and relatives in the healing rituals would intensify the emotional effects of the music upon the patient.

Music and Medicine in Antiquity

The primitive man who was sick enjoyed a special position in society. He was the guiltless victim of secret powers which were recognized and warded off by the medicine man. In higher stages of civilization, man was not an innocent victim, but rather one who, through suffering, had to atone for his sins. Where such a view was prevalent, the sick person was socially isolated in a particularly severe way. This approach to healing and disease was held by Babylonian society, and can be found in the Old Testament of the Bible.[18]

In the developing civilizations of the Babylonians and Egyptians the theory of disease shifted from magic to religion. Babylonian medicine was an elaborate system of relgious medicine; all disease came from the gods, and the task of the priest-physician was to discover and interpret the intention of the gods so he could placate them. By the time of the golden age of Greece, a rational system of medicine came into being that attempted to interpret the nature of health and disease.[19]

In the civilizations of the Hebrews, Babylonians, and Egyptians the close relationship between music and medicine is clearly apparent since they both were infused by the religious philosophy that prevailed in the cultures of these peoples. The account of David's playing of the

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[18]Sigerist, op. cit., pp. 65-86.

[19]Ibid., pp. 132-133.

harp for King Saul during his attacks of melancholy has been repeated innumerable times. This account from the Old Testament of the Bible does not necessarily attribute miraculous powers to the music, but it does serve to illustrate the belief held by the Hebrew people that music had the power to affect the emotions and feelings of individuals. The music that was part of the temple rites of the Egyptians and Babylonians also served when medical aid was sought through healing rituals. The incantations of the medical papri were to be emitted with the proper "voice" and contained the elements of music. The fact that the rituals were not to be varied made them more comprehensible and communicative to the hearer.

Diserens and Fine[20] define the difference between the magical approach and the religious approach to healing as the contrast between an aggressive approach to drive out illness and a submissive attitude seeking relief through supplication and entreaty of the deities. The efforts to appease or persuade the gods must at all time assume a communal form, which in turn helps to determine the individual behavior of the believers. Music is used to bring about a like-mindedness on the part of the group, to enhance suggestibility, and to lull or abolish criticism.

The theory of the four cardinal humors, that exerted a tremendous influence over medicine for the following two thousand years, was advanced during the time of Hippocrates. The four humors were:[21] blood, originating in the heart; phlegm, in the brain; yellow bile, in the liver; and black bile, in the spleen. This theory was further developed by Galen

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[20]Diserens and Fine, op. cit., pp. 125-141.

[21]Sigerist, op. cit., pp. 148-163.

and still more by the Arabs--particularly in the eleventh century, A.D. Each humor had elementary qualities; i.e., blood was hot and moist like air; phlegm, cold and moist like water; yellow bile, hot and dry like fire; and black bile, cold and dry like earth. When the humors were normal in quantity and quality and well mixed, man was in good health; when one humor came to dominate in an abnormal way, the balance was upset and the individual was sick. The practical consequence was that physicians were taught to direct the treatment so as to assist the innate healing power of the body. This theory of disease causation was not the only one in antiquity; there were other schools of physicians, especially the Empiricists, who pointed out that the purpose of medicine was to cure sick people, and that doctors belonging to very different schools still procured the same results.[22]

While it is possible to present two contrasting theories of disease in the life of the ancient Greeks, the rational and the mystical (religious), it is apparent that in practice they are intermingled depending upon the philosophy of the individual sufferer and the circumstances of the illness. The use of music along with rational methods of medicine as practiced by Hippocrates and the Empiricists contrasts with the religious-mystical system practiced by the followers of the "cult of Aesculapius." The prevailing belief in the ethical and moral powers of music to bring man into harmony with himself and his universe were no doubt utilized in many illnesses that had a psychosomatic genesis.

There are accounts from Asclepiades,[23] the Roman physician, who calmed seditious mobs through a change in the music or the playing of a

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[22] Ibid.

[23] Bruno Meinecke, "Music and Medicine in Classical Antiquity," Music in Medicine, ed. Dorothy M. Schullian and Max Schoen (New York: Henry Schuman, Inc., 1948), pp. 70-85.

particular type of music. The cure of insomnia was believed to be aided by hearing harmonious strains of music from a distance; Asclepiades also treated insanity through the medium of harmonious sounds. Xenocrates used the music of the organ with life results. Caelius Aurelianus used the Phrygian key to treat dejection at one time and rage at another since it is both pleasing and stimulating; the Dorian key was to be played for those who were affected with laughing and childish giggling. It was generally believed that music was a cure for snakebites. There was also the general belief that music was effective in combating pestilence; the ancients recognized that a downcast spirit with its resulting fatigue might predispose the body to disease while a relaxed, joyful frame of mind strengthened its resistance. Capella[24] asserted that fevers as well as wounds healed with music. Persons subject to sciatica or lumbago would be free from its attacks if the flute were played in the Phygian mode over the area affected. Galen recommended music as an antidote to the bite of vipers and scorpions.[25, 26]

It may be assumed then, for the ancient Greeks and later the Romans, the use of music as a therapeutic agent was closely allied with the particular type of treatment employed, rational or mystical (religious). For the physician who employed rational methods in the treatment of diseases, music became an adjunct in the over-all course of the treatment since there was a very strong orientation toward the use of music for moral and ethical purposes. Where there was a strong suggestion that music provided a cure for a disease or disorder, it is more often linked

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[24] Ibid., p. 84.

[25] Ibid.

[26] Diserens and Fine, op. cit., pp. 145-150.

to temple cults of healing or to events where the propitiation of the gods had become important to secure relief from disease and to regain health. As Henderson[27] points out music was like a second language to the classical Greek minds, capable of expressing the passions and emotions of the people. This is, perhaps, unparalleled in Western culture, but certainly it is the antithesis of the idea of music as a closed world existing for its own sake on its own terms. It was like all Greek art, "mimetic" or representative, a direct photography, as it were, of mental objects formed by the "ethos" and "pathos" of the soul.

The Romans took over much of Greek culture including the religious figures and the approach to the power of music to influence behavior; however, in Roman civilization music continued the decline that began in later Greek antiquity--the trend away from the moral and ethical purposes held during Plato's time to more emphasis on the sensuous and emotional effects of music.

Music and Medicine in the Middle Ages

Christianity introduced the most revolutionary and decisive change in the attitude of society towards the sick. It came into the world as a religion of healing, a restorative both spiritual and physical. It taught that disease was not a disgrace or a sin, nor was the sick man an inferior. When Christianity became the religion of the state, society assumed the obligation to care for its sick members. The sick man assumed a preferential position which has been his ever since that time. However, attitudes that prevailed before the Christian era were never entirely

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[27] Isabel Henderson, "Ancient Greek Music," The New Oxford History of Music, Vol. I: Ancient and Oriental Music, ed. Egon Wellesz (London: Oxford University Press, 1957), pp. 376-402.

overcome. For this reason, disease in many instances was still considered a punishment and a sin.[28] Coleman points out that mental illness was associated with demonology. Many of the crude, harsh measures employed for the treatment of the insane were the reflection of the belief that a demon had gained control of the sick person and this demon had to be "exorcised."[29]

Greek medicine was a pagan art for which there was no room in the early Christian Church. Gradually, however, a reconciliation took place. When Christianity became the official religion of the Roman state, it had to compromise with necessity by taking over the cultural heritage of the past. The rational medical systems of antiquity were saved but, for centuries, little progress was made because religious medicine was close to the people. Elements of faith healing have survived through all ages. Today the American doctor is a physician of body and mind alike. He cannot underestimate the importance of social and psychological factors in the genesis of disease and its treatment.[30]

Throughout the scholastic Middle Ages, art was considered to be the servant of the Church. The scholars took Pythagoras as one of their principal figures from antiquity. Their theoretical writings show a preoccupation with symbolism and number mysticism rather than with sounds and melodies. By contrast, the theologians were quite cognizant of the power of music. For them, heathen music was diabolic and the faithful had to be protected from its influences. Thus a similarity to Greek thought becomes apparent--music must be carefully regulated and molded by

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[28]Sigerist, op. cit., pp. 65-71.

[29]James C. Coleman, Abnormal Psychology and Everyday Life (New York: Scott, Foresman and Company, 1956), pp. 22-23.

[30]Sigerist, op. cit., pp. 138-142.

the Church otherwise association with profane music would have a deleterious effect on the hearers, especially on the young people.

In the prevailing atmosphere of music for every occasion whether for solemn public ceremonies, private receptions, or music to accompany the armies that went to war, it is to be expected that the use of music for therapeutic purposes would be the rule rather than the exception. Music was not silenced even during the worst of the plague according to the accounts of music in daily life from the "Decameron"[31] by Boccaccio.

The theories of music therapy practiced in antiquity continued to be advocated during the Middle Ages. The scholars and philosophers of this era venerated the ancients and accepted the use of music in therapy as part of the teachings of antiquity. Religion influenced all phases of life during the Middle Ages. Medicine was largely religious medicine. Sigerist[32] gives examples of hymns that were used as remedies for colds; music was composed in honor of the saints who protected mankind from illness. Whenever persons of high rank were ill, it was the custom of the court musician to write special compositions for them, if not to help them, then, at least, to cheer them during their suffering.

Music and Medicine From the Middle Ages to the Twentieth Century

Both Carapetyan[33] and Sigerest[34] discuss the treatment of disease during the Renaissance in terms of the classical theory of the four humors

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[31] Giovani Boccaccio, The Decameron, trans. by John Payne (New York: Scott, Foresman and Company, 1956), pp. 22-23.

[32] Sigerist, op. cit., pp. 96-98.

[33] Armen Carapetyan, "Music and Medicine in the Renaissance and in the 17th and 18th Centuries," Music and Medicine, ed. Dorothy M. Schullian and Max Schoen (New York: Henry Schuman, Inc., 1948), pp. 117-140.

[34] Sigerist, op. cit., pp. 131-146.

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[34] Sigerist, op. cit., pp. 131-146.

in the body--blook, phlegm, yellow bile, and black bile. Out of this came the four temperaments--sanguine, phelgmatic, choleric, and melancholic.[35]

Just as medicine set forth the four component humors of the body, the theories of music set forth four musical elements and related them to cosmic elements. They formed a harmony in music just as the four humors formed a harmony in the body. These four elements were: soprano compared with fire; alto with air; tenor, water; and bass, earth.[36]

The humors were also extended to include the four musical modes:[37] Dorian, phlegm, and water; constituted the phlegmatic temperament; Phrygian, fire and yellow bile, the choleric temperament; Lydian, air and blood, the sanguine temperament; and the mixolydian, earth and black bile, the melancholic temperament. Carapetyan has described the relationship thusly:

> . . . . while medicine utilized a concept more commonly known in music, musical theory in turn borrowed from medicine by defining harmony in music in exactly the same terms by which medical theory defined the harmony that was health. . . . the word harmony would be meaningless if it did not signify a bringing together of elements totally different from one another, whether in the cosmos, in the human body, or in music.[38]

It may be assumed that certain effects of music that were believed to be therapeutic were actually practised, and within the context of the times were, no doubt, effective.

The scientific approach to medicine had its beginnings in the Renaissance with the study of anatomy taking a central position. The

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[35]Carapetyan, op. cit., p. 121.

[36]Ibid., p. 122.

[37]Ibid., pp. 122-123.

[38]Ibid., p. 123.

pathological method in physiology developed during the eighteenth century and clinical medicine had its development during the early nineteenth century. The one field that was not influenced by a scientific approach was therapy. Traditional methods of treatment remained in practice. As a whole, the treatment of disease in the early nineteenth century had not progressed much beyond that of Hippocrates and Galen.[39]

Gradually, in the late nineteenth and early twentieth century, therapy began to reflect the many discoveries in anatomy, surgery, bacteriology, and biochemistry. Scientific discoveries and methods were incorporated into the treatment of disease. The knowledge in the various areas of medicine no longer sought only to explain the causes of disease, they endeavored to treat and prevent them. Medicine had made a long journey through magic, religion, and philosophy to reach the scientific stage.

While the late eighteenth and the nineteenth century still disclosed an affinity of music and medicine, it was during this time that the divergence of the two fields had its beginning. Not until the middle of the twentieth century was there to develop another philosophy of medical treatment that included the arts in its theory of treatment. This does not mean that music was not used for treatment during this period but that the use of music as therapy was examined more critically in terms of scientific methods and procedure. The circumstances of its use are usually described as special cases, rather than as representative of a general theory or commonly held belief.[40]

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[39]Sigerist, op. cit., pp. 229-242.

[40]Ruth Boxberger, "Historical Bases for the Use of Music in Therapy," Music Therapy, 1961 Eleventh Book of Proceedings of the NAMT, ed. Erwin H. Schneider (Lawrence, Kansas: Allen Press, 1962), pp. 125-166.

Early Twentieth Century

Accounts of music as therapy prior to World War I follow the pattern of the nineteenth century. They are individual case histories rather than descriptions of music as part of a larger field of therapy.

With the advent of the phonograph there was more interest shown in the use of music in the hospital setting. Music was used in wards as a diversion during the day and as an aid for sleep at night.[41] Its use was also reported in the operating rooms to mitigate the dread of operations and it was considered effective during local analgesia.[42] Its use was also suggested for dentist's waiting rooms and other areas where patients waited their turn to see the physician.[43]

From reports of the use of music with mental patients, it may be assumed that it had considerably more use in mental hospitals than in general hospitals during this period of time. The actual therapeutic value of the music is not clearly stated since the accounts stress the efficacy of the music and give little or no information about the total treatment situation. This is not meant to discount the value of music in the clinical setting but rather to stress that these accounts cannot be used as objective evidence of the value of music as a therapeutic medium.[44, 45]

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[41] E. O. Kane, "The Phonograph in the Operating Room," Journal of the American Medical Association, XLII (June, 1914), p. 1829.

[42] W. P. Burdick, "The Use of Music During Anesthesia and Analgesia," The American Yearbook of Anesthesia and Analgesia, ed. F. H. McMechan (New York: Surgery Publishing Company, 1916), pp. 164-167.

[43] Jessie A. Jarvis, "From the Outside Looking In," The American Yearbook of Anesthesia and Analgesia, ed. F. H. McMechan (New York: Surgery Publishing Company, 1916, pp. 168-170

[44] Sidney Licht, Music In Medicine (Boston: New England Conservatory, 1946), pp. 11-12.

[45] Doris Soibelman, Therapeutic and Industrial Uses of Music (New York: Columbia University Press, 1948), pp. 10-13.

One of the leading figures advocating the use of music therapy during this time was Eva Vescelius, a musician, who devoted great efforts toward the development of the field. She was the author of a number of articles and a booklet, Music in Health. Shortly before her death in 1917 she completed a lengthy manuscript which summarizes much of her work in music therapy.[46] She revealed that she relied strong on vibrations, produced by music, saying, "We are organized vibrations. The object of all cures is to change discordant vibrations into harmonious ones."[47]

Vescelius appeared to have had some success in her work at the various hospitals. How much of this was due to novelty of the experience for the patients, to her own personal enthusiasm, and to the music is difficult to ascertain. In 1903, she founded the National Therapeutic Society of New York City. She exerted considerable influence on a number of other persons who were active in the field of music therapy.

In 1919 Columbia University announced a course in "Musiotherapy" to be taught by Margaret Anderton, who had gained experience in the field during her work with wounded service men during World War I. The course was to stress an approach based on the needs of the patient. First, in terms of the manner in which music can be administered to neuropsychiatric patients whose difficulties are largely mental and second, the way music can be used in conjunction with physical medicine to assist patients whose difficulties are largely orthopedic.[48]

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[46]Eva G. Vescelius, "Music and Health," Music Quarterly, IV (July 1918),pp. 376-400.

[47]Ibid., p. 378.

[48]"Columbia University to Heal Wounded by Music," Literary Digest, (March 1, 1919), pp. 59-62.

Two other advocates for the use of music for therapeutic purposes were Isa Maude Ilsen (a nurse, hospital executive, and music director), and Harriet Ayer Seymour (pianist and teacher). Mrs. Seymour published a guide to the therapeutic use of music, What Music Can Do For You.[49]

During the years between the two World Wars, there was interest in utilizing scientific methods in the study of the effects of music. The studies centered on the discrimination of pitch differences, ending preferences, consonance and dissonance, and the development of tests in music. The studies on the effective qualities of music centered upon two main streams of investigation such as the physiological responses and the psychological responses to music. The value of these studies for the field of music in therapy has been in supplying reliable information useful in the development of methods and techniques for clinical work. Reports of these studies have appeared in leading music, psychological and education journals.[50] The growing interest in the influence of music on behavior employing experimental methods for the study of music as therapy provided a more objective approach to the field.

Status of Music as Therapy Prior to World War II.

Although music was being used during this time in the hospitals, there was not yet a general philosophy of treatment that considered music was one of the forms of therapy. The power of music to influence human behavior too often was espoused by musicians who made extravagant claims for its therapeutic qualities without providing scientific evidence to support them. In those areas where scientific investigations of the

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[49] Harriet Ayer Seymour, What Music Can Do for You (New York: Harper and Brothers, 1920).

[50] A comprehensive bibliography of the outstanding studies was compiled by Max Schoen, Chairman of the Committee on the Psychology of Music Teachers National Association. The bibliography was published in the Volume of Proceedings of the MTNA for 1940, 1941, and 1942.

effects of music were being made, the results were applicable only indirectly to the therapeutic uses of music.

The term "music therapy" enjoyed a certain vogue prior to World War II. However, there was little evidence that would merit the claim that it was a professional field and as such could demand of higher education a degree training program.[51]

The brief period from the end of World War II to the present has seen music therapy established as one of the professions contributing to the care of the mentally ill, and currently launching a preventative treatment for persons with a potential for becoming mentally ill. Some attempts were made to use music in military hospitals after World War I.[52] World War II, however, was largely responsible for music therapy as we know it today. The USO showed that such a potent morale force helped develop the idea that permanent music programs could be used to help patients get well.[53] As early as 1948, a survey conducted by the National Music Council showed that 117 hospitals had the services of full-time music therapists.[54]

The National Association for Music Therapy was organized in 1950 with less than 100 members. Today the association numbers more than 700.[55] Fifteen institutions of higher learning offer degrees in music

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[51]Betty J. Keem, "A Study of the Historical Aspects of Music Therapy Leading to a Degree Program," (unpublished research paper prepared for Education 8048: Higher Education in the U. S., Michigan State University, East Lansing, Michigan, Fall 1963).

[52]Ibid.

[53]"Red Cross Music," National Music Council Bulletin, September 1945, pp. 20-21.

[54]"Hospital Music Survey," National Music Council Bulletin, September 1948, pp. 10-11.

[55]"Membership Directory," Journal of Music Therapy Vol. II, No. 1 (Lawrence, Kansas: Allen Press, March 1965), pp. 25-35.

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[55]"Membership Directory," Journal of Music Therapy Vol. II, No. 1 (Lawrence, Kansas: Allen Press, March 1965), pp. 25-35.

therapy, and sixteen hospitals are approved as clinical training institutions.[56]

The brief period from 1945 to the present has seen the synthesis of the earlier music therapy concepts into the beginnings of a systematic science or art with a respectable body of discipline and competent clinical procedures.

To some extent this rapid growth can be attributed to the significant amount of research completed. Equally important has been the development of the National Association for Music Therapy. Most of the credit must be given to the complex of mental health professions in our pragmatic society, that have created a climate in which music therapy is needed.

Within the context of this historical background the framework for the research project will be further built by briefly examining the development of allied professions that aided the growth of music therapy and its subsequent transformation to related arts therapy.

Developments in Allied Professions

Psychoanalysis. Around the turn of this century, Freud initiated the psychoanalytic movement that became, within a relatively short period of time, the dominant movement in psychiatry. It seems safe to say that the most important developments in psychiatry during the first thirty years of this century were accomplished either in amplification or criticism of Freud's theories.[57] Even our most recent advances in social psychology and group dynamics owe much, conceptually and semantically, to

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[56]Keem, op. cit., pp. 24-35.

[57]Karl Menniger, The Human Mind (New York: Alfred A. Knopf, 1959) pp. 276-361.

his earlier discoveries. Freud's views on conflict changed as his theories developed. However, the psychoanalytic view on a basic type of conflict remained fairly stable.[58] Freud stated that unconscious strivings of the individual, often unacceptable socially, came into conflict with the prohibitive part of the personality, made up generally of socially acquired controls. These two aspects of the psyche, the "I will" and the "thou shalt not" compromise and find expression in the third part--the conscious, acting part of us. Topographically, this could be stated in this manner: the id comes in conflict with the superego, and compromises between these two are expressed by the ego.[59] A story often told in psychology classes illustrates this phenomenon. A young man, while walking down the street, sees a beautiful young lady. The id says, "Let's go after her"; the superego says, "Leave her alone"; and the ego says, "Let's go get a sandwich, and we'll come back later and see if she's still here."

The analytic concept of a conflict, a part of which was discussed above, can be taken as an illustration of the individual-oriented, or "intra" psychology. According to this view, both theory and therapy are concerned with the individual. The main core of psychoanalytic therapy consists in the uncovering of repressed material in the individual's unconscious, usually through the technique of free association.[60] Freud recognized a type of group behavior, but even here his views were individual-oriented. Collective behavior was considered to be an extension

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[58] Ibid., pp. 274-380.

[59] Sigmund Freud, Group Psychology and the Analysis of the Ego (New York: Boni and Liveright, 1932).

[60] Menniger, op. cit., p. 269.

of individual action with cultural restraints removed. Therefore, an individual interacting in a crowd could behave in an unrestrained manner because he felt free to "throw off the repressions of his unconscious instincts."[61]

A consequence of the individual-oriented psychology is that it required a one-to-one relationship in therapy. Since all psychological conflict is viewed as emanating from within the psyche, the therapist is required to spend many hours alone with the patient in order to work through the repressed material. It would be impossible to submit the large numbers of patients in our hospitals today to psychoanalysis or any type of depth therapy. It would require several times the number of psychiatrists available to extend adequate coverage.[62]

Milieu Therapy. An outgrowth of the Freudian movement provides a second event of importance to music therapists. Milieu terapy was developed at the Menniger Clinic in Topeka, Kansas during the 1930's. Under this concept, a protective, controlled environment was initiated as an adjunct to the treatment of psychiatric patients. Recreation activities such as basketball, volleyball, golf, touch football, tennis, and boxing; arts and crafts activities including leatherwork, ceramics, painting, weaving, and metalwork; and musical activities such as orchestra, dance band, and private lessons on the various musical instruments were made available to patients. Use of these activities were not unusual at this time. Most institutions had recreational programs of various kinds.[63]

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[61]Freud, op. cit., pp. 81-89.

[62]Michigan State Psychiatric Hospital patient populations average 3,000 per hospital. The psychiatric staff varies from one (Kalamazoo) to thirty (Pontiac and Traverse City) full-time staff psychiatrists.

[63]William Van de Wall, Music in Institutions (New York: Russell Sage Foundation, 1936).

However, an important advance occurred when these activities were analyzed for their inherent therapeutic values and, at times, were prescribed much as drugs were being prescribed at other institutions.[64] For example, a patient with a considerable amount of unconscious hostility might be assigned to menial, unpleasant activities such as gardening, sawing wood, or scrubbing the floor with a toothbrush. The goal in a situation such as this might be to "work off" hostility, and to bring some of it to the surface so that it could be expressed consciously.[65]

This aspect of the milieu program must still be placed under the heading of "intra" psychology in that the utilization of activities was still directed toward the inner life of the individual. Another important potential of the activity program, however, was being utilized at the same time. Each activity was conceived and utilized as a "life situation," and close attention was paid to interpersonal relationships developed by the patient in these activities. Questions such as, "How did basketball practice go today?" became an integral part of the treatment program. Relationships between patient and therapist, patient and patient, and patient and group could be assessed and manipulated in therapy.[66] For the first time the music therapist became a primary agent in the treatment of patients. He was required to know the patient's medical and social background as well as his immediate and long-term goals. His activities were guided by psychiatric prescription and frequent staff consultations.

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[64]Interview with Robert K. Unkefer, Director of Music Therapy Training Program, Michigan State University, February, March and April, 1964.

[65]Ibid.

[66]Karl Menniger, A Manual for Psychiatric Case Study (New York: Grune and Stratton, 1962), p. 52.

The use of prescribed activities with the emphasis on relationships, marks the beginning of what might be called the "inter" phase of psychiatric treatment. Group situation is now used to effect personality modification even though theoretical guidance is still derived from psychoanalytic principles. Milieu therapy has exerted a considerable amount of influence in the psychiatric institutions of this country.[67] Certain aspects of the milieu program, such as prescribed activities, are now commonplace,[68, 69] but difficulties have been encountered in its utilization in the large psychiatric hospital. Therapeutic effectiveness of the milieu program depends upon the close cooperation between psychiatrist and activity therapist. Such cooperation is usually difficult to achieve in larger institutions because of the scarcity of psychiatrists. Milieu therapy has given music, occupational and recreational therapists a valid theoretical framework in which to operate and has helped create an identity for them in the psychiatric profession.[70,71,72]

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[67] Maxwell Jones, et al., The Therapeutic Community (New York: Basic Books, 1953).

[68] Ibid.

[69] Jurgen Ruesch, Therapeutic Communication (New York: W. W. Norton and Company, 1961), pp. 11-27.

[70] Objectives and Functions of Occupational Therapy, compiled by the American Occupational Therapy Association (Dubuque, Iowa: William C. Brown, 1959).

[71] Yearbooks of National Association of Music Therapy; Articles and Proceedings of National Conferences Vols. I-XII, 1951-1962 (Lawrence, Kansas: Allen Press, 1952-63).

[72] Objectives and Functions of Music Therapy, currently being compiled by the National Association of Music Therapy under the guidance of E. Thayer Gaston, Director of Music Therapy Training Program and Music Education, University of Kansas, Lawrence, Kansas.

Social Psychology and Group Dynamics. A third development, parallel to the second, should be mentioned as important to music therapists. This concerns the emergence of two professions that possibly are accomplishing the first major revolution in psychiatric treatment since the advent of the psychoanalytic movement. These professions are social psychology and group dynamics. Social psychology is concerned with the development of the individual in relation to his environment, and particularly with the influences that groups in the environment exert on his beliefs and actions.[73] Group dynamicists are interested in the acquisition of knowledge, through empirical means, about the structure and function of various types of groups.[74] Both of these professions have helped develop the realization that mental health and illness is often caused by the individual's interaction in groups and that groups may be used as agents in his treatment or prevention of illness.[75, 76]

A number of social psychologists and social psychiatrists are now actively engaged in therapy in our mental institutions. A few are currently engaged in public school research projects, such as "inner-city" school programs and teacher effectiveness.[77, 78] Their emphasis on the

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[73]Tamotsu Shibutoni, Society and Personality: An Interactionist Approach to Social Psychology (New York: Prentice-Hall, 1961).

[74]Matthew B. Miles, Learning to Work in Groups (New York: Bureau of Publications--Teachers College, Col. University, 1959).

[75]Leo Srole, et al., Mental Health in the Metropolis (New York: McGraw-Hill and Company, 1962).

[76]One of the multi-concepts of the Flint Community School organization, Flint, Michigan.

[77]Allison Davis is currently engaged in such a study in the Chicago "inner-city" public schools. Similar studies are being conducted in Detroit, Michigan, New York City, and Cleveland, Ohio schools.

[78]Bruce J. Biddle and William J. Ellena (eds.), Contemporary Research on Teacher Effectiveness (New York: Rinehart and Winston, 1964).

etiological and therapeutic potentials of groups have given music therapists new and important theoretical constructs with which to operate. As an example, the work of Jones[79] and his associates has demonstrated that patients, when placed in groups, may be effectively helped by other patients when elements such as group cohesiveness and group pressures are introduced and utilized. Similar findings have been uncovered in a recent "inner-city" school disturbed youth study.[80]

Within this historical framework the development of music therapy leading to a more complex related arts therapy will be traced, and a definition of related arts therapy illustrated with clinical examples will be advanced.

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[79] Jones, et.al., op. cit.

[80] Report of the "Personalized Curriculum Program: (PCP) for Junior and Senior High School Drop-outs," (Flint, Michigan, Flint Community Schools, 1965).

CHAPTER III

THE DEVELOPMENT OF RESEARCH IN MUSIC THERAPY AND RELATED ARTS THERAPY DEFINED WITH CLINICAL EXAMPLES

Research

Emergence. An interesting analogy can be noted in the growth of psychiatry, milieu therapy, social psychology, and group dynamics, and the development of music therapy research. As stated before, Freud and his psychoanalytic concepts dominated American institutional psychiatry after 1910. These concepts were given the label of "intra" psychology. The immediate history of music therapy also shows considerable concern with the effects and affects of music on the individual. Such early investigators as Hyde and Scalopino,[1] Diserens,[2] and Treves[3] noted the effects of music on the pulse rate, blood pressure, striated musculature, and respiration rate. Schoen and Gatewood,[4] investigating the mood affects of music using 20,000 subjects, found these affects to be

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[1]Ida H. Hyde and W. Scalopino, "Influence of Music Upon Electrocardiogram and Blood Pressure," American Journal of Physiology, No. 46 (April 1918), pp. 35-38.

[2]Charles M. Diserens, The Influence of Music on Behavior (Princeton, New Jersey: Princeton University Press, 1926).

[3]N. E. Treves, "Study of Music on Cancer Patients," No. 16 (August 1927), pp. 123-131.

[4]Max Schoen and Ester L. Gatewood, "An Experimental Study of the Nature of Musical Enjoyment," in Effects of Music ed. Max Schoen (New York: Harcourt, Brace and Company, 1927).

"strikingly uniform." Altshuler and Shebesta[5] reported favorable results in a study titled "Music as an Aid in the Management of the Psychotic Patient."

An unpublished study by Dreher[6] showed that the unmusical as well as the more musical exhibit galvanic changes while listening to music. But these electrical changes were found to be much weaker in the unmusical subjects.[7] Shrift,[8] in a later galvanic study, determined that the human organism reacts in a significantly different manner to stiumulative music than it does to sedative music. Husband's[9] laboratory findings indicated that different types of music increased the sway of people who were attempting to stand still. Jazz caused greater sway than music of other styles. Work at Stanford University laboratories carried the Husband study further to show that even thinking of jazz music can increase sway.[10] Jensen[11] studied the effects of jazz and dirges on

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[5]Ira M. Altshuler and B. H. Shebesta, "Music as an Aid in the Management of the Psychotic Patient," Journal of Nervous and Mental Disorders No. 94 (August 1941), pp. 179-183.

[6]R. E. Dreher, "The Relationship Between Verbal Reports and Galvanic Skin Responses to Music" (unpublished Thesis on file at Indiana University, Bloomington, Indiana, 1947).

[7]The galvanic skin response refers to the fact that the electrical resistance of the skin is measurably decreased whenever, during emotional states, perspiration is produced on the skin surfaces: R. I. Henkin, "The Prediction of Behavior Response Patterns to Music," Journal of Psychology 44 (1957), pp. 111-127.

[8]Donald C. Shrift, "The Galvanic Skin Response to Two Contrasting Types of Music," Music Therapy, 1956 ed. E. Thayer Gaston (Lawrence, Kansas: Allen Press, 1957), pp. 235-239.

[9]R. W. Husband, "The Effects of Musical Rhythms and Pure Rhythms on Bodily Sway," Journal of General Psychology, 11 (1934), pp. 328-336.

[10]That music can stimulate compensatory movement which can aid one's sense of balance has been demonstrated by W. Lavere in "The Influence of Musical Training and Musical Accompaniment on the Sense of Equilibrium" (unpublished Thesis, Syracuse University, Syracuse, New York 1950).

[11]M. B. Jensen, "The Influence of Jazz and Dirge Music Upon Speed and Accuracy of Typing," Journal of Educational Psychology, 22 (1939), pp. 458-462.

typing. Although jazz seemed to have no effect on the speed of his subjects' typing it did increase the errors. Dirges, on the other hand, decreased the typing speed but had no effect on errors.

Pivot Point. Early in 1950, music therapy entered a new phase. Graduate students, under the direction of E. Thayer Gaston,[12, 13] were investigating problems such as the sedative effects of music on acutely disturbed patients,[14] the effects of music on children's drawings,[15] and postural responses to music.[16] Shatin reported positive behavioral differences in two studies[17, 18] exploring the applications of rhythmic stimuli to long term schizophrenic patients. Research by Alward and Rule (Keem)[19] shows that unaccepted behavior of emotionally disturbed children in a public school classroom can be changed, in certain cases, to more acceptable

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[12]Interview with William W. Sears, Director of Music Therapy Training Program, Indiana University, Bloomington, Indiana, October 1964.

[13]Interview with Erwin H. Schneider, Acting Dean, School of Music, Ohio University, Columbus, Ohio, November 1964.

[14]Donald E. Michel, "A Study of the Sedative Effects of Music for Acutely Disturbed Patients in a Mental Hospital," Music Therapy, 1951 ed. E. G. Gilliland (Lawrence, Kansas: Allen Press, 1952), pp. 182-183.

[15]Danny E. Orton, "Development of Criteria for Study of the Influences of Music on Children's Drawings," Music Therapy, 1952 ed. E. G. Gilliland (Lawrence Kansas: Allen Press, 1953), pp. 261-265.

[16]William W. Sears, "Postural Responses to Recorded Music," Music Therapy, 1951 ed. E. G. Gilliland (Lawrence, Kansas: Allen Press, 1952), pp. 197-198.

[17]Leo Shatin, "The Application of Rhythmic Music Stimuli to Long Term Schizophrenic Patients," Music Therapy, 1957 ed. E. Thayer Gaston (Lawrence, Kansas: Allen Press, 1958), pp. 169-178.

[18]_____, "The Influence of Rhythmic Drumbeat Stimuli Upon the Pulse Rate and General Activity of Long Term Schizophrenic," Journal of Mental Sciences No. 430 (London, England: January 1957), p. 103.

[19]Eileen Alward and Betty Rule (Keem), "An Experiment in the Use of Music with Emotionally Disturbed Children," Music Therapy 1959 ed. Erwin H. Schneider (Lawrence, Kansas: Allen Press, 1960), pp. 125-129.

behavior when subjected to music therapy. It should be noted that the majority of research at this time was still concerned with the "intro" point of view.

One reason for the predominant interest in this line of research was the realization that certain types of music could be used to control behavior.[20] Sedative music could sometimes be used to quiet disturbed wards,[21] and stimulative music could often be used to raise the mood level of apathetic patients.[22] Sedative music also was found to be helpful when used for mental patients experiencing tension and anxiety during dental procedures.[23] Also, during this period the "iso principle" was started by Altshuler.[24] This principle, which originated with the ancient Greeks,[25] is homeopathic in that moods are matched by music and the music is then altered to bring about a desired mood change. For example, highly stimulative music might be played for disturbed patients and as the music becomes quieter or more sedative, the moods and behavior of the patients often change with the music.[26]

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[20]Paul R. Farnsworth, The Social Psychology of Music (New York: Dryden Press, 1958), pp. 259-264.

[21]Robert F. Burns, "A Study of the Influence of Familiar Hymns on Moods and Associations: Potential Applications in Music Therapy" (unpublished Thesis, University of Florida, 1958).

[22]Ibid.

[23]Harold Lee Jacobson, "A Study of the Effects of Sedative Music on the Tension and Anxiety Experienced by Mental Patients During Dental Procedure," Bulletin of the National Association of Music Therapy No. 5 (September 1956), pp. 9-10.

[24]Ira M. Altshuler, "The Part of Music in Resocialization of Mental Patients," Occupational Therapy and Rehabilitation No. 20 (1941), pp. 75-86.

[25]Julius Portnoy, The Philosopher and Music (New York: Humanities Press, 1955), pp. 163-171.

[26]Altshuler, op. cit., p. 76.

Testing the "iso principle" with apathetic schizophrenic patients, Skelly and Haslerud[27] found that the patients general activity seemed to follow the mood of the music. When stimulating march music was played apathy decreased, and when sedative music was played the apathy increased. Simon,[28] et.al. reported that psychotic patients recognized and accepted "mood music" although it had little affect on their overt behavior. Orton determined the effects of the iso principle to be the same with both normal and psychotic subjects.[29]

The prevelence of electric shock treatment (EST) during this period was another area that affected music therapy research. Mental patients seemed to need some type of therapy to aid them when coming out of electric shock treatment. Shatin, Gilmore, and Cotter[30] found a definite positive relationship between music and post-electro-shock awakening. An earlier study by Murdock and Eaton[31] attempted to support the use of music as an adjunct to electroshock therapy by a series of observational case studies.

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[27]C. G. Skelly and G. M. Haslerud, "Music and the General Activity of Apathetic Schizophrenics," Journal of Abnormal Social Psychology No. 47 (April 1952), pp. 188-192.

[28]Benjamin Simon, et al., "The Recognition and Acceptance of Mood in Music by Psychotic Patients," Journal of Nervous and Mental Disorders, No. 114 (1951), pp. 66-78.

[29]Mary Ryder Orton, "Application of the Iso-Moodic Principle in the Use of Music and Psychotic and Normal Subjects" (unpublished Thesis, University of Kansas, Lawrence, Kansas, 1953).

[30]Leo Shatin, T. Gilmore, and W. Kotter, "A Study of the Relationship Between Music and Post-Electro-Shock Awakening," Disorder of Nervous System No. 8 (August 1954), p. 15.

[31]Harry M. Murdock and Merrill T. Eaton, "Music as an Adjunct to Electroshock Treatment," Journal of Nervous and Mental Disorder No. 116 (1952), pp. 336-339.

Current Trends. The discovery of tranquilizing drugs along with their use, on a massive scle, seriously curtailed the "intra" type of research. Behavior could be altered much faster and for longer periods of time with drugs than was possible before. This led music therapy research in other directions. In the past eight years one of the main experimental facets has been music as a rehabilitation factor. Many of the experiments being conducted today generally concern the use of music in the facilitation of social interaction.

Shatin,[32] Blair and Brooking,[33] and Goward and Licht,[34] concluded in their studies that music plays an important role in the rehabilitation of the mentally ill. Zanker and Glatt[35] found that certain kinds of music had a positive affect on the successful rehabilitation of alcoholic and neurotic patients, whereas other kinds of music had a negative affect. An unpublished report by Keem[36] cites the successful use of music in the rehabilitation of a psychotic patient. Another unpublished report by

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[32]Leo Shatin, "Some Psychiatric Aspects of Long-Term Hospitalization. The Rehabilitative Role of Recreational and Special Activities," Mental Hygiene No. 41 (April 1957), pp. 487-496.

[33]Donald Blair and Meir Brooking, "Music as a Therapeutic Agent," Mental Hygiene No. 41 (April 1957), pp. 228-237.

[34]Barbara Goward and Sidney Licht, "Music for the Hospitalized Patients," eds. W. R. Dutton, Jr. and Sidney Licht Occupational Therapy, Principles and Practices (Springfield, Illinois: Charles Thomas, 1957), pp. 127-141.

[35]A. Zanker and M. M. Glatt, "Individual Reactions of Alcholic and Neurotic Patients to Music," Journal of Nervous and Mental Disorders No. 123 (1956), pp. 395-402.

[36]Betty J. Keem, "Employment of Public School Teachers with Mental Illness Histories" (unpublished document of case studies filed in office of music consultant, Flint, Michigan public schools).

Paterson[37] recites the success of an ongoing case study in the use of music in the rehabilitation of a schizophrenic patient.

Griffin, Cotter, and Kurz[38] reporting on the influence of music on geriatric patients concluded that music activities: increased interest in environment; provided a happier and more congenial atmosphere in the dining room; and served, either directly or as a tool, to reduce the sound level of a female geriatric day hall by inducing a more favorable atmosphere for both staff and patient. Dillinger,[39] in a case study titled "Music and Music Therapy as the Patient Experiences Them," reports favorable interaction taking place between the psychotic patient and the therapist. Sommer[40] found that suitable background music increased the frequency of interactions and pause lengths in group psychotherapy sessions. An unpublished study by Kerr[41] showed that more positive interaction with psychotic patients takes place when listening to music performed by musicians in person than when listening to the same music coming from a phonograph. In a study of handbell ringing as a music

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[37]Janet M. Patterson, "Rehabilitation of a Schizophrenic Female Patient: Case Study" (unpublished case study on file in Occupational Therapy office of Traverse City State Hospital, Traverse City, Michigan).

[38]Jack Griffin, Vance Cotter, and Charles Kurz, "The Influence of Music on Geriateric Patients," Music Therapy, 1957 ed. E. Thayer Gaston (Lawrence, Kansas: Allen Press, 1958), pp. 159-166.

[39]George E. Dillinger (M.D.), "Music and Music Therapy as a Patient Experiences Them," Music Therapy, 1958, ed. Erwin H. Schneider (Lawrence, Kansas: Allen Press, 1959), pp. 193-214.

[40]Dorothy T. Sommer, "The Effect of Background Music on Frequency of Interaction in Group Psychotherapy," Music Therapy, 1957 ed. E. Thayer Gaston (Lawrence, Kansas: Allen Press, 1958), pp. 167-168.

[41]B. J. Kerr, "A Study to Determine the Effects of 'Live' and 'Canned' Music on Psychotic Patients" (unpublished paper on file Cincinnati Conservatory of Music, Cincinnati, Ohio, 1942).

therapy operation, Fultz[42] reports that handbell group membership opened up communication lines, and patterns of interaction developed where they were previously non-existent. In an article titled "'Scribbling' in Music Therapy"[43] Ruppenthal sums up three case studies by strongly recommending that the music therapist must and can accept "music scribblings" as a way of opening the door of communication. Furthermore, the music therapist must and can tolerate "musical scribblings" until the time comes for more positive interaction with the patient.

In a cooperative related arts therapy study, Goldstein, Lingas, and Sheafor,[44] present data resulting from an evolutionary process rather than from an isolated experience or idea. The purposes of the study were threefold:

1. to show that interpretation or creative movement to music can serve as a means of sublimating inappropriate emotional feelings or responses;
2. to show that nonverbal communication can be used as an effective means of group unification; and
3. to show the benefits which can be derived when adjunctive therapists from different disciplines combine their knowledge and talents in unified efforts.[45]

This study reflects the movement of the therapeutic team approach and the close interaction and exchange of information among all disciplines concerned, including the patient himself.[46] The latest research points

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[42]Arthur F. Fultz, "A Study of Handbell Ringing as a Music Therapy Operation," Music Therapy 1961 ed. Erwin H. Schneider (Lawrence, Kansas: Allen Press, 1962), pp. 169-182.

[43]Wayne Ruppenthal, "'Scribbling' in Music Therapy," Journal of Music Therapy, Vol. II, No. 1 (March 1965), pp. 8-10.

[44]Carole Goldstein, Catherine Lingas, and Douglas Sheafor, "Interpretive or Creative Movement as a Sublimation Tool in Music Therapy," Journal of Music Therapy Vol. II, No. 1 (March 1965), pp. 11-15.

[45]Ibid., p. 11.

[46]George A. Stanford, "Orchestration of the New Mental Hospital Theme," Journal of Music Therapy Vol. I, No. 4 (December 1964), pp. 124-128.

strongly to related arts therapy rather than straight music therapy. Although artists,[47, 48] dancers,[49, 50, 51, 52, 53, 54] and actors[55, 56, 57]

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[47]According to Charles Beal, Art Consultant, Flint Public Schools and Stuart Hodge, Director of Flint Institute of Arts, artists in general in United States have avoided moving into the area of therapeutic art. The art world prefers to have the art discipline image remain singularly as an artistic expression of a culture rather than take the chance of being relegated to a "lesser societal" role with therapeutic value.

[48]Reports of therapeutic art are spasmadic and usually pertain to accounts of artists, such as Van Gogh, who have been institutionalized or paintings by patients requested by psychiatrists in hopes of reaching the patient's "inner-self." Examples of the latter case are: Naumburg, Margaret. Psychoneurotic Art: Its Function in Psychotherapy (New York: Grune and Stratton, Inc., 1953); and _____. Schizophrenia Art: Its Function in Psychotherapy (New York: Grune and Stratton, Inc.,1950).

[49]Marian Chace, "Dance as an Adjunctive Therapy with Hospitalized Mental Patients," Bulletin of the Menniger Clinic No. 17 (November 1953), pp. 219-225.

[50]_____, "Measurable and Intangible Aspects of Dance Sessions," Music Therapy, 1957 ed. E. Thayer Gaston (Lawrence, Kansas: Allen Press, 1958), pp. 151-156.

[51]_____, "Report of a Group Project, St. Elizabeth's Hospital," Music Therapy, 1954 ed. E. Thayer Gaston (Lawrence, Kansas: Allen Press, 1958), pp. 151-156.

[52]_____, "Rhythm in Movement as Used in St. Elizabeth's Hospital," Group Psychotherapy ed. J. Moreno (New York: Beacon House, 1946).

[53]Elizabeth Rosen, "Dance as a Therapy for the Mentally Ill," Teachers College Record No. 55 (New York: Columbia University, 1954), pp. 215-222.

[54]_____, Dance Psychotherapy (New York: Teachers College, Columbia University, 1957).

[55]Performers of drama have not formally or unformally alluded to their art as a therapeutic tool. However, therapists in other disciplines have attempted to use dramatic art in several ways. Most research accounts refer to psychodrama. Many hospitals have drama clubs, but the inherent values have not been scientifically tested.

[56]J. L. Moreno, "Psychodrama and Group Psychotherapy," Sociometry No. 9 (May/August 1946), pp. 249-253.

[57]_____, "Psychomusic," Psychodrama ed. J. L. Moreno (New York: Beacon House, 1946), pp. 277-314.

[58], [59] have alluded to the use of their discipline as a therapeutic tool, there has not been a body of formal research built nor an organization formed to support the dance, art, or drama discipline in therapy. Music therapy appears to be the only formalized therapeutic art discipline, and therefore the undergirding for the arts in therapy.

Music Related Arts Therapy Definition with Clinical Examples

Definition. Music and/or related arts therapists today are concerned with persons who are not communicating adequately with others. Their patients may be physically, emotionally, or mentally handicapped individuals with varying degrees of disability ranging from temporary to chronic diagnosis. The larger majority of music-related arts therapists work with psychiatric patients confined to mental institutions. Within the past two years music therapists have formally expanded their activities in public schools. Currently, in Michigan, two public school systems employ music therapists.[60]

A recently formulated definition of related arts therapy advanced for this research project by Keem states that the directed use of related

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[58] Eva F. Rudyar, "Methods of Sound and Movement as an Adjunct to Psychodrama," Psychodrama No. 4 (1951), pp. 44-99.

[59] R. Wittenberg, "Psychiatric Concepts in Group Work Applied Through the Media of Drama and Music," American Journal of Orthopsychiatry No. 14 (January 1944), pp. 76-83.

[60] The role of the music therapist is different in these two school systems. In the Lansing, Michigan public schools the therapist is considered a consultant in music for the teachers of the mentally handicapped children. In the role the therapist is expected to "teach" music in the special education classrooms. In Flint, Michigan schools the therapist works directly with the physically and emotionally handicapped children, in addition to the severely mentally disturbed students. In the latter school system music therapy for the mentally handicapped program is, by tradition, an integral part of the regular school music program.

arts therapist as an agent in the treatment, rehabilitation (and/or learning), and entertainment of patients. Because music is conceived to be the basis of related arts therapy the term music therapy and related arts therapy is used interchangeably in the report of this research project.

In modern psychiatric hospitals it is assumed that psychiatric patients need treatment because they can no longer communicate adequately with other people. A patient's interpersonal relationships have disrupted to the point he must have a controlled, non-threatening environment in which to erect new, realistic defenses to meet the strains of everyday living. The hospital serves as a "mikrokosmos," or small world,[61] in which staff members exert every effort to give the patient new experiences in living, new methods for meeting everyday problems and new ways of getting along with people. Therapy is designed to enable the patient to experience fully, to accept what he has experienced, and to share these experiences with others.[62]

Each staff member has a rather well-defined part to play in this effort and the cooperative efforts of the combined staff are mobilized toward returning the patient to the larger--outside community as a responsible, well-functioning member of society. This cooperative approach is known as the "psychiatric team" concept.[63] Because many patients require physical as well as psychological care, the psychiatrist, with his medical

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[61]William Caudell, The Psychiatric Hospital as a Small Society (Cambridge: Harvard University Press, 1958), pp. 285-301.

[62]Jurgen Ruesch, Therapeutic Communication (New York: W. W. Norton and Company, 1961), pp. 482-484.

[63]Karl Menniger, A Manual for Psychiatric Case Study (New York: Grune and Stratton, 1962), p. 18.

background, is traditionally the team leader. The other treatment team members include all the activities therapists, psychologists, psychiatric social workers, psychiatric nurses, nursing aides, attendents and other psychiatrists. In public schools the team usually is headed up by the principal of the building and includes the classroom teacher, home visitor, psychologist, medical advisor, music supervisor, music therapist and other pertinent teaching personnel, and/or occupational therapists.[64]

A distinction is made in the definition between the use of music and the music therapist. This is due to the belief that there are some therapeutic values inherent in the music itself.[65] This is closely related to the "intra" concept discussed earlier. Philosophers, educators and medical personnel have emphasized the therapeutic potentials of music for several centuries. Probably the best summary of these ideas is expressed by Gaston.

> Music is basically a means of communication and many times succeeds in communicating when less subtle means fail. There would be no music, and perhaps no need for it, if we could communicate verbally that which we so easily can communicate with music. . . The fine arts, especially music, have always offered man a means for expression more true and deeper than words. Such use is generally beneficial.[66]

While inherent therapeutic elements in music and fine arts are easily inferred, empirical investigation appears to be almost an impossibility. For this reason, and because of current psychiatric practices, the emphasis is placed on a well-trained musician with a well-rounded fine arts knowledge and a strong, formally acquired psychological background.

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[64]A description of the Flint Community Schools "therapeutic team."

[65]Carlos Chavez, Musical Thought (Cambridge: Harvard University Press, 1961), pp. 19-34.

[66]E. Thayer Gaston, "Nature and Principles of Music Therapy," Music Therapy, 1954 ed. E. Thayer Gaston (Lawrence, Kansas: Allen Press, 1955), p. 154.

The use of the term "treatment" or "therapy" for patients has had a considerable amount of controversy. Without probing the semantics of the question, such as what is treatment and what is therapy, it is possible to state that in certain specific areas, music therapists do engage in therapy. These areas include therapeutic potentials inherent in the activity, direct, controlled procedure with supervision and goal-direction as a prerequisite for therapeutic procedure.[67]

Clinical Examples. Inherent therapeutic potentials in music should not be confused with those potentials found in the music therapy activity. While the two are interrelated, it is helpful to think of them as separate entities. Most music therapists conduct ward programs without supervision by medical personnel.[68] In some hospitals as much as fifty per cent of the therapist's working hours are spent in the wards. Several types of activities, including group singing, rhythm band, exercise to music and simple dance programs are used. These activities may be therapeutic if the therapist formulates realistic goals and works toward their accomplishment. For example, when patients are confined to closed wards, muscles tend to become flaccid, and many patients show progressive loss of attention span and increased disorientation. This is particularly true of geriatric patients. Regular exercise and a simple dance program show psychological benefits.[69] If the therapist is careful to learn each patient's name and manages to speak with him during the

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[67]Ruesch, op. cit., pp. 460-467.

[68]Examples of activities like this can be found in the following midwest hospitals: Indiana--Beatty Memorial Hospital, Richmond State Hospital, Larue Carter Hospital; Wisconsin--Madison State Hospital, Milwaukee County Hospital.

[69]Observed by Betty J. Keem as ongoing activities in the following Michigan psychiatric hospitals (or units): Traverse City State Hospital (June 1964-June 1965); Wayne County General Hospital: Psychiatric Unit (January 1965-June 1965); Winchester (Genesee County) Hospital (October 1962-May 1965).

activity, the session becomes even more beneficial. In this example, a certain activity is initiated with specific therapeutic goals in mind. The activity becomes therapeutic,and the music therapist is practicing therapy.

In another example, a patient, diagnosed as schizophrenic,paranoid type, was present at bi-monthly closed ward sings conducted by the music therapist in a Michigan hospital. This patient was noted for his uncooperativeness and hostility. The music therapist noticed that he seemed to have a good voice. After receiving the doctor's permission, the patient was invited to join the church choir. After a few months working with the music therapist, the patient learned to cooperate to a certain extent with other members of the group and gradually exhibited much less hostility during the sessions and on his ward. He was eventually moved to an open ward. As the musical activity was the only change in his schedule, it can be assumed that it contributed to his improvement.[70] In this instance, the music therapist was working without direction and with a patient who was not in psychotherapy. It seems reasonable to distinguish these accomplishments as therapeutic and the carrying out of the activity as therapy.

In a public school example, an emotionally disturbed nonverbal communicating fifth grade girl transferring into a school was observed by the music therapist furtively peeking at a creative dance class. After receiving permission from the principal and classroom teacher, the music therapist asked the disturbed student to join the creative dance group. In a few weeks the student began to verbalize vile complaints to members of the group. The complaints were indicative of a poor body image. By manipulating comments of the group the music therapist promoted a more perfect body image for the disturbed student. As the

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[70]Interview with Clemens F. Fitzgerald, M.D., Director of Psychiatric Research and Education,Wayne County General Hospital,January 1965.

student's self-esteem increased the disturbance lessened and more acceptable verbal communication was exhibited. Other school personnel were "clued in" to current happenings in the creative dance class. The case is not yet closed. The "therapeutic team" is working toward an even more acceptable communication pattern, even though positive communication progress has been reported.[71] Certainly this activity could be classified as therapeutic.

The second therapeutic area, that of direct controlled procedure under psychiatric or principal supervision, may utilize some techniques employed in the first area. The difference lies in the amount of supervision given and in the way in which the activity fits into the over-all hospital or school treatment program. As stated earlier, the "psychiatric team" concept implies that all professional staff members work together in an integrated program designed to help the patient or student get well. The following example may serve as an illustration of a hospital procedure: A Caucasian female, age 17, was brought to the hospital by her mother. She was untidy, sullen, hostile and occasionally seemed to lose contact with reality. She was given the tentative diagnosis of schizophrenia, paranoid type. The prognosis was guarded. Because it was felt this patient could not stand groups, she was assigned to individual activities in the recreation department, occupational therapy and in the music department. In music she expressed a desire to play the piano and lessons were begun. After a few weeks, it was found that the strongest relationships she had made were in the recreation and music departments.

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[71]Reported by M. Ann Johnson, R.M.T., Flint Community Schools. The school setting for this report is one of Flint's "inner city" schools with a specialized BTU (Better Tomorrow for Urban Youth) curriculum.

Consequently the occupational activities were dropped and most of her time was spent in the other two departments. Almost daily the doctor would check her progress report. The doctor directed the music therapist to give the patient support and gratification whenever possible and to work toward building her self-esteem. Progress was to be praised realistically and failure minimized or ignored.

Since the patient had come from a home dominated by her mother and grandmother, she was assigned exclusively to male therapists. After a month the patient's hostility had diminished considerably, autistic tendencies were no longer observed and it was possible to include her in group activities.

During this period she expressed an interest in dixieland jazz. Records were found, and she spent one hour a week with the music therapist listening to records and discussing everything from music to men. At this time the doctor directed the therapist to begin commenting on the patient's appearance. This led to discussion of clothes and the patient asked to be accompanied downtown to purchase new clothing and cosmetics. A trip to the beauty shop for a shampoo and set, a bath, new clothes and make-up caused considerable comment among the patients and staff members. After approximately four months, the patient was discharged and seemed to make a good adjustment in the community.[72]

The next example shows some events leading up to a patient's discharge under an integrated hospital therapy program. During the hospitalization period, a psychiatric social worker made several trips to the patient's home, discussed her illness with the family and was able to

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[72]Interview with John Hsu, M.D., Director of Research, Pontiac State Hospital, February 1965.

convince them that some changes were desirable in the home environment. A psychologist assisted in the original diagnosis and gave the patient several tests before she left the hospital. Nursing personnel, occupational, recreational and music therapists knew the patient's medical history and gave her as much support and encouragement as possible under a blanket prescription. The psychiatrist directed the therapeutic team, prescribed appropriate medication and was responsible for the patient in therapy.

A parallel case in the public schools can be cited. A pre-school deaf male child with an unusual amount of fear of people, causing regressed behavior, was referred to the adjunctive therapies division of his special school by the diagnostician. The referral was supported by medical advice from the Children's Health Clinic. Individual finger painting and dance-drama were the two forms of therapy he seemed to enjoy. After several weeks of individual dance-drama, the music therapist was directed to involve one, then two other pre-school deaf children. In several months the subject was well integrated with his peer (pre-school deaf) group, which, in turn, was in the process of growing in communication with the larger school-community world.[73]

In the latter case, the team consisted of a school diagnostician, medical personnel, classroom teacher, home visitor, music therapist, music supervisor and building principal.

The term "rehabilitation" generally has two meanings. One refers to the returning or restoring of a person or object to an original state

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[73]Report by Eileen Alward, Principal of Durant-Tuuri-Mott Community School, Flint, Michigan. Durant-Tuuri-Mott houses "normal" as well as "orthopedic" children.

or condition. The second refers to the restoring of one's capacity to make a living. In the public school it is used in these two ways but carries the connotation of "learning" or "relearning," for K-12, junior college and adult education division.[74] While many hospitals prepare patients to make a living through manual arts training and work assignments, the term "psychiatric rehabilitation refers to a somewhat different meaning. It refers to those activities that are aimed specifically toward the preparation of the patient to get along socially in the larger community outside the hospital or school.[75]

As stated earlier, a patient enters the hospital because of a disturbance in interpersonal relationships with the people around him. He no longer has the capacity to interact in a satisfactory manner. While therapy is concerned with modifications in the patient's personality, rehabilitation must be concerned with outward behavioral manifestations that might either inhibit or facilitate relationships with people around him. Many psychiatric patients tend to be unprepossessing. They are often untidy, fail to dress appropriately and pay little attention to hair or fingernails. Some people have disgusting eating habits and relatively few know how to dance or play card games.

It is a function, or should be, of the activity therapists to assess each patient's social capabilities and deficiencies. Capabilities should be developed and deficiencies corrected. To discharge an untidy patient, for example, would invite readmission. Music therapists work with other activity therapists in all of the mentioned areas. In

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[74]This is an integral part of the Flint Community School philosophy.

[75]Interview with Arthur M. Dundon, M.D., Clinical Director, Traverse City State Hospital, Traverse City, Michigan, June 1964.

addition, they would teach the patient social and square dancing, develop any musical talent that might foster recognition and acceptance for the patient in a group and direct the patient in art activities, such as painting, sketching, or dancing. In the same manner, the recreation therapist would give the patient skills in volleyball, tennis, baseball, badminton and other sports that would prepare him for effective group interaction. The community school situation can be equated in a parallel fashion.

The last part of the definition states that music therapists are concerned with entertainment of subjects whether patients or pupils. This is an important part of any hospital or school music program. Activities in this area include patient/student dances, the utilization and supervision of outside entertainment groups, entertainment for special programs, such as Chritmas shows, bus trips[76] etc. The importance of entertainment should not be minimized. It helps make hospital/school routine more bearable and tends to create a better atmosphere which facilitates the more serious business of therapy-learning. In addition, it helps to promote qualitative use of leisure time.[77]

Within this broad frame of reference the chapters in part two will be devoted to delineating the research project designed to study

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[76]Bus sight-seeing trips, sponsored by Dale Clapham, R.T., are particularly popular at the Traverse City State Hospital. One of the patients' favorite recreational-entertainment bus trips is going to a concert at the National Music Camp, Interlochen, Michigan.

[77]Significant "leisure time" conceptual changes have occurred within the past five years. Leisure and the Schools: 1961 Yearbook of the American Association for Health, Physical Education, and Recreation. Editor John L. Hutchinson (Washington D.C.: American Association for Health, Physical Education, and Recreation, 1961), pp. 5-12.

the process and outcomes of related arts therapy with certain psychotic patients selected at random and confined in three Michigan psychiatric hospitals. Findings will be reported and implications will be discussed followed by a brief summary including conclusions and recommendations.

PART TWO

CHAPTER IV

PROCEDURE AND DESIGN OF STUDY

Setting

Geographic Location. Three Michigan psychiatric hospitals were selected to participate in the investigation to study the process and outcomes of related arts therapy with certain psychotic patients. The hospitals were chosen according to the following criteria:

1. American Psychiatric Association approval for the complete three year residency program in which graduate medical doctors may obtain the additional necessary education and training to become fully certified psychiatrists.

2. Approval by the Joint Commission on Accreditation of Hospitals.

3. Membership in the Michigan Hospital Association and American Hospital Association.

4. Facilities for the psychiatric affiliation of student nurses from General Hospitals and college programs throughout the state.

5. American Occupational Association and Music Therapy National Association approval for internship to complete the necessary training to become registered occupational and/or music therapists.

6. An education and research department that is recognized by the associations named in the above items as making an outstanding contribution to the field of knowledge concerning the care and treatment of the mentally ill.

In addition, these hospitals are recognized by the above mentioned medical associations for their out-patient clinics and competent

American Red Cross Gray Ladies. They are also approved by the Council for Clinical Training as centers for clinical pastoral training for students of theology in the United States and Canada.

Two of the three hospitals selected for this study are state supported institutions. The third is county supported. The first state supported institution, located in an industrial urban center, has a committing area of six rural counties as well as four urban counties. The second state supported institution is situated in a city of 18,432 permanent residents, increased by 210,000 ten-week summer residents, according to its 1965 chamber of commerce report. Thirty nine counties, in lower Michigan, make up the committing area of this hospital. The thirty nine county area, considered rural, contains a few scattered service centers and one industrial town. The remaining hospital, the third in this study, is the psychiatric unit of a complex county health department. Its supporting and committing area is one, densely populated, industrial, urban county.

Hospital Administration. The state supported hospitals have similar organizational plans. (See Tables 1, 2.) Both hospitals have a medical superintendent at the top administrative level. The clinical director, director of the children's unit, and the business executive are at the second administrative level and each of these directors report to the medical superintendent. Reporting to the clincial director, in each hospital, are the directors of education and research, nursing, and social services. The occupational and recreational therapies in hospital one, are two separate departments with a director who is responsible to the clinical director. Related arts therapy, in this hospital, is attached to the recreational department. In the second

TABLE 1. HOSPITAL 1--ADMINISTRATIVE ORGANIZATIONAL PLAN (SCHEME)

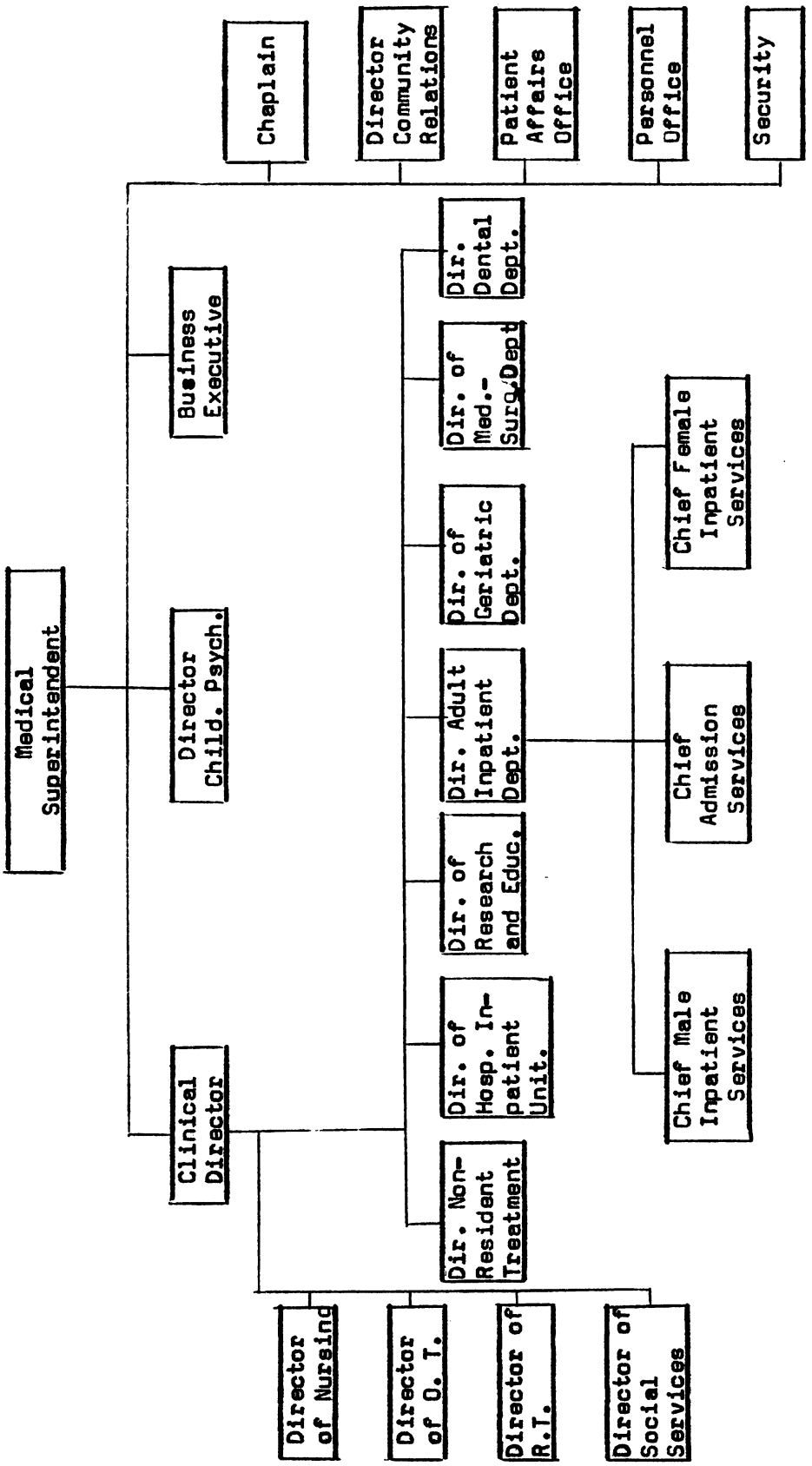
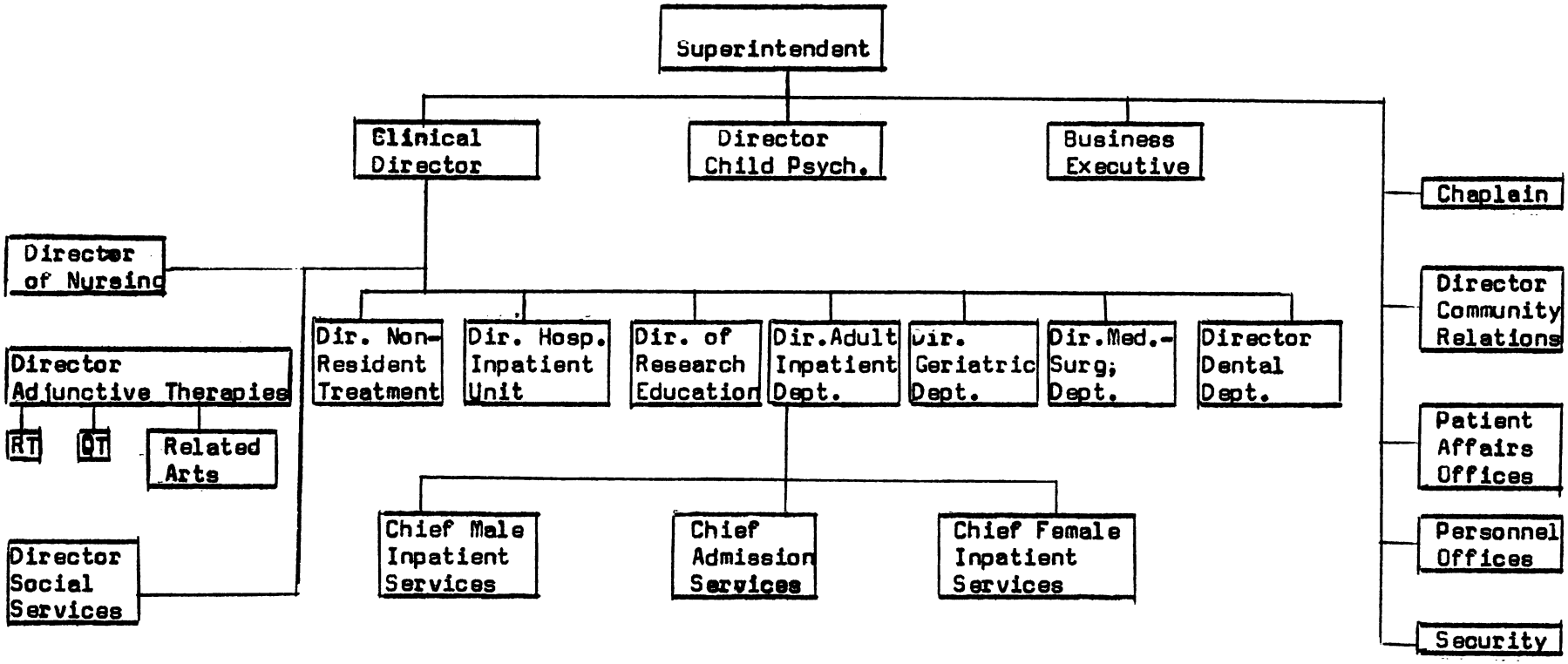


TABLE 2. HOSPITAL 2--ADMINISTRATIVE ORGANIZATIONAL PLAN



hospital the therapies, occupational, recreational and related arts are classified under the adjunctive therapies department with one director who reports to the clinical director.

A comparable organizational plan can be outlined for the psychiatric unit of this county supported health department (see Table 3). In this unit the psychiatric director is given the role equivalent to the role of the clinic director in the state institutions. The directors of education and research, nursing, male and female wards, psychology and ancillary programs report to the psychiatric director. Related arts therapy in this institution, is a vital and well established program attached to the ancillary division.

Other salient features of these three hospitals can be pointed out as: (1) hospital beds--2925 (first state hospital), 2950 (second state hospital), and 2998 (county institution); (2) the average of 30 full-time psychiatrists for each hospital; (3) total number of hospital employees--821 (hospital 2), 989 (hospital 3), and 910 (hospital 1); and (4) over 50 per cent of the newly admitted patients, in each hospital, has a psychotic disorder.

Subjects

Population. A psychotic disorder defined by Coleman[1] is a functional psychoses, meaning: personality disintegration with disorientation for time, place, and/or person. Coleman[2] further delineates psychotic disorders by categorizing them into four groups, namely:

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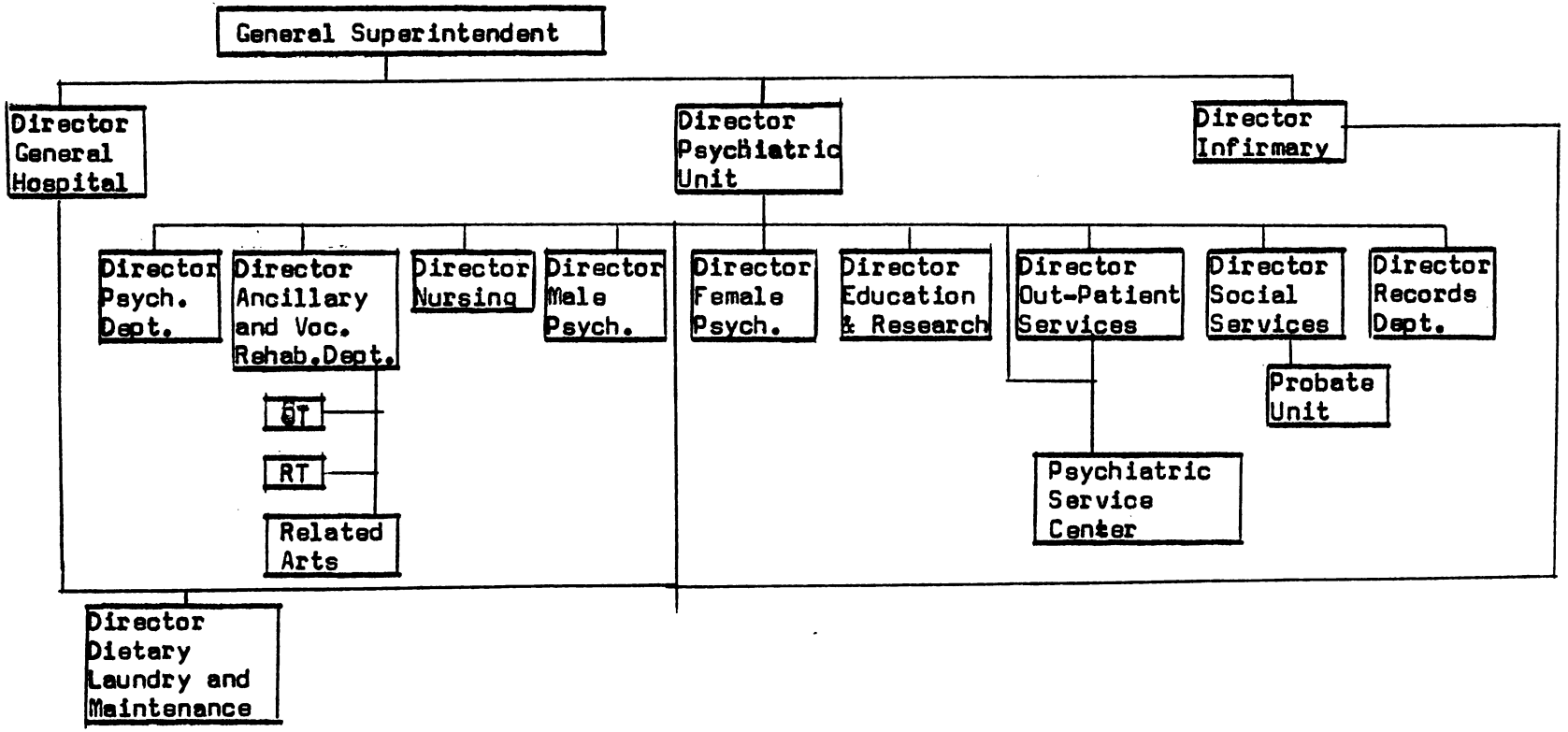
[1]James C. Coleman, Abnormal Psychology and Modern Life (Chicago: Scott Foresman and Co., 1956), pp. 224-314.

[2]Ibid.

TABLE 3. HOSPITAL 3--ADMINISTRATIVE ORGANIZATIONAL PLAN



1. Involutional psychotic reaction-depression in involutional period without previous psychoses.

2. Affective reactions--exaggerations of mood with related thought disturbance.

   a. Manic-depressive reaction--prolonged periods of excitement or depression or mixture or alternation of the two.

   b. Psychotic depressive reaction--severe depressions and delusions of unworthiness.

3. Schizophrenic reactions--a group of psychotic reactions with disturbances in reality relationships and thought processes and emotional distortion.

   a. Simple type--apathy and indifference without conspicuous delusions or hallucinations.

   b. Hebephrenic type--severe disorganization with silliness, mannerisms, delusions, hallucinations.

   c. Catatonic type--conspicuous motor behavior with excessive motor activity and excitement or generalized inhibition and stupor.

   d. Paranoid type--poorly systematized delusions; often hostility and aggression.

   e. Acute undifferentiated type--sudden schizophrenic which may clear up or develop into another definable type.

   f. Chronic undifferentiated type--chronic, mixed symtomatology not fitting other types.

   g. Schizo-affective type-admixture of schizophrenic and affective reactions.

   h. Childhood type--schizophrenic reactions occurring before puberty.

   i. Residual type--mild residual symptoms following more severe case.

4. Paranoid reactions--persistent delusions usually without hallucinations. Behavior and emotional responses consistent with delusions. Intelligence well preserved.

An average of 23% of new patients admitted to mental institutions, are schizophrenic.[3] Most of these patients fall between the ages of 15 and 34. Currently, schizophrenic patients make up 50% of the resident population of mental hospitals because of their youth on admission and long-term hospitalization. The prevalence of schizophrenia and its present status in mental hospitals are the central reasons for delimiting the subjects of this study to those between the ages of 20 to 29 with a schizophrenic reaction type diagnosis.

Sampling. The question as to how many subjects would be selected in order to provide adequate data was based on the assumption of numbers. It was assumed that the average patient load for each related arts therapist would contain approximately thirty patients. Approximately one third of this load would fall into the category of illness and age limitation set by this study. Therefore, a stratified random sampling procedure[4] was used by the directors of education and research in each hospital to select 10 female and 10 male schizophrenic patients, between the ages of 20 to 29, with a predicting holding power[5] of 4 months, as the subjects for this study. The subjects, female and male, in each hospital were randomly divided into an experimental and control group. The total number of subjects was 60.

The 60 subjects fall into the nine schizophrenic reaction types as follows: 21 paranoid, 20 chronic undifferentiated, 6 catatonic, 6

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[3]D. W. Martin, The Mentally Ill Do Get Well (Pontiac: Pontiac Pontiac State Hospital, 1964), pp. 8-9.

[4]The stratified random sampling techniques employed by the 3 directors of education and research are typical of those described in Statistical Inference by Walker and Lev.

[5]Holding power, in this frame of reference, means length of hospital time.

schizo-affective, 4 acute undifferentiated, 2 simple, 1 childhood, and 0 hebephrenic and residual (see Table 4). Delineated further: the 21 schizophrenic reaction paranoid subjects fell into the following groups--6 female experimental, 7 female control, 2 male experimental, and 6 male control patients. The 20 schizophrenic reaction chronic undifferentiated subjects were divided as follows: 5 female experimental, 5 female control, 7 male experimental, and 3 male control patients. The six schizophrenic reaction catatonic subjects fell into the following groups: 1 female experimental, 1 female control, 2 male experimental and 2 male control patients. The six schizophrenic reaction schizo-affective subjects were divided into the following categories: 2 female experimental, 1 female control, 2 male experimental and 1 male control patients. The schizophrenic reaction acute undifferentiated group of 4 fell into the following classification: 1 female experimental, 1 male experimental, and 2 male control patients. One male experimental and one male control patient made up the schizophrenic reaction simple group of 2, and only 1 female control was diagnosed as schizophrenic reaction childhood type patient.

Before related arts therapy began the subjects selected for the research project had either a fair or a poor prognosis (see Table 5). In hospital "one" four experimental subjects had a poor prognosis and six had a fair prognosis. The control group contained six subjects with a fair prognosis and four subjects with a poor prognosis. Hospital "two" had the same number of experimental subjects with a fair and poor prognosis. However, in the control group three had a poor prognosis and seven had a fair prognosis. This was almost reversed in hospital "three" where eight experimental subjects had a poor prognosis and two had a fair prognosis and in the control group the "third hospital," seven subjects

TABLE 4. SCHIZOPHRENIC REACTION DISTRIBUTION OF 60 SUBJECTS IN THIS STUDY

	Hosp.I				Hosp.II				Hosp.III				
Reaction Type	FE	FC	ME	MC	FE	FC	ME	MC	FE	FC	ME	MC	Total
1				1			1						2
2													0
3		1		1	1		1				1	1	6
4	4	2	1	1		1	1	3	2	4		2	21
5	1							2			1		4
6		2	3	2	2	2	2		3	1	2	1	20
7			1		2	1					1	1	6
8						1							1
9													0

1-simple

2-hebephrenic

3-catatonic

4-paranoic

5-acute undifferentiated

6-chronic undifferentiated

7-schizo affective

8-childhood

9-residual

TABLE 5. PROGNOSIS, AGE DISTRIBUTION OF 60 SUBJECTS IN THIS STUDY

			Hosp.I		Hosp.II		Hosp.III	
		Patients	Prog.	Age	Prog.	Age	Prog.	Age
EXP.	F	1	3	26	3	27	3	21
		2	2	23	2	23	2	29
		3	3	27	2	25	3	26
		4	2	20	2	22	2	25
		5	2	28	2	21	3	29
	M	1	3	22	2	25	3	26
		2	2	24	3	26	3	22
		3	2	26	3	27	3	29
		4	3	28	2	24	3	29
		5	2	29	3	20	3	20
CONT.	F	1	2	14	1	15	2	19
		2	2	22	2	29	2	21
		3	2	28	2	24	2	21
		4	3	25	2	29	3	22
		5	2	26	3	28	3	22
	M	1	3	21	3	27	3	29
		2	2	24	2	24	3	23
		3	3	26	2	24	2	21
		4	3	28	2	20	3	28
		5	3	29	3	26	3	29

2-fair
3-poor

had a poor prognosis and three had a fair prognosis. All of the 60 subjects selected for this study were between the ages of 20 and 29, (see Table 5) and all were in closed wards.

General Treatment

In the mental hospital community the whole of a patient's time is thought of as treatment. Treatment, to be effective, not only involves the handling of the individual's psychotic problems but also an awareness of the fresh problems which the fact of being in a mental institution may create for the patient and what aspects of the social situation can be used to aid treatment. The patient, the social milieu in which he lived and worked, and the hospital community of which he has become a member are all important and interact on each other.[6]

Roles of Hospital Personnel. In the hospital setting all the various personnel who come into contact with the patient are important to the treatment. The nurses and attendants are with patients most of the time, whereas other personnel contact is sporadic. It is convenient to consider the role of the nurse and attendant under three general headings--authoritarian, social and therapeutic. They must align themselves with authority by their responses to problems presented by the patients, but the action taken must be tempered with an understanding of the motives behind the patients' behavior. The social role of the nurse and attendant is an all important one and, for this reason, they would be more aptly termed "social workers." They must attempt to understand the patients' individual problems aided by reading the case notes,

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[6]Maxwell Jones, The Therapeutic Community (New York: Basic Books Inc., 1953) p. 53.

and daily tutorials. They must also be prepared to be flexible and not adhere to any one social formula. They must constantly guard against satisfying their own needs rather than ministering to the patients'. The treatment role of the nurse and attendant is to interpret or transmit the ward culture to the patient. Thus the aim is not only to encourage and support the patient when his condition calls for it, but to attempt to get him to participate in the various social, work and community activities.[7] The nurses and attendants in the three hospitals were considered, by their respective hospital directors of education and research, to be effective therapeutic agents.

In our culture the role of the doctor is still associated with a certain amount of magic and is nearer to that of the witchdoctor than many people realize. Much of the magic associated with medicine has been carried over to the lay concept of the psychiatrist and the steady stream of films and books on psychiatric topics with which the public is fed has contributed largely to this state of affairs.[8]

In most psychiatric hospitals the doctor behaves towards the patients, nurses, attendants and adjunctive therapists much as he would in a general hospital, except in relation to the psychiatric interview itself. The patient is unaware of any fundamental difference between a physician and a psychiatrist. The relationship in the three selected hospitals to the patients is a complex one. The three directors of education and research indicated that the doctor's role is far removed from that of the analyst and, at the extreme, the doctors are by no

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[7] Ibid. pp. 36-38.

[8] Ibid. pp. 39-40.

means absorbed into the patient community. The patients' attitude toward the doctor in these three hospitals is usually an ambivalent one. He is a miracle worker who should be able to solve all their problems but he is also a figure of authority who may be feared or distrusted. The doctor's role, in relation to the patients, is considered in five main aspects as social, supportive, by example, activating, and interpretive.[9]

In the three participating hospitals the doctors freely take part in social situations. Meeting patients informally or talking or dancing with them are common occurances. The supportive role is linked to the social role but goes further. In various treatment situations, where no interpretive approach is possible or desirable, the doctor helps the patient in every possible way to attain some realistic goal. The discussion group with patient participation affords an excellent opportunity for behavior by example. Hostility is frequently expressed towards the doctor. This is met by explanation, interpretation, or accepted without comment, reprisals or show of anger. Stimulating the patient to play an active role is important. The skill with which various doctors can induce this activity in patients varies considerably as do the techniques which they employ. Interpretation of patient behavior is the main function of the doctor. Clinical directors of the three institutions in this study are of the opinion their respective staffs are well qualified and subscribe to the described treatment above.

The adjunctive therapist's role is that of supporting the already established treatment. Much depends upon the therapist's ability to

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[9] Ibid. p. 40.

communicate, his understanding of people and situations, his personal experience with pathology and therapy and his willingness to help other people learn to communicate.[10] In contact with patients, the three related arts therapists behave like an ordinary human being according to the three hospital directors of research and education. Instead of deferring to an impersonal method, these related arts therapists convey to the patient that no two people communicate in the same way and the patient must put up with some of the therapist's idiosyncrasies. The therapist's courage to be himself and to reveal himself induces the patient to do the same.

In addition to the motivation of the patient to gain or regain a state of well-being, the therapist displays effectiveness through the three fundamental processes of understanding, acknowledging and agreeing. Understanding involves the establishment of an accurate idea or model of the patient's behavior in the therapist's mind. Acknowledging refers to the specific response of the therapist to the patient's purposive or involuntary messages. Agreeing implies the isolation of certain aspects in the world of human experience and establishing correspondence of views or opinions. Once the patient has experienced success in these processes of communication he will seek more of them and hence learn to develop better human relations. This, in turn, puts him in a better position to solve his own problems.[11]

The adjunctive therapist must also have specific teaching skill knowledge, such as: occupational, drama and music.

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[10]Jurgen Ruesch, Therapeutic Communication (New York: W. W. Norton, 1961), p. 465.

[11]Ibid. p. 466.

Specific Treatment

Definition. Related arts therapy, as used in this study, is the directed use of the related arts with music as the basis for improving either the organ systems or the functions of, communication of man and the related arts therapist as an agent in the treatment, rehabilitation (and/or learning), and entertainment of patients. Because music is conceived to be the basis of related arts therapy it must be assumed that the related arts therapists, in the three hospitals in this study, were qualified musicians, performers and teachers. This assumption was found to be correct by judgment of the directors of research and education in each hospital. It was also assumed that each therapist had a basic knowledge of other art forms, such as dancing, drama, and painting. This assumption was verified again by the directors of education and research and by the chairman of the adjunctive therapy division in each hospital.

Related arts therapy was prescribed by the director of this research project for each of the 30 schizophrenic experimental patients. The therapeutic aims for each patient was considered in setting up the treatment as well as the patients' needsand interests. To do this the director of this research interviewed[12] each patient, read their case histories and consulted their psychiatrists about the milieu treatment. Each related arts prescription was designed to be an adjunct to, as well

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[12]Unfortunately no standardized procedure for conducting a psychiatric interview is yet available. In general, as in every interview, it is important to establish rapport. In this process it is usually worthwhile to explain the purpose of the interview as a desire to know the patient better in order to plan his treatment in the hospital. Nondirective interviewing was used in order to develop a therapeutic relationship. When necessary to question directly it was left to the end of the interview.

as an effective supporter of, the already established hospital program for each patient.

The following criteria, based on schizophrenic needs, was used for prescribing suitable related arts activities:[13]

1. Those providing opportunity for actual or symbolic gratification or oral and anal needs in accordance with degree of regression.

   a. Oral needs: eating, biting, sucking, chewing, blowing, etc.

      Examples:

      (1) Pictures of food--looking at, collecting scrapbook, painting, drawing, colors of food.

      (2) Drama--receiving food, tobacco, candy (in various social settings) preparation of food.

      (3) Blowing--whistling, musical instruments, blowing over coke bottle filled with water and tuned to a specific pitch.

      (4) Singing--reciting, reading aloud

   b. Anal needs: Handling, excretory substitutes; progressing toward retentive activities and culminating in socially acceptable collecting.

      Examples:

      (1) Smearing or building--clay, paint, whitewashing, pasting, etc.

      (2) Cleaning musical instruments.

      (3) Preparing copper pipes for musical sounds, cutting wood for xylophones, cleaning and preparing material for rhythm instruments, etc.

      (4) Washing and scrubbing--costumes and scenery for plays, stages, dance floors, etc.

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[13] This criteria was adopted from the Occupational Therapy criteria titled "Characteristics of Suitable Activities" The Objectives and Functions of Occupational Therapy compiled by the American Occupational Therapy Association (Dubuque, Iowa: Wm. Brown Book Co., 1958) pp. 133-135.

(5) Collecting--for artistic processing--string, leaves, stamps, nature collections.

2. Those providing opportunity for improvement in sensory perception and motor coordination through use of

   a. Gross muscle activities such as circle dancing, skipping.

   b. Rhythms--marching, clapping, stamping, rhythm bands.

   c. Bright colors and/or various textures to stimulate interest and focus attention.

   d. Activities having definite delineation of form, as coloring books, jigsaw puzzles, cutouts, tracings, stuffed toys, stenciling.

3. Those providing opportunity for appropriate dependency which may be gradually relinquished as patient matures.

   a. Permitting extensive guidance and assistance.

      (1) Allows patient to be waited on--set up projects, give materials, etc.

      (2) Can be learned by imitation--a minimum of verbalization and maximum of working together.

      (3) A sequence of clearly defined and simple steps which can be taught unit by unit.

   b. Requiring minimal patient initiative and planning and avoiding decisions beyond capacity of patient.

4. Those providing opportunities for development of self-concept, ego strength, sense of personal worth and a standard of values.

   a. Establish sense of personal identity.

      (1) Personalized project, for own use and/or possession--song, poem, picture.

      (2) A musical instrument and/or practice area reserved for his own use.

   b. Foster ego growth.

      (1) Provide gratification of infantile needs.

      (2) Provide narcissistic gratification--self care, repairing, personal grooming, posture.

(3) Insure successful endeavor within current capacity.

(a) When patient's capacity to function in an activity is minimal, the following characteristics will probably be necessary:

(1) Simple short-term units.

(2) Structured.

(3) Readily-controlled material

(4) Limited requirements for mental-motor coordination.

(5) Few new processes.

(6) Repetition of units.

(b) As the patient progresses, gradually introduce activities or projects in which increased demands are made and in which patient is able to experiment with handling frustration, developing initiative, utilizing opportunity and assuming degree of responsibility for his own feelings and actions.

(c) Foster sense of personal worth and own standard of values.

(1) Encourage and respect patient's expression of his own feelings and ideas relative to activities.

(2) As patient can tolerate it, encourage him to make his own decisions about his projects.

(3) Try to guide patient into the activity where he will be naturally a performer in his group but avoid making him feel that he is under pressure to meet your standards.

(4) As patient progresses, gradually introduce situations in which he can successfully compete.

5. Those encouraging constructive release of hostility..

a. Initially use activities which are non-aggressive and do not arouse patient's fear of his own hostility--soft, non-resistive, easily controlled materials.

b. As patient can tolerate it, introduce activities where aggressive action has a constructive result (rhythm instrument and clay models.)

c. Use activities which have supportive limits, such as hammering in mold and cutting to a line.

6. Those providing opportunity for reality testing and the experience of consensus of shared reality.

a. Use activities which offer a maximum of reality contact.

(1) Provide sensory contact.

(2) Provide well-defined structure.

(3) Preclude autistic thinking.

(a) Will not become automatic.

(b) Involve representational or reproductive rather than creative techniques.

b. Activities which provide opportunity for agreement on nature of reality.

(1) Have easily understood and accepted values and purposes.

(2) Have established standards.

(3) Have established techniques.

(4) Require inter-communication.

7. Those providing opportunity for patient to experience a sense of belonging.

a. Sharing common experience and feelings.

b. Experiencing acceptable and well-deserved approval from others.

c. Contributing a particular skill useful to the group.

8. Those providing opportunity for social interaction.

a. Facilitating communication by

(1) Symbolic expression of feelings.

(a) Through process.

(b) Through product.

(2) Achievement which results in expression of favorable comment by increasing give-and-take.

(a) Sharing musical instruments.

(b) Sharing musical books.

(c) Sharing art equipment (paints, brushes)

(d) Helping others.

(e) Preparing work for other patients.

(f) Finishing projects.

(g) Group projects.

Prescriptions. In the first hospital 7 experimental subjects were assigned basic piano lessons, 1 basic percussion lessons, 1 voice lessons, and 1 elementary music form in preparation for composition (see Table 6). The piano students varied in their former experience. One subject, a former piano major in a major university, was assigned to relearn an elementary concerto and to paint her correlative feelings. The other subjects assigned to piano lessons, were given other art experiences such as: drama club, singing simple folk songs, voice cultivation and trumpet lessons. The percussionist was expected to play in the band as soon as possible and the vocalist was assigned to choir as a group activity.

There were 7 experimental subjects assigned to piano in the second hospital. Voice lessons were prescribed for two of these piano students, one to group-listening-discussion-folk-dancing, The other piano students were assigned to activities such as musical comedy, history and listening, painting, listening and discussion and voice cultivation. The voice students were assigned to elementary tap dancing and ward sings. The group listening-discussion-folk-dancing subject was expected to have individual therapy sessions as soon as he could relate to the therapist on a one to one basis.

TABLE 6. RELATED ARTS PRESCRIPTIONS FOR 30 EXPERIMENTAL SUBJECTS IN THIS STUDY

	Patients	Hospital 1	Hospital 2	Hospital 3
F	1	Piano	Voice-dance-piano-listening-discussion	Voice-ballet-drama
	2	Piano - music	Piano-listening-discus.	Dance and songs, Music listening
	3	Elementary form (pop) composition-piano	Piano-art	Art, drama, discussion and read.
	4	Piano - Drama	Piano-voice-listening,disc.	Dance, Music listening
	5	Piano-sing simple fold songs	Piano-listening and discussion	Piano
M	1	Piano-trumpet-drama club	Piano-voice	Alto sax-tap dance
	2	Piano-voice lessons-choir	Piano-voice-choral small groups	Piano
	3	Voice	Voice	Piano
	4	Piano	Piano-folk dance	Voice and piano
	5	Drum lessons-band	Listening- folk dance-Discussion	Piano

Hospital "three" had only 4 experimental subjects assigned basically to piano lessons, 2 to voice, 1 to dance, 1 to history of art, and 1 to alto saxophone lessons. The 4 piano students were not given another art activity but the 2 voice students were assigned drama readings. The dancers were given music listening activities and discussions and the alto saxophone student was scheduled to play with a small jazz combo.

The thirty experimental patients were, in addition to their regular hospital routine, given one half-hour individual related arts therapy treatment per week as described above for a total of twelve weeks. The 30 control patients were expected to follow their already prescribed, by their doctor, hospital routine.

Data Gathering Instruments

The selection of psychiatric data gathering instruments to be used in this investigation was accomplished with the assistance of the Director of Research and Education at Traverse City State Hospital and the Bureau of Education Research at Michigan State University.

Not only were the tests limited to consider the psychiatric usefulness, but also to determine to what extent the instruments met the criteria of the experimental design for which they would be used. Inherent in the considerations was the need to have statistically workable data.

Prior to the beginning of the related arts therapy treatment and, after the 12 therapy sessions, subjects in both the experimental and control groups were tested by qualified psychiatric personnel on the staff of the three hospitals. These tests were: Inpatient Multi-dimensional Psychiatric Scale (Lorr, et. al.); Hospital Adjustment Scale (Ferguson); and California Q-Set (Jack Block).

Other tests administered to the 3 related arts therapists were the Gordon Personal Profile, and the Gordon Personal Inventory (Leonard V. Gordon). In addition, recorded transcripts of the therapy sessions were kept by the related arts therapists. These records were A Therapy Behavior Checklist and informal notes on each patient in the experimental group.

IMPS. The Inpatient Multidimensional Psychiatric Scale[14] is designed to measure ten psychotic syndromes established by repeated factor analyses (Lorr, McNair, Klett, and Lasky 1960). It consists of brief, unlabelled rating scales and dichotomous items. Ratings are based on observations of patient behavior and patient verbal reports of beliefs, attitudes and feelings as obtained in an interview.

Each syndrome is regarded as a unitary pattern of response present to a greater or less degree in all patients. Further, it is assumed that the more severe the syndrome the more probable that deviant behavior will be manifested. Thus a low score implies a mild degree of disturbance while a high score implies a severe degree of disturbance.

The syndromes are each defined by a group of scales which measures a common unitary reaction tendency. The names given the syndromes are somewhat arbitrary but the intent is to describe the underlying reaction or response pattern. The following descriptions are given by Lorr, et al, for the ten syndromes:

A. Excitement (EXC). The syndrome is characterized by an excess and acceleration of the individual's speech and motor activities. There is also a lack of restraint in the expression of emotion and feeling. Mood level and self-esteem are unusually high.

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[14]Maurice Lorr, et al., Inpatient Multidimensional Psychiatric Scale Manual (Palo Alto: Consulting Psychologist Press, Inc., 1962).

B. Hostile Belligerence (HOS). A complaining, griping attitude, manifest hostility, and an inclination to express resentment towards and to feel suspicious of others' intentions are evident in this syndrome.

C. Paranoid Projection (PAR). This syndrome is defined by beliefs that attribute a hostile and controlling intent to the world around the patient.

D. Grandiose Expansiveness (GRN). The syndrome appears to represent a stage beyond paranoid projection. The individual characterized by this syndrome has found an explanation for his persecution. He is really an important personage with a divine mission and unusual powers.

E. Perceptual Distortion (PCP). Hallucinations that threaten, accuse, and demand define this syndrome. The underlying mechanism is one of distortion of sensory and perceptual stimuli. Voices say "bad" things about the patient.

F. Anxious Intropunitiveness (INP). Three elements appear to characterize this syndrome: anxiety, turning against the self, and lowered mood level. The reaction is one in which the individual experiences guilt and remorse and holds himself to blame for real or imagined faults. Thus the underlying defense is morbid intropunitiveness.

G. Retardation and Apathy (RTD). The syndrome is defined by a slowing down and reduction of ideation, speech, and motor behavior. At the extreme there is apathy and disinterest. The underlying reaction appears to be one of giving up the attempt to cope with one's problems.

H. Disorientation (DIS). This syndrome measures varying degrees of disorientation. As represented here, it probably is not due to brain injury but is indicative of autism or intense self-directed attention.

I. Motor Disturbance (MTR). Rigid bizarre postures, grimacing, and repetitive movements are the principal behaviors defining this syndrome.

J. Conceptual Disorganization (CNP). Disturbances in the stream of thought evidenced in irrelevant answers and incoherent or rambling speech characterize this syndrome. These are suggestive of a disorganization in thinking processes.[15]

Many rating scales are constructed to assess some vague general dimension as hospital adjustment, over-all morbidity, severity of illness

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[15] Ibid., pp. 3-4.

or psychoticism. When all measures are correlated positively as with intelligence, it is meaningful to speak of a general measure of "level." Lorr states on the other hand "that all measures of rated psychopathology are not all positively related."[16] "In fact," he says "the presence of one syndrome may preclude the presence of another. In order to determine the general patterns of morbidity, an analysis was made of the correlation factors of the 10 syndromes. The three patterns or second order factors identified (Lorr, et al., 1961) formed the basis for the three morbidity scores developed.

The first measure is bipolar and defines an excitement versus retardation pattern. The score is the sum of EXC and HOS minus RTD. The second pattern is one of tendency toward distortion of thinking and perception. To score, the syndrome scores of PAR, PCP, and GRN are added. The third and last pattern is one of schizophrenic disorganization. The raw score is obtained by adding the MTR, DIS, CNP and RTD syndrome scores.[17]

Inasmuch as standardization of IMPS has just been completed, broad support for its validity is lacking. IMPS at present is primarily a research tool of higher reliability and substantial factorial validity. It is likely to reflect change resulting from treatment. A few other suggested uses for IMPS are:

1. IMPS provides a quantitative record of change in clinical status resulting from modes of hospital care and treatment. The therapist can follow the changes occurring in the ten dimensions if a record is made at suitable intervals during treatment.

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[16] Ibid., p. 5.

[17] Ibid.

2. It can also be of use along with other information in assessing a patient's readiness for hospital release.

3. It is especially useful in research. It may be used to evaluate the effects of new treatment procedures.[18]

Clinical psychologists in each of the three hospitals in this study administered the IMPS to the 60 selected subjects. The director of this research project held IMPS in-service sessions for the clinicians before they started to use the instrument. One hour was the average time allowed for each psychiatric interview. However, some interviews did take longer. From 30 to 45 minutes were allowed to complete the IMPS answer sheet.

HAS. The primary purpose of the Hospital Adjustment Scale[19] is to provide a quantitative estimate of the hospital adjustment of psychiatric patients. This estimate is based upon the actual behavior of the patients. The secondary purpose of the scale is to provide a summary of patients' day-to-day behavioral patterns. Upon the basis of presently available norms and clinical experience in using the scale, its use has been determined to be appropriate with adult patients of either sex hospitalized in any type of psychiatric institution.

HAS is a list of 90 statements about behavior. The statements were so selected as to be descriptive of the behavior of many psychiatric patients. Each of the statements has been keyed in such a manner that it is possible to obtain a score indicative of the patient's general level of hospital adjustment.

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[18] Ibid., p. 6.

[19] Paul McReynolds, and James T. Ferguson, Clinical Manual for the Hospital Adjustment Scale (Palo Alto: Consulting Psychologists Press, Inc. 1951).

It is suggested, in the HAS manual, that the scale be filled out by the psychiatric aide, psychiatric technician, or nurse most familiar with the day-to-day behavior of the patient.[20] Nurses and/or attendants in the three hospitals who had control or experimental patients in their wards, were instructed, by the director of this research project how to fill out the HAS scale. Approximately 15 to 20 minutes were allowed for filling out each scale.

Four scores are obtained from the HAS as follows: (1) the total score, based on all 90 items; (2) the Group I score, based on the first 42 items, and relating to communication and interpersonal relations; (3) the Group II score, based on items 43 through 67 inclusive, and relating to care of self and social responsibility; and (4) the Group III score, based on items 68 through 90 inclusive, and relating to work, activities, and recreation.[21]

It is difficult to state precisely the psychiatric meaning of HAS scores. A low total score, of course, reflects poor hospital adjustment and a high score indicates good hospital adjustment. But hospital adjustment should not be equated with degree of pathology or with severity and extent of symtomotology. It is possible that some patients who evidence pronounced psychotic symptoms will score average on the HAS. Contrariwise, some patients who evidence minimal classical psychotic symptomotology may score low on the HAS. Thus HAS does not furnish a summary of the patient's pathology. It indicates rather the extent to which he is incapacitated, in the context of the hospital environment, or a function of his illness. It describes the extent to which the

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[20] Ibid., p. 3.

[21] Ibid., pp. 3-4.

illness has infringed upon his productive functioning, the extent to which he is able, with the illness, to function adequately. This measuring of functioning has specific reference to the context of the patient's hospital environment. If he were living in a different environment the patient might function differently. Inferences as to how the patient might operate in a given different environment may be drawn from his HAS scores but such interpretations are indirect.

The total score is a direct function of the extent to which the behavior of the patient reflects an expanding or contracting personality. The raw total scores have no meaning in an absolute sense, but only when comparing one patient with other patients, or with patients in general. However, the meaning of the subscores is definitive: Group I--communication and interpersonal relations skill; Group II--skill in caring for self and social responsibility; and Group III--work, activities, and recreational skill.

The manual lists the following suggested uses of the HAS:

1. The clinician may read the statements about a given patient in order to obtain a better picture of his typical behavior.

2. By reference to the HAS scores, the clinician may obtain an estimate of how the patient compares in level of functioning with other patients.

3. The scale may be used periodically for a given patient as a means of evaluating changes in level of functioning.

4. The scores may be used in the over-all comparison of patients in different wards of different hospitals.

5. The scale may be used to help evaluate the capacity of a patient to cope adequately with different types of environments either at various places within the hospital or upon discharge.

6. The scale may be used for matching groups for research purposes and for helping to evaluate the effects of various types of treatment.[22]

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[22] Ibid., p. 5.

The HAS limitations in brief are: it concerns behavior only; it does not attempt to measure such personality variables such as depression, anxiety, reality orientation, or aggressiveness.

California Q-Set. The California Q-Set (CQ)[23] by Jack Block is a Q-Sort method for describing comprehensively, in contemporary psychodynamic terms, an individual's personality.

The non-comparability of clinical formulations of differences in language usage is a great obstacle to clinical communication and research. Many controversies arise and persist because of this language problem. Thus, clinical interpretations of a patient may differ.

The purpose of the 100 items in the CQ-set is to provide a basic English for clinicians to use in their formulations of individual personalities. Ideally the items should permit the portrayal of any kind of pathology and any kind of normalcy. It is felt that the use of a standard language and procedure permits description of an individual in a way that is not too atomizing or constraining and by so doing enables comparisons to be made which otherwise could not be achieved.

In the CQ-sort method, the observation-judge-evaluator is given a set of statements or items previously developed. Appendix II lists the 100 items included in the CQ-set. These statements constitute the entire vocabulary the judge is permitted to employ. In application, the 100 items are arranged by the evaluator so as to characterize the particular person being formulated. That is, the items are put in an order of representativeness (or significance) for the individual with those most characteristic of him being given high scores, while those least

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[23] Jack Block, The Q-Sort Method in Personality Assessment and Psychiatric Research (Springfield, Ill.: Charles C. Thomas, 1961), [illegible].

characteristic are scored low. Conventionally, the Q-items are printed separately on cards, permitting easy arrangement and re-arrangement of the items until the desired ordering is obtained. This general scaling procedure has become known as the Q-sort technique. The prefixing letter, Q, has no especial significance. By historical accident, the method came to be identified this way.[24]

The CQ-sort imposes certain technical restraints, in that the evaluator must order the Q-items into 9 categories with an assigned number of items placed in each category. The number of items distributed into each category being respectively 5, 8, 12, 16, 18, 16, 12, 8, and 5. At the larger number end of the continuum are placed the items describing the most salient features of the individual, at the other end are placed the most salient, in a negative sense in formulating the personality description.

Three observational judges were employed giving a concensus score which is generally considered more highly reliable than scores based upon single observation judgments. In-service sessions with the judges before they used this instrument were conducted by the author. One hour was allowed for each individual card sorting.

The various analytical possibilities of the CQ-procedure, as described by Block,[25] fall into two categories, namely: analysis at the level of item-by-item comparisons and analysis of the correspondence or similarity between Q-sorts. Within each of these broad classes, a pair of subclasses may be elaborated. Under item analysis we have: the comparison of item placements in one Q-sort with item placements in

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[24] Ibid., p. 11.

[25] Ibid., Chapter VII "Research Applications of the CQ-Set," pp. 89-115.

another Q-sort and the comparison of Q-item placement in one group of individuals with Q-items placements in another group of individuals. Similarities among CQ-sorts may be the correspondence of Q-sorts with a criterion (or conceptual or defining) Q-sort; or the intercorrelation of Q-sorts to permit, via factor of cluster analysis, the discernment of types or clusters of people.

Gordon Personal Profile. The Gordon Personal Profile[26] provides a simply obtained measure of four aspects of personality which are significant in the daily functioning of the normal person, namely: Ascendance, Responsibility, Emotional Stability, and Sociability. The four are relatively independent and psychologically meaningful traits which have been found to be important in determining the adjustment and effectiveness of an individual in many social, educational and industrial areas.

The Profile is a companion instrument to the Gordon Personal Inventory, which measures the following four additional traits: Cautiousness, Original Thinking, Personal Relations and Vigor. The two instruments together have been used to cover eight important factors in the personality domain. Both are appropriate for use with high school, college, industrial and general adult groups. It was administered to the three related arts therapists who participated in this research project.

The Profile consists of 18 sets of four descriptive phrases, each of the four personality traits is represented. Two of the four phrases are of similar high average preference value (as considered by typical individuals to be equally complimentary) and the other two are of similar low average preference value (equally uncomplimentary).

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[26]Leonard V. Gordon, Gordon Personal Profile Manual (New York: Harcourt, Brace and World, Inc., 1963 rev.).

The testee is asked to mark one item in each group of phrases as being most like himself and one as being least like himself. Through this forced-choice technique, individuals must make what, in effect, is a three-level ranking within each set of four items.

The Profile is unusually efficient in terms of time and effort required for administration and scoring. It is self-administering and respondents can complete it in from 7 to 15 minutes.

In general, the nature as well as the degree of the relationship between Profile scores and performance criteria should be determined. Highly useful discriminations may occur at one end of the trait continuum even when the over-all relationship is low.

The long term stability of the trait scores has not been investigated. However, the magnitude of the correlations obtained for a three-month interval suggests that stability over even longer intervals would be reasonably satisfactory. The standard deviation is approximately 5 to 6 points and reliability coefficients around .80. Thus the standard error of measurement of an individual Profile trait would approximate 2.5 score points.

High and low scores on each of the Gordon Personal Profile Scales are interpreted as follows:

1. Ascendency (A).
   Those individuals who are verbally ascendant, who adopt an active role in the group, who are self-assured and assertive in relationships with others, and who tend to make independent decisions, score high on this scale. Those who play a passive role in the group, who listen rather than talk, who lack self-confidence, who let others take the lead, and who tend to be overtly dependent on others for advice, normally make low scores.

2. Responsibility (R).
   Individuals who are able to stick to any job assigned them, who are persevering and determined, and who can be relied on, score high on this scale. Individuals who are unable to stick to tasks that do not interest them, and who tend to be flighty or irresponsible, usually make low scores.

3. Emotional Stability (E).
   High scores on this scale are generally made by individuals who are well-balanced, emotionally stable, and relatively free from anxieties and nervous tension. Low scores are associated with excessive anxiety, hypersensitivity, nervousness, and low frustration tolerance. Generally a very low score reflects poor emotional balance.

4. Sociability (S).
   High scores are made by individuals who like to be with and work with people, and who are gregarious and sociable. Low scores reflect a lack of gregariousness, a general restriction in social contacts, and, in the extreme, an actual avoidance of social relationships.[27]

Gordon Personal Inventory. Similar to the Profile in most aspects, the Inventory[28] differs in the number of items used to measure each of its four traits. The 20 Inventory items (Profile has 18 items) make up the four scales which are scored separately. Forced-choice technique is again used, and considered to be one of its principal attributes.

Reliability data have been determined for three independent groups. Estimates of the standard error of measurement for an individual trait score average between 2.5 and 3 points.

Both the profile and the inventory have been found to have applications in selection, appraisal, vocational guidance, personal counseling, and basic research. Providing a total of eight established personality traits, the two were easily administered in sequence by the author to the three related arts therapists. A comprehensive coverage of the trait domain was considered desirable. However, where specific hypotheses are held regarding particular traits, one may administer only the instrument containing the trait(s) relevant to the hypotheses being studied.

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[27] Ibid., p. 3.

[28] _____, Gordon Personal Inventory Manual (New York: Harcourt, Brace and World, Inc., 1963 rev.).

High and low scores on each of the Gordon Personal Inventory scales are interpreted as follows:

1. Cautiousness (C).
   Individuals who rate high are cautious, who consider matters very carefully before making decisions, and do not like to take chances or run risks, score high on this scale. Those who are impulsive, act on the spur of the moment, make hurried or snap decisions, enjoy taking chances and seek excitement, score low on this scale.

2. Original Thinking (O).
   High scoring individuals like to work on difficult problems, are intellectually curious, enjoy thought-provoking questions and discussion, and like to think about new ideas. Low scoring individuals dislike working on difficult or complicated problems, do not care about acquiring knowledge, and are not interested in thought-provoking questions or discussions.

3. Personal Relations (P).
   High scores are made by those individuals who have great faith and trust in people, and are tolerant, patient, and understanding. Low scores reflect a lack of trust or confidence in people, and a tendency to be critical of others and to become annoyed or irritated by what others do.

4. Vigor (V).
   High scores on this scale characterize individuals who are vigorous and energetic, who like to work and move rapidly, and who are able to accomplish more than the average person. Low scores are associated with low vitality or energy levels, a preference for setting a slow pace, and a tendency to tire easily and be below average in terms of sheer output or productivity.[29]

Therapy Behavior Checklist. A therapy behavior checklist (TB)[30] was devised by the author for the purpose of recording behavior evident during the related arts therapy sessions. The eight selected syndromes were largely based on the IMPS ten psychotic syndromes.

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[29] Ibid., p. 3.

[30] Adapted from the IMPS by Lorr, et al. This checklist was used for a three month period, prior to the beginning of this research project, for the purpose of testing its ease to use as a tool for recording certain described observed behavior.

Each syndrome was regarded as a unit of behavior response present to a greater or less degree in the subjects. Further, it was assumed that the more severe the syndrome the more probable that deviant behavior will be manifested. Thus a low score implies a mild degree of disturbance while a high score implies a severe degree of disturbance.

The syndromes, each defined by a five point rating scale which measured reactions during the related arts therapy sessions, were defined as follows:

1. Excitement (EXC). The syndrome is characterized by an excess and acceleration of the subject's speech and motor activities. There is also a lack of restraint in the expression of emotions and feelings. Mood level and self-esteem are usually high.

2. Hostile Belligerence (HOS). A complaining griping attitude, manifest hostility, and an inclination to express resentment towards and to feel suspicious of others' intentions are evident in this syndrome.

3. Retardation and Apathy (RTD). The syndrome is defined by slowing down and reduction of ideation, speech, and motor behavior. At the extreme there is apathy and disinterest. The underlying reaction appears to be one of giving up the attempt to cope with one's problems.

4. Anxiety (ANX). Three elements appear to characterize this syndrome: anxiety, turning against self, and lowered mood level. The reaction is one in which the individual experiences guilt and remorse and holds himself to blame for real or imagined faults.

5. Conceptual Disorganization (CNP). Disturbances in the stream of thought evidenced by irrelevant answers and incoherent or rambling speech characterize this syndrome. These are suggestive of a disorganization in thinking process.

6. Motor Disturbances (MTR). Rigid bizarre postures, grimacing, and repetitive movement are the principal behaviors defining this syndrome.

7. Mode of Dress and Personal Upkeep (MDP). A slovenly, unkempt, unclean appearance is characteristic of this syndrome. There is also an attitude of indifference to personal upkeep or an obvious negligence. Mood level and self-esteem seem to be unusually low.

8. Mood Fluctuations (MFL). This syndrome is characterized by gross mood changes--frequent, abrupt and almost instantaneous. Mood level and self-esteem oscillate from low to high.[31]

This instrument, coupled with informal explanatory notes about observed behavior of patients in the experimental group compiled by the related arts therapist, was considered to be valuable for reporting case histories.

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[31] B. Keem, Manual for Related Arts Therapy Behavior, unpublished document prepared for this research project.

CHAPTER V

FINDINGS AND CASE STUDIES

Statistical Treatment of the Data in the Study

Related arts therapy, using music as a basis for the treatment of the adult schizophrenic patient, cannot fulfill its obligations to society unless it can scientifically support its assumed values. This requires not only the technical skills to meet the requirements of each particular art and patient, but also an understanding as to whether or not it would, according to the laws of probability, have a maximum chance of improving either the organ systems or the functions of communication of the adult schizophrenic patient to the extent that the patient is capable of moving toward the ultimate goal, release from psychiatric care.

Parametric statistical methods, where applicable, were used to analyze the data collected from this study. In each instance caution was exercised so that parametric statistical treatments were not used to analyze small sub-population responses where a comparison between responses would seem desirable. Non-parametric statistical treatment for the small sub-population responses in this study would be appropriate but it was felt to be unwarranted in view of the total raw data and research design. Some data did not lend themselves to either parametric or non-parametric statistical analysis.

The design employed in the study resulted in sub-populations that were of equal ends or numbers. Although any of several parametric or

or non-parametric methods might have been used to analyze the data, it was felt that the use of R. A. Fisher's three way analysis of variance test and the appropriate F tests, to test for significant differences, was the most powerful and would lend itself best to the interpretation of data collected from the IMPS, designed to measure psychotic syndromes and morbidity patterns. Fisher's three way analysis of variation, and appropriate F tests, was also felt to be most suitable for the HAS data. The author chose to employ this particular method since it was felt the total variation in the IMPS and HAS data should be reduced to components associated with possible sources of variability whose relative importance was necessary to assess.[1]

The statistical method for conducting a chi-square (χ^2) test was used to analyze the data relating to aspects of personality changes as measured by the CQ-Set instrument. The χ^2 distribution, one of the most versatile in statistical theory,[2] was chosen since it was deemed necessary to determine the reality of association between the experimental and control groups.

Specific Analyses of the Effectiveness of Related Arts Therapy

Chi-Square. The California Q-Set (Form III)[3] used in the study was, in part, used to isolate and measure the potential effectiveness of related arts therapy on 100 personality traits of the experimental and control group. This measurement took the form of the following categories:

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[1]Helen Walker and Joseph Lev, Statistical Inference (New York: Holt, Rinehart and Winston, 1953), pp. 348-386.

[2]M. J. Moroney, Facts from Figures (Baltimore: Penguin Books, 1951), p. 249.

[3]Jack Block, The Q-Sort Method in Personality Assessment and Psychiatric Research (Springfield: Charles C. Thomas, 1961), pp. 62-88.

(9) extremely characteristic or salient, (8) quite characteristic or salient, (7) fairly characteristic or salient, (6) somewhat characteristic or salient, (5) relatively neutral or unimportant, (4) somewhat uncharacteristic or negatively salient, (3) fairly uncharacteristic or negatively salient, (2) quite uncharacteristic or negatively salient, and (1) extremely uncharacteristic or negatively salient. Two of these categories, 8 and 9, were considered to be the most characteristic traits of each subject and two categories, 1 and 2, were considered to be the least characteristic traits. A forced choice of CQ-Set sorting methods rendered 36 of the 100 items thirteen most and thirteen least salient descriptive for each subject.

Specifically the raw data were grouped into four columns of even ends representing experimental and control before and after therapy personality characteristics. A significant shift from most to least characteristic traits was computed by assessing each of the one hundred items a shifting significance such as: (1) positive, (2) negative, or (3) no change or a change of no importance. A significant change was considered to be a shift from the 8-9 most salient before therapy to the 1-2 least salient after therapy categories, or vice versa.

The raw data categorical shifts were then grouped into two columns of equal ends, one column representing the experimental group and the other representing the control group. These data were then subjected to the chi-square test of significance. The ^{2}, then, being applied to each of the one hundred items in each of the two groups, was able to provide a statistically accurate appraisal of the personality trait changes between those who had related arts therapy and those who did not.

The results of the investigation, reported in Table 7, revealed nine of the possible thirty-six "most" or "least" characteristic traits demonstrated a positive statistical change from the 0.01 to the 0.05 per cent level of significance. Not any of the possible thirty-six "most" or "least" characteristic traits demonstrated a negative statistically significant change. The nine CQ-Set personality most and least characteristic items demonstrating a significant positive change were:

1. Is critical, skeptical, not easily impressed.
3. Has a wide range of interest. (N.B. Superficiality or depth of interest is irrelevant here.)
22. Feels a lack of personal meaning in life.
26. Is productive; gets things done.
40. Is vulnerable to real or fancied threat, generally fearful.
55. Is self-defeating.
56. Responds to humor.
84. Is cheerful. (N.B. Extreme placement toward uncharacteristic end of the continuum implies unhappiness or depression.)
96. Values own independence and autonomy.

A close examination of the CQ-set raw data reveals some interesting interrelationships. Table 8 lists the rank order of the thirteen "most" and thirteen "least" characteristic traits of the sixty schizophrenic subjects in this study. These traits were considered to be descriptive of the CQ-set schizophrenic personalities found in this study. Among the thirty-six items descriptive of the schizophrenic personality, even of the nine traits demonstrating a positive significant change after therapy, were found. The seven items were:

40. Is vulnerable to real or fancied threat, generally fearful.
55. Is self-defeating.

TABLE 7. X^2 APPRAISAL OF CQ-SET ITEM CHANGES BETWEEN THOSE WHO HAD RELATED ARTS THERAPY AND THOSE WHO DID NOT[4]

CQ-SET ITEM	EXP.			CONTROL			Total	df	Chi Square	Level of Significance
	o	1	2	o	1	2				
1 - is critical, skeptical, not easily impressed	26.00 28.00	4.00 2.00	.00 .00	30.00 28.00	.00 2.00	.00 .00	56.00 4.00 .00	1	4.286	p < 0.05
3 - wide range of interests	25.00 27.50	5.00 2.50	.00 .00	30.00 27.50	.00 2.50	.00 .00	55.00 5.00 .00	1	5.455	p < 0.02
22- feels a lack of personal meaning in life	25.00 27.50	5.00 2.50	.00 .00	30.00 27.50	.00 2.50	.00 .00	55.00 5.00 .00	1	5.455	p < 0.02
26- productivity, gets things done	24.00 26.50	6.00 3.50	.00 .00	29.00 26.50	1.00 3.50	.00 .00	53.00 7.00 .00	1	4.043	p < 0.05
40- is vulnerable to real or fanciful threats, generally fearful	25.00 27.00	5.00 2.50	.00 .50	29.00 27.00	.00 .50	1.00 .50	54.00 5.00 1.00	2	6.295	p < 0.05
55- self-defeating	26.00 28.00	4.00 2.00	.00 .00	30.00 28.00	.00 2.00	.00 .00	56.00 4.00 .00	1	4.286	p < 0.05
56- responds to humor	25.00 27.50	5.00 2.50	.00 .00	30.00 27.50	.00 2.50	.00 .00	55.00 5.00 .00	1	5.455	p < 0.02
84- is cheerful	24.00 26.50	6.00 3.50	.00 .00	29.00 26.50	1.00 3.50	.00 .00	53.00 7.00 .00	1	4.043	p < 0.05
96- values own independence and autonomy	22.00 26.00	8.00 4.00	.00 .00	30.00 26.00	.00 4.00	.00 .00	52.00 8.00 .00	1	9.231	p < 0.01

Summary: 9 CQ-set personality significant changes - 5 $p \leq 0.05$ - 1, 16, 40, 55, 84.
3 $p \leq 0.02$ - 3, 22, 56.
1 $p \leq 0.01$ - 96.

Code: o = no change or no change of significant importance; 1 = positive change; 2 = negative change

[4]Chi-square computation from raw data.

TABLE 8. A CQ-SET DESCRIPTION OF THE 60 SCHIZOPHRENIC SUBJECTS IN THIS STUDY

MOST SALIENT (8-9)	LEAST SALIENT (1-2)
12. Tends to be self-defensive.	2. Is a genuinely dependable and responsible person.
68. Is basically anxious.	*3. Has a wide range of interests.
78. Tends to ruminate and have persistent, preoccupying thoughts.	*96. Values own independence and autonomy.
19. Seeks reassurance from others.	*26. Is productive; gets things done.
37. Is guileful and deceitful, manipulative, opportunistic.	35. Has warmth; has the capacity for close relationships; compassionate.
*40. Is vulnerable to real or fancied threat, generally fearful.	5. Behaves in a giving way toward others.
*55. Is self-defeating.	61. Creates and exploits dependency in people (N.B. Regardless of the techniques employed.)
67. Is self-indulgent.	75. Has a clear-cut, internally consistent personality.
49. Is basically distrustful of people in general; questions their motivations.	83. Able to see the heart of important problems.
38. Has hostility towards others.	*84. Is cheerful.
48. Keeps people at a distance; avoids close interpersonal relationships.	60. Has insight into own motives and behavior.
*22. Feels a lack of personal meaning in life.	33. Is calm, relaxed in manner.
	71. Has high aspiration level for self.

*Items demonstrating a statistically significant change in the experimental group after therapy.

22. Feels a lack of personal meaning in life.

3. Has a wide range of interest.

96. Values own independence and autonomy.

26. Is productive; gets things done.

84. Is cheerful.

A comparison was then made between the CQ-set descriptive schizophrenic personality developed in this study and the CQ-set descriptive optimally adjusted personality that was built by clincial psychologists[5] (see Table 9). Several interesting interrelationships were revealed. First, eight of the thirteen least salient items in the optimally adjusted personality appear as the most salient items in the schizophrenic personality, and eight of the thirteen most salient items in the optimally adjusted personality appear as the least salient items in the schizophrenic personality. Second, six of the nine items demonstrating a positive significant change were found as one of the most or least salient items in the optimally adjusted personality. Thus, all but one of the seven items demonstrating a significant change appearing as a schizophrenic "least" or "most" salient trait, also appear as one of the optimally adjusted personality most or least salient traits.

Although nine, or 25 per cent, of the possible thirty-six personality traits did make a significant positive change, only seven, or 18.82 per cent, appeared to have a significant influence on the improvement of the schizophrenic personality. Further, only six, or 16.66 per cent, of the salient schizophrenic personality traits seem to move toward the optimally adjusted personality description as a result of related arts therapy.

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[5]Ibid., p. 144.

TABLE 9. A CQ-SET DESCRIPTION OF THE OPTIMALLY ADJUSTED ADJUSTED PERSONALITY AS VIEWED BY CLINICAL PSYCHOLOGISTS[6]

MOST SALIENT (8-9)	LEAST SALIENT (1-2)
35. Has warmth; has the capacity for close relationships; compassionate.	45. Has a brittle ego-defense system; has a small reserve of integration: would be disorganized and maladjusted when under stress or trauma.
2. Is a genuinely dependable and responsible person.	78. Feels cheated and victimized by life; self-pitying.
60. Has insight into own motives and behavior.	86. Handles anxiety and conflicts by, in effect, refusing to recognize their presence; repressive or dissociative tendencies.
*26. Is productive; gets things done.	*22. Feels a lack of personal meaning in life.
64. Is socially perceptive of a wide range of interpersonal cues.	*55. Is self-defeating.
70. Behaves in an ethically consistent manner; is consistent with own personal standards.	*40. Is vulnerable to real or fancied threat, generally fearful.
*96. Values own independence and autonomy.	48. Keeps people at a distance; avoids close interpersonal relationships.
77. Appears straightforward, forthright, candid in dealings with others.	68. Is basically anxious.
83. Able to see to the heart of important problems.	37. Is guileful and deceitful, manipulative, opportunistic.
51. Genuinely values intellectual and cognitive matters. (N.B. ability or achievement are not implied here.)	36. Is subtly negativistic; tends to undermine and obstruct or sabotage.
33. Is calm, relaxed in manner.	38. Has hostility towards others (N.B. Basic hostility is intended here; mode of expression is to be indicated by other items.)
17. Behaves in a sympathetic or considerate manner.	76. Tends to project his own feelings and motivations onto others.
*3. Has a wide range of interests. (N.B. Superficiality or depth of interest irrelevant here.)	97. Is emotionally bland; has flattened effect.

*Items demonstrating a statistically significant change in the experimental group after therapy.

[6] Ibid.

The ultimate goal for psychiatric hospital treatment for each patient was considered to be the release from psychiatric treatment. Release from treatment means that the patient has regained his ability to function in society, or he has become more acceptable to society. Patients in psychiatric institutions are placed in wards that are closed or in wards with different degrees of openness. Closed war status indicates the patient's lack of ability to function within the confine of the hospital. For the patient's own protection he is placed in the closed ward. As the patient gains better control of himself he is allowed to move about the hospital with various degrees of freedom in the open ward. Achieving out-patient status is an indication that the patient is better able to function in society but needs periodical help from the hospital. Complete release is achieved when the patient is emperically judged able to function in society without psychiatric aid.

The raw data concerning ward status changes did not lend themselves to statistical treatment. However, ward status change was considered by the author to be an important aspect of the study. The raw data concerning ward status change, therefore, were inspected and compared to the CQ-set data discussed above.

The number of ward status changes for the subjects in this study was compiled in two columns of equal numbers. One column represented the experimental group as those who received related arts therapy and the other column the control group, being those who did not receive related arts therapy. The results are reported in TABLE 10.

It was found that all subjects, control and experimental, were in closed wards before therapy. After therapy, six experimental and 20 of the control subjects had not moved from the closed ward. Fifteen more control than experimental subjects apparently were not able to

TABLE 10. AFTER THERAPY WARD STATUS CHANGE FOR 60 SUBJECTS IN THIS STUDY

Hospital*	EXP.			CON.		
	1	2	3	1	2	3
Hos. 1	3	4	3	7	1	2
Hos. 2	1	5	4	6	2	2
Hos. 3	2	4	4	7	2	1
Total	6	13	11	20	5	5

*Code: 1 = closed ward

2 = open ward

3 = out patient basis

function well enough to move from the security of the closed ward to a more open environment. Eight more experimental than control subjects made the change from a closed to an open ward and six more experimental than control subjects moved from the closed ward to an out patient basis. Although twenty-four experimental and ten control subjects made a ward change for the better, not one of them, during the experimental period, achieved the ultimate goal of release from psychiatric treatment. Ward status movement in this study indicated that seventy-five per cent of experimental subjects moved toward the ultimate goal of open society and twenty-five per cent remained static. Whereas, only twenty per cent of the control subjects moved toward the ultimate goal and eighty per cent remained in the security of the closed ward.

A comparison was made between the per cent of ward status changes and the per cent of significant CQ-set schizophrenic personality changes. An interesting interrelationship was revealed.

Seventy-five per cent of the patients receiving related arts therapy moved from a closed to an open ward. This indicates that related arts therapy, in general, had a beneficial influence on the adult schizophrenic patient in this study. The influence of related arts therapy on the personality of the adult schizophrenic patient in this study was recorded at 18.82%. From this it could be theorized that although related arts therapy generated only a small number of personality trait changes, the resultant personality was a factor in aiding the movement of the adult schizophrenic patient from a closed to an open environment.

The personalities of the three related arts therapists were inspected and comparisons were made with changes in the CQ-set schizophrenic personality and ward status changes. Without a statistical model neither

function well enough to move from the security of the closed ward to a more open environment. Eight more experimental than control subjects made the change from a closed to an open ward and six more experimental than control subjects moved from the closed ward to an out patient basis. Although twenty-four experimental and ten control subjects made a ward change for the better, not one of them, during the experimental period, achieved the ultimate goal of release from psychiatric treatment. Ward status movement in this study indicated that seventy-five per cent of experimental subjects moved toward the ultimate goal of open society and twenty-five per cent remained static. Whereas, only twenty per cent of the control subjects moved toward the ultimate goal and eighty per cent remained in the security of the closed ward.

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The personalities of the three related arts therapists were inspected and comparisons were made with changes in the CQ-set schizophrenic personality and ward status changes. Without a statistical model neither

parametric nor non-parametric seemed to lend itself to testing the raw data. The author considered the therapists personality profile data important enough to compare with the number of CQ-set personality trait changes deemed significant in each hospital.

To do this, a personality chart, based on eight traits deemed important in determining the adjustment of normal individuals by Gordon,[7, 8] was constructed. A comparison of the personality charts for the three therapists (Table 11) revealed that the therapists in hospitals two and three were nearly alike in six of the eight traits. In three of these traits therapists in hospitals two and three scored higher than the therapist in hospital one, and in three of these traits therapist in hospitals two and three scored lower. The traits were:

higher	lower
original thinking	cautiousness
personal relation	vigor
emotional stability	sociability

In the trait referred to as ascendency (active role), therapists in hospital one and two were alike, and in the responsibility trait not any of the therapists were alike. In the latter trait, two therapists in hospital two had the highest score and the therapists in hospital one, the lowest score. Total personality trait scores for the therapists reflected the same score for therapists in hospitals two and three and a lower score for therapist in hospital one.

The number of CQ-set personality traits computed to be significant when tested by the χ^2 test of significance was then counted for each

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[7] Leonard V. Gordon, Gordon Personal Inventory Manual (New York; Harcourt, Brace and World, Inc., 1963 Rev.), p. 3.

[8] _____, Gordon Personal Profile Manual (New York: Harcourt, Brace and World, Inc., 1963 Rev.), p. 3.

TABLE 11. A COMPARISON OF THE THREE THERAPISTS EIGHT PERSONALITY TRAITS, DEEMED IMPORTANT IN THE ADJUSTMENT OF THE NORMAL INDIVIDUAL

	Personality Traits	Th.1	Th.2	Th.3
Gordon Personal Inventory	C	34	28	30
	O	27	33	31
	P	25	29	29
	V	32	30	30
	Total	118	120	120
Gordon Personal Profile	A	21	21	23
	R	30	36	33
	E	26	29	30
	S	25	22	22
	Total	102	108	108
	Grand Total	220	228	228

CODE: C = cautiousness A = ascendance (active role)

O = original thinking R = responsibility

P = personal relations E = Emotional stability

V = vigor s = sociability

hospital (see Table 12.) Hospital one had 24 positive and 6 negative changes. Hospital two had 63 positive and one negative and hospital three had 56 positive and 1 negative changes.

TABLE 12. CQ-SET SIGNIFICANT PERSONALITY TRAIT CHANGES AFTER THERAPY FOR 30 EXPERIMENTAL SUBJECTS IN THIS STUDY

Hos.	Pos. Changes	Neg. Changes
1	24	6
2	63	1
3	56	2

In this study the experimental groups that had the most significant changes were in hospitals two and three. The related arts therapists' personalities in these two hospitals had the same high score in comparison to the therapists in hospital one. From this, one could theorize that personality factors of related arts therapists who were responsible for the greatest number of significant schizophrenic personality changes were those who scored the highest in original thinking, personal relations, responsibility and emotional stability. Caution must be exercised not to generalize this theory to other populations until further testing deems it more reliable.

An interrelationship was apparent between the CQ-Set schizophrenic personality changes, therapists personality traits and the number of ward status changes. Therapists' personality traits that were theorized to be factors affecting significant CQ-set schizophrenic personality traits, had a similar effect on numbers of patients who moved from closed to open wards or out patient status (see Table 10, p. 101.) Hospital two had 9 experimental patients changing ward status.

Hospital three had 8 experimental patients changing ward status, whereas hospital one had only 7 experimental patients changing wards. Hence, another theory was put forth. Related arts therapists who scored the highest in original thinking, personal relations, responsibility and emotional stability not only exerted the greatest influence on significant CQ-Set schizophrenic personality changes but also exerted the greatest influence on schizophrenic ward status changes. Again, caution should be exercised in applying this theory to other populations until further testing deems it more reliable.

Three Way of Variance-IMP. In this study, as in the case in any social science research, not all operating variables could be isolated and controlled. Three variables in this study, hospital, group, and sex, and their several resultant interactions, could be, and were, isolated and tested for significant effects on ten psychotic syndromes and three morbidity patterns before and after the therapy period by the Inpatient Multidimensional Scale.[9] Raw data were subjected to a three way analysis of variance test with the appropriate F test.

The raw data were arranged in two groups of three columns of equal numbers. Group one represented before therapy IMP scores, and group two represented after therapy IMP scores. In each group, column one represented variable one, a hospital; column two represented variable two, a group and column three represented variable three, sex. The method of computing significant effects on the IMP scores presented in Table 13 was patterned after a form used by Walker and Lev.[10] All raw

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[9]Maurice Lorr, et al. Inpatient Multidimensional Psychiatric Scale (Palo Alto: Consulting Psychologist Press Inc., 1962).

[10]Walker and Lev, op. cit., p. 355.

TABLE 13. SUBDIVISION OF THREE VARIABLES AND RESULTANT INTERACTIONS FOR IMP SYNDROMES AND MORBIDITY PATTERN[11]

Syndrome or Morbidity Pattern	Source of Variation	Sum of Squares	df	Mean Square	F	F.95 or F.99
EXC	A C	31.633333	2	15.816667	4.09935*	
	A B C	31.033333	2	15.516667	4.02160*	3.19 $p < 0.05$
INP	A	20.033333	2	10.016667	5.64319*	5.08 $p < 0.01$
RTD	A	14.233333	2	7.116667	3.37349*	3.19 $p < 0.05$
Dis	A	97.6000000	2	48.800000	4.94595*	3.19 $p < 0.05$
MTR	A	20.800000	2	10.400000	3.20823*	3.19 $p < 0.05$
Morbidity II	A	1328.03333337	2	664.01666668	6.08260*	5.08
	A B	1320.43333335	2	660.21666669	6.04779*	$p < 0.01$
Morbidity III	A	737.43333336	2	368.71666668	4.96198*	3.19 $p < 0.05$
	B	299.26666668	1	299.26666668	4.02736**	4.11

*estimation of error 48
**estimation of error 55

CODE: A = Hos

B = Group

C = Sex

[11]Only psychotic syndromes or patterns of morbidity reflecting $p < 0.05$ are reported in this table.

data changes indicated a positive change, rather than negative. Thus, it was accepted that any significant change would be interpreted as positive rather than negative.

As evidenced by the examination of data in Table 13, five of the ten psychotic syndromes and two of the morbidity patterns had a change significant to the 0.05 or 0.01 level of confidence. They were: EXC, INP, RTD, DIS, MTR, morbidity patterns II and III. The analysis indicated that most of the significant changes in the five syndromes could be attributed only to variable one the hospital. The interaction between the three variables hospital, sex, and group had a significant effect on the EXC syndrome and the interaction of the two variables hospital and group, had significant effects on morbidity pattern II. In only one IMP subscore morbidity pattern III did the first and second variable, hospital and group appear to have a singularly significant effect without the influence of interaction.

By inspecting the mean and standard deviation data of the three variables, resultant interactions and subfactors therein, for the IMP syndromes and morbidity scores, reported in Table 14, it was possible to determine which factor within the variable had the most influence on the test of significance. In variable A hospital two seemed to have the greatest influence on three of the syndromes INP, DIS, and MTR. Hospital three exerted the greatest influence on the two syndromes-- EXC, RTD, and morbidity pattern III. Hospital one had the least influence of all the hospitals on significant changes in IMP psychotic syndromes or morbidity patterns. In the singular variables, A and B, morbidity pattern III was influenced greatly by hospital three and the control group. In the interaction between variables A, B, and C, the male and female control group in hospital three and the female experimental group in hospital two

TABLE 14. MEAN AND STANDARD DEVIATION OF THREE VARIABLES, RESULTANT INTERACTIONS AND SUBFACTORS THEREIN FOR IMP SYNDROMES AND MORBIDITY SCORES

IMP Scores	Source of Variation	Mean	Standard Deviation	
EXC	AC	-.170000000	.40013886 F	Hos. I
		.110000000	.27264140 M	
		.010000000	.05676462 F	Hos. II
		-.040000000	.11737878 M	
		-.040000000	.06992059 F	Hos. III
		-.040000000	.05163978 M	
	ABC	.000000000	.07071068 F	Hos. I
		.02000000	.19235384 M	
		.34000000	.53197744 F	
		.24000000	.29664794 M	
		.02000000	.04472136 F	Hos. II
		.06000000	.13416408 M	
		.04000000	.05477226 F	
		.02000000	.10954451 M	
		.06000000	.08944272 F	Hos. III
		.06000000	.05477226 M	
		.02000000	.04472136	
		.02000000	.04472136 M	
INP	A	.03000000	.15593521	Hos. I
		-.09500000	.08870412	Hos. II
		-.09000000	.12937095	Hos. III
RTD	A	.03000000	.13168943	Hos. I
		-.10500000	.18488973	Hos. II
		-.09000000	.10711528	Hos. III
DIS	A	-.02000000	.49375042	Hos. I
		-.04000000	.12311740	Hos. II
		-.30000000	.17770466	Hos. III
MTR	A	.05500000	.26650763	Hos. I
		-.04500000	.09986833	Hos. II
		-.08500000	.12680279	Hos. III

TABLE 14. Continued

IMP SCORES	Source of Variation	Mean	Standard Deviation	
Morbidity II	A	3.10000000	14.84622936	Hos. I
		-8.10000000	10.59245014	Hos.II
		-4.85000000	6.51536645	Hos.III
	AB	7.00000000	14.88474237 E	Hos. I
		- .80000000	14.48984319 C	
		-15.60000000	5.39958846 E	Hos. II
		- .60000000	9.09456492 C	
		- 5.40000000	6.04060335 E	Hos.III
		- 4.30000000	7.24262077 C	
Morbidity III	A	1.80000000	10.26286098	Hos. I
		-3.75000000	7.85309192	Hos. II
		-6.65000000	7.80199030	Hos.III
		-5.10000000	9.26748115	EXP.
		- .63333333	8.86093065	CON.

displayed the same amount of influence on the EXC syndrome.

Several conclusions, from the preceding data, are as follows: 1. Psychotic syndromes and morbidity patterns, as measured by Inpatient Multidimensional Scale, were, in general, neither positively nor negatively affected by related arts therapy, 2. the significant changes in five out of 10 psychotic syndromes and two out of three morbidity patterns reported in this study, were attributed to differences in hospital milieu therapy treatment and 3. hospitals two and three had the greatest influence on the IMP psychotic syndrome and morbidity pattern significant changes.

Three Way Analysis of Variance--HAS. A three way analysis of variance, and the appropriate F test, were also applied to raw data assembled from administering the Hospital Adjustment Scale before and after therapy to the sixty subjects in this study.

The raw data were again arranged in two groups of three columns of equal number. Group one represented before therapy scores and group two represented after therapy scores. Column one in each group represented variable one the hospital. Column two represented variable two the group and column three represented variable three sex. The method used in computing significant effects on the HAS score in Table 15 is the same as reported for computing significant effects on the IMP scores in Table 13. Both were patterned after a form used by Walker and Lev.[12]

The three way analysis of variance and its appropriate F test revealed that only the total HAS score reflected a change to the 0.05 level of significance. Further, the significance was evidenced in only

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[12]Walker and Lev, loc. cit.

TABLE 15. SUBDIVISION OF THREE VARIABLES FOR HAS SCORES [13]

HAS SCORE	SOURCE OF VARIATION	Sum of Squares	df	Mean Square	F	F 95
Total	B	3920.41666673	1	3920.41666673	5.76765*	4.04 $p < 0.05$

*estimation of error 48

TABLE 16. MEAN AND STANDARD DEVIATION OF VARIABLE TWO HAS SCORE SUBFACTORS

HAS Score	Source of Variation	Mean	Standard Deviation
Total	B	E 23.4000000	E 27.28091413
		C 7.2333333	C 21.85640178

CODE: B = group

E = experimental

C = control

[13] Only HAS sub scores reflecting $p < 0.05$ are reported in this table.

the second variable group. When consulting Table 16 for the mean and standard deviation of the group it is evident that the control group exerted the most influence on the test of significance. From this it could be concluded that subjects in the control group became better adjusted to their hospital environment than did those who were in the experimental group. One must exercise caution, however, when evaluating this item. It is difficult to state precisely the psychiatric meaning of the HAS score. A low total score, of course, reflects a poor hospital adjustment and a high score indicates good hospital adjustment. It must be understood, however, that this measure of functioning has specific reference to the context of the patient's environment, namely the hospital environment. If the patient were living in a different environment he might function differently. One of the objectives of the related arts therapy sessions was to set up, during the middle phase as nearly as possible, a real life situation, such as society environment as a whole rather than limit the environment to the hospital. One could theorize that related arts therapy in encouraging adjustment to real life environment, might not foster better hospital adjustment. Contrariwise, it could be responsible for the reverse.

Case Studies

All therapy sessions were recorded and the process of therapy was described in meaningful categories of behavior as measured by personality traits and psychotic syndromes. Records and therapy behavior check lists were consulted for additional facts reported in the case studies. Two case studies, one female and one male, were selected from the thirty subjects in the experimental group to describe the process and illustrate various stages of related arts therapy. This included the beginning,

that which was under way and that which was toward the end.

The initial phase of related arts therapy is devoted to the process of getting acquainted. This involved exploration of the patient's ways of communication and elimination of emergencies so that work can proceed smoothly. The middle phase of therapy is concerned with the acceptance of existing conflicts, understanding of resistances and working through their problems. In the middle phase of therapy, one important prerequisite for improvement is the true life experience. The later phases of therapy are characterized by the fact that some conflicts have worked through so that various aspects of the patient's existence appear to be more consistent.

Case History: (Female). Background information revealed this female subject to be twenty-eight years old, single and Catholic. She was considered to be above average intellectual ability. She was the oldest of three children in the family. Her sister is a school teacher and apparently has a well adjusted marriage. The only known fact about the brother was that he was in the armed forces. The patient's mother had a record of mental illness which included several hospitalizations. During the mother's hospitalization periods, the patient experienced feelings of insecurity and emotional deprivation which seemed to result in the patient not being able to establish concrete adult relationships. Her parents were divorced and the father remarried. The patient entered a convent twice. Both times she was released because of breakdowns she suffered after extensive periods of solitary confinement which was required by the Order she joined. She successfully completed three years of college but failed to complete the fourth year because she became extremely religiously delusional. On several occasions she formed and maintained the position of the crucifix with her body. She frequently

was overheard expressing the idea that she was the bride of Christ and once, it was reported, verbalized that she was pregnant by Immaculate Conception. Upon hospital commitment her diagnosis was schizophrenic paranoid and she was given a fair prognosis. She was assigned to a closed ward.

At the beginning of related arts therapy the patient displayed a lack of interest in appearance and dress. She was moderately withdrawn, asocial, aloof, alternated between under and overactivity and did not accept hospitalization. Her first verbal communication to the therapist indicated a rejection of her father and step-mother. She spoke about her reticence in living with the step-mother and father, accused her father of "running her life," and "choosing her friends." She also communicated a desire to teach elementary school. The related arts therapy prescription, therefore, included musical, dance, and dramatic materials that could be used in an elementary classroom situation. The patient gradually accepted the therapist in the role of a college teacher and herself in the role of a college student.

During the middle phase of therapy the patient built a repertoire of approximately thirty-six songs appropriate for use in an elementary classroom, twelve assorted dances (including folk, tap, and ballet) and learned to recognize various musical forms, such as opera, symphony, string quartet and musical comedy. She also became familiar with drama terms. During this stage of therapy the patient vacillated verbally but maintained a desire to teach school. Her mode of dress and personal appearance, in general, became upgraded. She was included in several outings and participated in planning for a group of patients to attend a symphony concert, a musical play, and a ballet. She was moved from the closed ward to an open ward. She also was permitted to visit classes in

the childrens' school in the hospital. Group-related arts activities were then included in her related arts therapy treatment. She became a member of the choir and the drama club.

The last phase of therapy was not reached during the experimental time limit. However, her manners were increasingly more pleasant. She became more interested in her personal appearance and mode of dressing and use of cosmetics. She was still confined to the hospital environment and still rejected hospitalization but was beginning to verbalize her desire to have more adult friends. Twice she was reported as having a regression to her religious delusions. On both occasions she was able to return, with minimal help, to a more acceptable behavior pattern.

The therapeutic treatment team concurred that related arts therapy had a positive effect on the behavior of this patient. The objective CQ-set personality and IMP psychotic syndrome tests empirically supported this opinion of the treatment team. Her HAS test raw score indicated a lower than average hospital adjustment.

Case History: (Male). A twenty-one year old Caucasian male was commited when he was eighteen. He was considered to have below average intellectual ability and had completed the ninth grade in school. During his tenth grade in school his family, mother, father, and eight siblings (four boys and four girls) moved to the country. The family had inadequate transportation and became almost isolated from the community. However, it was known that when the family lived in town, the parents discouraged the children from establishing peer group friends. It was reported, in the patient's history, that incest was the siblings favorite pastime. The patient's mode of communicating was non-verbal. He was diagnosed as schizophrenic reaction, simple type, and was housed in a closed ward.

At the beginning of the related arts therapy the patient physically objected to leaving the ward and going to the therapy area. The therapist then, set up a related arts activity in the patient's ward on a one-to-one basis. Again, the patient physically objected to being subjected to this treatment. At this stage the patient began to verbalize certain "feelings" with one syllable words such as "no." The therapist organized an informal group therapy session in the closed ward and chose to ignore the patient. Two sessions were devoted to playing recordings of various kinds of marches. A small group of psychotic male patients in the ward reacted by marching spontaneously. The ignored patient skirted the fringe area of the ward group during the first session. During the second session he joined the group by sitting down on a chair as far away from the therapist as he could without being located in another section of the ward. During the third ward session, the therapist played recordings that were requested by the group. Among these requests was an "old-time-fiddle"square dance tune. This led to elementary square dancing and the playing of a real violin by the therapist and one of the ward patients. The activity seemed to attract the ignored patient still on the fringe. He reacted to the musical activities by tapping his toe and nodding his head. Gradually, the ignored became a group member and began to communicate verbally as well as non-verbally with the therapist and one of the attendants.

The last phase of therapy was not completed for this patient during the time limitation of the study, but the initial stages were set. The patient accepted the therapist as well as the related arts therapy. He was capable of moving from his closed ward to the therapy area without the security of an attendant. His mannerisms, although not polished,

were improving. He was becoming more open toward hospital personnel and other patients even though he suffered many regressions. Simple song sessions seemed to be his favorite arts activities. Next came piano lessons and last on the list of activities, in which he would participate, was reading about and listening to musical comedies. He was included in two group outings. One was an outdoor concert and the other, a folk song singing session, in a "coffee haus." On both occasions he dressed appropriately and displayed good manners.

It was agreed, informally, by all personnel coming in contact with this patient, that related arts therapy appeared to have a positive effect on the behavior of this patient. Empirically the CQ-set personality test supported this notion. The patient's psychotic syndromes and morbidity patterns, as measured by IMP, did not change significantly. However, the patient's HAS scores changed for the better but not significantly.

The two reported case histories are examples of the thirty case histories collected for this study. The thirty histories supported the data collected from the California Q-Set (form III), Inpatient Multidimensional Scale, and Hospital Adjustment Scale, administered to the experimental and control group before and after therapy. Each history was similar in structure but different in content.

A brief summary, conclusions and recommendations are given in the next chapter.

CHAPTER VI

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The central purpose of this study was to report findings of an investigation to study the process and outcomes of related arts therapy with certain psychotic patients, selected at random and confined in three Michigan psychiatric hospitals. To accomplish this the therapy sessions were recorded and the process of therapy was described through the use of meaningful categories of behavior as measured by the recorded typescripts. The outcomes of therapy were reported through the use of objective measures of personal level of functioning before and after a three months therapy session.

Several converging lines of theory and research were involved in this study. First, the study addressed itself to the lawfulness of behavior in therapy. Second, the study questioned the interaction of related arts, therapists, and patients. Third, it raised the question of the kind of personality reorganization postulated as a result of the interaction of related arts therapy.

It was hypothesized that related arts therapy, although apparently effective by consensus of those practicing the art, can be objectively proved to be an effective therapy. Further, its potentialities can be insured by correctly identifying those factors which enhance and support its effectiveness.

The design for the study undertaken in three Michigan psychiatric institutions, attempted to determine:

1. The actual value of the interaction between this type of therapy and the behavior of the adult psychotic patient.
2. The effectiveness of related arts therapy on the psychotic syndromes and morbidity patterns of the adult psychotic patient.
3. The actual value of this type of therapy as it relates to the personality of the patient;
4. The value of the related arts therapists personality as the therapist interacts with the patient.
5. The identification of factors and interactions that are most conducive to the success of related arts therapy with adult psychotic patients.

If related arts therapy fulfills its assumed obligations to society and is to be considered a worthwhile activity, it must:

1. Possess the potential for improving, either the organ systems or the functions of, communication of the patient.

2. The related arts therapist must be an agent in the treatment, rehabilitation (and/or learning), and entertainment of patients.

3. Related arts therapy, and its agent, should provide the patient with an approach to communication which would enhance the patient's chances for release from psychiatric treatment.

4. The patient should be empirically judged better able to function in society, or more acceptable to society.

One of the basic purposes of the study, then, was to determine if related arts therapy and its agent, the therapist, is really capable of producing this kind of change in the adult psychotic patient.

Conclusions

The findings of this research, as summarized in Chapter V, indicate that related arts therapy, using music as a basis for the treatment of the adult schizophrenic patient, can scientifically support its assumed effectiveness as a therapeutic medium. Further, certain factors which enhance and support its effectiveness can be identified.

The personalities of the experimental subjects reflected a statistically significant improvement in twenty-five per cent of the schizophrenic characteristic traits as a result of related arts therapy. However, only two-thirds of the traits, displaying an improvement, appeared to move toward the optimally adjusted personality. The improvement of the schizophrenic personality was accompanied by a change in ward status. The majority of the patients receiving related arts therapy changed from the closed ward to a more open environment such as an open ward or an out patient status. Whereas, the majority of the patients not receiving related arts therapy did not have a significant improvement in their personality traits, nor move from the security of the closed ward.

The majority of patients whose personality improvement was significant and whose ward-status change influenced the over-all hospital ward status change, were in hospitals two and three. A significant interrelationship was revealed. Therapists working in hospitals two and three had a similar personality trait profile as measured by Gordon Personal Profile and Inventory. These data give evidence that therapists who promoted the most beneficial personality and ward status changes with the adult schizophrenic patient, scored higher in:

1. original thinking
2. personal relation

3. emotional stability

and lower in:

1. cautiousness
2. vigor
3. sociability

than did the therapist who influenced the least amount of beneficial changes.

It appeared that the personality of the therapist is a significant factor in the success of related arts therapy. Further, the personality of the therapist most likely to be successful can be predicted. However, this hypothesis should be isolated and tested for statistical significance before applying it to similar populations, since there is not a significant testable model.

Related arts therapy had little or no effect on the psychotic syndromes or morbidity patterns as measured by the Inpatient Multidimensional Scale. Half of the syndromes and two-thirds of the morbidity patterns did reflect a significant positive change. This change, however, could only be attributed to total hospital milieu treatment rather than to related arts therapy.

More psychotic syndromes and morbidity patterns than personality traits exhibited a positive improvement in the adult schizophrenic subjects. Although the number of personality changes were small, the resultant reorganized personality exerted more influence on patient and ward status change than did the improvement of psychotic syndromes and morbidity patterns. Thus, related arts therapy, in this study, had a significant role in promoting beneficial results for the adult schizophrenic patient by moving him closer to his ultimate goal which is release from psychiatric treatment.

Hospital adjustment, as measured by Ferguson's Hospital Adjustment Scale, was affected adversely in this study by related arts therapy. Subjects in the control group exhibited better hospital adjustment after the experiment than did those who were given related arts therapy. Related arts therapy encouraged adjustment to a more open society and in so doing it apparently did not foster a better hospital adjustment.

Case histories, in general, support the conclusions drawn from the analysis of the data collected for this study.

Recommendations

The above conclusions lead us to generalize to populations where the conclusions might prove a need for further investigation. It would appear desirable, therefore, to conduct similar studies in other areas involving larger numbers of subjects. It would also appear that before similar studies be conducted two assumptions emerging from this study be empirically examined. The first assumption was related to the CQ-Set schizophrenic personality description. It would be statistically expedient to have a CQ-Set schizophrenic personality description deemed by clinical psychologists. The second assumption pertained to the therapists personality. A standardized personality profile, for the related arts therapists, would lend itself to statistical treatment and therefore be of value to future research in this area.

The conclusions drawn from the analysis of data collected for this study were based on data collected from the most reliable objective instruments available at present. Although these instruments were used with utmost caution, they were still dependent upon human judgment and thereby subjected to human error. However, until more objective instruments are developed it is recommended that the results of the testing reported in this study be accepted as valid.

Other recommendations would include:

1. a follow-up of the experimental patients in this research.
2. a similar research design applied to other psychiatric disorders, particularly character disorders.

Concluding Statement

The author makes no claim that this research has provided all the answers to all the questions on the effectiveness of related arts therapy. It has been, at best, a beginning and an attempt to discover relationships that heretofore have been undiscovered. An analogy can be made between John H. Thatcher's statement, "No administrator can be effective unless he has an understanding of the adults who make up his student body, and just as important, those in his community who are not in his adult education program."[1] A correlative statement, by Keem, "Related arts therapy can not effectively be used as a therapeutic agent unless we have an understanding of the factors which interact and produce beneficial results and just as important, factors which do not interact and do not produce beneficial results."[2]

The data for this study have provided us with the foundations for that kind of knowledge. Emerging from this study is the recognition of related arts factors that will ultimately assist hospital milieu therapy treatment teams in making better decisions regarding treatment as it relates to the needs of the hospitalized adult schizophrenic patient.

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[1]John H. Thatcher, Public School Adult Education, A Guide for Administrators (Albany, New York: Public National Association of Public School Adult Educators, 1963), p. 111.

[2]Betty J. Keem, Music Consultant, Flint Public Schools, "Unpublished Lecture" presented to Great Lakes Music Therapy Regional Convention, Flint, Michigan, April 1965.

BIBLIOGRAPHY

AND

APPENDICES

Public Documents

U.S. President, 1961-63 (J. F. Kennedy). Message from the President of the United States Relative to Mental Health and Mental Retardation. House Document No. 58. 88th Congress, 1st Session, February 3, 1963.

Books

American Association of Occupational Therapy. Objectives and Functions of Occupational Therapy. Dubuque: Wm. C. Brown, 1958.

Artiss, Lt. Col. Kenneth L. Milieu Therapy in Schizophrenia. New York: Grune and Stratton, 1962.

Bennis, W. G. et al. Interpersonal Dynamics. Homewood, Illinois: The Dorsey Press, 1964.

Biddle, Bruce J., and Ellena, William J. Contemporary Research on Teacher Effectiveness. New York: Holt, Rinehard and Winston, 1964.

Block, Jack. The Q-Sort Method in Personality Assessment and Psychiatric Research. Springfield, Ill.: Charles C. Thomas, 1961.

Boccaccio, Giovanni. The Decameron. Translated by John Payne. New York: Liveright Publishing Co., 1943.

Boas, Frank. Primitive Art. Cambridge: Harvard University Press, 1927.

Caudell, William. The Psychiatric Hospital as a Small Society. Cambridge: Harvard University Press, 1958.

Chavez, Carlos. Musical Thought. Cambridge: Harvard University Press, 1961.

Coleman, James C. Abnormal Psychology and Everyday Life. New York: Scott, Foresman and Company, 1956.

Diserens, Charles M. The Influence of Music on Behavior. Princeton: Princeton University Press, 1926.

Farnsworth, Paul R. The Social Psychology of Music. New York: Dryden Press, 1958.

Freud, Sigmund. Group Psychology and the Analysis of the Ego. New York: Boni and Liveright, 1932.

Jones, Maxwell, et al. The Therapeutic Community. New York: Basic Books, 1953.

Leisure and the Schools. Editor John L. Hutchinson. 1961 Yearbook of the American Association for Health, Physical Education, and Recreation. Washington D.C.: American Association for Health, Physical Education, and Recreation, 1961.

Licht, Sidney. Medicine in Music. Boston: New England Conservatory, 1946.

Menniger, Karl. A Manual for Psychiatric Case Study. New York: Grune and Stratton, 1962.

_____. The Human Mind. New York: Alfred A. Knopf, 1959.

_____. Vital Balance; The Life Process in Mental Health and Illness. New York: Viking Press, 1963.

Miles, Matthew. Learning to Work in Groups. New York: Columbia University, 1959.

Moroney, M. J. Facts From Figures. Baltimore: Penguin Books, 1951.

National Association of Music Therapy. Objectives and Functions of Music Therapy. Lawrence, Kansas: 1965-66. (In process)

Naumberg, Margaret. Psychoneurotic Art: Its Function in Psychotherapy. New York: Grune and Stratton, Inc., 1953.

_____. Schizophrenic Art: Its Function in Psychotherapy. New York: Grune and Stratton, Inc., 1953.

Portnoy, Julius. The Philosopher and Music. New York: Humanities Press, 1955.

Rosen, Elizabeth. Dance in Psychotherapy. New York: Teachers College, Columbia University, 1957.

Ruesch, Jurgen. Psychiatric Care. New York: Grune and Stratton, 1964.

_____. Therapeutic Communication. New York: W. W. Norton and Company, 1961.

Sapir, Edward. Edited by David G. Mandelbaum. Culture, Language and Personality. Berkeley: University of California Press, 1958.

Schullian, Dorothy M. and Max Schoen (eds). Music and Medicine. New York: Henry Schuman, Inc., 1948.

Seymour, Harriet Ayer. What Music Can Do For You. New York: Harper and Brothers, 1920.

Shibutani, Tamotsu. Society and Personality: An Interactionist Approach to Social Psychology. New York: Prentice-Hall, 1961.

Sigerist, Henry. Civilization and Disease. Ithaca: Cornell University Press, 1944.

Soibelman, Doris. Therapeutic and Industrial Uses of Music. New York: Columbia University Press, 1948.

Srole, Leo, et al. Mental Health in the Metropolis. New York: McGraw-Hill and Company, 1962.

Thatcher, John H. Public School Adult Education, A Guide for Administrators. Albany, New York: National Association of Public School Adult Educators, 1963.

Van de Wall, William. Music in Institutions. New York: Russell Sage Foundation, 1936.

Walker, Helen and Lev, Joseph. Statistical Inference. New York: Holt, Rinehart and Winston, 1953.

Yearbooks of National Association of Music Therapy: Articles and Proceedings of National Conferences. Vols. I-XII, 1951-1952, Lawrence, Kansas: Allen Press, 1952-1963.

Articles and Periodicals

Altshuler, Ira M. and Shebesta, B. H. "Music as an Aid in the Management of the Psychotic Patient," Journal of Nervous and Mental Disorders No. 94, (August 1941), pp. 179-183.

Altshuler, Ira M. "The Part of Music in Resocialization of Mental Patients." Occupational Therapy and Rehabilitation No. 20 (1941), pp. 75-86.

Alward, Eileen, and Rule (Keem) Betty. "An Experiment in the Use of Music with Emotionally Disturbed Children," Music Therapy 1959. Ninth Book of Proceedings of the National Association for Music Therapy. Edited by Erwin H. Schneider, Lawrence, Kansas: Allen Press, pp.125-129.

Boxberger, Ruth. "Historical Bases for the Use of Music in Therapy," Music Therapy 1961, Eleventh Book of Proceedings of the National Association for Music Therapy. Edited by Erwin H. Schneider. Lawrence, Kansas: Allen Press, pp. 125-166.

Blair, Donald and Brooking, Mair. "Music as a Therapeutic Agent," Mental Hygiene No. 41 (April 1957), pp. 228-237.

Burdick, W. P. "The Use of Music During Anethesia and Analgesia," The American Yearbook of Anethesia and Analgesia. Edited by F. H. McMechan. New York: Surgery Publishing Co., 1916, pp. 164-167.

Carapetyan, Armen. "Music and Medicine in the Renaissance and in the 17th and 18th Centuries," Music and Medicine. Edited by Dorothy M. Schullian and Max Schoen, New York: Henry Schuman, Inc., 1948, pp. 117-140.

Chace, Marian. "Dance as an Adjunctive Therapy with Hospitalized Mental Patients." Bulletin of the Menniger Clinic No. 17. (November 1953), pp. 219-225.

_____. "Measurable and Intangible Aspects of Dance Sessions." Music Therapy 1957. Edited by E. Thayer Gaston. Lawrence, Kansas: Allen Press, 1958, pp. 151-156.

_____. "Report of a Group Project, St. Elizabeth's Hospital." Music Therapy 1954. Edited by E. Thayer Gaston. Lawrence, Kansas: Allen Press, 1955, pp. 187-190.

_____. "Rhythm in Movement as Used in St. Elizabeth's Hospital." Group Psychotherapy. Edited by J. Moreno. New York: Beacon House, 1946.

"Columbia University to Heal Wounded by Music," Literary Digest, LX (March 1, 1919,) pp. 59-62.

Densmore, Frances. "The Use in the Treatment of the Sick American Indians," Music and Medicine. Edited by Dorothy M. Schullian and Max Schoen. New York: Henry Schuman, Inc., 1948, pp. 25-45.

Dillinger, George E. (M.D.). "Music and Music Therapy as a Patient Experiences Them," Music Therapy 1958. Edited by Erwin H. Schneider. Lawrence, Kansas: Allen Press, 1958, pp. 193-214.

Fultz, Arthur F. "A Study of Handbell Ringing as a Music Therapy Operation," Music Therapy 1961. Eleventh Book of Proceedings of the National Association of Music Therapy. Editor Erwin H. Schneider. Lawrence, Kansas: Allen Press, pp. 169-182.

Gaston, E. Thayer. "Nature and Principles of Music Therapy," Music Therapy 1954. Editor E. Thayer Gaston. Lawrence, Kansas: Allen Press, 1955.

Goldstein, Carole, Lingas, Catherine, and Sheafor, Douglas. "Interpretive or Creative Movement as a Sublimation Tool in Music Therapy," Journal of Music Therapy, Vol. II, No. 1 (March 1965), pp. 11-15.

Goward, Barbara and Licht, Sidney. "Music for the Hospitalized Patient," Occupational Therapy: Principles and Practices. Edited by Dutton and Licht. Springfield, Illinois: Charles Thomas (1957), pp. 127-141.

Griffen, Jack, Cotter, Vance, and Kurz, Charles. "The Influence of Music on Geriatric Patients," Music Therapy 1957. Seventh Book of Proceedings of the National Association of Music Therapy. Editor E. Thayer Gaston. Lawrence, Kansas: Allen Press, pp. 159-166.

Henderson, Isabel. "Ancient Greek Music," The New Oxford History of Music, Vol. I: Ancient and Oriental Music. Edited by Egan Wellesz. London: Oxford University Press, 1957, pp. 376-402.

Henkin, R. I. "The Prediction of Behavior Response Patterns of Music," Journal of Psychology 44 (1957), pp. 111-127.

"Hospital Music Survey," National Music Council Bulletin (September 1948), pp. 10-11.

Husband, R. W. "The Effects of Musical Rhythms and Pure Rhythms on Bodily Sway," Journal of General Psychology, 11 (1934), pp. 328-336.

Hyde, Ida H., and Scalopino, W. "Influence of Music Upon Electrocardiogram and Blood Pressure," American Journal of Physiology, 46 (April 1918), pp. 35-38.

Jacobson, Harold Lee. "A Study of the Effects of Sedative Music on the Tension and Anxiety Experienced by Mental Patients During Dental Procedure," Bulletin of the National Association of Music Therapy No. 5 (September 1956), pp. 9-10.

Jarvis, Jessie A. "From the Outside Looking In," The American Yearbook. Edited by F. H. McMechan. New York: Surgery Publishing Co., 1916, pp. 168-170.

Jensen, M. B. "The Influence of Jazz and Dirge Music Upon Speed and Accuracy of Typing," Journal of Educational Psychology 22 (1931), pp. 458-462.

Kane, E. O. "The Phonograph in the Operating Room," Journal of the American Medical Association, XLII (June 1914), p. 1829.

Lang, Henry Paul. "The Role Music Plays Among the Arts," Music and Medicine, XXXV (October 1949), pp. 602-608.

Meinecke, Bruno. "Music and Medicine in Classical Antiquity," Music and Medicine. Edited by Dorothy M. Schullian and Max Schoen. New York: Henry Schuman, Inc., 1948, pp. 47-94.

"Membership Directory," Journal of Music Therapy, Vol. II, No. 2 (March 1965), pp. 25-35.

Michel, Donald E. "A Study of the Sedative Effects of Music for Acutely Disturbed Patients in a Mental Hospital," Music Therapy 1951, First Book of Proceedings of the National Association for Music Therapy. Edited by E. G. Gilliland. Lawrence, Kansas: Allen Press, pp. 182-183.

Moreno, J. L. "Psychodrama and Group Psychotherapy." Sociometry No. 9 (May/August 1946), pp. 249-253.

_____. "Psychomusic." Psychodrama. Edited by J. L. Moreno. New York: Beacon House, 1946, pp. 277-314.

Murdock, Harvy M. and Eaton, Merrill T. "Music as an Adjunct to Electroshock Treatment," Journal of Nervous and Mental Disorder No. 116 (1952), pp. 336-339.

Orton, Danny E. "Development of Criteria for Study of the Influences of Music on Children's Drawings," Music Therapy 1952, Second Book of Proceedings of the National Association for Music Therapy. Editor E. G. Gilliland. Lawrence, Kansas: Allen Press, pp. 261-265.

Radin, Paul. "Music and Medicine Among Primitive Peoples," Music and Medicine. Edited by Dorothy M. Schullian and Max Schoen. New York: Henry Schuman, Inc., 1948, pp. 3-24.

"Red Cross Music," National Music Council Bulletin (September 1948), pp. 20-21.

Rosen, Elizabeth. "Dance as a Therapy for the Mentally Ill." Teachers College Record No. 55. New York: Columbia University, 1954, pp. 215-222.

Rudyor, Eva F. "Methods of Sound and Movement as an Adjunct to Psychodrama." Psychodrama No. 4 (1951), pp. 44-99.

Ruppenthal, Wayne. "'Scribbling' in Music Therapy." Journal of Music Therapy. Vol. II, No. 2 (March 1965), pp. 8-10.

Schneider, Marious, "Primitive Music," The New Oxford History of Music Vol. I: Ancient and Oriental Music. Edited by Egan Wellesz. London: Oxford University Press, 1957, pp. 1-82.

Schoen, Max, and Gatewood, Ester L. "An Experimental Study of the Nature of Musical Enjoyment," in Effects of Music. Edited by Max Schoen. New York: Harcourt, Brace and Company, 1927.

Sears, William W. "Post Responses to Recorded Music," Music Therapy 1951, First Book of Proceedings of the National Association for Music Therapy. Editor E. G. Gilliland. Lawrence, Kansas: Allen Press, pp. 197-198.

Shatin, Leo. "Some Psychiatric Aspects of Long-Term Hospitalization. The Rehabilitative Role of Recreational and Special Activities," Mental Hygiene No. 41 (April 1957), pp. 487-496.

_____. "The Application of Rhythmic Music Stimuli to Long-Term Schizophrenic Patients," Music Therapy 1957, Seventh Book of Proceedings of the National Association for Music Therapy. Edited by E. Thayer Gaston, Lawrence, Kansas: Allen Press, 1958, pp. 169-178.

_____. "The Influence of Rhythmic Drumbeat Upon the Pulse Rate and General Activity of Long-Term Schizophrenic," Journal of Mental Sciences No. 430, London, England: January 1957, p. 103.

Shatin, Leo, Gilmore, T. and Kotter, W. "A Study of the Relationship Between Music and Post-Electro-Shock Awakening," Disorder of Nervous System, No. 8 (August 1954), p. 15.

Shrift, Donald C. "The Galvanic Skin Test to Two Contrasting Types of Music," Music Therapy 1956, Sixth Book of Proceedings of the National Association for Music Therapy. Edited by E. Thayer Gaston. Lawrence, Kansas: Allen Press, 1957, pp. 235-239.

Simon, Benjamin, et al. "The Recognition and Acceptance of Mood in Music by Psychotic Patients," Journal of Nervous and Mental Disorders No. 114 (1951), pp. 66-78.

Skelly, C. G. and Haslerud, G. M. "Music and the General Activity of Apathetic Schizophrenics," Journal of Abnormal Social Psychology No. 47 (April 1952), pp. 188-192.

Sommer, Dorothy T. "The Effect of Background Music on Frequency of Interaction in Group Psychotherapy," Music Therapy 1957. Seventh Book of Proceedings of the National Association of Music Therapy. Editor E. Thayer Gaston. Lawrence, Kansas: Allen Press, pp. 167-168.

Stanford, George A. "Orchestration of the New Mental Hospital Theme." Journal of Music Therapy, Vol. I, No. 4 (December 1964), pp. 124-128.

Treves, N. E. "Study of Music on Cancer Patients," Hospital Social Services, No. 16 (August 1927), pp. 123-131.

Vescelius, Eva G. "Music and Health," Music Quarterly, IV (July 1918), pp. 376-400.

Wittenberg, R. "Psychiatric Concepts in Group Work Applied Through the Media of Drama and Music." American Journal of Orthopsychiatry No. 14 (January 1944), pp. 76-83.

Zanker, A. and Glatt, M. M. "Individual Reactions of Alcholic and Neurotic Patients to Music," Journal of Nervous and Mental Disorders No. 123 (1956), pp. 395-402.

Reports

Flint Community Schools. Personalized Curriculum Program. A Progress Report to the Community on the PCP (junior and senior high school drop-out program) Program.

Martin, D. W. The Mentally Ill Do Get Well. A Report Purposed by D. W. Martin, M.D., Superintendent of the Pontiac State Hospital. Pontiac: Pontiac State Hospital, 1963.

Manuals

Gordon, Leonard V. Gordon Personal Inventory Manual. New York: Harcourt, Brace and World, Inc., 1963 rev.

_____. Gordon Personal Profile Manual. New York: Harcourt, Brace and World, Inc., 1963 rev.

Lorr, Maurice, et al. Impatient Multidimensional Psychiatric Scale Manual. Palo Alto: Consulting Psychologist Press, Inc., 1962.

McReynolds, Paul and Ferguson, James T., Clinical Manual for the Hospital Adjustment Scale. Palo Alto: Consulting Psychologists Press, Inc., 1951.

Unpublished Material

Boxberger, Ruth. "A Historical Study of the National Association for Music Therapy." Unpublished doctoral dissertation, Department of Education, University of Kansas, 1963.

Burns, Robert F. "A Study of the Influence of Familiar Hymns on Moods and Associations: Potential Application in Music Therapy." Unpublished Thesis, University of Florida, 1958.

Dreher, R. E. "The Relationship Between Verbal Reports and Galvanic Skin Responses to Music." Unpublished thesis, Department of Music, University of Indiana, 1947.

Keem, Betty J. "A Study of the Historical Aspects of Music Therapy Leading to a Degree Program." Unpublished document for Education 8048: Higher Education in the United States, School of Education, Michigan State University, 1963.

_____. "Employment of Public School Teachers with Mental Illness Histories." Unpublished document of case studies. Flint Public Schools, Music Consultant's office.

_____. "Unpublished Lecture" Presented to Great Lakes Regional Music Therapy Conference, Flint, Michigan. April 1965.

Kerr, Betty J. "A Study to Determine Effects of 'Live' and 'Canned' Music on Psychotic Patients." Unpublished paper and file Cincinnati University Conservatory, 1942.

Lavere, W. "The Influence of Musical Training and Musical Accompaniment on the Sense of Equilibrium." Unpublished thesis, Syracuse University, 1950.

Orton, Mary Ryder. "Application of the Iso-Moodic Principle in the Use of Music with Psychotic and Normal Subjects." Unpublished thesis, University of Kansas, 1953.

Paterson, Janet. "Rehabilitation of a Schizophrenic Female Patient: Case Study." Unpublished case study. Traverse City State Hospital, Occupational Therapy Department.

Other Sources

Flint Institute of Arts, Flint, Michigan. Personal interview with Stuart Hodge, Director. April 1965.

Flint Public Schools, Flint, Michigan. Personal interview with Eileen Alward, Principal, Durant-Tuuri Mott Community School. May 1965.

_____. Personal interview with Charles C. Beal, Art Consultant. April 1965.

_____. Personal interview with Ann Johnson, R.M.T. September 1964 to May 1965.

Indiana University. Personal interview with William W. Sears, R.M.T., Director of Music Therapy Training Program. October 1964.

Michigan State University. Personal interviews with Robert Unkefer, R.M.T., Director of Music Therapy Training Program. February, March, and April 1964.

Ohio University. Personal interview with Erwin H. Schneider, R.M.T., Acting Dean, School of Music. November 1964.

State of Michigan. Personal interview with James Peal, M.D., Assistant Director of Department of Mental Health. April 22, 1965.

Traverse City State Hospital. Personal interviews with Dale Clapham, Recreational Director. June 1964 to May 1965.

_____. Personal interviews with Arthur M. Dundon, M.D., Clinical Director. June 1964.

Wayne County General Hospital. Personal interview with Clemens F. Fitzgerald, M.D., Director of Psychiatric Research and Education. January 1956.

Pontiac State Hospital. Personal observations of music therapy activities from February 1965 to May 1965.

Traverse City State Hospital. Personal observations of music therapy activities from June 1964 to May 1965.

Wayne County General Hospital: Psychiatric Unit. Personal observations of music therapy activities from January 1965 to May 1965.

Winchester (Genesee County) Hospital. Personal observations of music therapy activities from October 1962 to May 1965.

APPENDIX I

THE COVER LETTER

Dear_____:

I am presently pursuing a research sto study the effects of related arts therapy on certain psychotic subjects confined in Michigan psychiatric institutions. This project is for the completion of requirements for a Ph.D. degree in Education from Michigan State University. The design of the proposed study includes the following criteria for selecting participating hospitals:

1. American Psychiatric Association approval for the complete three year residency program in which graduate medical doctors may obtain the additional necessary education and training to become fully certified psychiatrists.

2. Joint Commission on Accreditation of Hospitals full approval.

3. Michigan Hospital Association and American Hospital Association membership.

4. Facilities for the psychiatric affiliation of student nurses from General Hospitals and college programs throughout the state.

5. American Occupational Association and Music Therapy National Association approval for internship to complete the necessary training to become registered occupational and/or music therapists.

6. An education and research department that is recognized by the associations named in the above items as making an outstanding contribution to the field of knowledge concerning the care and treatment of the mentally ill.

It has been reported to me that your hospital meets these requirements.

I would like to have an appointment with you to explore the possibilities of including your hospital in this study.

Your cooperation in this matter would be greatly appreciated.

Sincerely yours,

(Mrs.) Betty J. Keem

BJK:cw

APPENDIX II

SAMPLES OF INSTRUMENTS

USED IN THIS STUDY

1. The California Q-Set (FORM III)
2. California Q-Set Record Sheet
3. Hospital Adjustment Scale
4. Gordon Personal Inventory Answer Sheet
5. Gordon Personal Profile Answer Sheet
6. Behavior Evident During Music Therapy Session
7. Inpatient Multidimensional Psychiatric Scale Answer Sheet

THE CALIFORNIA Q-SET (FORM III)[1]

Specified 9-point distribution (N = 100):
5, 8, 12, 16, 18, 16, 12, 8, 5

$$r = 1 - \frac{\text{Sum dip}^2}{864}$$

1. Is critical, skeptical, not easily impressed.

2. Is a genuinely dependable and responsible person.

3. Has a wide range of interests (N.B. Superficiality or depth of interest is irrelevant here.)

4. Is a talkative individual.

5. Behaves in a giving way toward others. (N.B. regardless of the motivation involved.)

6. Is fastidious.

7. Favors conservative values in a variety of areas.

8. Appears to have a high degree of intellectual capacity. (N.B. whether actualized or not.) (N.B. Originality is not necessarily assumed.)

9. Is uncomfortable with uncertainty and complexities.

10. Anxiety and tension find outlet in bodily symptoms. (N.B. If placed high, implies bodily dysfunction; if placed low, implies absence of autonomic arousal.)

11. Is protective of those close to him. (N.B. Placement of this item expresses behavior ranging from over-protection through appropriate nurturance to a laissez-faire, under-protective manner.)

12. Tends to be self-defensive.

13. Is thin-skinned; sensitive to anything that can be construed as criticism or an interpersonal slight.

14. Genuinely submissive; accepts domination comfortably.

15. Is skilled in social techniques of imaginative play, pretending and humor.

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[1]Jack Block, The Q-Sort Method in Personality Assessment and Psychiatric Research (Springfield, Ill.: Charles C. Thomas, 1961), pp. 132-136.

16. Is introspective and concerned with self as an object. (N.B. introspectiveness per se does not imply insight.)

17. Behaves in a sympathetic or considerate manner.

18. Initiates humor.

19. Seeks reassurance from others.

20. Has a rapid personal tempo; behaves and acts quickly.

21. Arouses nurturant feelings in others.

22. Feels a lack of personal meaning in life.

23. Extrapunitive; tends to transfer or project blame.

24. Prides self on being "objective," rational.

25. Tends toward over-control of needs and impulses; binds tensions excessively; delays gratification unnecessarily.

26. Is productive; gets things done.

27. Shows condescending behavior in relations with others. (N.B. extreme placement toward uncharacteristic and implies simply an absence of condescension, not necessarily equalitarianism or inferiority.)

28. Tends to arouse liking and acceptance in people.

29. Is turned to for advice and reassurance.

30. Gives up and withdraws where possible in the face of frustration and adversity. (N.B. If placed high, implies generally defeatist; if placed low, implies counteractive.)

31. Regards self as physically attractive.

32. Seems to be aware of the impression he makes on others.

33. Is calm, relaxed in manner.

34. Over-reactive to minor frustrations; irritable.

35. Has warmth; has the capacity for close relationships; compassionate.

36. Is subtly negativistic; tends to undermine and obstruct or sabotage.

37. Is guileful and deceitful, manipulative, opportunistic.

38. Has hostility towards others. (N.B. Basic hostility is intended here; mode of expression is to be indicated by other items.)

39. Thinks and associates to ideas in unusual ways; has unconventional thought processes.

40. Is vulnerable to real or fancied threat, generally fearful.

41. Is moralistic. (N.B. Regardless of the particular nature of the moral code.)

42. Reluctant to commit self to any definite course of action; tends to delay or avoid action.

43. Is facially and/or gesturally expressive.

44. Evaluates the motivation of others in interpreting situations. (N.B. Accuracy of evaluation is not assumed.) (N.B. again. Extreme placement in one direction implies pre-occupation with motivational interpretation; at the other extreme, the item implies a psychological obtuseness, S does not consider motivational factors.)

45. Has a brittle ego-defense system; has a small reserve of integration; would be disorganized and maladaptive when under stress or trauma.

46. Engages in personal fantasy and daydreams, fictional speculations.

47. Has a readiness to feel guilty. (N.B. regardless of whether verbalized or not.)

48. Keeps people at a distance; avoids close interpersonal relationships.

49. Is basically distrustful of people in general; questions their motivations.

50. Is unpredictable and changeable in behavior and attitudes.

51. Genuinely values intellectual and cognitive matters. (N.B. Ability or achievement are not implied here.)

52. Behaves in an assertive fashion. (N.B. Item 14 reflects underlying submissiveness; this refers to overt behavior.

53. Various needs tend toward relatively direct and uncontrolled expression; unable to delay gratification.

54. Emphasizes being with others; gregarious.

55. Is self-defeating.

56. Responds to humor.

57. Is an interesting, arresting person.

58. Enjoys sensuous experiences (including touch, taste, smell, physical contact.)

59. Is concerned with own body and the adequacy of its physiological functioning.

60. Has insight into own motives and behavior.

61. Creates and exploits dependency in people. (N.B. Regardless of the technique employed, e.g., punitiveness, over-indulgence.) (N.B. At other end of scale, item implies respecting and encouraging the independence and individuality of others.)

62. Tends to be rebellious and non-conforming.

63. Judges self and others in conventional terms like "popularity," "the correct thing to do," social pressures, etc.

64. Is socially perceptive of a wide range of interpersonal cues.

65. Characteristically pushes and tries to stretch limits; sees what he can get away with.

66. Enjoys esthetic impressions; is esthetically reactive.

67. Is self-indulgent.

68. Is basically anxious.

69. Is sensitive to anything that can be construed as a demand. (N.B. No implication of the kind of subsequent response is intended here.)

70. Behaves in an ethically consistent manner; is consistent with own personal standards.

71. Has high aspiration level for self.

72. Concerned with own adequacy as a person, either at conscious or unconscious levels. (N.B. A clinical judgment is required here; number 74 reflects subjective satisfaction with self.)

73. Tends to perceive many different contexts in sexual terms; eroticizes situations.

74. Is subjectively unaware of self-concern; feels satisfied with self.

75. Has a clear-cut, internally consistent personality. (N.B. Amount of information available before sorting is not intended here.)

76. Tends to project his own feelings and motivations onto others.

77. Appears straightforward, forthright, candid in dealing with others.

78. Feels cheated and victimized by life; self-pitying.

79. Tends to ruminate and have persistent, pre-occupying thoughts.

80. Interested in members of the opposite sex. (N.B. At opposite end, item implies absence of such interest.)

81. Is physically attractive; good-looking. (N.B. The cultural criterion is to be applied here.)

82. Has fluctuating moods.

83. Able to see to the heart of important problems.

84. Is cheerful. (N.B. Extreme placement toward uncharacteristic end of continuum implies unhappiness or depression.)

85. Emphasizes communication through action and non-verbal behavior.

86. Handles anxiety and conflicts by, in effect, refusing to recognize their presence; repressive or dissociative tendencies.

87. Interprets basically simple and clear-cut situations in complicated and particularizing ways.

88. Is personally charming.

89. Compares self to others. Is alert to real or fancied differences between self and other people.

90. Is concerned with philosophical problems; e.g., religions, values, the meaning of life, etc.

91. Is power oriented; values power in self or others.

92. Has social poise and presence; appears socially at ease.

93a. Behaves in a masculine style and manner.

93b. Behaves in a feminine style and manner. (N.B. If subject is male, 93a. applies; if subject is female 93b. is to be evaluated.) (N.B. again. The cultural or sub-cultural conception is to be applied as a criterion.)

94. Expresses hostile feelings directly.

95. Tends to proffer advice.

96. Values own independence and autonomy.

97. Is emotionally bland; has flattened affect.

98. Is verbally fluent; can express ideas well.

99. Is self-dramatizing; histrionic.

100. Does not vary roles; relates to everyone in the same way.

CALIFORNIA Q-SET RECORD SHEET

After sorting, insert the category number for each card in the appropriate box below. Be sure each category contains the specified number of cards.

Subject: _____ Sorter: _____ Informational source: _____ Date: _____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20

21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40

41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60

61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80

81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100

Specified CQ distribution

Category value	1	2	3	4	5	6	7	8	9
Number of items in category	5	8	12	16	18	16	12	8	5

N.B. A value of 9 indicates "most characteristic"; a value of 1 indicates "least characteristic".

Formula for correlation between CQ sorts: $r = 1 - \frac{\text{sum } d^2}{864}$

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HOSPITAL ADJUSTMENT SCALE

For Evaluating Patients' Behavior in a Psychiatric Hospital

JAMES T. FERGUSON, M.D. **PAUL McREYNOLDS, PH.D.**

EGERTON L. BALLACHEY, PH.D.

INSTRUCTIONS TO OBSERVER: The purpose of this Scale is to help you to report on the behavior of the patient named below. The Scale consists of a number of statements which describe some of the ways patients act in different places in a psychiatric hospital. These statements were taken from descriptions of patients made by *psychiatric aides* in a large psychiatric hospital.

You are to mark each statement as True (T), Not True (NT), or in some cases as Doesn't Apply (DA), for the patient named below. Marking a statement T, NT, or DA should be based on actual observation by yourself or others of the patient for the past *two weeks to three months.* The behavior described in a statement is true if present most or all of the time during the past *two weeks to three months.*

Think of the patient named below as you have seen him act in the last two weeks to three months. Look at statement No. 1 on the next page. If No. 1 is generally True—that is, True most or all of the time—for the patient, put a circle around T. If No. 1 is generally Not True for the patient, put a circle around NT. *You must put a circle around either T or NT for all statements which have only T and NT in front of them.*

A few of the statements, for example No. 2, have DA in front of them, as well as T and NT. DA is to be circled when the statement Doesn't Apply to the patient. Look at No. 2. If, during the past three months, the patient has not had any visitors, No. 2 obviously Doesn't Apply to him and you would circle DA. If the patient did have visitors and No. 2 was generally True for the patient, put a circle around T. If the patient had visitors and No. 2 was generally Not True for the patient, put a circle around NT. Also, if the statement concerns Occupational Therapy and the patient did not have O. T. during the past three months either on or away from the ward, then DA should again be circled.

Note that if a statement *does* apply to the patient but you don't know the answer (T or NT), you should make an attempt to find out the answer and mark it the best you can. *Do not circle DA just because you don't know offhand whether T or NT is correct.* Circle DA as sparingly as possible; use it only when a statement clearly Doesn't Apply to the patient.

Be sure you have circled the right letters. It is necessary to mark *all* statements, but you may have to observe the patient more, or secure information from other personnel, before marking some of them.

Be sure to mark every item. Don't leave any out.

Patient's last name	First name	Middle name	Register No.

Name of hospital	Ward	Name and title of observer

	Group	I	II	III	Total
How long have you known the patient?					
	No. of E's				
.....yrs. .....mos.	No. of C's				
.....weeks	Raw score				
Date	Percentile				

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1.	T	NT		The patient ignores the activities around him.
2.	T	NT	DA	The patient gets dressed up for visitors.
3.	T	NT	DA	The patient follows events in the daily paper.
4.	T	NT	DA	The patient laughs if he's kidded.
5.	T	NT	DA	The patient writes sensible and understandable letters.
6.	T	NT		The patient stays by himself.
7.	T	NT		The patient spends a lot of time talking to himself.
8.	T	NT		The patient doesn't mix with other patients.
9.	T	NT		The patient's talk is mostly not sensible.
10.	T	NT		The patient doesn't make distinctions between new and old personnel.
11.	T	NT		The patient chooses to talk either to the personnel or to patients who talk sensibly.
12.	T	NT	DA	The patient doesn't want social group contacts with other patients.
13.	T	NT		The patient never says more than 3 or 4 words at a time.
14.	T	NT	DA	The patient doesn't open letters unless someone tells him to.
15.	T	NT		The patient talks about sports with the aide.
16.	T	NT		The patient can tease another patient back into good humor.
17.	T	NT		The patient answers sensibly if talked to.
18.	T	NT	DA	The patient sometimes remarks when it's time for a family visit.
19.	T	NT		The patient doesn't have close friends on the ward.
20.	T	NT		The patient isn't backward about talking to you after he gets acquainted.
21.	T	NT		The patient can talk sensibly if you ask him to.
22.	T	NT		The patient won't discuss many subjects.
23.	T	NT	DA	The patient never asks for a pass (short stay away from hospital).
24.	T	NT		The patient talks about his family with the aide.
25.	T	NT	DA	The patient never writes a letter.
26.	T	NT		The patient seems to enjoy being talked to.
27.	T	NT		The patient doesn't take part in back and forth conversation.
28.	T	NT	DA	The patient plays ball with other patients.
29.	T	NT	DA	The patient is either silent or talks foolishly during visits.
30.	T	NT		The patient sometimes approaches the aide with dry humor about his situation in the hospital.
31.	T	NT		The patient is always chatting with someone.
32.	T	NT		The patient's words aren't understandable.
33.	T	NT	DA	The patient asks to leave the hospital to visit his family.
34.	T	NT		The patient resents it if he's asked a question.
35.	T	NT		The patient will always reply if you make some remark to him.
36.	T	NT		The patient talks over happenings on the ward with the aide.
37.	T	NT		The patient's talk is mostly straight, sensible talk.
38.	T	NT		The patient starts conversations with aides to become better acquainted.
39.	T	NT		The patient can take teasing.
40.	T	NT		The patient never volunteers any information about himself.
41.	T	NT		The patient knows the names of all the doctors, nurses, and aides.
42.	T	NT	DA	The patient maintains a correspondence.

43.	T	NT		The patient has to be pushed to follow routine.
44.	T	NT		The patient wants to do the right thing on the ward.
45.	T	NT	DA	The patient seldom dresses up.
46.	T	NT		The patient doesn't like to change his clothes.
47.	T	NT		The patient takes no pride in his personal appearance.
48.	T	NT	DA	The patient is very interested in his clothes.
49.	T	NT		The patient is making realistic plans for when he leaves the hospital.
50.	T	NT		The patient occasionally needs supervision with dressing.
51.	T	NT		The patient's clothes are unbuttoned.
52.	T	NT		The patient has to be reminded to attend to routine.
53.	T	NT	DA	The patient never combs his hair.
54.	T	NT		The patient yells at attendant when he's dissatisfied.
55.	T	NT		The patient stays neat and clean.
56.	T	NT		The patient never asks for anything; he waits for things to be given to him.
57.	T	NT		The patient has to be dressed.
58.	T	NT	DA	The patient behaves exceptionally well when taken off grounds.
59.	T	NT		The patient occasionally has to be reminded to change his clothes.
60.	T	NT	DA	The patient takes pleasure in fixing his hair.
61.	T	NT		The patient easily becomes upset if something doesn't suit him.
62.	T	NT		The patient is usually sloppy.
63.	T	NT	DA	The patient keeps his clothes cleaned and pressed.
64.	T	NT		The patient likes to do the opposite of what he's asked to do.
65.	T	NT	DA	The patient is so well dressed that he can't be distinguished from a "normal" person.
66.	T	NT	DA	The patient seems to manage his money.
67.	T	NT	DA	The patient is interested in looking well when he leaves the hospital on trips.
68.	T	NT	DA	The patient plays cards occasionally.
69.	T	NT	DA	The patient is a good worker in shop.
70.	T	NT		The patient asks if there's work for him to do.
71.	T	NT	DA	The patient doesn't take part in ward games.
72.	T	NT	DA	The patient always attends ward parties.
73.	T	NT	DA	The patient will do anything for recreation that comes up.
74.	T	NT		The patient reads newspapers and magazines.
75.	T	NT	DA	The patient won't do any assigned duties.
76.	T	NT	DA	The patient is willing to do any extra chore.
77.	T	NT		The patient is interested in nothing.
78.	T	NT	DA	The patient doesn't take part in recreation.
79.	T	NT	DA	The patient doesn't need supervision on a job.
80.	T	NT	DA	The patient has to be helped along to stick to any activity.
81.	T	NT	DA	The patient doesn't take part in athletics.
82.	T	NT	DA	The patient helps out when needed.
83.	T	NT	DA	The patient isn't capable of doing a good job at anything.
84.	T	NT		The patient shows no reaction to entertainment.
85.	T	NT	DA	The patient doesn't like to go out for exercise.
86.	T	NT	DA	The patient helps take care of the laundry.
87.	T	NT		The patient would sit all day if not directed to an activity.
88.	T	NT	DA	The patient does a good job, once someone gets him started.
89.	T	NT	DA	The patient is very interested in O. T.
90.	T	NT	DA	The patient works well on the ward.

ADDITIONAL CLINICAL DATA. This space is provided for those clinicians who may find it desirable to have recorded on this form clinical information of a type not directly surveyed by the HAS behavioral statements. See *Clinical Manual for the HAS* for suggestions regarding its use.

Start with this page. Mark your answers in column **A** →

	A
	M L
a very original thinker	
a somewhat slow and leisurely person	
tends to be critical of others	
makes decisions only after a great deal of thought	
	M L
believes that everyone is essentially honest	
likes to take it relatively easy at work or play	
has a very inquiring attitude	
tends to act on impulse	
	M L
a very energetic person	
doesn't get angry at other people	
dislikes working on complex and difficult problems	
prefers gay parties to quiet gatherings	
	M L
enjoys philosophical discussions	
gets tired somewhat easily	
considers matters very carefully before acting	
does not have a great deal of confidence in people	
	M L
likes to work primarily with ideas	
does things at a rather slow pace	
very careful when making a decision	
finds a number of people hard to get along with	
	M L
a great person for taking chances	
becomes irritated at other people quite readily	
can get a great deal done in a short time	
spends considerable time thinking of new ideas	
	M L
a very patient person	
seeks thrills and excitement	
able to keep working for long stretches	
would rather carry out a project than plan it	
	M L
feels very tired and weary at the end of the day	
inclined to make hurried or snap judgments	
doesn't get resentful toward other people	
has a great thirst for knowledge	
	M L
does not act on the spur of the moment	
becomes irritated by faults in others	
lacks interest in doing critical thinking	
prefers to work rapidly	
	M L
inclined to become very annoyed at people	
likes to keep "on the go" all the time	
would rather not take chances or run risks	
prefers work requiring little or no original thought	

Turn the page and go on.

Mark your answers in column B →	B		A	
	M	L	M	L
a very cautious person				
prefers to work rather slowly				
very tactful and diplomatic				
would rather not occupy the mind with deep thoughts				
	M	L	M	L
loses patience readily with people				
has somewhat less endurance than most people				
tends to be creative and original				
doesn't care much for excitement				
	M	L	M	L
tends to act on hunches				
has a great deal of vigor and drive				
doesn't trust people until they prove themselves				
enjoys questions involving considerable thought				
	M	L	M	L
doesn't like to work at a fast pace				
has great faith in people				
tends to give in to the wishes of the moment				
enjoys working out complicated problems				
	M	L	M	L
a very energetic worker				
accepts criticism with very good grace				
dislikes problems requiring a great deal of reasoning				
inclined to act first and think afterward				
	M	L	M	L
speaks nothing but the best about other people				
very cautious before proceeding				
not interested in thought-provoking discussions				
does not hurry in going from place to place				
	M	L	M	L
doesn't have an inquiring mind				
doesn't act on impulse				
generally bursting with energy				
becomes irritated by weaknesses in other people				
	M	L	M	L
able to get more things done than other people				
enjoys taking chances just for the excitement				
takes offense when subjected to criticism				
would rather work with ideas than things				
	M	L	M	L
very trustful of other people				
prefers work that is routine and simple				
does things on the spur of the moment				
full of vigor and vitality				
	M	L	M	L
makes decisions much too quickly				
has a great liking for everybody				
maintains a lively pace at work or play				
does not have a great interest in acquiring knowledge				

A

3 4 5 6 7 8 9 10 11 12

C
O
P
V

Gordon Personal Inventory

y Leonard V. Gordon

Percentile Rank	C	O	P	V
99				
95				
90				
75				
50				
25				
10				
5				
1				
Score →				
Percentile Rank →				

Norms used_____

ame _____ Age ____ Sex _____

ate_____ Marital Status _____

hool *or* Firm _____

rade *or* Occupation _____

ity _____ State _____

irections:

In this booklet are a number of descriptions of personal characteristics of people. These descriptions are grouped sets of four. You are to examine each set and find the one description that is *most like you.* Then make a solid ack mark between the pair of dotted lines following that statement, in the column headed M (*Most*).

Next examine the other three statements in the set and find the one description that is *least like you;* then make a lid black mark between the pair of dotted lines following that statement, in the column headed L (*Least*). Do ot make any marks following the two remaining statements.

ere is a sample set:

	M	L
prefers to get up early in the morning		
doesn't care for popular music		
has an excellent command of English		
obtains a poorly balanced diet	■	

Suppose that you have read the four descriptive statements in the sample and have decided that, although several the statements may apply to you to some degree, "obtains a poorly balanced diet" is *more like you* than any of the hers. You would fill in the space following that statement in the column headed M (*Most*), as shown in the sample.

You would then examine the other three statements to decide which one is *least like you.* Suppose that "prefers to et up early in the morning" is *less like you* than the other two. You would fill in the space following that statement the column headed L (*Least*), as shown in the sample above.

For every set you should have *one* and *only one* mark in the M (*Most*) column, and *one* and *only one* mark in the (*Least*) column. There should be *no* marks following two of the statements.

In some cases it may be difficult to decide which statements you should mark. Make the best decisions you can. emember, this is not a test; there are no right or wrong answers. You are to mark certain statements in the way in hich they most nearly *apply to you.* Be sure to mark *one* statement as being *most like you* and *one* as being *least ke you,* leaving two statements unmarked. Do this for every set. Turn the booklet over and begin.

Start with this page. Mark your answers in column A →

a good mixer socially.....
lacking in self-confidence.....
thorough in any work undertaken.....
tends to be somewhat emotional.....

not interested in being with other people.....
free from anxieties or tensions.....
quite an unreliable person.....
takes the lead in group discussion.....

acts somewhat jumpy and nervous.....
a strong influence on others.....
does not like social gatherings.....
a very persistent and steady worker.....

finds it easy to make new acquaintances.....
cannot stick to the same task for long.....
easily managed by other people.....
maintains self-control even when frustrated.....

able to make important decisions without help..
does not mix easily with new people.....
inclined to be tense or high-strung.....
sees a job through despite difficulties.....

not too interested in mixing socially with people..
doesn't take responsibilities seriously.....
steady and composed at all times.....
takes the lead in group activities .....

a person who can be relied upon.....
easily upset when things go wrong.....
not too sure of own opinions.....
prefers to be around other people.....

finds it easy to influence other people.....
gets the job done in the face of any obstacle.....
limits social relations to a select few.....
tends to be a rather nervous person.....

doesn't make friends very readily.....
takes an active part in group affairs.....
keeps at routine duties until completed.....
not too well-balanced emotionally.....

Turn the page and go on.

Mark your answers in column B →	B		A	
	M	L	M	L
assured in relationships with others				
feelings are rather easily hurt				
follows well-developed work habits				
would rather keep to a small group of friends				
	M	L	M	L
becomes irritated somewhat readily				
capable of handling any situation				
does not like to converse with strangers				
thorough in any work performed				
	M	L	M	L
prefers not to argue with other people				
unable to keep to a fixed schedule				
a calm and unexcitable person				
inclined to be highly sociable				
	M	L	M	L
free from worry or care				
lacks a sense of responsibility				
not interested in mixing with the opposite sex				
skillful in handling other people				
	M	L	M	L
finds it easy to be friendly with others				
prefers to let others take the lead in group activity				
seems to have a worrying nature				
sticks to a job despite any difficulty				
	M	L	M	L
able to sway other people's opinions				
lacks interest in joining group activities				
quite a nervous person				
very persistent in any task undertaken				
	M	L	M	L
calm and easygoing in manner				
cannot stick to the task at hand				
enjoys having lots of people around				
not too confident of own abilities				
	M	L	M	L
can be relied upon entirely				
doesn't care for the company of most people				
finds it rather difficult to relax				
takes an active part in group discussion				
	M	L	M	L
doesn't give up easily on a problem				
inclined to be somewhat nervous in manner				
lacking in self-assurance				
prefers to pass the time in the company of others				

A	R	E	S

Gordon Personal Profile

By Leonard V. Gordon

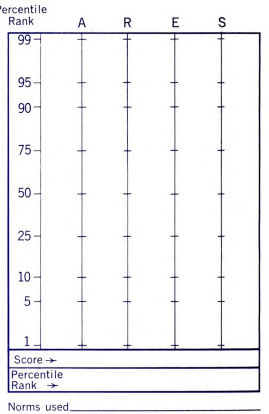
Name _____ Age _____ Sex _____

Date _____ Marital Status _____

School *or* Firm _____

Grade *or* Occupation _____

City _____ State _____



Norms used _____

Directions:

In this booklet are a number of descriptions of personal characteristics of people. These descriptions are grouped in sets of four. You are to examine each set and find the one description that is *most like you.* Then make a solid black mark between the pair of dotted lines following that statement, in the column headed M (*Most*).

Next examine the other three statements in the set and find the one description that is *least like you;* then make a solid black mark between the pair of dotted lines following that statement, in the column headed L (*Least*). Do *not* make any marks following the two remaining statements.

Here is a sample set:		M	L
	has an excellent appetite		
	gets sick very often		■
	follows a well-balanced diet		
	doesn't get enough exercise	■	

Suppose that you have read the four descriptive statements in the sample and have decided that, although several of the statements may apply to you to some degree, "doesn't get enough exercise" is *more like you* than any of the others. You would fill in the space following that statement in the column headed M (*Most*), as shown in the sample.

You would then examine the other three statements to decide which one is *least like you.* Suppose that "gets sick very often" is *less like you* than the other two. You would fill in the space following that statement in the column headed L (*Least*), as shown in the sample above.

For every set you should have *one* and *only one* mark in the M (*Most*) column, and *one* and *only one* mark in the L (*Least*) column. There should be *no* marks following two of the statements.

In some cases it may be difficult to decide which statements you should mark. Make the best decisions you can. Remember, this is not a test; there are no right or wrong answers. You are to mark certain statements in the way in which they most nearly *apply to you.* Be sure to mark *one* statement as being *most like you* and *one* as being *least like you,* leaving two statements unmarked. Do this for every set. Turn the booklet over and begin.

Name _____ Diagnosis _____

Hospital _____ Date: Exam _____ DD _____

Primary Diagnosis _____ Prognosis _____

Other Diagnosis _____ Prognosis _____

DIRECTIONS: Circle one point on each numbered vertical scale.
(See manual for implicit directions.)

Syndrome	1	2	3	4	5	6	7	8	9	10	11	12	Remark
1. EVC	0	0	0	0	0	0	0	0	0	0	0	0	
	1	1	1	1	1	1	1	1	1	1	1	1	
	2	2	2	2	2	2	2	2	2	2	2	2	
	3	3	3	3	3	3	3	3	3	3	3	3	
	4	4	4	4	4	4	4	4	4	4	4	4	
2. HOS	0	0	0	0	0	0	0	0	0	0	0	0	
	1	1	1	1	1	1	1	1	1	1	1	1	
	2	2	2	2	2	2	2	2	2	2	2	2	
	3	3	3	3	3	3	3	3	3	3	3	3	
	4	4	4	4	4	4	4	4	4	4	4	4	
3. HTO	0	0	0	0	0	0	0	0	0	0	0	0	
	1	1	1	1	1	1	1	1	1	1	1	1	
	2	2	2	2	2	2	2	2	2	2	2	2	
	3	3	3	3	3	3	3	3	3	3	3	3	
	4	4	4	4	4	4	4	4	4	4	4	4	
4. ANX	0	0	0	0	0	0	0	0	0	0	0	0	
	1	1	1	1	1	1	1	1	1	1	1	1	
	2	2	2	2	2	2	2	2	2	2	2	2	
	3	3	3	3	3	3	3	3	3	3	3	3	
	4	4	4	4	4	4	4	4	4	4	4	4	
5. CYP	0	0	0	0	0	0	0	0	0	0	0	0	
	1	1	1	1	1	1	1	1	1	1	1	1	
	2	2	2	2	2	2	2	2	2	2	2	2	
	3	3	3	3	3	3	3	3	3	3	3	3	
	4	4	4	4	4	4	4	4	4	4	4	4	
6. PSY	0	0	0	0	0	0	0	0	0	0	0	0	
	1	1	1	1	1	1	1	1	1	1	1	1	
	2	2	2	2	2	2	2	2	2	2	2	2	
	3	3	3	3	3	3	3	3	3	3	3	3	
	4	4	4	4	4	4	4	4	4	4	4	4	
7. MDF	0	0	0	0	0	0	0	0	0	0	0	0	
	1	1	1	1	1	1	1	1	1	1	1	1	
	2	2	2	2	2	2	2	2	2	2	2	2	
	3	3	3	3	3	3	3	3	3	3	3	3	
	4	4	4	4	4	4	4	4	4	4	4	4	
8. MIF	0	0	0	0	0	0	0	0	0	0	0	0	
	1	1	1	1	1	1	1	1	1	1	1	1	
	2	2	2	2	2	2	2	2	2	2	2	2	
	3	3	3	3	3	3	3	3	3	3	3	3	
	4	4	4	4	4	4	4	4	4	4	4	4	

ANSWER SHEET

INPATIENT MULTIDIMENSIONAL PSYCHIATRIC SCALE (IMPS)

PATIENT'S NAME _____ CODE # _____

HOSPITAL _____ WARD NO. _____ TYPE OF WARD _____

SEX _____ AGE _____ DIAGNOSTIC IMPRESSION _____

RATER'S NAME _____ POSITION OF RATER _____

DATE OF RATING _____ RATING PERIOD _____

DIRECTIONS

CIRCLE ONE POINT ON EACH NUMBERED VERTICAL SCALE AS ILLUSTRATED BELOW. ASTERISKED ITEMS APPEAR IN BRIEF SCALE.

EXTREMELY	8	(8)	8	8	8
MARKEDLY	7	7	7	(7)	7
DISTINCTLY	6	6	6	6	6
QUITE A BIT	5	5	5	5	5
MODERATELY	(4)	4	4	4	4
MILDLY	3	3	3	3	3
A LITTLE	2	2	2	2	2
VERY SLIGHTLY	1	1	1	1	(1)
NOT AT ALL	0	0	(0)	0	0
SCALE NO.	(1)	(2)	(3)	(4)	(5)

EXAMPLE: ON THE CHARACTERISTIC ASSESSED BY SCALE 1 THE PATIENT IS RATED "MODERATELY" COMPARED WITH THE NORMAL PERSON. ON SCALE 2 HE IS RATED "EXTREMELY", AND ON SCALE 3 HE IS RATED "NOT AT ALL". ON SCALE 4 HE IS RATED "MARKEDLY". ON SCALE 5 HE IS RATED "VERY SLIGHTLY".

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EXTREMELY	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8
MARKEDLY	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7
DISTINCTLY	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
QUITE A BIT	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
MODERATELY	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
MILDLY	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
A LITTLE	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
VERY SLIGHTLY	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
NOT AT ALL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SCALE NO.	*(1)	*(2)	*(3)	(4)	*(5)	*(6)	(7)	(8)	*(9)	(10)	(11)	(12)	(13)	*(14)	(15)

EXTREMELY	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8
MARKEDLY	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7
DISTINCTLY	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
QUITE A BIT	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
MODERATELY	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
MILDLY	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
A LITTLE	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
VERY SLIGHTLY	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
NOT AT ALL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SCALE NO.	*(16)	(17)	(18)	(19)	(20)	*(21)	(22)	(23)	(24)	*(25)	(26)	(27)	(28)	(29)	(30)

EXTREMELY	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8
MARKEDLY	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7
DISTINCTLY	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
QUITE A BIT	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
MODERATELY	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
MILDLY	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
A LITTLE	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
VERY SLIGHTLY	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
NOT AT ALL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SCALE NO.	(31)	(32)	(33)	(34)	*(35)	(36)	(37)	(38)	(39)	(40)	(41)	(42)	(43)	(44)	(45)

VERY OFTEN	4	4	4	4	4	4	4	4	4	4	4	4	4		
FAIRLY OFTEN	3	3	3	3	3	3	3	3	3	3	3	3	3		
A FEW TIMES	2	2	2	2	2	2	2	2	2	2	2	2	2		
ONCE OR TWICE	1	1	1	1	1	1	1	1	1	1	1	1	1		
NOT AT ALL	0	0	0	0	0	0	0	0	0	0	0	0	0		
SCALE NO.	(46)	*(47)	(48)	(49)	(50)	(51)	(52)	*(53)	(54)	(55)	*(56)	(57)	(58)		

YES	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
NO	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	*(59)	(60)	*(61)	(62)	(63)	*(64)	(65)	(66)	(67)	(68)	*(69)	(70)	*(71)	(72)	(73)	(74)	*(75)				

INPATIENT MULTIDIMENSIONAL PSYCHIATRIC SCALE

SCORING SHEET

EXCITEMENT (EXC) _____

7.	____	UNRESTRAINED
* 9.	____	HURRIED SPEECH
12.	____	ELEVATED MOOD
15.	____	SUPERIORITY
17.	____	DRAMATIZATION
20.	____	LOUD
26.	____	OVERACTIVE
*35.	____	EXCESS SPEECH
37.	____	DOMINATES

HOSTILE BELLIGERENCE (HOS) _____

* 5.	____	VERBAL
11.	____	CONTEMPT
18.	____	ATTITUDE
*25.	____	IRRITABILITY
28.	____	BLAMES OTHERS
32.	____	BITTER
34.	____	COMPLAINTS
36.	____	SUSPICIOUS

PARANOID PROJECTION (PAR) _____

44.	____	DELUSIONAL
*59.	____ x8	REFERENCE
60.	____ x8	PERSECUTION
*61.	____ x8	CONSPIRACY
62.	____ x8	PEOPLE CONTROLLING
63.	____ x8	EXTERNAL CONTROLLING
68.	____ x8	BODY DESTRUCTION

GRANDIOSE EXPANSIVENESS (GRN) _____

15.	____	SUPERIORITY
54.	____ x2	VOICES EXTOLL
*64.	____ x8	UNUSUAL POWERS
65.	____ x8	GREAT PERSONALITY
*69.	____ x8	DIVINE MISSION

PERCEPTUAL DISTORTION (PCP) _____

45.	____	HEARS VOICES
*53.	____ x2	VOICES ACCUSE
55.	____ x2	VOICES THREATEN
*56.	____ x2	VOICES ORDER
57.	____ x2	VISIONS
58.	____ x2	OTHER HALLUC.
67.	____ x8	IDEAS OF CHANGE

MORBIDITY SCORES

1. EXC + HOS − RTD = _____
2. PAR + GRN + PCP = _____
3. RTD + DIS + MTR + CNP = _____

ANXIOUS INTROPUNITIVENESS (INP) _____

*14.	____	BLAMES SELF
*21.	____	ANXIETY (SPECIFIC)
24.	____	APPREHENSIVE
27.	____	SELF DEPRECIATING
29.	____	DEPRESSED
31.	____	GUILT
39.	____ x-1	INSIGHT
40.	____	SUICIDAL
41.	____	OBSESSIVE
42.	____	FEARS
66.	____ x8	SINFULNESS
	8	SCORING CONSTANT

RETARDATION AND APATHY (RTD) _____

* 1.	____	SLOWED SPEECH
8.	____	LACK OF GOALS
13.	____	FIXED FACIES
*16.	____	SLOWED MOVEMENTS
19.	____	MEMORY DEFICIT
22.	____	SPEECH BLOCKING
23.	____	APATHY
33.	____	WHISPERED SPEECH
38.	____	FAILURE TO ANSWER

DISORIENTATION (DIS) _____

70.	____ x-1	HOSPITAL
*71.	____ x-1	STATE
72.	____ x-1	KNOWS NO ONE
73.	____ x-1	SEASON
74.	____ x-1	YEAR
*75.	____ x-1	AGE
	6	SCORING CONSTANT

MOTOR DISTURBANCES (MTR) _____

* 6.	____	POSTURING
10.	____	TENSION
30.	____	SLOVENLY
46.	____ x2	GIGGLING
*47.	____ x2	GRIMACING
48.	____ x2	REPET. MOVEMENTS
51.	____ x2	TALKS TO SELF
52.	____ x2	STARTLED GLANCES

CONCEPTUAL DISORGANIZATION (CNP) _____

* 2.	____	IRRELEVANT
* 3.	____	INCOHERENT
4.	____	RAMBLING
49.	____ x2	NEOLOGISMS
50.	____ x2	STEREOTYPY

PATIENT'S NAME _____ CODE # _____

RATER'S NAME _____ DATE OF RATING _____

PROFILE SHEET

IMPS

STANDARD SCORE	EXC	HOS	PAR	GRN	PCP	INP	RTD	DIS	MTR	CNP	STANDARD SCORE
					RAW SCORES (TWO RATERS)						
8.0	104	115		55	68	130	122		81	56	8.0
-	101	112		53	67	127	119		79	55	-
-	98	109		52	65	124	116	8	77	53	-
-	96	106		50	63	121	113		75	52	-
-	93	103	110	49	61	118	110		73	50	-
7.5	90	100	107	47	59	114	107		71	49	7.5
-	88	98	104	46	57	111	104	7	69	47	-
-	85	95	101	44	55	108	101		67	46	-
-	82	92	98	43	53	105	98		66	44	-
-	80	89	94	41	52	102	95		64	43	-
7.0	77	86	91	40	50	99	93	6	62	41	7.0
-	74	83	88	38	48	96	90		60	40	-
-	72	80	85	37	46	92	87		58	38	-
-	69	77	82	35	44	89	84		56	37	-
-	66	75	79	33	42	86	81	5	54	35	-
6.5	63	72	76	32	40	83	78		52	34	6.5
-	61	69	73	30	38	80	75		50	33	-
-	58	66	70	29	37	77	72		48	31	-
-	55	63	67	27	35	74	69	4	46	30	-
-	53	60	64	26	33	71	66		44	28	-
6.0	50	57	61	24	31	67	63		42	27	6.0
-	47	55	58	23	29	64	61		40	25	-
-	45	52	55	21	27	61	57	3	38	24	-
-	42	49	52	20	25	58	55		36	22	-
-	39	46	49	18	24	55	52		34	21	-
5.5	37	43	46	17	22	52	49		32	19	5.5
-	34	40	43	15	20	49	46	2	30	18	-
-	31	37	40	14	18	45	43		28	16	-
-	29	34	37	12	16	42	40		26	15	-
-	26	32	34	10	14	39	37		24	13	-
M 5.0	23	29	31	9	12	36	34	0-1	22	12	5.0 M
-	20	26	28	7	10	33	32		20	11	-
-	18	23	25	6	9	30	29		18	9	-
-	15	20	22	4	7	27	26		16	8	-
-	12	17	19	3	5	24	23		14	6	-
4.5	10	14	16	1	3	20	20		12	5	4.5
-	7	12	13	0	1	17	17		10	3	-
-	4	9	10		0	14	14		8	2	-
-	2	6	7			11	11		6	0	-
-	0	3	4			8	8		4		-
4.0		0	1			5	5		2		4.0
-			0			2	2		0		-
-						0	0				-

* ONLY THE BOTTOM SCORE OF EACH CLASS INTERVAL IS GIVEN. EACH INTERVAL EXTENDS FROM THE GIVEN SCORE UP TO BUT NOT INCLUDING THE NEXT HIGHER SCORE. TO PROFILE, CIRCLE THE PATIENT'S SCORE IN EACH COLUMN AND CONNECT CIRCLES WITH STRAIGHT LINES.