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MUSIC THERAPY ASSESSMENT FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES: A SURVEY STUDY

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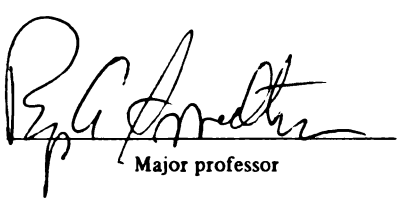

Major professor

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MUSIC THERAPY ASSESSMENT FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES: A SURVEY STUDY

By

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A THESIS

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ABSTRACT

MUSIC THERAPY ASSESSMENT FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES: A SURVEY STUDY

By

Kristen Mei Cole, MT-BC

The purpose of this study was to survey music therapists working with children with developmental disabilities to examine and describe the following: (a) the major skill areas and subcategories most frequently assessed, (b) how these areas are assessed, (c) the common features of their current assessment tools, (d) the positive and/or negative aspects of their current assessment tools, and (e) the three most important features desired in a standardized music therapy assessment for use in their clinical practice. Of the 207 respondents who expressed interest in completing a music therapy assessment survey in a pilot study, 108 surveys were returned for a 52% return rate; 95 (46%) were used as data for this study. The respondents most frequently assessed the following major skill areas: Motor (95%), Communication (83%), Social (79%), Cognitive (64%), and Music (35%). Of the 34 (36%) respondents who enclosed an actual assessment form with their survey, 100% require data collection through behavior observation. Respondents most frequently noted the following positive aspects of their forms: Thorough (34%), Individualized (26%), and Easy to Use (26%), and the following negative aspects of their forms: Subjective (28%), Limiting (26%), and Time Consuming (22%). The 3 most commonly desired features of a standardized assessment were the following: Easy to Use (23%), Comprehensive (19%), and Adaptable (13%).

To A., A., B., M., R., R., and Z. for continuing to inspire my music therapy practice.

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- And, to Nick, who rustled through the bird's nest every day, among other things, without complaint, and kept me on my toes. Now it's time for me to return the favor.

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Chapter 1

INTRODUCTION

The music therapy profession lacks formal assessment tools (Isenberg-Grzeda, 1988; Jones, 1986; Lipe, 1991; Maranto, 1991; Wilson & Smith, 2000; York, 1994). Unfortunately, the profession suffers a lowered respect, approval, and credibility due to a lack of formal tools and the increased use of informally designed music therapy assessment tools (Isenberg-Grzeda, 1988). Because music therapists work in a wide variety of clinical settings, assessments in the profession vary greatly. An assessment used for an older adult nursing home resident would not be appropriate for a child with autism. A music therapist working with a child with cerebral palsy would certainly want to assess gross motor skills, whereas the same therapist may not be as concerned with gross motor skills when assessing an oncology patient. Because music therapists treat clients and patients with a variety of needs, a general assessment tool would be extremely difficult to design and implement. Some authors have suggested the development of assessment instruments for specific diagnostic areas (York, 1994). Due to the lack of population-specific music therapy assessment tools, music therapists often have little choice but to use a tool that may be unfamiliar to them or unsuitable to their population. Some of these tools are outdated and require extensive adaptations and adjustments that often require too much time of the busy music therapy professional.

In the specific population of the developmental disabilities (DD), music therapy assessment research is scarce (Wilson & Smith, 2000). Several clinician-designed assessment tools and processes exist (Boxill, 1985; Brunk & Coleman, 2000; Hintz, 2000; Scalenghe & Murphy, 2000; Wigram, 2000), but almost none have been the subject of

scholarly research. Even more scarce are formal music therapy assessment tools for children with DD (Wilson & Smith, 2000). Many of the articles, including the American Music Therapy Association (AMTA) Standards of Clinical Practice (2000), provide the therapist only with suggested assessment areas, leaving the therapist to create an assessment form and compose music tasks to evaluate the skill areas. With about 11% of music therapists working with clients with DD (Elkins, 2000), more resources for that population and possibly even a standardized assessment form should be accessible.

The number of music therapists working with students with DD in school settings is growing (Chester, Holmberg, Lawrence, & Thurmond, 1999; Smith & Hairston, 1999; Wilson & Smith, 2000). With the official confirmation of music therapy as a related service for Individualized Educational Plans (IEP) (Warlick, 2000) and the increased requests to insurance companies for reimbursement for music therapy services, a standardized assessment for children with DD would help to increase professional integrity, potential referrals, and reimbursement. Grant (1995, in Wilson & Smith, 2000) states that while "there has been a lack of unanimity within the music therapy profession concerning the need for standardization, there is now greater impetus to proceed in this area" (p. 111). Teachers, parents, and other pertinent professionals who request music therapy assessment services, as well as insurance companies who are evaluating services for reimbursement, should receive a completed form that is valid (Rider, 1981) and comparable to other therapeutic assessment tools (Jones, 1986). Other professions, such as physical therapy, occupational therapy and speech therapy, have all given attention to the standardization of assessment tools, but music therapy has not.

The concept for this study was born from a combination of expressed needs of

music therapists working with children with DD, as evidenced in several recent research articles, round-table discussions, and national conference meetings, and an emerging interest of the researcher. The timeliness of this research study is confirmed by an investigation by Wilson and Smith (2000). In their study, the authors note the growth in numbers of music therapy service providers in school settings, suggesting the increased need for investigation into the development of a standardized music therapy assessment tool. Also, they note a lack of availability of the "titled" or "model" assessment tools for music therapists and a clear paucity in research concerning these tools. Based on the results of their study, the researchers suggest that there is a need for additional research in music therapy assessment and continued development and design of music therapy assessment tools.

Purpose

The purpose of this study was to survey music therapists working with children with DD to examine and describe the following: (a) the major skill areas and subcategories most frequently assessed, (b) how these areas are assessed, (c) the common features of their current assessment tools, (d) the positive and/or negative aspects of their current assessment tools, and (e) the three most important features desired in a standardized music therapy assessment for use in their clinical practice. In addition, the researcher hopes that the results of the survey will provide information for use in the development of a formal music therapy assessment tool for children with DD and create increased dialogue regarding standardized music therapy assessment tools.

Definitions

For the purpose of this study, "children with developmental disabilities" was

defined as "persons age 0-17 who have failed to progress at a normal rate in at least one of the following areas: (a) motor skills, (b) adaptive skills, (c) communication skills, (d) cognitive skills, and (e) social skills" (Boxill, 1985, p. 29) and/or have been labeled or diagnosed by a medical doctor as having "autism, mental retardation, and sensory/motor/physical/cognitive impairments" (Elkins, 2000, p. 28).

In addition, a "music therapy assessment tool" was defined as "any music-based evaluation of a child's psychological, educational, social, behavioral, physiological, or musical functioning completed prior to the delivery of music therapy or other services/interventions" (Wilson & Smith, 2000, p. 99) and or "any evaluative measure where the response to a music-based stimulus or question was a major determinant for measuring the success of a later intervention" (Wilson & Smith, 2000, p. 99).

Chapter 2

REVIEW OF LITERATURE

While much of the past 30 years of music therapy literature has included the topic of music therapy assessment tools, few research studies, including those specific to children with DD, have been published. Although research studies in the area of music therapy assessment tools are lacking, book chapters and literature reviews focusing on general assessment guidelines and specific implications for DD provide helpful insight into assessment development, design, and implementation.

Assessment Development Guidelines

Through their own clinical experiences and literature reviews, music therapy clinicians have formulated specific guidelines for assessment creation and implementation. Isenberg-Grzeda (1988) noted four considerations that not only affect the choice of the assessment and what the therapist assesses, but the way the assessment and responses are interpreted. First, she suggests considering a population-specific assessment and making certain the assessment meets the demands and requirements of the therapist's treatment facility. Additionally, she states that the therapist's personal relationship with music and the therapist's philosophy of life will have a great effect on the assessment choice.

Bruscia (1988) lists seven criteria needed for a clinically effective assessment. The assessment should contain clear objectives and be conducted by a qualified therapist. The tool should be unique, and should employ effective methods of data collection. The assessment should produce reliable data that will help lead to valid conclusions. Adherence to ethical standards should always be incorporated.

Along with having guidelines for construction of the assessment form and

implementation of the process, the AMTA Standards of Clinical Practice (2000) state that music therapy assessments are required to address these following areas of functioning: psychological, cognitive, communication, social, physiological, and musical.

Davis, Gfeller, and Thaut (1992) list the following nine skill areas that are evaluated by interdisciplinary team assessments and should be considered in music therapy assessments: medical, cognitive, social, physical, vocational/education, emotional, communication, family, and leisure skills.

Hanser (2000) suggests that therapists consider several criteria before beginning a formal evaluation. First, therapists should consider assessing cognitive skills, sensory-motor development, music skills, and social/emotional behavior. Second, therapists should refer to other assessments that might have already been completed on the client by other therapy professionals. Third, the measuring device should be efficient and easy to implement. Finally, the therapist should consider how the skills will be measured and within what context the skills will be examined.

Assessment Tools: General Music Therapy

A limited amount of research has been conducted using researcher-created music therapy assessments with clients in educational, psychiatric, and geriatric settings.

Rider (1981) designed a music therapy assessment based on the visual assessment tasks devised by Jean Piaget and developed 15 auditory music tasks that involved Piagetian developmental concepts such as mental imagery, seriation, class inclusion, and conservation. The researcher administered the test to typical preschool and elementary age children (n=109). The two statistics yielded by the Guttman scalogram analysis, reproducibility (R=.981) and scalability (S=.901), demonstrated that Musical-Perception

Assessment of Cognitive Development (M-PACD) is reliable as a developmental scale. In addition, the Kendall rank correlation coefficient yielded a significant ($p<.0001$) correlation between age and developmental level. Rider noted that the M-PACD should be tested with children with disabilities, as his research only studied typical children.

Jones (1986) decided to use Rider's M-PACD with students with mental retardation ($n=20$). Due to the lack of available subjects, they were not randomly selected. All students were diagnosed using the Stanford-Binet Intelligence Scale as either severe, trainable, or educable mentally retarded. M-PACD was administered to each student and the results were analyzed using the Spearman Rank-Order correlation. The researcher found a significant ($p<.001$) relationship between the developmental order manifested by mentally retarded and non-handicapped students. In addition, the Pearson Product-Moment Correlation yielded a significant ($p<.01$) correlation between the number of tasks mastered by each student and his or her mental and chronological age. While the results indicate that M-PACD could be used as a tool for assessing cognitive development, the limitation of subject selection, the use of two-part verbal cues instead of the suggested one-part command, and the subjects' preference for prompting of tasks indicate that some caution should be exercised in generalizing this study. Jones suggested continued research aimed at verifying the validity and reliability of M-PACD.

The Residual Music Skills Test (RMST) for persons with Alzheimer's disease is another music therapist designed and researched assessment tool. York (1994) designed this tool based on items that would reflect active and receptive musical tasks that might be encountered in a music therapy session and items that would correspond to similar, nonmusical items contained in the Mini Mental State Examination (MMSE). In addition,

the RMST tasks were compared to the National Assessment of Educational Progress and the rhythm subset of the Luria-Nebraska Neuropsychological Battery. After a pilot study was completed and revisions were made, the finalized RMST and the MMSE were administered to subjects with a probable diagnosis of Alzheimer's disease (n=37). Subjects with a past history of formal or informal music training, education below the eighth grade level, or visual or hearing impairments were excluded. In addition to the experimenter, one additional rater was trained in the use and scoring of the test and was present during the experimenter administration of both the RMST and the MMSE. Interrater reliability was .96 for the RMST and .98 for the MMSE. A pattern of stronger correlations was identified between items that required singing in the RMST. In addition, language subscores of the RMST and the MMSE were also highly correlated, and correlations between total scores of the tests (r =.61) suggest that the RMST may be measuring unique cognitive functions not covered by the MMSE. The experimenter states that based on the results, the RMST is an improvement over existing qualitative behavioral assessments currently used in nursing homes and adult day care facilities because its reliability and validity can be determined. The test needs further research, specifically with a larger sample size and with comparisons of normal control groups and patients with cognitive impairments.

Similar to York's study of persons with Alzheimer's disease, Lipe (1995) focused on the use of music performance tasks in the assessment of cognitive functioning of older adults with dementia. The subjects were women (n=37) aged 57-99 years who resided in a nursing home or attended an adult day care center. The researcher administered the MMSE, the Severe Impairment Battery (SIB) and 19 specially designed music

performance tasks, while the social worker at the nursing home and a nurse at the adult day care center administered the Brief Cognitive Rating Scale (BCRS). Two senior music therapy students along with the researcher were raters. Interrater reliability was .92. Pearson's Product-Moment Correlation indicated strong relationships between cognitive and music task performance, and the music performance tasks were found to be consistent with the other tests. The researcher states that the results of this study and of York's (1994) study indicate the possibility of quantifying music task performance with reliability and validity.

Wells (1988) discussed the individual music therapy assessment procedure that she used with emotionally disturbed adolescents. The assessment contains three tasks: (a) song choice: the client chooses and sings songs from a pre-organized list that describes him or her, (b) story of music: the client writes a story to his/her choice of four classical music titles, and (c) instrumental improvisation: the client explores different instruments, chooses an instrument that best describes him or herself, improvises with the therapist, chooses an instrument for each family member, and then improvises again or sings a chosen song with the therapist. Each task lists several areas of assessment with asset and deficit items based on his/her response to the task. The author demonstrated the implementation process of the assessment through a case example of a 12-year-old male with oppositional disorder and borderline personality disorder. The author suggested that this assessment is effective in providing projective and diagnostic data and determining client suitability for music therapy services.

Cassity and Theobold (1990), interested in assessments and treatments employed by music therapists working with clients involved with domestic violence, sent out an

initial letter of inquiry and a participation form to all (n=2,564) registered, active, and certified music therapists recorded by the National Association for Music Therapy (NAMT) and American Association for Music Therapy (AAMT). Eighty music therapists responded to the letter, agreed to participate in the survey, and completed and returned the questionnaire. The survey was constructed based on the NAMT [now AMTA] Standards of Clinical Practice (AMTA, 2000), and an assessment model created by Lazarus (1976, in Cassity & Theobold, 1990). The questions sought to identify areas most frequently addressed in assessment and treatment. The validity of the survey was determined by a panel of five music therapists and five domestic violence counselors. Descriptive statistics revealed that behavior, affect, and music behaviors were assessed by 100% of the respondents. In respondents working with battered women, "imagery" (86.96%), "cognitive" (82.61%), "interpersonal" (86.96%), "drug problems" (73.91%), and "physical well being" (73.91%) were also assessed. The researchers used this information to operationally define music therapy as used with domestic violence clients in terms of what was being assessed and what procedures were being implemented. The researchers encouraged others to do the same for other disability areas. Because "speech" was assessed by a minority of the respondents, the researchers recommended additional research into the relative importance of speech in the AMTA Standards of Clinical Practice (AMTA, 2000).

In order to define and measure the common body of knowledge relating to psychiatric music therapy assessment and treatment, Cassity and Cassity (1994) conducted a survey study of 100 music therapy clinical training directors in psychiatric settings. The survey was constructed based on reviews of literature in the area of psychiatric treatment,

music therapy, and assessment. The questions sought to identify areas most frequently addressed in music therapy assessment. A panel of five Registered Music Therapists employed as clinical training directors in psychiatric settings evaluated the surveys. The respondents (n=65) rated "observation of patient's non-music behavior" as most important for adults, "interpersonal relationships" as most important for adolescents, and "concentration," "attention span," and "retention" as most important for children. In addition, 72% of all surveyed believed that a standardized music therapy assessment was needed, and 92% believed that a psychiatric music therapy treatment manual was needed. The researchers stated that a common body of knowledge exists in psychiatric music therapy and encouraged others to use these results to design a standardized assessment form.

Assessment Tools: Developmental Disabilities

Based on their review of literature in developmental disabilities, Cohen, Auerbach, and Katz (1978) posed five dilemmas that are faced by music therapists who assess children with DD. The first is whether the therapist should try to obtain a totality of significant information or settle for a portion of the whole. Second, the therapist may have to adjust assessment procedures for each client, due to the variation in functioning levels. The third dilemma concerns the procedures used by the therapist in the assessment. The therapist must decide whether to rely on tests and measurements, rating forms, and other data gathering devices or to create his/her original assessment form and method. The fourth dilemma involves the impracticality of the assessment, and questions whether the music therapist can feasibly complete a long assessment for each client. Finally, the therapist's competency, attitudes, and philosophy all must be taken into consideration.

Without giving a specific assessment example, the authors generally suggested that the assessment must incorporate all aspects of the person's functioning relative to music response and musical activity, and the assessment primarily should be concerned with whether music should be the modality of choice for the client. Also, the assessment should be broad based to include a wide range of functioning levels and should be formalized and systematized.

Cohen and Gericke (1972) designed a music therapy assessment form based on their experience with clients with DD. They discussed the different types of assessments, areas of functioning that should be assessed, and how the therapist should go about assessing the client. While this article contains good suggestions, the material is outdated and the form is too general to be applied to any specific population. Many adjustments would be required to meet the needs of today's music therapists.

Griggs-Drane and Wheeler (1997) discussed the use of functional assessment in music therapy treatment with clients with autism, specifically with an adolescent female who was challenged by a severe mental impairment, autism, and blindness. The authors stated that functional assessment enables the music therapist to accurately assess environmental, transitional, and musical intervention issues. The senior author examined the functional assessment completed by the special education supervisor on the above-mentioned client in order to see a clear picture of the client's behaviors. A music therapy clinical student then completed a functional assessment in the music setting in order to note any attending and behavioral changes that occurred and indicated these behaviors on a scatter plot. The assessment then continued throughout the semester, with the student recording the occurrence and nonoccurrence of behaviors during the music therapy

sessions. At the end of the year, the scatter plot showed that aggressive behaviors were noticeably lower during music therapy. The authors concluded that functional assessment effectively evaluates the impact the music has on the client and clearly indicates which musical styles are most reinforcing of positive behavior.

Boxill (1985) has written about all facets of music therapy with this population and designed a sample assessment for children with DD. Her lengthy assessment chapter emphasized the need for therapist knowledge of the tests commonly administered to clients, the various approaches to assessment, normal and abnormal development in adaptive, motoric, communicative, cognitive, affective and social functioning, and musical characteristics attributed to developmental and maturational stages. In Boxill's experience, the music therapist must have a complete knowledge of normal developmental behaviors in the many assessment areas in order to fully assess the client. She included several helpful tables showing normal developmental milestones for motor skills, language skills, social skills, and cognitive skills. Most pertinent, she provided the reader with an actual assessment form, treatment goals and objectives, and music tasks for each section of the assessment. In addition, she included a treatment plan form, a progress report form, and an annual evaluation form. Although her book is now fifteen years old, the information and forms she provided are still appropriate for practice today.

Cassity (1985) conducted a survey of music therapists (n=192) that were identified as working with trainable mentally retarded (TMR) children to determine: (a) the adaptive behaviors most frequently assessed, (b) the music activities most frequently utilized to assess the behaviors, (c) the music behaviors most frequently assessed, and (d) music activities most frequently used to assess the music behaviors. Additional questions focused

on the involvement of music therapists in the initial assessment of TMR children, the use of assessment in program planning, and the opinions of music therapists regarding assessment. Music therapists were also asked to return the survey with a copy of their current assessment tool. The researcher found that the most frequent adaptive behavior categories were communication skills, sensory-motor skills, and social skills. The most frequent music behavior categories were reflexive behaviors (moving head toward sound, etc.), nonlocomotor movement and locomotor movement, singing, and listening. Specific music activities for assessing the behaviors included singing, rhythmic movement, music instruments, and music listening. The researcher then used the responses to create guidelines for a common music therapy assessment tool for TMR children.

Wilson and Smith (2000) examined literature from 1980-1997 regarding music therapy assessment in school settings. This study was conducted in response to music therapists' requests for information relating to the availability of music therapy assessments and the feasibility of a standardized assessment tool. The researchers used three different online data bases (ERIC, PsychINFO, and Article 1st) and hand searched Arts in Psychotherapy, Journal of Music Therapy, Journal of Research in Music Education, Journal of the International Association of Music for the Handicapped, Music Therapy, and Music Therapy Perspectives to answer five research questions. For the purpose of the study, assessment was defined as "any music-based evaluation of a child's psychological, educational, social, behavioral, physiological, or musical functioning completed prior to the delivery of music therapy or other services/interventions" (Wilson & Smith, 2000, p. 99). The researchers found little commonality in assessment tools being used. Using descriptive statistics, the researchers found that of the 41 studies reviewed,

only 20 reported using a "named" or "titled" assessment tool, while 21 reported using an untitled, experimenter-designed, original assessment tool. In addition, little replication of existing assessments was found. Out of 16 "titled" assessments, only 3 were found in more than one research study, and only 3 of the 20 studies using "titled" assessments actually published a copy of their assessment with the study; only 6 of the 21 remaining studies published the assessment tool. The authors also found that most assessments (39%) compared data obtained from other assessment measures or from other populations. The musical element being assessed most frequently was music perception, and the most frequent nonmusical elements included self-expression (10%), motor responses (10%), and behavior responses (7%). The most frequent population assessed in the studies was children with developmental disabilities (44%). The authors noted the increase in number of music therapy service providers in school settings, suggesting the increased need for research in music therapy assessment and the development of a standardized music therapy assessment tool for music therapists working in school settings.

Pilot Study

In order to collect demographic information to assist in the development of the survey for this study and to discover the interest in completing a survey on music therapy assessment practices, 593 degree-holding, registered (RMT and CMT) or board-certified (MT-BC) music therapists recorded in the 2000/2001 AMTA Member Database as working with clients with DD were selected to receive an initial letter and participation survey. The researcher purchased mailing labels from AMTA for all the music therapists listed in the database as of March 1, 2001.

The participation survey (see Appendix B) was designed to obtain general

demographic information, such as age of clients, years worked, highest degree level, work setting and clinical context, assessment source, and interest in completing a survey on music therapy assessment practices. The survey questions were then created to address the aforementioned areas of interest in a format that would take a small amount of time to answer. The completed survey was examined by two music therapy professors, one music education professor, and one special education professor at Michigan State University to check for clarity, and small changes were made by the researcher before mailing them to the respondents.

The researcher first received permission to conduct this study from the Michigan State University Committee on Research Involving Human Subjects (UCRIHS). Then, an initial cover letter similar to a letter sent by Cassity (1985), a participation survey (see Appendix A and B), and a self-addressed stamped envelope were sent to each of the respondents. The respondents were asked to complete and return the survey by April 10, 2001, allowing three weeks for survey return. Five days after the deadline for returning the survey, the responses were separated from the identifying information to ensure confidentiality, and the data was analyzed. Because this researcher was concerned with the responses from music therapists working with children with DD, the respondents who worked only with adults with DD were asked to answer the first question and then return the rest of the survey uncompleted. The participation surveys were correspondingly numbered with a copy of the address labels to account for those who had returned their survey, because those respondents who worked only with adults with DD or those who chose not to participate in the study were not asked to include their name and address. All data was kept in a secure area accessed only by the researcher.

A total of 364 surveys were returned for a return rate of 61%. Four surveys were returned to sender due to incorrect addresses on the labels and 4 surveys were returned uncompleted. The data collected in the pilot study represented 356 surveys. In accordance with the participation survey questions, the researcher found the following information regarding music therapists working with clients with DD:

1. What is the age of the respondents' current clients with DD? Of the 356 responses, 246 (69%) work with children in some capacity while 84 (24%) work with adults only. Also, 17 (5%) no longer work with clients with DD, and 10 (2%) are not working as music therapists.

2. What are the client populations assessed and treated outside of DD? Of the 246 respondents that work with children, 39 (16%) work with children and adults with DD along with other adult and children populations outside of DD, and 12 (5%) work only with children with DD along with other adult and children populations outside of DD. The researcher categorized the responses into the following five major "other" categories: psychiatry, medical, geriatrics, other DD, and other (see Table 1).

Table 1

Other Populations Listed by Music Therapists Working with Children with Developmental Disabilities (n=53)

Population	#	%
Psychiatry (includes Substance Abuse, Dual Diagnosis, Behavior disorders, Attention Deficit Hyperactivity disorder, Oppositional Defiance disorder)	30	57
Medical (includes Cancer, Terminal Illness, Hospice, Oncology Chronic Pain, Cervovascular Accident, Traumatic Brain Injury, Physical Disabilities, Visual Impairments)	20	38
Geriatrics (includes Geriatric Psychiatry and Alzheimer's Disease)	17	32
Other Developmental Disabilities (Retts Syndrome, Cerebral Palsy)	3	6
Other (Typical Children)	2	4

Note: Some respondents work with more than one *other* population.

3. How many years have the respondents worked as music therapists? Of the 246 respondents that work with children, 91 (37%) have worked for 12 or more years, followed by 47 (19%) who have worked for 3-5 years, 42 (17%) who have worked for 0-2 years, 37 (15%) who have worked for 9-11 years, and 29 (12%) who have worked for 6-8 years.

4. What are their highest degrees earned? Of the 246 respondents working with children with DD, 139 (57%) practice with bachelor's degrees and 107 (43%) practice with a master's degree or higher.

5. What are their graduate degree titles? The researcher organized the graduate degree titles into the following 7 categories: advanced music therapy (including any degree with music therapy as the emphasis), special education, general education, related, music,

no title given, and unsure of title (See Table 2). Of the 148 respondents with academic work above a master's degree, 61 (41%) are currently taking classes towards or have completed a degree in advanced music therapy.

Table 2

Concentration Areas of Advanced Degrees for Music Therapists working with Children with Developmental Disabilities
(n=128)

Degree Area (Masters and Doctorate in progress and completed)	#	%
Advanced Music Therapy: Any degrees with Music Therapy as the Emphasis (i.e.: Master's of Music Education in Music Therapy, Masters of Music in Music Therapy, Master's of Creative Arts Therapy/Music Therapy etc.)	61	48
Special Education: Any degrees with Special Education as the Emphasis	21	16
Related: Any degrees with a related emphasis, such as Psychology, Counseling, Health Administration, Speech and Language Pathology	21	16
No Title Given	18	14
Music: Any degree with an emphasis on Music other than Music Therapy	14	11
General Education: Any degrees with General Education as the Emphasis	10	8
Unsure of Title	2	2

Note: Some respondents have more than one master's degrees and also were choosing between two degrees

6. Where are they currently employed? A total of 106 (43%) of the music therapists who with children with DD work in public schools (see Table 3). The data represents multiple responses from some of the respondents as many work in more than one clinical setting. Respondents in all the years-worked categories worked most frequently in public schools except those who have worked 6-8 years; they work most in the client's home. Places of employment indicated as "other" by the respondents included the following: private practice office, day treatment clinic, early childhood center, community settings, music therapy center, daycare center, music therapy clinic, parent

support group, childhood development clinic, outreach center, residential treatment center, autism society office, music and art therapy organization, community center, music retailer, vocational settings, state school, 0-3 program at a sheltered workshop, and outpatient clinic.

Table 3

Clinical Work Settings with Children with Developmental Disabilities
(n = 218)

Settings	#	%
Public School	106	49
In Client's Home	64	29
Private School	33	15
Hospital	25	11
In Therapist's Home	22	10
Developmental Center	19	9
Community Music School	12	6
Group Home	3	1

Note: Some respondents work in more than one clinical setting and type of hospital was not specified.

7. What are the context(s) within the work setting(s) of their music therapy services? Of the 246 respondents, 157 (64%) provide music therapy in both individual and group settings (either small, large, or both), 46 (19%) provide only individual sessions, and 43 (17%) provide only group (either small, large, or both) sessions. Small groups were defined as 2-4 clients and large groups contained 5 or more clients. Additional contexts written in the "other" category included the following: mainstreamed classrooms, music therapy consultations, chorus groups, dance groups, bell choirs, regular classrooms, parent/child groups, and family therapy groups.

8. Where did they obtain their assessment? Of the 246 respondents, 115 (47%) use

a self-created assessment tool that was adapted from other sources. Forty-two (17%) obtained their tool from colleagues, 40 (16%) use a self-created original tool, 25 (10%) use a tool from their current workplace, and 18 (7%) use a tool from a book (see Table 4). The researcher noticed that Coleman and Brunk's SEMTAP assessment was mentioned by name 13 times and Boxill's assessment was mentioned by name 1 time.

Table 4

Assessment Source for Music Therapists working with Children with Developmental Disabilities
(n=246)

Assessment Source	#	%
Self Created: adapted from other sources	115	47
Colleague	42	17
Self Created: original	40	16
Current Workplace	25	10
Books	18	7
Internship	11	5
No Formal Assessment	9	4
Undergraduate Program	7	3
Other -- (previous music therapist at workplace; core curriculum goal book; grad school; professor)	5	2
Research Articles	4	2
Former Workplace	3	1
Conferences	3	1

Note: Some respondents chose more than one source for their assessments

9. Do they have an interest in completing a future music therapy assessment survey? Of the 246 respondents working with children with DD in some capacity, 207 expressed an interest in completing a future music therapy assessment survey.

Delimitations

The researcher notes that the subjects may not be representative of the entire population of music therapists working with children with DD. Many graduate students

are also board-certified and active, but may not be listed under the specific disability areas due to their "student membership" status as opposed to "professional membership" status. In addition, membership is not a requirement for practice; some music therapists working with children with DD may not be AMTA members.

Chapter 3

METHOD

Due to the lack of research in music therapy assessment and the expressed need for increased research in a standardized assessment (Wilson & Smith, 2000), the researcher designed a survey to examine the current assessment practices of music therapists working with children with developmental disabilities. The responses from the survey serve as the data in this study, and a coding system and descriptive statistics are used to analyze the responses. Results provide music therapy professionals with helpful and useful information regarding current music therapy assessment practices, in addition to aiding in the future development of a formal music therapy assessment tool.

Respondents

The survey was sent to the music therapists (n=207) working with children with DD in some capacity, and who had responded to the initial letter and participation form sent for the pilot study and expressed an interest in completing a survey on their current assessment process and tool.

Survey Development

The survey (see Appendix C) was constructed to allow the respondents to give descriptive answers regarding their current assessment areas. In Section 1, the researcher stated that the respondents would find 6 lined papers (3 double-sided) for the written responses. On the enclosed sheets, the respondents were asked to state a major assessment area, a subcategory area under that major area, and then an explanation of the tasks used to assess that area. Sample answers were provided to assist the respondents in understanding the process. Respondents were asked to be clear and descriptive in their

responses, and permission was given to duplicate the six sheets if necessary or to type/handwrite responses on separate papers.

In Section 2, the researcher instructed the respondents to enclose a copy of their current assessment tools if they used a hard-copy, unpublished assessment tool. Respondents who used a published form were asked to note the name and author of the tool. The respondents also were asked to discuss briefly the positive and negative aspects of their current assessment tools, and list what would be the three most important features of a standardized music therapy assessment form for children with developmental disabilities for use in their clinical practice. If the respondents did not feel a standardized assessment would be feasible, they were asked to discuss the reasons for this in the lines provided. Finally, respondents interested in receiving a copy of the results were asked to write their names and addresses on the provided lines.

A panel of three experts in survey design and/or developmental disabilities served as judges to determine clarity of the instructions, the ease with which the responses could be provided in the space allowed, and how well the survey addressed the topic (assessment procedures). The panel members consisted of Dr. Michael Cassity, Professor of Music Therapy at Southwestern Oklahoma State University, Dr. Cynthia Taggart, Associate Professor of Music Education at Michigan State University, and Mr. Roger Smeltekop, Associate Professor of Music Therapy at Michigan State University. In addition, a copy of the survey was sent to an independent reader who was not on the AMTA member list, but was a practicing music therapist working with children with DD. This reader completed the actual survey and e-mailed comments to the researcher. After making minor adjustments, the survey was mailed to the respondents.

Procedure

The researcher received permission to conduct the pilot study and this current study from the Michigan State University Committee on Research Involving Human Subjects (UCRIHS). Then, the researcher sent a cover letter (see Appendix D), two consent forms (see Appendix E), a copy of the survey, a large self-addressed stamped envelope, and a one-dollar bill (for incentive and extra postage) on June 18 and 19, 2001. The cover letter thanked the respondents for returning the participation survey and expressing interest in participation in this current survey study. Also, the respondents were instructed to keep one consent form for their records and mail back a signed one with the completed survey. The cover letter also instructed the respondents to give detailed and descriptive information about their assessment processes and to complete the survey even if they did not use specific assessment tools or forms.

The surveys were correspondingly numbered with a copy of the address labels to account for those who had returned their surveys, because the researcher needed to send out follow-up emails to those respondents who had not returned their survey by the deadline (July 6, 2001). Because the postage was difficult to predict due to variability in the possible number of pages returned in both the survey and possible assessment forms, the researcher placed a 76-cent stamp on the self-addressed stamped envelope and enclosed a one-dollar bill. The researcher also placed a label on the outside of the self-addressed stamped envelope near the envelope lip to remind the respondents to enclose a consent form, survey, and assessment tool if necessary.

On July 1, 2001, the researcher decided to send out a follow-up email to all 207 original survey participants, which included a thank-you to those who had completed their

surveys, and a notice to those who had not, instructing them that the deadline had been extended to July 31 to accommodate busy summer schedules. Finally, on August, 1, 2001, the researcher sent a final follow-up notice, again thanking those who had completed their surveys, and instructing those who had not to please return their surveys by August 15, 2001. In addition, the researcher asked anyone who had not received a survey or had misplaced it to reply to the email and request that another one be sent.

Data Analysis

After August 15, 2001, the researcher began by examining overall return rate in both frequency and percentage. The researcher then examined the surveys to determine whether the data was usable for this study. From this point, the survey responses are referred to by Section 1 and Section 2. In Section 1, respondents were asked to describe name the major and subcategory areas they assess and describe their assessment process. For Section 2, respondents were asked to respond to three questions. In Questions 1 and 2 respectively, respondents wrote the title of their assessment if they had one and the positive and/or negative aspects of their assessment forms. In Question 3, respondents were asked to list the three most important features of a standardized music therapy assessment tool for use in their clinical practice.

First, Section 1 data was analyzed. Using large and small note cards for major and subcategory skill areas, respectively, the researcher analyzed each survey according to frequency, by writing the respondent's survey number on the corresponding major and subcategory note card. This process was then repeated for each major and subcategory area. After this process was completed, the researcher used colored pencils to mark certain subcategory areas within a major category that had identical task explanations but

different names. Then, the assessment tasks were analyzed for common themes and listed under each subcategory area according to frequency. Specific music examples were listed under each assessment task.

Next, the information in Section 2 was analyzed in 2 parts. In Part 1, the researcher tabulated the number of respondents who had enclosed their actual assessment forms and tabulated and compiled the number and names of the "titled" assessments. Then, using 10 criteria for analyzing the specific features of assessment forms from Cassity (1985), the researcher examined the specific features of the untitled assessment forms according to frequency.

In Part 2, the researcher examined the responses to Questions 2 and 3. To complete this process, the researcher used note cards to compile the respondents' positive and negative aspects of their current assessments and then used colored pencils to code the data for common themes according to frequency. Finally, the researcher repeated this process with respondents' three most important features of a standardized assessment in their clinical practice.

Chapter 4

RESULTS

Return Rate

The surveys were mailed to 207 music therapists who had indicated interest in completing a future music therapy assessment survey on a previously mailed participation survey. Of the total number of music therapists identified, 108 returned the surveys for a 52% return rate. Of that number, 6 surveys were unusable due to gross completion errors, and 7 surveys were returned not completed but accompanied by notes and emails from respondents stating that they had not done music therapy assessments recently, or did not implement music therapy assessments due to their job situation. Ninety-five surveys (46%) were used as data for this study. Considering the amount of time and detail needed to complete this survey, the final return rate was deemed appropriate.

Section 1

Of the 95 usable responses, 80 responses (84%) were used as data for Section 1. Six respondents who use the Special Education Music Therapy Assessment Process (SEMTAP) (Brunk and Coleman, 1999) and an adapted SEMTAP process did not include their assessment process, and nine respondents did not accurately complete this section of their survey. Tables 5-13 show all related subcategories and task explanations for each major skill area. The data represent multiple subcategories under each major skill area and multiple task explanations under each subcategory area. The data are presented using the following code: (a) N = total number of respondents, (b) n = specific number of therapists responding to that subcategory or task explanation, and (c) % = n of N.

Of the 80 responses, 76 (95%) listed Motor as a major skill area. Other names for

Motor included the following: (a) Sensori-motor, (b) Physio-motor, (c) Physical, (d) Perceptual/Motor, (e) Fine Motor, and (f) Gross Motor. The two most common subcategory areas under Motor were Fine Motor Skills (92%) and Gross Motor Skills (91%). Tactile Sensitivity was the next most common, with only 6 (9%) of the respondents listing it as a subcategory.

Respondents most commonly asked clients to grasp and play rhythm instruments (66%), strum the guitar and/or autoharp with a pick or fingers (43%), and play the keyboard (39%) in order to assess Fine Motor Skills. In assessing Gross Motor Skills, respondents most commonly asked clients to imitate and perform basic motions/movements using upper and lower extremities (72%), followed by reaching for an instrument (23%), and spontaneously and creatively moving (16%).

The researcher found that 24 (32%) of the respondents listed Sensory subcategories, such as Tactile Sensitivity, Auditory Tracking, Visual Tracking, Sensory Functioning, and Perception under the Motor skill area. Also, 2 respondents listed Oral Motor under the Motor skill area.

The second most common major skill area was Communication (N=80; n=66; 83%). Other names for Communication included the following: (a) Vocal Expression, (b) Vocalizations, (c) Speech Production, (d) Expressive Language, (e) Language, (f) Language Development, and (g) Verbal Skills. The three most common subcategories were Expressive Language/Verbal Skills (89%), Receptive Language (53%), and Non-Verbal Communication (21%).

Respondents most commonly asked clients to verbalize choices of an activity/instrument/song (39%), fill-in-the-blank of a pre-existing song (36%), and answer

questions (20%) in order to assess Expressive Language. In order to assess Receptive Language, the respondents most often assess the client's ability to follow directions (83%), identify pictures/objects (23%), and respond to their names in a song (14%). Non-Verbal Communication was assessed by observing the use of gestures (64%), sign language (43%), and props and pictures (21%).

Included in this major skill area as a subcategory were Singing/Vocal Skills (15%) and Eye Contact (5%). Only 7 (11%) respondents listed Vocalizations/Pre-Verbal Skills as a subcategory.

The third most common major skill area was Social (N=80; n=63; 79%). Other names included the following: (a) Behavior, (b) Attentiveness, (c) Social/Emotional Skills, (d) Social/Behavioral Skills, (e) Interpersonal Skills, and (f) Relatedness/Relationship. The three most common subcategories were Peer/Adult Interaction (44%), Attending Skills (37%), and Sharing/Turn-Taking (17%).

Respondents most commonly engaged in imitative, parallel, and/or interactive music-making (39%), passing and sharing instruments (36%), and conversing with others (21%) as means to assess Peer/Adult Interaction. In assessing Attending Skills, respondents observed making and/or maintaining eye contact (61%) and attending to task (48%). In order to assess Sharing/Turn-Taking, the respondents encouraged passing and exchanging instruments (73%) and playing in response to name (18%).

Respondents also included Follows Directions (21%) under this major skill area, in addition to Emotional Expression (6%), Communication Skills (6%), and Interactions with the Environment/Objects (3%).

The fourth most common major skill area was Cognitive (N=80; n=51; 64%).

Other names included the following: (a) Cognitive/Perceptual, (b) Cognitive/Sensory, (c) Cognitive/Academic, and (d) Academic. The three most common subcategory areas were Concepts (63%); Sequencing/Memory (33%), and Auditory Perception/Discrimination (25%).

In order to assess Concepts, respondents most commonly encouraged clients to identify them through prop and picture songs (72%), identify them by pointing (44%), match them on a keyboard (9%). Clients were asked to recall verses of multi-verse songs (59%) and recall melodies, themes, and new songs (29%) to assess Sequencing/Memory. Respondents assessed Auditory Perception/Discrimination by evaluating the client's ability to identify changes in tempo and dynamics (46%) and repeat simple melodies (23%).

Subcategories also listed under Cognitive included, but were not limited to, the following: (a) Attending Skills (20%), (b) Follows Directions (16%), (c) Specific Academic Skills (14%), (d) Spatial Awareness (10%), (e) Sorting (6%), and (f) Self Care (6%).

The fifth most common major skill area was Music (N=80; n=28; 35%). The three most common subcategories were Rhythm/Beat (75%), Melody/Tonal (61%), and Instrument Exploration (32%) and Interest/Preference (32%).

Respondents most commonly assessed Rhythm/Beat by encouraging the client to imitate and match rhythms (71%), keep a steady beat (48%), and adapt to rhythmic changes (24%). Respondents assessed melody/tonal by encouraging the client to match pitches (59%), sing a familiar song (53%), and finish a musical phrase (12%). Instrument Exploration was assessed by allowing the client to choose an instrument and play (89%) and identify instruments by name (33%). Clients' Interest/Preference was assessed by

observing their response to music (67%) and asking them to choose a song or style (56%). The researcher noted that all the subcategories, save ones that only had one response, were original to the Music major skill area and were not listed under any other major skill area.

The sixth most common major skill area was Emotional (N=80; n=13; 16%). Other names included the following: (a) Affect, (b) Psychosocial, and (c) Affective Expression. The three most common subcategories were Identify/Express Feelings (62%), Mood/Affect (38%), and Awareness of Self and Others (23%).

In order to assess Feeling Expression, the respondents most commonly asked clients to identify feelings in the music with words (38%) and with pictures (25%), and play feelings on an instrument (25%). All 5 respondents encouraged clients to display a wide range of affect in order to assess Mood/Affect. Respondents observed client's ability to interact with the therapist (67%) and the music (33%) in assessing Awareness of Self and Others.

The seventh most common major skill area was Sensory (N=80; n=10; 13%). The three most common subcategory areas were Visual (60%), Auditory (60%), and Tactile (60%). Respondents assessed Visual by observing reactions to color and light (50%), abilities to read charts (33%) and track stationary and moving objects (33%). Auditory was assessed by observing reactions to loud and soft (67%) and pitched and non-pitched sounds (50%). Tactile was assessed by the client's ability to tolerate different textures (83%).

The eighth most common major skill area was Adaptive (N=80; n=7; 9%). Other names included the following: (a) Functional Life/Self Help Skills and (b) Daily Living

Skills. The only 2 subcategories were Personal Responsibilities (100%) and Attention (29%). Clients were assessed by their eating and drinking abilities (33%), toileting (14%), and dressing/undressing (14%). Attention was assessed by the client's ability to focus on a given task (100%).

Major skill areas receiving only 1 or 2 responses were as follows: (a) Case History (N=80; n=2; 3%), (b) Impulse Control (N=80; n=1; 1%), (c) Achievement (1), and (d) Mental Awareness (1).

Section 2

Question 1a.

Of the 95 usable responses, 33 (35%) mentioned using a titled assessment. The most commonly mentioned assessment was SEMTAP (n=23; 70%), followed by Boxill (n=5; 15%). See Table 14 for more details.

Table 14
Frequency of Titled Assessments

N=33

Assessment	n	%
SEMTAP	23	70
Boxill	5	15
*Other (Music Therapy)	3	9
**Other (Non-Music Therapy)	2	6

*Other (Music Therapy): Music Therapy Functional Skills Assessment, by Becky Gleasman, Cleveland Music Settlement Music Therapy Assessment Tool, and A Model for Understanding Music Development, by C. Briggs.

**Other (Non-Music Therapy) Battelle Developmental Inventory combined with Music Activities, and Assessment, Evaluation, and Programming System for Infants and Children, by Paul H. Brooks, and Cullier Azusu Scale.

Question 1b.

Of the 95 usable responses, 34 (36%) enclosed an actual assessment form. This tabulation and analysis did not include "titled" assessment forms. However, if the respondent adapted a "titled" assessment process/tool and enclosed the form, then the researcher included this form in the analysis. The researcher chose ten criteria from Cassity's study (1985) to use in the analysis of the enclosed forms. All 34 (100%) assessments collect data by directly observing client's behavior and 33 (97%) of the forms identify the behaviors being assessed. The most common assessment format is a checklist (n=16; 47%), followed by a symbol system (n=9; 26%), and a narrative form (n=8; 24%). Only three (9%) tools provide specific music activities/tasks to be used in the assessment and 2 (6%) tools specify a specific assessment procedure. See Table 15 for more details.

Question 2: What do you feel are the positive and negative aspects of your current assessment tool/process/form?

Of the 95 responses, 84 (88%) gave positive and/or negative aspects of their current assessment forms. Only one respondent did not answer the question, and ten respondents stated that they did not use an assessment tool/process/form because either they saw a large number of clients in a group setting or they didn't have a "formal" assessment to refer to in order to answer the question.

Table 15

Features Relating to the Design of Assessment Tools
Employed by Music Therapists

N=34

Feature		n	%
A.	Examiner collects assessment data by directly observing client's behavior	34	100
B.	Tool identifies specific observable behavior to be assessed	33	97
C.	Tool provides space for the therapist's comments or appraisal of the client's response	28	82
D.	Tool provides a checklist format for recording client responses (i.e. presence-absence, yes-no)	16	47
E.	Tool provides a system of symbols or space for recording client responses (i.e. +/-, circling, letters representing words)	9	26
F.	Tool is in narrative form	8	24
G.	Tool includes a combination of two or more techniques for recording behavior (i.e. rating scale, checklist, narrative, symbols)	8	24
H.	Tool utilizes a rating scale for recording behavior	4	12
I.	Tool provides specific music activities for use in the assessment process	3	9
J.	Tool specifies a specific assessment process	2	6

In reviewing the 84 responses, the researcher found 113 positive aspects and 86 negative aspects. Many respondents wrote more than one positive aspect or negative aspect in their responses. The researcher analyzed the responses and created the following five positive aspect categories, arranged by frequency: (a) Thorough (N=113; n=38; 34%): this category included respondent references to the words "thorough" or "comprehensive," (b) Individualized (N=113; n=29; 26%): this category included respondent references to the word "individualized" or comments highlighting the individual nature of the assessment, (c) Easy to Use (N=113; n=29; 26%): this category included respondent references to the words "easy" and/or "easy to use," in addition to any aspects of the form/process that made it easy to use, (d) Shows Music Therapy Viability (N=113; n=10; 9%): this category included respondent references to the music therapy assessment showing need for services, and (e) Understood by Other Disciplines (N=113; n=7; 7%): this category included respondent references to the music therapy assessment being read and/or understood by professionals in other disciplines.

The researcher also created the following five negative aspect categories, arranged by frequency: (a) Subjective (N=86; n=24; 28%): this category included respondent references to the words "subjective," "not concrete," and/or "biased," (b) Limiting (N=86; n=22; 26%): this category included respondent reference to the word "limiting," or comments regarding not covering enough, (c) Time Consuming (N=86; n=19; 22%): this category included respondent references to the words "takes too much time," "time consuming," or some references to time being a negative factor, (d) Technical Difficulties (N=86; n=14; 16%): this category included respondent references to specific parts of their forms/process that involved the form construction itself or specific requirements in

completing the form/process, and (e) Broad (N=86; n=7; 8%): this category included respondent references to the words "vague" and "broad" and those basic concepts in some capacity. Under each category, the researcher included several sample responses. See Table 16 and 17 for details.

Question 3: What would be the three most important features of a standardized music therapy assessment form for children with developmental disabilities for use in your clinical practice? (If you do not wish to use a standardized assessment form, please state the reasons for your answers on the lines below).

Respondents answered this question in four different ways. First, of the 95 responses, 60 (62%) listed at least one important feature. Second, 13 (14%) listed features according to specific goal areas. Third, 11 (12%) listed features according to what a standardized music therapy assessment would do for the music therapy profession. Finally, 11 (12%) explained why they did not wish to use a standardized assessment tool. The researcher grouped the responses according to the manner in which the respondents answered the question. The question asked for three features. Most of the respondents gave three responses to the question, while others only listed one or two. Sample responses for each direction and subsequent categories are included in Tables 18-21.

Of the 60 respondents listing at least one feature for a standardized assessment, a total of 151 features were grouped by the author into the following nine categories according to frequency: (a) Easy to Use (n=35; 23%): this category included respondent references to the word "easy" and similar meaning words in some capacity, (b) Comprehensive (n=29; 19%): this category included respondent references to the words "thorough" and "comprehensive" and similar meaning words in some capacity,

(c) Adaptable (n=20; 13%): this category included respondent references to the word "adaptable" and similar meaning words in some capacity, (d) Reliable and Valid (n=16; 11%): this category included respondent references to the words "reliable" and "valid" and similar meaning words in some capacity, (e) Efficient (n=15; 10%): this category included respondent references to the word "concise" and similar meaning words in some capacity, (f) Provides Specific Music Therapy Tasks (n=10; 7%): this category included respondent references to activity guides, bibliographies, and lists of activities and songs, (g) Compares Skills With and Without Music (n=10; 7%): this category included respondent references to the concept of comparing skills with and without music, (h) Compares Responses to "Typical" Developmental Scale (n=8; 5%): this category included respondent references to the need to compare skills to a "normal" or "typical" developmental scale, and (i) Provides Goal Areas and Interpretation Guidelines (n=8; 5%): this category included respondent references to "specific goal areas," "specific guidelines," and similar meaning words. See Table 18 for more details.

Of the 13 respondents listing features according to specific goal areas, a total of 37 responses were grouped into the following five categories according to frequency: (a) Motor (n=11; 30%), (b) Communication (n=9; 24%), (c) Social (n=7; 19%), (d) Cognitive (n=5; 14%), and (e) Music (n=5; 14%). See Table 19 for more details.

Table 19

Question 3: Specific Goal Areas for Standardized Music Therapy Assessment

N=37 Responses; 13 Respondents

Goal Area	n	%
Motor	11	30
Communication	9	24
Social	7	19
Cognitive	5	14
Music	5	14

Of the 11 respondents listing features according to what a standardized music therapy assessment would do for the music therapy profession, a total of 13 responses were grouped into the following three categories according to frequency: (a) Continuity Within the Music Therapy Profession (n=5; 38%): this category included respondent references to the words "uniformity," "continuity," and/or "commonality," (b) Justification of Services (n=4; 31%): this category included respondent references to the idea that the assessment form will show the need for music therapy, and (c) Respect from Others (n=4; 31%): this category included respondent references to "credibility," "respect," and other similar meaning words. See Table 20 for more details.

Of the 11 respondents listing why they did not wish to use a standardized music therapy assessment in their current clinical practice, a total of 11 responses were grouped into 1 category: (a) Variance in Clientele (11; 100%): this category included respondent references to the individual needs of each client in some capacity. See Table 21 for details.

Chapter 5

DISCUSSION

The purpose of this study was to examine and describe the assessment practices of music therapists working with children with DD in order to begin to address the needs of clinicians working with this client population. The results suggest some interesting and important findings.

Section 1

Based on the Section 1 results, it appears that music therapists working with children with DD are assessing a wide range of skill areas using music-based tasks, activities, and experiences. The skill areas are mostly congruent with the following AMTA Standards of Clinical Practice for music therapists providing treatment for persons with DD: Motor, Physiological, Social/Emotional, Sensory, Communicative, and Cognitive Functioning. The skill areas reported in this study greatly differ from the following AMTA Standards of Clinical Practice for music therapists conducting assessments with persons with DD: Motor Functioning, Sensory Integrative Functioning, Emotional States, Coping Skills, Infection Control Procedures, and Attending Behaviors.

While the wide range of major skill areas and subcategories could contribute to a comprehensive assessment, the researcher noted a few areas that seemed out of the compass of music therapy treatment. Though only a few respondents mentioned skills such as toileting, and dressing and undressing, to name a few, these might be better assessed by other disciplines. While the knowledge of these skills may be important, music therapists must accommodate practical limitations. Music therapists might consider tailoring their assessments to the needs of each client, understanding that some areas may

not need to be assessed.

In compiling the major skill areas and subcategory areas, the researcher noted the increased number of repeated subcategories in several different major skill areas. Many of the subcategories could easily fit under several different major skill areas. For example, a task or experience that involves following directions could be seen as assessing both receptive language (i.e., Communication) and/or auditory processing (i.e., Cognitive).

The researcher also noted a number of seemingly misplaced subcategories in several different major skill areas. For example, many respondents listed Auditory, Visual, and Tactile Perception under Motor Functioning, while the researcher might have placed those subcategories under Sensory Functioning. Respondents may have had conceptual differences regarding the different major categories, as evidenced by the variety of different "titles" for each category, thus leading to the seeming "misplacements." Also, many music therapists may not fully understand the definitions of each functioning area and which subcategory areas fit under each one.

Only 28 respondents listed "Music" as a major skill area with only 9 listing "Interest/Preference" as a subcategory. Many respondents used "instrument choice" or "song choice" in other categories such as "Communication," "Motor," and "Cognitive," and may have evaluated the client's preference at that time. In addition, respondents might be required to assess specifically "non-musical" goals for Individualized Educational Plans (IEPs) and may not include the skill area of "Music" in their actual assessment, but note their musical responses in relation to "non-musical" areas.

Ten respondents listed "Sensory" as a major skill area. Other respondents noted sensory issues under "Motor" (n=24) while others included them under "Cognitive"

(n=18). Again, the conceptual differences in major skill areas may have affected the number of respondents marking "Sensory" as a major skill area.

No respondents noted multicultural considerations in their assessment of children with DD, nor did music therapists note using "culturally diverse" music in their practice. Respondents may not be working with children from diverse cultures, or they may adapt "typical" songs to fit the needs of their diverse clients. Also, music therapists may not be aware or informed of the role multiculturalism plays in music therapy practice.

Section 2

Question 1

The results regarding the frequency of titled assessments were not surprising, as the results from the pilot study indicated that most respondents used self-created assessment forms.

All the assessments were conducted by collecting observable data. In addition, the most commonly used format was a checklist. This may be because music therapists often complete assessments within single sessions and need something that is quick to fill out. In addition, music therapists may not have the luxury of video taping each session and need something quick and efficient so that they will not forget important observations.

The results relating to the design features of the assessment tools showed that only three tools actually gave specific music activities. As a unique profession that uses music as its treatment medium, it seems the most important aspect of an assessment tool would be the inclusion of examples of how the music is being used to assess the skill areas. On the other hand, the music may be so unique or idiosyncratic to each individual that the music therapists could not "standardize" their music. This may also be why only two tools

outlined a specific process for the user. The process may have to be changed for each client, and the therapist simply needs a loose but fundamental format to follow, rather than a specific process.

Question 2

The respondents had many positive comments to make about their current assessment tools considering the apparent increasing focus on the need for a standardized music therapy assessment. Many respondents stated that their form was individualized; this aspect may not be congruent with the development of a standardized music therapy assessment form. From the overall tone of the positive comments, it appeared that music therapists were satisfied with their current assessment tools.

The negative comments focused on assessments being too subjective and not standardized. In general, the music therapists surveyed do not feel confident in their professional opinions about what they observe and experience in the music therapy session. In contrast to that observation, one respondent stated that the music therapist's professional opinion should be enough.

Another negative aspect was that the assessments were time-consuming. Some music therapists may use several sessions to complete an assessment, while others may need to complete an assessment in one session or within a group setting. One positive aspect of a time-consuming assessment might be that the therapist may have the opportunity to form a relationship with a client before completing an official assessment. Music therapists who work with children with DD may encounter many clients who will not perform well on assessments implemented by someone with whom they have no prior relationship.

A smaller complaint was that the music therapy assessment was too broad. The researcher concludes that due to the wide range of disabilities seen by music therapists working with DD, a music therapy assessment for children with DD may not meet the needs of the great variety of clients within this large disability area.

Question 3

This question was interpreted by the respondents in three different ways. The question may have been more effective if the researcher had given specific examples of the word "feature." Most respondents (n=60; 63%) listed specific features of a standardized assessment tool.

From the comments, it seemed that many respondents would like a standardized form but are not willing to make the compromises necessary to complete such a form. For instance, respondents want a form that is easy to use and efficient but is also comprehensive. If a music therapist must complete an assessment within a music therapy session and produce a written document directly following the session, a comprehensive form may not be feasible. Music therapists may have to negotiate for documentation hours and assessment sessions, like other health professionals are allowed, in order to provide a complete and thorough assessment.

The researcher also observed from the responses that music therapists want a form that is valid. A valid form must be a result of intense scientific testing. As Wilson and Smith (2000) noted in their study, few music therapy assessments have been the object of scientific scrutiny.

Finally, several respondents expressed a desire for a scale or format with which to compare their music observations. Research has been conducted in examining typical

music behaviors of "typical" children to provide music therapists with a developmental scale. The larger questions are, "What does that really tell about the child with the disability?" and "How will that help in planning treatment?" Researchers are still examining the role that music development plays in overall cognitive functioning.

Chapter 6

IMPLICATIONS AND RECOMMENDATIONS

These findings present several implications for clinical practice, music therapy education and research. The results provide music therapists working with similar clients the opportunity to compare and/or affirm their own music therapy assessment processes. Music therapists might find their processes reaffirmed by the similarities of their procedures to those of other music therapists, or they may find new skill areas to add to their assessments. In addition, many respondents included specific music examples, which might assist new music therapists who need ideas or more seasoned music therapists who need new resources. Also, music therapists need to know what others are doing so that they can refer clients confidently to others for assessments, consultations, and other services. The level of music therapy competency varies greatly and, in order for music therapists to maintain good standing in the professional world, a common level of practice is necessary. These findings show that music therapists working with children with DD are generally using similar tasks, experiences, and assessment practices.

The results suggest that music therapists might consider the role cultural differences can play in the treatment process. With the growing number of clients from diverse cultures seeking music therapy from primarily dominant-culture music therapists, cultural issues should be considered before the assessment and treatment take place. The process might begin by asking the child's parents questions regarding their cultural practices, music preferences, and views of therapy and the treatment process. Therapy is viewed in many different ways, both positively and negatively, and such views could have implications for the music therapist's treatment approach.

The findings may assist AMTA in two ways. First, while the results are congruent with the AMTA Standards of Clinical Practice for music therapists providing treatment for persons with DD, they do not reflect the standards for music therapy assessment for persons with DD. The results suggest a re-evaluation of the assessment sections of the Standards of Clinical Practice. Understanding what music therapists are actually doing in their assessments might assist in defining appropriate assessment standards. Second, an examination of the assessment process will assist the continuing work in insurance reimbursement. Considering that many music therapists who attempt to obtain reimbursement must first complete a music therapy assessment, knowledge of current assessment practices may help those committed to government relations, employment relations, and reimbursement issues.

The results of this study provide implications for music therapy education. The importance of assessment in the treatment process cannot be over- emphasized in music therapy training programs. In order for music therapists to show the need for their services, music therapy assessments must be consistent and well-implemented. Music therapy educators should use these findings to prepare their students better in understanding the major skill areas and how music can be used to assess those areas. In addition, understanding what those responses mean to the client, the therapist, and others involved, is an important part of the assessment process.

These results certainly present an opportunity for the creation of a music therapy assessment tool. Not only do the results show what music therapists are currently assessing and how they are doing it, but they show what music therapists want in an assessment form. Although the definition of a "standardized assessment form" has yet to

be determined, this researcher believes a process could be created for use with specific clients with a specific disability for implementation by therapists from a particular theoretical orientation. Isenberg-Grzeda (1988) states that the therapist's philosophy of treatment and the use of music in therapy are important considerations when constructing a music therapy assessment tool. The music therapist's personal beliefs about the role of music in music therapy and their treatment philosophy greatly influence the decision of what and how to assess. For example, an assessment tool could be created for use by a behaviorally-oriented music therapist with children aged two to six with autism. This assessment might be a valid tool for them to use in their practice if they needed to complete an "official" assessment for Individualized Educational Plan (IEP) or insurance reimbursement purposes. Similar forms could be created for use with persons with other disabilities and by music therapists from particular theoretical backgrounds. Currently, music therapists are creating their own forms and using what was apparently taught in their undergraduate programs and/or internships. This researcher believes that any form that had been a subject of scholarly research with actual clients would be helpful.

Recommendations

Continued focus in the area of music therapy assessment is needed. Researchers might consider conducting a similar research study with other disability areas. Because AMTA surveys its members each year regarding their area of "specialty," access to respondents is readily available. Considering the positive response to this survey, researchers interested in surveying music therapists working with other client populations may find a similar level of interest in participating in such studies. The researcher suggests several considerations for such replication. First, the survey might be more effective if

constructed with the music task examples as the major headings with the major skill areas and subcategories as the subheadings. This way, the respondents could also outline assessment process. Second, a question asking respondents about the context in which their music therapy assessment was completed would be helpful. Also, an additional question on the survey might ask the respondents to define what a standardized assessment meant to them. Finally, the survey might include a question addressing the specific theoretical orientations of the respondents and the role that plays in the choice and implementation of the assessment.

Music therapists might consider conducting an action research project by examining their current assessment tools over time and observing whether they are valid. Considering that most respondents were satisfied with their assessment tool, a scientific examination of such tools would be helpful for other practicing music therapists.

This researcher suggests a study testing the reliability and validity of the Special Education Music Therapy Assessment Process (SEMTAP) (Brunk and Coleman, 1999). Because SEMTAP is the most-used "titled" assessment, researchers might consider making it a subject of scholarly research. The concept of SEMTAP seems quite effective, and while researching such an individualized process may be difficult, this assessment is the closest the music therapy profession has come to creating a standard assessment process.

An interesting and appropriate research study might be to interview experienced music therapists about their assessment processes. Observations and interviews of three or four outstanding music therapists might be helpful in understanding how the needs of music therapists have or have not changed, what they have found to be successful, and

how their experiences have or have not influenced their assessment processes.

A survey of music therapy educators regarding their inclusion of the topic of assessment in undergraduate and graduate music therapy education would be useful. While there are AMTA performance competencies, music therapy educators may emphasize assessment differently from one another and present it in a variety of ways. Also, a similar survey of internship directors would be helpful. Understanding how music therapists are being prepared in assessment will help researchers come closer to creating a viable assessment form.

This study represents an in-depth inquiry into the assessment practices of music therapists working with children with DD. The information obtained will be helpful in creating a future assessment form to be used with children with DD in some capacity, in addition to providing practical assessment applications for music therapy clinicians and educators.

The music therapy profession can only benefit from persistent focus on the music therapy assessment process. Music therapy assessment is often the only means for a music therapist to represent his/her client and the client's relationship and response to the music, as well as to advocate for music therapy services. For a client seeking treatment, the assessment process and tool can be a deciding factor in the approval or denial of services and the difference between an accurate or an inexact portrayal of his/her abilities. For a music therapist seeking credibility, the assessment process and tool can be the link to integrity and professional recognition. Continued inquiry into music therapy assessment and the interpretation and meaning of musical responses will not only assist music therapists in their clinical practices, but will promote continued growth and development

of the music therapy profession.

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TABLES

Table 5

Major Skill Area: Motor (N=80; n=76; 95%)

Alternate Titles: Sensori-motor, Physio-motor, Physical, Perceptual/Motor; Fine Motor; Gross Motor

Subcategory Areas

1.00 Fine Motor Skills (N=76; n=70; 92%)

1.10 Grasp and play different rhythm instruments (N=70; n=46; 66%) (Music examples: Therapist accompanies client on guitar or piano; therapist models the playing of same instrument; therapist sings song that calls for client to play specific instrument; sings "Tingalayo" from L. Birkenshaw Fleming's Come On Everybody Let's Sing to accompany and encourage client; sings Lollipop Song" with drum/mallet; sings" This Old Man" with finger drums; sings "Mr. Sun" while clients play variety of instruments; client chooses instrument and therapist sings "Shake [or the appropriate movement] Shake your instrument (repeated three times) Till the song says STOP;" therapist and client engage in improvisation; therapist plays songs with instrumental interludes to encourage the client to play a variety of instruments).

1.11 Strum guitar and/or autoharp with a pick or with fingers (n=30; 43%) (Music examples: Therapist plays left hand 7th chord and root alternating while client strums or plucks; sings an age appropriate song to accompany client).

1.12 Play keyboard (n=27; 39%)

(Music examples: Improvises on black and white keys; plays one finger song such as "Are You Sleeping?").

1.13 Participate in "finger play" song (n=6; 9%)

(Music examples: Sings "Eeency, Weency Spider").

1.14 Press buttons on a Q-Chord or Omnichord (n=5; 7%)

(Music examples: Sings "You Are My Sunshine" while client presses buttons).

1.15 Point to objects and body parts with finger (n=2; 3%)

1.16 Hold puppets and/or toys (2)

1.17 Use an access switch (2)

1.18 Play the glockenspiel (2)

(Music examples: Therapist creates a pentatonic set-up and improvises a song about them playing the glockenspiel).

1.19 Clap and tap during song (2)

1.20 Turn pages of a songbook (n=1; 1%)

1.21 Use a tape/CD player

2.00 Gross Motor Skills (N=76; n=69; 91%)

(Includes "Motor Imitation")

2.10 Imitate and perform basic motions/movements using upper and lower extremities and trunk through song (N=69; n=50; 72%)

(Music examples: Therapist plays pre-recorded music including the following: The Youngheart Records "We All Live Together" series to

encourage movement, non-vocal music "Slide Whistle Suite"; Therapist uses titled songs including: "If You're Happy and You Know it," "Shake Your Sillies Out," "The Hokey Pokey," "Body Rock" by Greg and Steve, "The Chicken Dance," "Rock-a-my-Soul," "Boa Constrictor," "A Sailor Went to Sea," "When the Spirit says Sing," "Toes are Tapping," "Hot Hot Hot;" "Going to Kentucky," "Twist and Shout," Clap Clap Clap your Hands, "Uh-Huh" by Barry Bernstein, "Oh What a Miracle" by Hap Palmer, "To the Music" by Levin, "Head Shoulders Knees and Toes," "I Walk You Walk, by Janet Jones, "The Grand Duke of York," "The Foot Song" by Laurie Farnan, "Egg Shakin Blues," Let's Everyone Clap Hands with Me," "Cowboy Joe," an acapella song, "Hey Everybody" to "C is for Cookie" by Joe Raposo, "Adventures in Movement" by Dr. Jo Geiger, "Toot tee ta" "all about me" "Let's Make Music Together," "Gimme Ice Cream," "The Turning Song," "The Shaker Egg Song," and "The Body Rock;" therapist plays steady drumbeat and asks client to move to the beat; therapist creates a musical obstacle course).

2.11 Reach for Instrument (n=16; 23%)

(Music examples: Therapist holds guitar high and low and asks client to reach and play; therapist holds a paddle drum and asks client to reach and play; therapist encourages client to stand and reach keyboard; therapist asks client to play cymbals; therapist encourages client to play "hand-over-hand" on the piano).

2.12 Spontaneous/Creative Movement (n=11; 16%)

(Music Examples: Therapist improvises on piano or guitar and encourages client to freely move; therapist plays prerecorded music such as a George Winston CD).

2.13 Structured Dance (n=3; 4%)

(Music Examples: Therapist uses "The Chicken Dance," "The Macarena," "YMCA," Parachute dance, and the Hokey Pokey).

3.00 Tactile Sensitivity N=76; n=6; 9%)

3.10 Respond to touching and holding instruments (N=9; n=3; 50%)

3.11 Respond to vibro-tactile input (n=2; 33%)

(Music Example: Observe client's response to different types of pitches and timbres).

3.12 Explore textured objects

4.00 Auditory Tracking (N=76; n=4; 6%)

4.10 Respond to Sound (N=4; n=4; 100%)

(Music Example: Therapist plays sounds above, behind, and to left and right of client).

4.11 Respond to Name in song

(Music Example: Therapist sings client's name to see if client responds).

5.00 Visual Tracking (N=76; n=4; 6%)

5.10 Look in direction of instrument (N=4; n=3; 75%)

(Music Example: Therapist plays and holds instrument in different place to see if client tracks with eyes).

5.11 Follow fingers on the piano (n=2; 50%)

(Music Example: Therapist asks client to follow color/number stickers on keyboard).

6.00 Hand/Eye Coordination (N=76; n=4; 6%)

6.10 Play instruments (N=4; n= 3; 75%)

(Music Example: Therapist encourages client to play a drum set; therapist encourages client to play a pentatonic set-up xylophone).

6.11 Use props (bean bags, balls, balloons, ribbon sticks) (n=2; 50%)

6.12 Pass instruments

7.00 Sensory Functioning (N=76; n=4; 6%)

7.10 Accept application of deep pressure or light touch during song (N=4; n=2; 50%)

7.11 Bounce on a therapy ball

7.12 Attend to sound played out of sight

8.00 Body Awareness (N=76; n=3; 6%)

8.10 Identify Body Parts in song

8.11 Observe client movement around room

9.00 Perception (N=76; n=3; 6%)

9.10 Play a steady beat with the therapist (N=3; n=2; 67%)

9.11 Play loud and soft with the therapist

9.12 Read musical notes

10.00 Bilateral Dexterity (N=76; n=2; 3%)

10.10 5-finger piano exercises

10.11 Play 2-handed rhythm instrument

11.00 Oral Motor (N=76; n=2; 3%)

- 11.00 Make tongue noises
- 11.11 Listen to vocal quality in speaking and singing
- 11.12 Explore whistles and kazoos
- 11.13 Observe respiratory and breathing

Table 6

Major Skill Area: Communication (N=80; n=66; 83%)

Alternate Titles: Vocal Expression; Vocalizations; Speech Production; Expressive Language; Language; Language Development; Verbal Skills

Subcategory Areas

1.00 Expressive Language/Verbal Skills (N=66; n=59; 89%)

1.10 Verbalize choices of activity/instrument/song (N=59; n=23; 39%)

(Music Examples: Therapist sings "Friends are Special" from Kidsongs Lullaby by Nancy Cassidy and cues client to recall favorite activities; client chooses favorite song and/or instrument; therapist uses Q-Chord or drum machine to keep steady beat and composes a direction song).

1.11 Fill-in-the-Blank (n=21; 36%)

(Music Examples: Therapist sings "She'll be Coming Around the Mountain" or "Cotton Needs a Picking" and ask client to fill in parts of the song; therapist uses hello and goodbye songs or songs with instrumental interludes that allow for client to fill in the blank both verbally and instrumentally; therapist sings "Home on the Range" or "Wheels on the Bus" while playing guitar or omnichord; Therapist sings "Twinkle, Twinkle Little Star).

1.12 Answer Questions (n=12; 20%)

(Music Examples: Therapist incorporates questions into the song; therapist asks client about their music interests; therapist asks "wh" questions through song).

1.13 Songwriting (n=10; 17%)

(Music Examples: Therapist sings songs that client can suggest words such as "Mama's Taking us to the Zoo," "What Can We Do on a Rainy Day?;" therapist uses client's spontaneous words as a basis of an improvised song; therapist sings "Everybody Loves Saturday Night" and "What Can You Do in the Fall Time?;" therapist works with client to write songs about important aspects in their life, their feelings, and/or original thoughts).

1.14 Engage in Conversation (n=9; 15%)

(Music Examples: Therapist uses "Wheels on the Bus" with an interactive book; therapist encourages client to talk about him/herself; therapist encourages client to discuss his/her music therapy expectations).

1.15 Singing (n=8; 14%)

(Music Examples: Client chooses song to sing with therapist; therapist plays familiar songs and encourages client to sing).

1.16 Imitate Therapist (n=3; 5%)

(Music Examples: Therapist says words and asks client to imitate; therapist uses call and response songs).

1.17 Label and describe songs and instruments (n=1; 2%)

2.00 Receptive Language (N=66; n = 35; 53%)

2.10 Follow directions (N=35; n=29; 83%)

(Music Examples: Original songs; movement-to-music applications; sing verbal directives; therapist sings "_____ has a shaker" to Ruthlee Adler's "_____ Has a Hat" from Target on Music and ask them to

pass; therapist sings "Say your Name," "Clap, Clap, Clap Your Hands;" therapist sings "Clean-Up" or Movement song; therapist sings "Egg Shaking Song" acapella; therapist sings directives to the tune of "Skip to My Lou;" therapist asks client to select familiar instrument and follow directions in a movement song; therapist sings "Allelu" and "Gonna Shake my Sillies Out;" therapist sings "Raise your Hand, or "Jump Like a Jumping Bean;" therapist sings "The Color Song from "Wee Sing Games, Games, Games").

2.11 Identify pictures/objects (n=8; 23%)

(Music Examples: "Going on a Picnic"- client finds pictures of food used in the song and "Old McDonald"- client finds toy animal used in song; "Head and Shoulders" and "Clap Hands;" therapist sings "Look, Look, Look" by Betsy Brunk from "Learning Through Music" and have client choose objects by pointing or pictures).

2.12 Respond to name in song (n=5; 14%)

(Music Examples: Therapist sings hello and cues client to shake hands).

2.13 Gesture/Point to musical instruments (n=4; 11%)

2.14 Localize and track instrument/vocal sounds (n=3; 9%)

2.15 Discriminate between two extremes (loud/soft; fast/slow; stop/go) (n=3; 9%)

(Music Examples: Therapist encourages client to move or play instrument with both live and recorded music).

2.16 Imitate Therapist (n=3; 9%)

(Music Examples: Therapist encourages client to imitate given rhythms; therapist encourages client to imitate body movements and vocal sounds).

3.00 Non-Verbal Communication (N=66; n=14; 21%)

3.10 Observe Gestures (N=14; n=9; 64%)

(Music Examples: Therapist observes client with parent; therapist uses "Follow the Leader" songs; therapist engages in improvisatory drumming interaction with client).

3.11 Use of Sign Language (n=6; 43%)

(Music Examples: Therapist sings songs that use sign language; therapist sings song while client plays instrument and then signs "Play" and/or "Stop;" therapist sings songs using simple signs- "yes," "no," and "stop").

3.12 Use of Props and Pictures (n=3; 21%)

3.13 Engage in Instrumental Call and Response (n=2; 14%)

4.00 Singing/Vocal Skills (N= 66; n=10; 15%)

4.10 Call and Response/Imitation (N=10; n=4; 4%)

(Music Examples: Therapist sings animal sounds and encourages client to repeat; therapist sings simple echo songs "Are your Sleeping?" or "I'm Going to Leave Old Texas").

4.11 Singing Familiar Songs (n=3; 30%)

4.12 Fill-in-the-Blank (n=2; 20%)

4.13 Improvisation (n=1; 10%)

(Music Examples: Therapist encourages client to improvise on syllables to a Blues Progression).

5.00 Picture Exchange Communication Systems (PECS); (or other switches) (N=66; n=8; 12%)

5.10 Use to make choices in session (N=8; n=7; 88%)

(Music Examples: Client brings PECS to choose the next song; therapist sings "It's time for a choice, It's time for a choice, Which one do you want?" and client gives the card/object to the therapist; therapist encourages client to use PECS to choose instrument).

5.11 Use switch to fill-in-the-blank (n=3; 38%)

(Music Examples: Client pushes switch to make "moo" sound in "Old McDonald Had a Farm).

6.00 Vocalizations/Pre-Verbal Skills (N=66; n=7; 11%)

6.10 Improvisation (N=7; n=4; 57%)

(Music Examples: Therapist encourages client to use a variety of vocalizations; therapist improvises a song using the client's sounds/syllables).

6.11 Sing familiar songs with syllables (n=2; 29%)

6.12 Sing Syllable Songs (n=1; 14%)

(Music Examples: Therapist sings "Mm-Ah" or "B-B-B-Bubbles).

6.12 Use of whistles, horns, and kazoos (n=1; 14%).

(Music Examples: Therapist uses reed-horn to blow and encourage

vocalization).

7.00 Interactive Speech (N=66; n=5; 8%)

7.10 Engage in verbal/instrumental exchanges with others (N=5; n=3; 60%)

(Music Examples: Therapist engages in a drum conversation with the client).

7.11 Answers Questions (n=2; 4%)

(Music Examples: Therapist sings hello song and asks questions about the client).

7.12 Use sounds/words to gain attention (n=1; 20%)

7.13 Greet others (n=1; 20%)

8.00 Choice Making (N=66; n=3; 5%)

8.10 Make choice in song verbally and/or gesturally (N=3; n=3; 100%)

(Music Examples: Therapist encourages client to choose instrument; therapist sings "Transportation Song" paired with pictures of different means of transportation; therapist sings "What Do You Do?" by Kathleen Coleman to explore wants and needs; therapist sings "Play Your instrument name" and asks clients to choose an instrument to play during the song).

9.00 Eye Contact (N=66; n=3; 5%)

9.10 Cue therapist to continue song (N=3; n=3; 100%)

(Music Examples: Therapist encourages client to maintain eye contact in order to continue with song; therapist encourages client to make eye contact when singing "Hello" and "Good-bye").

10.00 **Breathing** (N=66; n=3; 5%)

10.10 Engage in breathing exercises (N=3; n=2; 67%)

10.11 Singing a familiar song (n=1; 33%)

Others (1 each): Hearing, Self-Expression; Identification of Animals; Cognitive Development

Table 7

Major Skill Area: Social (N=80; n=63; 79%)

Alternate Titles: Behavior; Attentiveness; Social/Emotional Skills, Social/Behavioral Skills; Interpersonal Skills; Relatedness/Relationship

Subcategory Areas

1.00 Peer/Adult Interaction (N=63; n=28; 44%)

1.11 Engage in imitative, parallel, and/or interactive music making (N=28; n=11; 39%)

(Music Examples: Therapist engages with client in improvisational instrument play; therapist plays musical "tag" on the keyboard, encouraging client to "chase" the therapist and reciprocate; therapist places two clients at either end of the piano and encourages them to play together; therapist engages in improvisational drumming).

1.12 Passing/Sharing Instruments (n=10; 36%)

(Music Examples: Therapist asks clients to pass instruments in a circle to music; therapist plays a familiar song, such as "Twinkle, Twinkle" or "BINGO" and encourages client to share instruments).

1.13 Converse with others (n=6; 21%)

(Music Examples: Therapist uses a bongo drum to play "Hello _____" in rhythm and encourages the clients to respond).

1.14 Greet and Gesture to others (n=5; 18%)

(Music Examples: Therapist encourages client to use appropriate social greetings in "hello" and "good-bye" songs; therapist uses songs that

include hand-shaking, high-"five"ing; and hand-slapping).

1.15 Engages in Play (n=2; 7%)

(Music Examples: Therapist uses hula hoop as centering focus and encourages client to hold hoop with therapist while they sing "Cobbler, Mend My Shoe," and/or "Birds Fly High;" therapist and client stand inside the hoop and rock together to "Row, Row, Row Your Boat;" therapist a and client sit on floor and roll the ball; therapist and client play "Peek-a-Boo").

1.16 Dancing with others (n=1; 4%)

(Music Examples: Therapist encourages clients to dance with others in a group setting).

2.00 Attending Skills (N=63; n=23; 37%)

2.10 Make and/or maintain eye contact (N=23; n=14; 61%)

(Music Examples: Therapist uses "hello" song to sing client's name and observe eye contact; therapist sings song "Look At Me;" therapist sings a song with pictures and holds them near his/her eyes to promote eye contact with client; therapist engages client in a turn-taking activity at the piano or drum where client is asked to look at therapist at the completion of his/her turn).

2.11 Attend to task (n=11; 48%)

(Music Examples: Therapist uses action songs and observes the duration of client's attention; therapist engages in improvisation with client; therapist sings songs with multiple verses, such as "There Was an Old Lady" or

"She'll be Coming Around the Mountain" in order to easily observe duration of eye contact).

3.00 Sharing and Turn-Taking (N=63; n=11; 17%)

3.10 Pass/exchange instruments with others (N=11; n=8; 73%)

(Music Examples: Therapist and client exchange instruments and play together; therapist and clients pass instruments in a circle).

3.11 Play in response to name (n=2; 18%)

(Music Examples: Therapist plays a song and clients can play only when the therapist sings their name; therapist sings "Play, Play, Play Uh-huh" to Barry Bernstein's "Shake, uh-huh" as the chorus and during the "verse" calls clients' names to encourage them to play).

3.12 Play with others (n=1; 9%)

(Music Examples: Therapist and client sing a "rolling" song and roll ball back and forth).

3.13 Engage in Improvisation (n=1; 9%)

(Music Examples: Therapist and client engage in improvisation, each person acting as the "leader" at certain points).

4.00 Awareness of Self and Others (N=63; n=10; 16%))

4.10 Passing/Sharing Instruments (N=10; n=4; 40%)

(Music Examples: Therapist employs "Pass the Instrument" Song to encourage clients to observe person on their left and right; therapist uses a call-response improvisational music experience (either instrumental or verbal); therapist and client play bells and pass mallets at the end of each

phrase).

4.11 Respond to name (n=3; 30%)

(Music Examples: Therapist chants client's name in song and observes response; therapist uses hello/greeting song to sing client's name).

4.12 Acknowledge others (n=2; 20%)

(Music Examples: Therapist uses "I Spy" to encourage clients to observe other people; therapist sings "Where is _____" and encourages clients to greet each person whose name is sung).

4.13 Improvisation (n=1; 10%)

(Music Examples: Therapist engages in improvisation with or alongside client to observe his/her reaction and participation within the music).

5.00 Direction Following (N=63; n=13; 21%)

5.10 Response to sung directions (N=13; n=10; 77%)

(Music Examples: Therapist uses song "I Am a Fine Musician" and encourages client to play instruments in the song;" therapist sings verbal directions using the song "Shake the Eggs to the Music" by Betsey Brunk from Prelude Music Learning Through Music Volume 2; therapist uses many different songs, including "Throw the Bean Bag and Catch" by Hap Palmer; therapist sings "If You Are Happy and You Know It" and "Hokey Pokey; therapist sings songs with the directives "stop" and 'go;" Therapist sings "Listen to the Water" on guitar and instructs clients to pass the rainstick).

5.11 Response to verbal instructions (n=2; 15%)

(Music Examples: Client assists therapist in putting instruments away).

6.00 Participation in Group Music Therapy (N=63; n=7; 11%)

6.10 Active in session (N=7; n=6; 86%)

(Music Examples: Therapist observes client's participation in various tasks).

6.11 Remains in Group (n=3; 43%)

6.12 Accepts leadership (n=1; 14%)

7.00 Response to Name and Greetings (N=63; n=6; 10%)

7.11 Response to Name (N=6; n=4; 67%)

(Music Examples: Therapist sings client's name and observes responses).

7.12 Response to "Hello" and "Good-bye" (n=3; 50%)

(Music Examples: Therapist sings "hello" and "good-bye" songs and observes client's ability to wave and/or greet others; therapist sings a adaptation of "Hello" by Betsey Brunk from the Prelude Music Learning Through Music Volume 2 and encourages client to fill in parts of "Hi, [client's name], Hi.").

8.00 Emotional Expression (N=63; n=4; 6%)

8.11 Affective responses (N=4; n=4; 100%)

(Music Examples: Therapist observes client's responses within the music therapy session).

8.12 Identify feelings in others (n=1; 25%)

(Music Examples: Therapist uses face cards and facial expression and asks client to identify or mirror).

9.00 Communication Skills (N=63; n=4; 6%)

9.10 Choice-Making (N=4; n=4; 100%)

(Music Examples: Therapist gives client choice of song and/or instrument).

9.11 Singing (n=1; 25%)

10.00 Interactions with the Environment/Objects (N=63; n=2; 3%)

10.10 Response to instruments, toys, etc.(N=2; n=2; 100%)

10.11 Response to Room (n=1; 50%)

Others (1 each): Transitions, Leadership, Spontaneity/Creativity, Independence, Response to Physical Contact, Oral Motor

Table 8

Major Skill Area: Cognitive (N=80; n=51; 64%)

Alternate Titles: Cognitive/Perceptual; Cognitive/Sensory, Cognitive/Academic; Academic

Subcategory Areas

1.00 Concepts (colors, numbers, letters, body parts, shapes) (N=51; 32; 63%)

1.10 Identify through prop and picture songs (N=32; n=23; 72%)

(Music Examples: Therapist sings "Oh, no, Poor, Joe" with pictures of missing body parts and the client has to fill them in; therapist uses color and letter cards; therapist sings a song asking client to find the red frog, black animal, etc; therapist uses "Clown Count" from Prelude Music, Visual Aids I, "Let's Sing a Song About..." by Janet Jones for shapes, "Lollipop Song" from the Prelude Music Learning Through Music Volume 2 for colors; and "The Hungry Worm Alphabet" from the Learning Workshop; therapist sings song about shapes and then asks client to match cut-out shapes with corresponding instruments (triangle, sand blocks, drum); therapist sings "5 Little Speckled Frogs and "I Like Ice Cream" and asks client to pick up the color in the song; therapist sings "Grandpa's Farm" or "Old McDonald" and asks client to pick a picture of an animal or a stuffed animal out of a bag; therapist plays drum and plays a rhythm for each letter of the client's name; therapist sings "This Old Man or "Going Over the Sea" and asks client to pick numbers out on a number chart of write them; therapist uses the book "Chicka, Chicka, Boom, Boom" and sings the words of the book while playing the guitar, asking the client to

point to the letter that was sung; therapist uses "10 Little Bunnies" and asks client to remove a bunny picture in succession).

1.11 Identify by pointing (n=14; 44%)

(Music Examples: Therapist sings song about body parts and asks client to point to them while singing; therapist sings "Number Rock," "Head Bone Connected to the Knee Bone," "Lollipop Song"- for colors, "ABC Song," and "Alphabet Rock; therapist uses improvised songs and chants; therapist uses "This is a Song About Colors" or Triangle, Circle, Square;" therapist uses "Head, Shoulders, Knees, and Toes;" therapist adapts "If You're Happy and You Know It;" therapist uses "Fish Hunt, "Color Clown, and" Butterfly"- for counting; therapist sings "Show me the Color" to the tune of "Someone's in the Kitchen with Dinah" or "I Like Red" by Kathleen Coleman; therapist sings).

1.12 Match concepts on keyboard (n=3; 9%)

2.00 Sequencing/Memory (N=51; n=17; 33%)

2.10 Recall through multi-verse songs (N=17; n=10; 59%)

(Music Examples: Therapist sings "She'll be Comin' Around the Mountain" and "The Boa Constrictor" and encourages the client to recall the order of words and/or movements; therapist sings "There's a Hole in the Bottom of the Sea").

2.11 Recall melodies, themes, new songs (n=5; 29%)

2.12 Recall through storytelling (n=1; 6%)

(Music Examples: Therapist improvises a story using instruments as the

characters and client much remember instruments in sequence).

2.13 Recall through instrument play (n=1; 6%)

(Music Examples: Therapist uses 3 frame drums and asks client to line them up, play, and then put them away so they all fit inside each other).

3.00 Auditory Perception/Discrimination (N=51; n=13; 25%)

3.10 Identify changes in tempo and dynamics (N=13; n=6; 46%)

(Music Examples: Therapist improvises on piano or guitar and client moves freely; therapist uses song "This Old Man" and instrument playing).

3.11 Repeat simple melodies (n=3; 23%)

3.12 Responds to name (n=2; 15%)

3.13 Follow sound with eyes (n=1; 8%)

3.14 Match instrument sounds (n=1; 8%)

(Music Examples: Therapist gives client bell and maraca and instructs client to play instrument that he/she hears).

3.15 Identify high/low and loud/soft (n=1; 8%)

4.00 Attending Skills (N=51; n=10; 20%)

4.10 Attend to given task (N=10; n=5; 50%)

4.11 Make eye contact with therapist (n=3; 30%)

(Music Examples: Therapist uses songs, such as "Old McDonald" to observe eye contact).

4.12 Follow instrument with eyes (n=2; 20%)

5.00 Direction Following (N=51; n=8; 16%)

5.10 Respond to sung directions (N=8; n=8; 100%)

(Music Examples: Therapist sings a song that directs client to play different instruments; therapist sings "Egg Shakin' Blues;" therapist sings a "Do What I Do" song; therapist encourages client to start and stop playing a simple rhythm instrument; therapist creates original songs involving directions for client to complete).

6.00 Academic Skills (N=51; n=7; 14%)

6.10 Engage in music that teaches school subjects (N=7; n=3; 43%)

(Music Examples: Therapist creates songs to teach math and science concepts).

6.11 Read a song sheet/book (n=3; 43%)

6.12 Match instrument names to instruments (n=1;14%)

7.00 Spatial Awareness (N=51; n=5; 10%)

7.10 Play instruments in given directions (left, right, up, down, etc) (N=5; n=5; 100%)

(Music Examples: Therapist uses "Hokey, Pokey" melody and sings directions).

8.00 Sorting (N=51; n=3; 6%)

8.10 Put instruments in corresponding box

8.11 Organize instruments in orders and rows

8.12 Arrange instrument by features

(Music Example: Therapist encourages client to play all the instruments that shake, etc.).

9.00 Self Care (N=51; n=3; 6%)

9.10 Identify self-care skills through songs (N=3; n=3; 100%)

(Music Examples: Therapist creates songs to discuss self-care topics such as dressing, cleaning, eating, etc.).

Others (1 each): Imaginary Play, Abstract Structures, Ability to try new tasks, Multi-tasks, Choice-making, Musical Conservation, Attempts Difficult Tasks, Expresses Thoughts and Ideas, Reality Orientation.

Table 9

Major Skill Area: Music (N=80; n=28; 35%)

Subcategory Areas

1.00 Rhythm/Beat (N=28; n=21; 75%)

1.10 Match/Imitate rhythm (N=21; n=15; 71%)

(Music Examples: Therapist plays a rhythm and asks client to play it back and/or play along; therapist sings a song where specific rhythms are added; therapist sings "BINGO" or "Deep in the Heart of Texas" and encourages clients to fill in the "open" spaces).

1.11 Keep a steady beat (n=10; 48%)

(Music Examples: Therapist plays guitar or piano and asks client to play along on body and/or drums; therapist encourages client to strum guitar).

1.12 Adapt to rhythmic changes (n=5; 24%)

2.00 Melody/Tonal (N=28; n=17; 61%)

2.10 Match pitches (N=17; n=10; 59%)

(Music Examples: therapist plays notes on the keyboard).

2.11 Sing a familiar song (n=9; 53%)

(Music Examples: Therapist plays songs such as "If You're Happy and You Know It," "Are You Sleeping," or "Happy Birthday").

2.12 Finish a musical phrase (n=2; 12%)

2.13 Adapt to changing keys (n=1; 6%)

3.00 Instrument Exploration (N=28; n=9; 32%)

3.10 Choose an instrument and play (N=9; n=8; 89%)

3.11 Identify instruments by name (n=3; 33%)

(Music Examples: Therapist sings "I'm a Rhythm Instrument" by Hap Palmer).

3.12 Learn instrument care (n=1; 11%)

(Music Examples: Therapist instructs client as to correct care for instrument).

4.00 Interest/Preference (N=28; n=9; 32%)

4.10 Response to music (N=9; n=6; 67%)

(Music Examples: Therapist uses a variety of music (recorded and live) and observes client reaction).

4.11 Choose a song or style (n=5; 56%)

(Music Examples: Therapist asks client's preference;

4.12 Choose an instrument (n=1; 11%)

5.00 Changes in Dynamics (N=28; n=3; 11%)

5.10 Adapt to changes in volume (N=3; n=3; 100%)

6.00 Musical Form/Phrasing (N=28; n=2; 7%)

6.10 Identify end of phrase (N=2; n=1; 50%)

(Music Examples: Therapist plays a phrase that involves an ending with a cymbal "crash" and observes client's ability to continue the phrasing).

6.11 Identify structure and form (n=1; 50%

(Music Examples: Therapist improvises a theme and observes client's ability to create an "ending" or structure).

Others (1 each): Range of Affect; Awareness, Startle Reflex, Movement, Sequencing, Reception, Perception, Conception, Sound Localization

Table 10

Major Skill Area: Emotional (N=80; n=13; 16%)

Alternate Titles: Affect; Psychosocial; Affective Expression

Subcategory Areas

1.00 Identify/Express Feelings (N=13; n=8; 62%)

- 1.10 Identify feeling in music with words (N=8; n=3; 38%)
- 1.11 Identify feeling in music with pictures (n=2; 25%)
- 1.12 Play feelings on instrument (n=2; 25%)
- 1.13 Write song about feelings (n=1; 13%)

2.00 Mood/Affect (N=13; n=5; 38%)

- 2.10 Display range of affect (N=5; n=5; 100%)

  (Music Examples: Therapist uses variety of songs to elicit affective response, such as "Pop Goes the Weasel"-surprise, "Silly Sound Song"-laughing, and "Three Little Pigs"- tense).

3.00 Awareness of Self and Others (N=13; n=3; 23%)

- 3.10 Interact with Therapist (n=2; 67%)
- 3.11 Interact with the music (n=1; 33%)

Others (1 each): Musical Expression, Spiritual, Observable Mannerisms, Attention to Task, Self-Esteem, Anger Management

Table 11

Major Skill Area: Sensory (N=80; n=10; 13%)

Alternate Titles: Awareness of Stimuli; Auditory and Visual Perception; Sensory Awareness; Perceptual Abilities

Subcategory Areas

1.00 Visual (N=10; n=6; 60%)

- 1.10 React to color and light (N=6; n=3; 50%)

  (Music examples: Therapist uses streamers and lighted tambourine; therapist uses colored shakers).

- 1.11 Read charts (near and far) (n=2; 33%)

- 1.12 Track stationary and moving objects (n=2; 33%)

2.00 Auditory (N=10; n=6; 60%)

- 2.10 React to loud and soft sounds (N=6; n=4; 67%)

- 2.11 React to pitched and non-pitched sounds (n=3; 50%)

- 2.12 React to start and stop (n=1; 17%)

3.00 Tactile (N=10; n=6; 60%)

- 3.10 Tolerate different textures (N=6; n=5; 83%)

  (Music Examples: Therapist uses scarves, toy animals, drums, etc.; therapist sings a "Sensory Song;" therapist encourages client to strum and touch the guitar; therapist uses a variety of vibrating toys).

- 3.11 Response to touch from therapist (n=1; 17%)

Others (1 each): Attention, Discrimination, Awareness, Environment, Memory

Table 12

Major Skill Area: Adaptive (N=80; n=7; 9%)

Alternate Titles: Functional Life/Self Help Skills; Daily Living Skills

Subcategory Areas

1.00 Personal Responsibilities (N=7; n=7; 100%)

1.10 Eat and Drink (N=7; n=3; 33%)

(Music Examples: Therapist plays "This is the way we eat our lunch" game with toy food and utensils).

1.11 Initiate Toileting (n=1; 14%)

1.12 Take off coat, boots, shoes (when applicable) (n=1; 14%)

1.13 Understand Traffic Safety (n=1; 14%)

(Music Examples: Therapist adapts "Wheels on the Bus" to include traffic safety).

1.14 Maintain Personal Hygiene (n=1; 14%)

2.00 Attention (N=7; n=2; 29%)

2.10 Focus on given task (N=2; n=2; 100%)

Others (1 each): Functional Objectives, Body Awareness, Recreational Skills, Follow Directions, Impulse Control

Table 13

Major Skill Area: Case History (N=80; n=2; 3%)

Subcategory Areas

1.00 Referral Reasons (n=2)

2.00 Medical

3.00 Social

Major Skill Area: Impulse Control (N=80; n=1; 1%)

Subcategory Areas

1.00 Parallel Play

2.00 Cooperative Play

Major Skill Area: Achievement (N=80; n=1; 1%)

Subcategory Areas

1.00 Motivation

2.00 Self Esteem

3.00 Risk Taking

Major Skill Area: Mental Awareness(N=80; n=1; 1%)

Subcategory Areas

1.00 Decision Making

2.00 Preferences

Table 16

Question 2: Positive Aspects
(Categories and Sample Responses)

N=113

Category #1: Thorough (n=38; 34%)

"Every little sub-skill on the assessment form is not assessed in every client, but I like the comprehensiveness. It serves as a good reminder for me..."

"There have been times when a narrative of the assessment session takes a lot of time. Sometimes over an hour if there is a lot of detail. Because of the detail provided though, the funding for sessions is almost always approved."

"Provides a thorough overview of client's strengths and weaknesses."

Category #2: Individualized (n=29; 26%)

"I am able to individualize the assessment process for each student."

"Each new client is approached with a sense of discovery, with as few preconceptions as possible. As a result, the shape of the assessment varies widely from client to client, and we are able to obtain what we call a 'musical portrait' of the client."

"I take a very spontaneous, creative approach to assessing clients. I come into the process with a few song ideas, a movement activity... and a very open mind."

Category #3: Easy to Use (n=29; 26%)

"My assessment tool follows my typical music therapy session format, so it's easy to use with a new student on an individual basis or within a group setting."

"Tracks progress and generally easy to administer."

"There are a lot of overlays that allow me to assess multiple skills in 1 activity several times."

Category #4: Shows Viability of Music Therapy Services (n=10; 9%)

"This assessment allows for some more concrete data to show progress towards goals and have music therapy interventions will help this process."

"The SEMTAP is a good instrument for determining whether or not a child should receive

music therapy as a related service in special education."

"Gives a good understanding/need for MT services."

Category #5: Understood by Other Disciplines (n=7; 7%)

"It's comprehensive and uses terminology that is common to several different settings."

"I made this form but haven't been using it. I feel it would be helpful if I were communicating with other disciplines..."

"Is a good adjunct to established play-based assessments used by other professionals on the team."

Table 17

Question 2: Negative Aspects
(Categories and Sample Responses)

N=86

Category #1: Subjective (n=24; 28%)

"I feel the assessment is too subjective and has no functional use for other professionals working with the student."

"Besides comparing a child's skills from the assessment to developmental criteria, there is no real concrete determination whether a child should receive music therapy services. It is solely based on my professional opinion. I'm finding that school districts want something more concrete."

"The downside is coming up with music activities that do not sway results. As a therapist you want the child to be successful so are my activities biased?

Category #2: Limiting (n=22; 26%)

"I feel it covers enough, yet I'm not sure if it assesses enough areas."

"The criteria are more academic or cognitive based. They seem limiting."

"I don't usually use a chart or checklist, and while this allows me flexibility, I also may sometimes miss a particular area."

Category #3: Time-Consuming (n=19; 22%)

"Our assessment is very thorough, but currently is too time consuming to write-up."

"The only negative aspect (although I do feel it is a necessary one) is that the process [SEMTAP] takes a lot of time (observation, planning, assessing, writing reports)."

"We like the assessment because it's very thorough, however, the final written report is often 6 or more pages and very time-consuming to put together."

Category #4: Technical Difficulties (n=14; 16%)

"No space to write comments."

"Does not list specific tasks to be used while assessing."

"Requires computer."

Category #5: Broad (n=7; 8%)

"It is not differentiated between individual or group therapy. It is not differentiated between ages, populations, and need areas..."

"My student's skills/needs are so different that I constantly need to change songs and activities for different students/classrooms."

"The current assessment tool we employ is vague. It is difficult to assess definitively a resident's specific needs and level of functioning."

Table 18

Question 3: Important Features for a Standardized Music Therapy Assessment Form (Categories and Sample Responses)

N=151 Features; 60 Respondents

Category #1: Easy to Use (n=35; 23%)

"Easy to fill out while conducting assessment."

"Must be easy to use so that attention is not diverted from the client during assessment."

"Accessible- Preferably as easy to complete as possible without sacrificing quality."

Category #2: Comprehensive (n=29; 19%)

"Comprehensive- Music assess a maximum range of skills (general and musical)."

"The form needs to be thorough enough to cover all areas being assessed."

"Thorough to cover all areas of functioning, including child's social history, medical history, music history, etc., reason for referral."

Category #3: Adaptable (n=20; 13%)

"Making sure that the assessment is adaptable enough to work with our many diverse clients."

"Ability to use the assessment with all ranges of ability levels and age"

"Must be useful for variety of ages and abilities."

Category #4: Reliable and Valid (n=16; 11%)

"Reliable and Valid: it must measure what it says it measures consistently."

"Provides valid and measurable information that can stand up to examination."

"Consistency, measuring what it should measure without having to adapt."

Category #5: Efficient (n=15; 10%)

"One page- 2 pages max.- for ease of filing/conciseness."

"Concise- our school district doesn't prefer an assessment which is lengthy..."

"For me because of the volume of students, I would want something that pinpoints targeted areas and can be filled out quickly with a minimum of commentary..."

Category #6: Provides Specific Music Therapy Tasks (n=10; 7%)

"Has an activity guide for the examiner so evals are consistent."

"Resource given to therapist with assessment forms for useful music, songs, activities, instruments found effective in assessment or treatment process."

"A bibliography and list of recordings."

Category #7: Compares Skills With and Without Music (n=10; 7%)

"The assessment must consider the student's performance with music as compared to functioning levels without music. In terms of special education requirements for related services, it is clear that if this cannot be documented, MT cannot be justified as a necessary related service."

"Comparison of IEP [Individualized Education Plan] behaviors/goals in non-music verses music setting."

"Comparing students' skills with and without music."

Category #8: Compares Responses to "Typical" Developmental Scale (n=8; 5%)

"Each assessment should cover specific developmental periods and be based on "normal" scales."

"Having a score of a "normal functioning child" to compare it to i.e. some children may exceed in some areas, and some may not. I have had some school systems request this."

"Developmental scale of "age" or "percentage" when skills should be reached in typical situations."

Category #9: Provides Goal Areas and Interpretation Guidelines (n=8; 5%)

"I would always know what to look for when assessing, become more aware of certain things- what to focus on."

"Specific areas of functioning being assessed and guideline for typical long-term goals and objectives appropriate for this group, based on experience of wide use of standard assessment."

"Specific skill measurements with specific guidelines for meeting the skill."

Table 20

Question 3: What a Standardized Assessment Will Do For the Profession

N=13 Responses; 11 Respondents

Category #1: Continuity Within Profession (n=5; 38%)

"Gives our discipline more uniformity."

"It would allow for consistency."

"It gives a common language to our profession..."

Category #2: Justifies Services (n=4; 31%)

"We'd have more uniform data to present to law makers etc. to support the benefits of music therapy."

"A clearer result regarding the need for music therapy comes to light."

"It could aid in justifying the use of MT by providing a score or percentage as OT [Occupational Therapy] and PT [Physical Therapy] standardized tests do."

Category #3: Respect from Others (n=4; 31%)

"Parents trust the results more because a standardized test often does not lie."

"Other professions honor your words and assessments more."

"Standardized form might provide more credibility to other professionals."

Table 21

Question 3: Why a Standardized Assessment Would Not Work

N=11 Responses; 11 Respondents

Category #1:Variance in Clientele (n=11; 100%)

"While I feel some administrators would be more likely to recognize MT with a standardized assessment tool, I cannot imagine one tool that would provide a reliable valid score for all students receiving special education."

"I have not found that one approach can fit all circumstances... individual differences vary greatly."

"I'm not sure if I would want to use a standardized form. There are so many different manifestations of DD. I typically rely on the situation, the child, my knowledge of their disorder, and intuition to guide me in pulling out what is important in my own assessment form."

APPENDICES

Appendix A

Initial Cover Letter

Roger Smeltekop, MM, MT-BC
Music Practice Building
Michigan State University
East Lansing, MI 48823

Kristen M. Cole, MT-BC
5690 Rawnsley Avenue, Apt. B
West Bloomfield, MI 48323

March 20, 2001

Dear Fellow Music Therapist,

The topic of formal and/or standardized music therapy assessment tools for children has been recently addressed in both the Journal of Music Therapy and Music Therapy Perspectives. Most of the articles suggested more research in the area of assessment, increased attention to the design of new forms, with implications for a standardized tool. We are a professor of and staff member in Music Therapy at Michigan State University and are interested in examining and understanding the current assessment practices of music therapists currently working with children with developmental disabilities (age 0-17).

Your name was listed in the 2001 American Music Therapy Association (AMTA) Member Database under the population listing of "developmental disabilities." If you work **only** with adults with developmental disabilities (age 18+), please disregard this letter, return the enclosed participation form, and mark "Adults with Developmental Disabilities (age 18 +)".

As music therapists working with children with developmental disabilities (age 0-17) in some clinical capacity, your input and response to a survey we have designed would be very useful and greatly appreciated. The survey will examine common music therapy assessment skill areas, the assessment process, current tools utilized, and the need for a standardized assessment. We hope to utilize the results to provide an awareness and understanding for both music therapy clinicians, music therapy educators, and AMTA regarding current assessment practices. In addition, we hope to provide useful information for the future development of a formal and/or standardized music therapy assessment tool. Please be aware that all information shared on the participation form and the survey, if you choose to participate, will remain confidential and your name will not be used in the study. All your postage costs will be paid and your only obligation would be to complete the survey. In addition, we will gladly mail you a copy of the study results at your request.

Please complete the enclosed participation form and return it using the enclosed self-addressed-stamped envelope for your convenience. Thank you in advance for your participation.

Sincerely,

Roger A. Smeltekop, MM, MT-BC
Professor, Music Therapy
Michigan State University

Kristen M. Cole, MT-BC
Music Therapy Clinic Supervisor
Michigan State University

Appendix B

Participation Form for Music Therapy Assessment Survey Study

1. I currently assess and work with the following populations: (please check **all** that apply)

____ Children with Developmental Disabilities (age 0-17)
(Defined as: Persons age 0-17 who have failed to progress at a normal rate in at least on of the following areas: (a) motor skills, (b) adaptive skills, (c) communication skills, (d) cognitive skills, and (e) social skills and/or have been labeled or diagnosed by a medical doctor as having autism, mental retardation, and sensory/motor/physical/cognitive impairments)

____ Adults with Developmental Disabilities (age 18 +)

____ Other (please specify) _____

* If you work **only** with adults with developmental disabilities, please **stop** here and return this form in the enclosed self-addressed stamped envelope.

2. How long have you been practicing as a music therapist? (please check **one**)

____ 0-2 years ____ 3-5 years

____ 6-8 years ____ 9-11 years

____ 12 + years

3. What is your highest level of education? (please check **one**)

____ Bachelor's Degree ____ Some Master's Work

____ Master's Degree ____ Some Doctoral Work

____ Doctoral Degree ____ other (please specify)

_____

4. If you have a graduate degree or are currently pursuing one, what is the degree title or what will it be? (please write in full):
(example: Master of Music degree in Music Therapy; Doctor of Philosophy in Clinical Psychology; etc.)

_____

5. I work with children with developmental disabilities (age 0-17) in the following settings:
(please check **all** that apply)

____ group home
____ developmental center
____ public school
____ private school
____ hospital
____ in your home
____ in the client's home
____ community music school
____ other (please specify all)

_____

_____

6. In the above setting(s), I see the clients in the following context(s):
(please check **all** that apply)

____ small group (2-4 clients)
____ individual sessions
____ large group (5 or more clients)
____ other (please specify)

_____

7. Where did you obtain the assessment you are currently using in your clinical practice?
(please check the **one** that **best** fits you)

____ colleague(s)
____ internship
____ undergraduate school(s)
____ research article(s)
____ conference(s)
____ former workplace
____ current workplace
____ professor(s)
____ book(s)
____ graduate school(s)
____ self-created (original)
____ self-created (adapted from other forms)
____ other (please specify)

_____

8. I currently assess and work with children with developmental disabilities (age 0-17) and (please check one): ***Be reminded that all your postage costs will be provided to you and your input will be very valuable to both this study and the music therapy profession.**

____ I would complete a survey regarding my music therapy assessment tool and process. **(Please include your name and address below)**

____ I would not complete a survey regarding my music therapy assessment tool and process. (Name and address optional if you choose not to participate in the survey)

Name_____ Credentials_____

Address_____

City_____ State_____ Zip Code _____

Email _____

Please return this form using the enclosed self-addressed-stamped envelope by **April 10, 2001**.

Thank you in advance for your response.

Roger Smeltekop, MM, MT-BC
Professor, Music Therapy
Music Practice Building
School of Music
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Appendix C

Music Therapy Assessment Survey

Section 1

Enclosed are 6 lined sheets to be used in the completion of this section. Each sheet has a **major** functioning area line and several **subcategory** lines, followed by several more **explanation** lines.

1. Please write a **major** functioning area that you assess.

2. Follow this with **any number** of **subcategory** areas.

3. Use the remaining lines to describe and provide examples for the tasks, activities, and/or strategies used in assessing those areas.

Please provide detailed and descriptive responses using the **major** and **subcategory** areas you currently assess. Your assessment process will determine how many of the lines you will need; **take as little or as much space as you want!** Feel free to copy the enclosed lined sheets if you have more than 6 major areas, or enclose separate sheets if you need more explanation space. **If plain paper would better suit your assessment process explanation, please feel free to discard the lined sheets and use your own (handwritten or typed).**

Example: Major area: **Motor Functioning**

Subcategory: **Gross Motor Skills**

Explanation: I use the songs "If You're Happy and You Know it" and/or "The Hokey Pokey." I sing the songs on guitar or piano (depending on client preference) and give verbal, musical, and/or gestural prompts to assess overall leg, arm, head, and torso movements.

Subcategory: **Fine Motor Skills**

Explanation: I use the piano and encourage the child to play the black and white keys with different hands and fingers. I also have the child attempt to strum a guitar with a pick, play egg shakers, and hold a paddle drum.

Section 2

1) Please enclose a copy of your current music therapy assessment tool **only if you use a specific form, format, or guideline(s).** If you use a published form, you do not need to enclose your form, but please write the name and author(s) on the line below:

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other side --

2) What do you feel are the positive and negative aspects of your current assessment tool/process/form?

3) What would be the **three** most important features of a standardized music therapy assessment form for children with developmental disabilities for use in your clinical practice? (If you do not wish to use a standardized assessment form, please state the reasons for your answer on the lines below)

1.

2.

3.

4) If you would like a copy of the results, please include your name and address on the lines below:

Please return the survey (including this form) using the enclosed self-addressed-stamped envelope by **July 6, 2001**. Please be reminded that all information you provide is confidential and your name will not be used in this study. Thank you in advance for your participation.

Major Area:_____

Subcategory:_____

Explanation: (process used and task examples)_____

_____

_____

_____

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Subcategory:_____

Explanation:_____

_____

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Subcategory:_____

Explanation:_____

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note: Six of this page (3 double-sided pages) were enclosed in the survey

Appendix D

Roger Smeltekop, MM, MT-BC
Music Practice Building
Michigan State University
East Lansing, MI 48823

Kristen M. Cole, MT-BC
5690 Rawnsley Avenue, Apt. B
West Bloomfield, MI 48323

June 10, 2001

Dear Fellow Music Therapist:

Thank you very much for returning our participation form and expressing interest in participating in our survey study of music therapists working with children with developmental disabilities and their current assessment practices. Many of you had very encouraging things to say regarding our efforts and the need for research in this specific area. Your input on this survey will be very helpful for music therapy clinicians and educators.

Enclosed you will find two copies of a consent form. Please keep one copy for your records and return a **signed** and **dated** copy with your completed survey.

The goal of the enclosed survey is to gain detailed and descriptive information about your assessment **process.** On Part 2 of the survey, you are asked to enclose an assessment tool/form if you use one. **Please still complete the survey even if you do not use a specific tool or form.** We are most interested in knowing the following: (a) what major functioning areas you assess, (b) what skill subcategory areas you assess, and (c) **how you assess the areas**- regardless of whether you write them down or follow a written format.

We are so very thankful in advance for your efforts in completing this survey. Please contact us via email, phone, or mail with any questions or concerns.

Sincerely,

Roger Smeltekop, M.M., MT-BC
Associate Professor of Music Therapy
Michigan State University

Kristen M. Cole, MT-BC
Music Therapy Clinic Supervisor
Michigan State University.

Appendix E

Consent Form

You are being requested to participate in a survey research study on assessment in music therapy for children with developmental disabilities (age 0-17). This project is being conducted by Roger Smeltekop, MM, MT-BC, Professor of Music Therapy and Kristen M. Cole, MT-BC, Music Therapy Clinic Supervisor, Michigan State University. The researcher will be examining the written survey responses for common themes in major functioning categories and subcategories in music therapy assessment. Common music therapy assessment form design will be examined and responses to one question regarding your five most important needs in a standardized music therapy assessment will be calculated with descriptive statistics.

As a participant, you will complete the survey, enclose a current assessment tool, and answer one question regarding your five most important needs in a standardized music therapy assessment tool. The survey will take approximately 35 to 40 minutes to complete. All the information you provide on the survey will be kept confidential and all the responses will be kept in a secure area that only the researcher can access. Your privacy will be protected to the maximum extent allowable by law. There are no risks to your personal health and/or well-being if you choose to participate in this study and you are free to discontinue your participation in this study at any time without penalty. All postage will be provided by the researcher in the form of self-addressed stamped envelopes.

As a music therapist working with children with developmental disabilities (age 0-17), I agree to participate in this study that will use my responses to the enclosed survey to examine common music therapy assessment skill areas, the assessment process, current tools utilized, and the need for a standardized assessment form.

All the information I provide will remain confidential and the results will be made available to me if I choose to request them. Please contact Roger Smeltekop, MM, MT-BC at (517) 353-6753, Kristen Cole, MT-BC at (248) 865-0129, and/or David Wright, Ph.D., Chair of the Michigan State University Committee on Research Involving Human Subjects at (517) 355-2180 with any questions or concerns.

Signed_____ Date_____

Printed name _____ Credentials _____

Address_____

City_____ State_____ Zip Code_____

Email _____