



OVERDUE FINES: 25¢ per day per item

RETURNING LIBRARY MATERIALS: Place in book return to remove charge from circulation records

CONTENT OF MASTER'S LEVEL CURRICULA

.

IN MUSIC THERAPY AND

ACADEMIC PROGRAMME DIRECTORS' ATTITUDES

TOWARD TRAINING

Βу

Connie Isenberg-Grzeda

A THESIS

Submitted to Michigan State University in partial fulfillment of the requirements for the degree of

MASTER OF MUSIC-MUSIC THERAPY

Department of Music

ABSTRACT

CONTENT OF MASTER'S LEVEL CURRICULA IN MUSIC THERAPY AND ACADEMIC PROGRAMME DIRECTORS' ATTITUDES TOWARD TRAINING

By

Connie Isenberg-Grzeda

The present study explores the content of Master's programmes in music therapy and educators' attitudes toward the education and differential skills of music therapists with basic and advanced training. A questionnaire served as the research instrument. Results show that music therapy core courses and research were stressed more, and music was stressed less, at the Master's than at the Bachelor's level. Directors of Bachelor's programmes expected a greater emphasis on psychology and special education at the graduate level than was reflected in programme content. The expressed attitudes of directors of Master's programmes toward specialization, verbal therapy techniques, and musicianship were not consistent with programme content. Educators distinguished between music therapists with graduate and undergraduate training on the basis of clinical skills but not music skills. The development of clinicians was perceived to be the most important goal of graduate training. Overall, many attitudes of educators at both levels coincided.

ACKNOWLEDGEMENTS

The author would like to express her sincere thanks to Dr. Dale Bartlett for his invaluable contributions in his capacity as advisor and as a friend. She also gratefully acknowledges the assistance of Mr. Robert Unkefer.

The author is grateful to Dr. Leslie Klein, not only for the time and energy he devoted to the development of the questionnaire and the determination of appropriate statistical procedures, but also for his moral support and friendship.

The author wishes to express her appreciation to Dr. E. Brussell for his assistance with the clarification of the appropriate utilization of a variety of statistical methods.

TABLE OF CONTENTS

INTRODUCTION	1	
Studies Related to the Master's Degree in Music Therapy	8	
Studies Related to the Master's of Social Work and Occupational Therapy	13	
METHOD	20	
Graduate Questionnaire	22	
Undergraduate Questionnaire	27	
Analysis	29	
RESULTS AND DISCUSSION		
Description of Graduate Programmes	32	
Comparison of Graduate and Undergraduate Curricula	48	
Comparison of Expectations of Directors of Bachelor's Programmes and Content of Master's Programmes		
Comparison of the Attitudes of Directors of Master's Programmes and Content of Master's Programmes	74	
Comparison of the Attitudes of Directors of Master's Programmes and Bachelor's Programmes	83	
SUMMARY AND CONCLUSIONS		
LIST OF REFERENCES		
APPENDIX A		

Questionnaires

APPENDIX B

Means and Ranges of Required Credits in Content Areas in Master's Programmes; Frequencies of Selection and Median Ranks Assigned to Backgrounds Considered to Provide Best Clinical and Teaching Skills

LIST OF TABLES

•

.

.

TABLE	1.	Percentages of Master's and Bachelor's Programmes Requiring Content Areas and of Directors of Bachelor's Programmes Expecting Inclusion	50
TABLE	2.	Percentage of Total Required Coursework Accounted for by Content Areas and Percentages Proposed by Directors of Bachelor's Programmes	51
TABLE	3.	Percentages of Academic Programmes Requiring Models of Music Therapy and of Directors of Bachelor's Programmes Expecting Inclusion	53
TABLE	4.	Percentage of Total Exposure to Models of Music Therapy Accounted for by Each Model in Master's and Bachelor's Programmes	55
TABLE	5.	Percentages of Academic Programmes Requiring Models of Therapy Other than Music Therapy and of Directors of Bachelor's Programmes Expecting Inclusion	56
TABLE	6.	Percentage of Total Exposure to Models of Therapy other than Music Therapy Accounted for by Each Model in Master's and Bachelor's Programmes	57
TABLE	7.	Percentages of Academic Programmes Requiring Therapeutic Settings and of Directors of Bachelor's Programmes Expecting Inclusion at Master's Level	59
TABLE	8.	Percentage of Total Exposure to Therapeutic Settings Accounted for by Each Type of Setting in Master's and Bachelor's Programmes	60
TABLE	9.	Percentages of Academic Directors Including Skills in Definitions of Functional Music	62

•

.

v

TABLE	10.	Percentages of Academic Directors Including Orientations, Median Ranks Assigned and Ranges	73		
TABLE	11.	Frequencies of Inclusion of Forms of Therapy and Median Ranks Assigned	84		
TABLE	12.	Frequency of Selection and Median Ranks Assigned to Music Skills by Directors of Master's Programmes	94		
TABLE	13.	Frequency of Selection and Median Ranks Assigned to Music Skills by Directors of Bachelor's Programmes	95		
TABLE	14.	Frequencies of Selection and Median Ranks Assigned to Clinical Skills by Directors of Master's and Bachelor's Programmes	97		
TABLE	15.	Frequency of Selection and Median Ranks Assigned by Directors of Master's Programmes to Professionals Considered Most Similar to Music Therapists	100		
TABLE	16.	Frequency of Selection and Median Ranks Assigned by Directors of Bachelor's Programmes to Professionals Considered Most Similar to Music Therapists	101		
APPENDIX B					
TABLE	Α.	Mean and Range of Required Credits in Content Areas in Master's Programmes in Music Therapy	131		
TABLE	в.	Frequencies of Selection and Median Ranks Assigned to Backgrounds Considered to Provide Best Clinical Skills by Directors of Master's and Bachelor's Programmes	132		
TABLE	с.	Frequencies of Selection and Median Ranks Assigned by Directors of Master's and Bachelo Programmes to Master's Degrees Considered to	or's		
		Provide Best University Teaching Skills	133 2		

vi

.

•

.

Music therapy is one of several disciplines in which the Bachelor's degree constitutes the basic professional degree. It is during undergraduate training that students acquire the professional knowledge that identifies them as music therapists and enables them to enter the work force. Professional knowledge, as defined by Schein (1972), consists of the following three elements:

- An underlying discipline or basic science component upon which the practice rests or from which it is developed.
- An applied science or "engineering" component from which many of the day-by-day diagnostic procedures and problem solutions are derived.
- 3. A skills and attitudinal component that concerns the actual performance of services to the client, using the underlying basic and applied knowledge. (p. 43)

The three elements, if viewed from the perspective of the training process, encompass both the academic and fieldwork components of professional education. Schein identified a trend in the professions toward increasing convergence in the knowledge and skill base. Convergence manifests itself in an increasing degree of consensus among the members of a profession as to which paradigms are "to be used in the analysis of

phenomena and high consensus as to what constitutes the relevant knowledge base for practice" (Schein, 1972, p. 44). Agreement among the members of a profession as to what should constitute the knowledge base for the profession is essential for two reasons. Firstly, it facilitates the elaboration and integration of a professional identity which is distinct from that of other professions. Secondly, it provides for the delimitation of the scope of the professional degree, thereby facilitating the conceptualization of advanced training.

Theoretically, the skills component of professional knowledge is derived from the basic and applied science components. For this to occur, there must be a body of knowledge which is commonly accepted by the members of a profession to represent the theoretical core of the discipline. Perusal of the official publications of the National Association for Music Therapy and the general music therapy literature emanating from the U.S. reveals a divergence of views regarding the existence of a theory specific to music therapy and the importance of music as the therapeutic tool. Attempts have been made to elaborate conceptual frameworks specific to music therapy, most notably by Sears (1968) and Gaston (1968). Contributions in the form of elaborations or critical analyses of the proposed frameworks have been limited. There are, however, many articles in which an attempt is made to relate music therapy to pre-existing frameworks and to describe

music therapy as one member of a group of therapies, thereby circumventing the larger issue of a coherent and internally consistent body of knowledge. Ruud (1973); in his Master's thesis, attacks this issue directly. He divides the field of psychiatry into four major approaches -- biological, behavioural, psychodynamic and humanistic -- and proceeds to illustrate how the various approaches in music therapy and the processes as elaborated by Sears (1968) are derived from these extant psychological schools of thought. (Unlike Brown (1975), who documents the influence of behaviourism and humanism on music therapy but implies the existence of a distinct theory specific to music therapy, Ruud asserts that music therapy, as a discipline, presently lacks an independent theory and is destined to remain dependent upon psychology for its theoretical framework.)

The lack of agreement that characterizes the views regarding the existence of a theoretical framework specific to music therapy also characterizes the views regarding the importance of music, per se, in therapy. Some authors have attempted to explore the basic nature of music therapy by focusing on the relative importance of <u>music</u> and <u>therapy</u>. Whereas Thompson (1960) stressed the importance of musicianship as equal to that of therapeutic skill, Braswell (1961) placed the stronger emphasis on therapy, as did Barnard (1953), who considered the therapist to be the true

therapeutic agent. Shatin, Kotter and Douglas-Longmore (1963) stressed personality factors rather than music skills as primary contributors to clinical success.

The philosophical type of research described above has been on the decline in recent years (Jellison, 1973). The interest in definitions, theoretical formulations and identification of directions and needs which are characteristic of philosophical research has been supplanted, in the literature, by a focus on experimental research, descriptions of techniques and methodologies, and descriptive investigations of various aspects of training. Jellison does not interpret this shift as "a process of decline in valuable ideas and theories" (p. 7), but rather as an increasing demand for the examination of ideas and theories which have already been postulated. An alternate interpretation of this shift is that the philosophical research resulted in the formulation of theories which were tentative and raised issues which were not easily resolved, and consequently, could not provide an adequate unifying force for the discipline. The shift from philosophical to experimental and descriptive research, viewed from the perspective of the latter interpretation, reflects a reduction in research on the basic science component of professional knowledge and an emphasis on the investigation of the applied science and skills components.

(One research method which has been widely used to explore the applied science and skills components is the descriptive

Various aspects of the training process for music study. therapists have been subjected to this form of investigation. Particular emphasis has been placed on the Bachelor's degree. Madsen (1965) proposed changes for the music therapy curriculum. He expressed the view that music history and theory are not very pertinent to music therapy and should, therefore, be required for only one year. He also stated that the role of the music therapist does not require professional level performance skills and consequently advocated that the study of the applied major instrument be restricted to one year. Galloway (1966), in a fairly comprehensive investigation of training, focused primarily on the undergraduate curriculum, the six-month clinical internship, and the opinions of music therapists regarding the extent to which these two levels of training provide music therapists with necessary skills.) Iley (1976) did a ten-year follow-up study and found that curricular changes were minimal. A limiting factor in the latter study was the method used to establish curricular content. University and department academic catalogues comprised the investigative tools, and, therefore, shifts in orientation and content could not easily be detected. Braswell, Maranto and Decuir (1979a, 1979b) included an investigation of the views of music therapists regarding academic and clinical training in a very comprehensive survey which covered many aspects of music therapy.

It is possible that the contribution of this persistent investigation of training has extended beyond the purely theoretical realm into the practical. It is not unlikely that these studies have, to some degree, served as the impetus for the current major initiative undertaken by the NAMT in the area of curricular revision. A revised Bachelor's level curriculum was presented to the Assembly of Delegates at the NAMT 1979 conference and received approval. In the revised curriculum, content statements replace course listings in the music therapy and music areas, and "credit distribution is not only given in semester and quarter hours but in percentages of the total degree requirements" (NAMT Newsletter, Dec. 1979).) The latter addition is significant in that it presents us with a clearer delineation of the relative value assigned to music and therapy, respectively, by an organized body of music therapists. It would seem that descriptive studies may contribute to the resolution of some of the issues raised in philosophical papers.

Interest in the Bachelor's programme, as reflected in the literature and the policies of the NAMT, has not been paralleled by equal interest in the Master's programme. In relation to Master's programmes, the NAMT serves primarily as an advisory agency rather than as an official body with the power to grant and withhold approval. The guidelines for establishing Master's degree programmes are sketchy and lacking in substantial content. They include the suggestion that only

those students who have completed a Bachelor's degree in music therapy or its equivalent and a six-month internship be accepted into a Master's programme. In relation to the content of the programmes, it is recommended that at least one-half of the hours be devoted to courses related to music therapy and should include therapy seminars, a practicum, and research. The tripartite division of music therapy related courses does not seem to reflect an orientation in the conceptualization of Master's level training. The Master's degree constitutes the advanced level of training for the profession and as such implies the refinement of knowledge and skills acquired at the undergraduate level and/or the acquisition of additional and different knowledge and skills. Whereas the refinement of knowledge and skills could produce a clinician superior to the clinician with a Bachelor's degree, the acquisition of new knowledge and skills could produce a music therapist with a professional role distinct from that of a clinician. It is important, therefore, to understand the nature of graduate training in music therapy and to attempt to ascertain is functions and goals.

The purpose of the present study is to explore the graduate training of music therapists with particular emphasis on two major areas. The first area of interest is the curricular structure and content of the Master's degree programme, per se, and the second area is the attitudes of music therapy educators toward the education and comparative skills,

functions, and roles of music therapists with Bachelor's degrees and music therapists with Master's degrees.

Studies Related to the Master's Degree in Music Therapy

There are only a limited number of studies in the literature which focus primarily on graduate level training in music therapy, per se. There are even fewer studies which investigate the differences between the graduate and undergraduate curricula and between the perceived or actual functions and skills of music therapists with Master's degrees and those with Bachelor's degrees.

The one component of graduate training in music therapy which has received recognition as a major contributor to the uniqueness of the Master's programme is research. Michel and Madsen (1969) referred to research as "the hallmark of graduate training" (p. 22). Gaston (1955-56) stressed the necessity for members of the faculty to have active interest and involvement in research to ensure the optimal climate for the teaching and sharing of research skills. Neither Gaston (1964) nor Schneider (1965) perceived the development of researchers to be the sole function of graduate training. Schneider viewed the acquisition of financial support for a pilot project in graduate training in 1964 and the subsequent gradual increase in the number of graduate programmes as indicative of two changes which were positively affecting the profession. The first change was the increased acceptance of

music therapy by the wider community, and the second change was the realization of music therapists that there was a need for "more knowledgeable and sophisticated music therapists -therapists trained in a more rigorous scientific fashion who will become both researchers and clinicians" (Schneider, 1965, p. 105). Gaston (1964), in reference to the aforementioned pilot project for graduate training, listed the goals of advanced training in music therapy. The goals included advanced clinical training, research, and scholarship in music therapy.

Michel (1965) presented a professional profile of NAMT members based on a survey completed in 1963. He compared his results to those of an earlier survey conducted in 1960 and found an increase in the percentage of NAMT members holding degrees in music therapy rather than in music. Despite the increase, 9.1% of the respondents held a Master of Music or Arts and only 2.1% held a Master of Music Therapy. Although Michel alluded to the importance of the increase in members holding a Master of Music Therapy, it is not possible to draw conclusions from these data regarding attitudes toward a Master's degree in music therapy for two reasons. The number of people holding an advanced degree in music therapy could be related to the relative availability of Master's programmes at that time, and the terminology or labels used, i.e., Master of Music versus Master of Music Therapy, could be subject to differential interpretation. А

respondent who has received a Master of Music with an emphasis or major in music therapy could indicate either response based on interpretation.

A much more recent survey of NAMT members conducted by Braswell et al. (1979b) provides a less ambiguous description of attitudes toward the Master's degree in music therapy. Almost 73% of the respondents claimed that they "would not feel more adequately prepared in job performance" (p. 60) if they held a Master's degree in music therapy. Almost 82% of the respondents felt that job security would not be more ensured and almost 69% believed that their status in relation to other professionals would not be raised by the acquisition of a Master's degree in music therapy. Music therapy was ranked the third most preferred discipline in which to obtain a Master's degree, following special education and psychology which were ranked first and second, respectively. Although the reasons for this apparent devaluation of graduate training in music therapy are difficult to ascertain, this study highlights the need to subject the Master's degree programmes to further investigation.

Hanser and Madsen (1972) selected one component of the curriculum, that is, research, and designed an experiment that would enable them to compare the research skills of undergraduate music therapy students to those of graduate level music therapy students. The subjects were undergraduate students in a Psychology of Music class and graduate students

in an Experimental Research in Music class at Florida State University. Both groups of students were required to conduct experimental research and to submit a research paper. Each of the graduate students contracted with the professor to receive a particular grade contingent upon meeting specific criteria. Undergraduate students, however, were guaranteed a noncontingent grade of "A". This differential grading system was intended to lower the motivation of the undergraduate students and increase that of the graduate students. The quality of graduate research, as determined by four independent judges, did not differ significantly from undergraduate research. These findings, although specific to one group of students at one university, reflect a discrepancy between generally accepted expectations of graduate training and the actualities of this level of training.

Galloway (1966), in a comprehensive investigation of attitudes toward training in music therapy, focused primarily on the undergraduate degree and clinical training. Some of his findings, however, touched tangentially on the graduate degree. When asked at which level specialization should occur, the clinical level (six-month internship) was preferred to the academic level (Bachelor's programme), but several respondents stated that specialization should occur at the graduate level. Research projects also tended to be preferred at the clinical level, but some respondents stated

that training in research should occur exclusively at the graduate level. The majority of respondents felt that it was not desirable for the NAMT to grant advanced certification to music therapists with Master's degrees.

Iley's (1976) follow-up study concentrated on verifying the presence or lack of curricular changes in the undergraduate programmes ensuing from the Galloway study recommendations. Minimal attention was given, therefore, to the Master's level programmes. Required course titles were listed, but the content of the programmes was not dealt with at depth since the focus of the study was the undergraduate curriculum.

In summary, most of the studies relating to graduate training in music therapy are in the form of philosophical and descriptive research. In philosophical papers the research component of graduate training is stressed. Descriptive studies investigate the attitudes of music therapists toward graduate training. Braswell et al. (1979b) found that a majority of the members of the NAMT felt that a Master's degree in music therapy could not enhance job performance or status in relation to other professionals and would not ensure job security. They also found that music therapy was considered the third most preferred discipline in which to obtain a Master's degree, following special education and psychology. Galloway (1966) found that most respondents did not consider it desirable for the NAMT to grant advanced

certification to music therapists holding Master's degrees. Hanser and Madsen (1972), in an experimental investigation of research skills, failed to find significant differences between the research skills of students at the undergraduate and graduate levels of training in music therapy at Florida State University. The research presented supports the need to subject the Master's degree in music therapy to further investigation.

Studies Related to the Master's of Social Work and Occupational Therapy

Both social work and occupational therapy are disciplines in which the Bachelor's degree represents the basic professional degree and the Master's degree represents an advanced level of training. Concerns have been raised in the professional literature of both disciplines regarding the distinctions between the Master's and Bachelor's levels of training, but these concerns have been channeled into different forms of investigation.

The basic professional degree in social work was originally the Master's degree but was later defined as the Bachelor's degree. This shift resulted in increased numbers of social workers with varying levels of skills and seems to have generated interest, as reflected in the literature, in assessing and defining the differential skills, roles, and functions of social workers with different levels of education. Barker and Briggs (1968), as reported in Regan (1976),

stressed the importance of clearly defining the tasks which fall under the mandate of the social worker with a Master's degree. They outlined the detrimental effects on the profession and the community of having MSWs and non-MSWs engage in the same tasks. Davis (1971) supported the necessity for MSWs to perform certain tasks which are different from the tasks performed by BSWs and specified the ability to assess and help a patient with severe emotional problems as falling within the domaine of the MSW. Regan (1976) developed a model for social work practice in which the tasks of the MSW included the development of a referral procedure, establishing in-service education programmes, staff supervision, consultation, and meeting the emotional-psychological needs of patients and families. The tasks of the BSW revolved around direct service to patients.

Lurie (1976) investigated, and made recommendations for, staffing patterns for social workers in hospitals and clinics. Although expressing the view that the differential use of BSWs and MSWs required further study and evaluation, he did provide several guidelines. He suggested that psychosocial assessments be made initially by an MSW; that there be one BSW on staff for every four to seven MSWs; and that experienced BSWs be allowed to undertake counselling responsibilities under the supervision of an MSW. He additionally advocated that BSWs be primarily responsible for the following tasks: interviewing for financial evaluations, arranging alternate

care, developing certain liaison relationships with community agencies, initiating and completing nursing home referrals, and serving as advocates for patients and families who are entitled to various benefits not yet received (p. 93).

Wattenberg and O'Rourke (1978) designed a study to compare the importance ascribed to certain social work tasks by MSWs and BSWs and the frequency with which these tasks were performed by members of the respective groups. A questionnaire was used as the instrument and respondents were required to indicate how important they considered each task to be and how frequently the task was performed. In the area of services to patients, there was considerable agreement between the two groups on both parameters -- importance and frequency. Group work was perceived as more important by MSWs than BSWs. MSWs conferred with colleagues more frequently and BSWs helped with finances and routines somewhat more frequently. More MSWs than BSWs helped patients with fears and anxieties. In the area of services to families, there were some discrepancies between the importance attributed to tasks and the frequency with which they were performed, but there were no significant differences between MSWs and BSWs. In the areas of management, administration, and planning, the only task which was performed more frequently by MSWs was supervision of other social workers. Although there were many discrepancies between the importance attributed to tasks and the frequency of performance in the area of community work, there were no significant between-group

differences. MSWs did view research as somewhat more important than did BSWs, but the difference was not significant. There were no differences in the importance attributed to educating other professionals or in the frequency with which this was done. Overall, very few significant differences were found and the hypothesis that BSWs regularly performed more routine duties than MSWs was not confirmed.

The occupational therapy literature reflects some interest in the delineation of the skills and functions of occupational therapists (e.g., Eliason & Gohl-Giese, 1979, and Gilfoyle & Hays, 1979), but this is largely restricted to basic professional skills and consequently does not include comparisons between occupational therapists with Master's degrees and those with Bachelor's degrees. Only limited attention has been given to the graduate programme, per se, and this has taken the form of descriptions of models of education and elaborations of guidelines for graduate education. There are two types of Master's degrees in occupational therapy (Reilly, 1969). The Advanced Professional Master's degree is designed for students who are accredited occupational therapists and the Basic Professional Master's degree is designed for students with undergraduate training in other disciplines. Much of the literature devoted to graduate training has focused on the distinctions between these two degree structures. Rogers (1980a, 1980b) explored the Master's degree structure in occupational therapy and compared it to other professions in which the Bachelor's

degree is the basic professional degree. She concluded that the occupational therapy graduate degree structure does not differ considerably from that of other professions, but nonetheless recommended that the dualism in graduate training be reduced by including advanced professional training within the Basic Master's curriculum. She recommended that the Master's curriculum include: the professional sciences and their development; application of the professional sciences; and liberal learning (p. 183).

Reilly (1969) described the curriculum in an Advanced Professional Master's degree programme. Research methods, directed research, seminars, and a thesis were required. The most commonly selected electives included personality and learning theory, the social-psychological aspects of growth and development, socialization, small groups, and role theory. The goals of the programme were to provide students with knowledge in sociology and psychology beyond that acquired at the undergraduate level, to provide training in research skills, and to provide students with the opportunity to "develop the repertoire of skills, attitudes, and discriminations necessary for acquiring the behavioral science theorizing point of view" (p. 304).

The American Occupational Therapy Association has produced a series of policy statements and guides regarding the establishment and the content of graduate programmes in occupational therapy. The most recent document is a guide

(AOTA, 1979) which includes a definition of the functions of graduate training and outlines the competencies which the graduate student is to possess upon completion of a Master's programme. It also includes the contributions which the graduate is expected to make to make to the profession. The ability of a graduate of a Master's programme to provide specialized professional services and to contribute to the development of the profession through research is stressed. The guide, although much more elaborate than the guidelines provided by the NAMT, does not represent an approval mechanism for Master's programmes in occupational therapy. It is the individual university which has ultimate control over graduate training.

In summary, both social work and occupational therapy are disciplines in which the basic professional degree is the Bachelor's degree. Consideration has been given, in the literature of both professions, to the basic and advanced levels of professional training. Within social work, attempts have been made to assess and define the differential skills and functions of BSWs and MSWs. Although models of social work practice which clearly distinguished between the two levels of training were elaborated (Regan, 1976), Wattenberg and O'Rourke (1978) found that many of the commonly held assumptions regarding the differential tasks of MSWs and BSWs were not confirmed by experimental investigation. In the occupational therapy literature, there were some studies in

which Master's level training was described. Comparative studies focused more on the differences between the Basic Professional Master's degree and the Advanced Professional Master's degree than on the differences between occupational therapists with Bachelor's and Master's degrees. The American Occupational Therapy Association has elaborated several policy statements and guides for graduate training, but these serve as guidelines rather than as official criteria for granting approval to Master's level programmes.

METHOD

Information regarding the structure and content of an academic programme can be gathered in several ways. One method is to obtain university and department course catalogues and to compile the information contained in these publications. The two most obvious weaknesses of this approach are the difficulty obtaining current information and the inherent limitations imposed by the actual format of course catalogues. Practicality and cost dictate that individual course descriptions be concise, thereby limiting the extent to which they can accurately and comprehensively reflect course content. Since it was fundamental for the purposes of this study to investigate, in depth, certain aspects of course content, this method was considered inappropriate and was eliminated as an option.

A second method whereby this type of information can be gathered is the interview. Since the universities which offer Master's programmes in music therapy are scattered throughout the United States, this alternative was deemed unsuitable. The method that seemed the most practical and efficient for obtaining information from the small, discrete and scattered population of directors of Master's programmes listed by the NAMT was the questionnaire. A questionnaire which could provide an accurate description of curricular content was

developed.

Since the objective of the study was not only to gather factual information regarding the Master's programme in music therapy, but also to attempt to elucidate the state of graduate training by assessing the degree of consistency between the actual content of, and attitudes toward, graduate training, it was necessary to develop two complementary questionnaires, one seeking factual information, the other, attitudinal. Galloway (1966) found that the attitudes of NAMT members toward certain aspects of undergraduate training tended to lack uniformity and that the attitudes of academic directors were at times at variance with those of two other specific categories of music therapists -- music therapy clinicians and directors of music therapy programmes/ internship supervisors -- as well as those of music therapy interns. It was decided, therefore, for the purposes of this study, to define the population in a much more narrow fashion and to focus on intra-group rather than inter-group concordance. Since the attitude questions dealt with aspects of graduate training and differences between music therapists with Master's degrees and those with Bachelor's degrees, it seemed appropriate to investigate the views of directors of Bachelor's and Master's programmes since they comprise the group of music therapists who have the greatest direct influence upon, and reponsibility for, the academic programmes.

A questionnaire was sent to the director of music therapy at each college and university listed in the NAMT brochure "A Career in Music Therapy". This list included all programmes approved by the NAMT as of August, 1978. There were eleven universities listed which offered graduate programmes, and one additional programme which had received recognition prior to the distribution of the questionnaires was included, increasing the total population of graduate programmes to twelve. There were forty-nine colleges/ universities which offered only undergraduate programmes. (There were, in fact, fifty-two undergraduate programmes listed, but four were members of a consortium and were, therefore, treated as one programme.)

Graduate Questionnaire

The graduate questionnaire was sent to the directors of music therapy at the twelve universities offering Master's programmes. Copies of the graduate and undergraduate questionnaire appear in Appendix A. The graduate questionnaire consists of two major sections, one factual, the other attitudinal,

Section A: Factual Information

This first section focuses primarily on factual information regarding the content and structure of the Master's programme in music therapy. It is five pages in length and contains fifteen questions. Although many of the questions

are subdivided, the majority were designed as filter questions, thereby eliminating unnecessary reading. Most questions are closed in form, but an "other" category was provided to ensure that respondents were not overly restricted by the options provided. Several questions require the respondent to estimate percentages and, consequently, are more time consuming. The length of the questionnaire and the time required to complete it could not have been reduced further without resulting in the loss of pertinent information. It was recognized that length and time required for completion are factors which ordinarily affect response rate (Warwick, 1975), but it was hoped that the relevance of the questionnaire to the work and professional concerns of the respondents would serve to motivate them sufficiently to counteract the effects of these other factors.

Since the function of graduate training in music therapy is, as viewed by Gaston (1964), to produce advanced clinicians, researchers, and scholars in music therapy, these areas were incorporated into the factual section of the questionnaire. To ascertain the role of research in graduate training, thesis requirements, the relative weight of research within the programme as determined by the proportion of assigned credits, and the ranking, by educators, of research as a goal of training were all investigated. Aspects of the programmes which could result in advanced clinical skills were also subjected to investigation. Among these were the practicum requirements, opportunities for

specialization, instruction in functional music, and assessment techniques. Scholarship is sufficiently abstract a term to defy direct correlation with specific tasks or skills. It undoubtedly overlaps with both research and clinical skills and extends beyond them. Of those areas of curriculum investigated, models of music therapy and models of therapy other than music therapy could be perceived as contributing to scholarship while remaining intimately linked to clinical skills. Space was provided for comments and elaboration and clarification of responses.

Section B: Attitudinal Information

The second section of the questionnaire was developed to obtain the views of academic directors on certain aspects of the training and clinical practice of music therapists. This section is two and one-half pages in length and contains eleven questions. All but one of these questions are "closed" in form, and the questions which are subdivided were constructed as filter questions. Since dichotomous questions, i.e., questions requiring "yes/no" responses, are subject to the least bias (Young, 1966) but provide only limited information, the form was employed but was followed by questions which yielded more information. Several of the questions provided respondents with a list of items from which they were required to select the three which they considered to be "the most important", "the most similar", or "the best" depending upon the question. The three items selected were to

be ranked from one to three, where one is equal to the most important. Although the content of the continuum was not consistent (for example, in some questions importance was rated, whereas in others similarity was rated), confusion was avoided by explicitly presenting the parameter to be examined within the context of each question.

Although the use of rating scales might have facilitated statistical analysis applied directly to the raw ranks, the inherent disadvantages outweighed the advantages and rendered the ranking method described above the preferred method. The format of the questionnaire would have had to be restructured to accommodate rating scales. This would have resulted in a longer questionnaire and one which would have required more time and effort on the part of respondents. Since there was already a risk of the questionnaire being too lengthy and time consuming, the use of rating scales would most probably have had an adverse effect upon response rate. A second problem presented by rating scales is the tendency of respondents to stay near the middle of the scale (Warwick, 1975). This obstacle to obtaining sharply focused responses was surmounted by the use, in this study, of one end of an implicit rating scale continuum. Those items which were perceived by the respondents to be unimportant were not assigned low ranks, but rather, were not ranked at all. The one disadvantage of the method used is that, given the limited size of the population, it lent itself more to

descriptive analysis and statistical analysis of frequency of selection than to statistical analysis applied to the ranks.

One of the objectives of the study was to evaluate the degree of consistency between attitudes toward graduate training and actual curricular content; and, therefore, the attitude section was constructed to cover several of the same areas as the factual section. Views regarding the inclusion of verbal therapy techniques, assessment skills, and specialization in the training of music therapists were investigated, and respondents were asked to indicate at which level of training these should occur. It was considered important to ascertain at which levels respondents believed specific skills should be acquired because their responses could indirectly reflect their attitudes toward the function of graduate training, and by extension, their attitudes toward the distinctions between graduate and undergraduate training. Several questions focused directly on these distinctions. Respondents were requested to select specific skills, musical and clinical, which they felt differentiate between music therapists with Master's degrees and those with Bachelor's degrees. They were also requested to compare the clinical skills of music therapists to those of members of related disciplines. Braswell et al (1979b) reported on music therapists' perceptions of the status of music therapy relative to other disciplines. If a

therapist's status within a facility is directly related to demonstrated clinical skills, it is important to examine both the skills acquired and the opinions of educators regarding these skills.

Undergraduate Questionnaire

The undergraduate questionnaire was sent to the directors of music therapy at the forty-nine NAMT-approved colleges/universities offering only Bachelor's level programmes. The questionnaire consists of two major sections, one factual, the other attitudinal. The factual section was sent as well to the directors of Master's level programmes.

Section A: Factual Information

The major purpose of this section was to gather information regarding the directors' of Bachelor's programmes expectations of graduate training. These expectations, if then compared to the actual content of Master's level programmes, could provide a measure of coherence within the discipline. The second objective was to gather information pertaining to the curricular content at the Bachelor's level in order to facilitate a comparison of certain aspects of the graduate and undergraduate curricula.

Section A of the undergraduate questionnaire is identical in design to Section A in the graduate questionnaire. The aspects of the curriculum included in the investigation are also the same. The questions differ only in that

"Master's degree" is replaced by "Bachelor's degree", and several questions which had relevance only to the Master's degree were dropped. Questions regarding respondents' views on graduate training were added, in almost all cases, as subsections of existing questions so as to ensure that the format remained consistent with that of the graduate questionnaire. This section is four and one-half pages in length and contains thirteen questions. Space was provided for comments and elaboration and clarification of responses.

The factual section of the undergraduate questionnaire was sent with the graduate questionnaire to the directors of Master's programmes. The rationale for including it was that it would provide an additional method for determining the degree of consistency among academicians in regard to their views of training, and between their views and the actual training provided. It would provide for a comparison of the undergraduate curricula at universities offering both levels of training and those offering only undergraduate training. A major problem presented by the inclusion of the additional form was that it increased considerably the length of the questionnaire and the time required to complete it. For this reason, the cover letter (see Appendix A) requested that the educators respond to the graduate questionnaire first, in the hope that the rate of return for the graduate questionnaire would not be adversely affected. Of those directors of Master's programmes who did respond, very few (n=4)
responded to the undergraduate form, thereby precluding a meaningful comparison of undergraduate programmes at universities with Master's programmes and at universities without Master's programmes in music therapy. These data were, therefore, omitted and not subjected to any form of analysis.

Section B: Attitudinal Information

This section is identical in all respects to the corresponding section of the graduate form.

Analysis

Analysis of the data was both descriptive and statistical in nature. The descriptive analysis employed primarily means, percentages, and for those questions seeking opinions or attitudes, proportions (based on frequency of selection of items) and medians. The correspondence between the proportions of respondents who selected items and the importance attributed to the item as measured by the median ranks assigned was described.

The limited size of the populations and the resultant limited size of the samples, and the small and unequal "n's" for individual items in the questions which required ranking were the major factors which rendered statistical analysis applied directly to the ranks less meaningful than descriptive analysis of the ranks and statistical analysis of frequencies of selection. The Pearson product moment correlation coefficient was employed to measure the degree of

relationship between certain aspects of the Master's and Bachelor's programmes, and between the expectations of the directors of Bachelor's programmes and the content of the Master's programmes. In questions requiring ranking of only three items, frequencies of selection were converted to ranks and the converted data were subjected to a Spearman's Rank Order Correlation to measure the degree of relationship between the views of directors of Master's and Bachelor's programmes. Statistical comparisons for individual items involving proportions were performed using chi square as a test of the significance of differences between proportions. For those questions in which the items were not independent and the data did not, therefore, meet the assumptions of a normal distribution, between-group differences were compared with the use of a nonparametric test, the Mann-Whitney U Test. In questions requiring ranking, all items selected by less than 50% of the respondents in both groups were not subjected to individual statistical analysis, but were used for discussion purposes if considered very relevant to the subject. The significance level was established at α =.05 for two-tailed tests.

To provide as complete a description as possible of the degree of consonance between the actual Master's programmes and views regarding this level of training, several comparisons were made. The Master's programmes were described and then compared to the expectations of the directors of

Bachelor's programmes. Certain aspects of the undergraduate curriculum were compared to the graduate curriculum to develop a better understanding of the real differences between these two levels of training. The attitudes of the directors of Master's programmes were compared to the actual Master's programmes. The degree of convergence in the views of academic directors was further explored by comparing the attitudes of the directors of Master's programmes to those of the directors of Bachelor's programmes.

RESULTS AND DISCUSSION

The information presented is derived from questionnaires sent to the directors of music therapy at the 12 graduate programmes and 49 NAMT-approved undergraduate programmes. All questionnaires returned by June 15, 1979 were included. Nine of the 12 graduate questionnaires, or 75%, and 35 of the 49 undergraduate questionnaires, or 71.4%, were returned. These rates of response were considered sufficiently high to provide an adequate representation of the respective populations.

Since some of the programmes were on a semester system and others were on a term or quarter system, all credits were converted to semester hours to ensure consistency and avoid confusion. The terms "semester hours" and "credits" are, therefore, used interchangeably in the text and constantly refer to semester hours.

Description of Graduate Programmes

Clinical experience, beyond that required by the NAMT for the purposes of registration, was not a requisite for entrance into a graduate programme in music therapy. In only one-third of the programmes (n=3) were applicants encouraged to acquire clinical experience as music therapists prior to embarking upon graduate studies. Among those directors who

did encourage the acquisition of clinical experience, there was no consensus as to the amount of experience preferred. The responses were evenly distributed across the three options offered: one year, two years, and more than two years.

Credits

The mean minimum number of credits required to obtain a Master's degree in music therapy was 37 semester hours. Since the range was from 30-73 credits and the upper extreme value was far greater than the next highest value of 40 credits, the median, 32 semester hours, better reflects the data. The percentage of the total number of course credits accounted for by the required courses ranged from 53.3%-100%, and the mean percentage was 67.9%.

Content Areas

Music therapy core courses (including practicum) and research courses (excluding thesis requirement) were required in 100% (n=9) of the programmes. Psychology of music/ acoustics courses and psychology courses were each required in 55.6% of the programmes, and music courses were required in 44.4% of the programmes. Courses in music education and special education were required in only 22.2% of the programmes. Recreation courses were not required in any programmes and sociology/anthropology courses and sciences were required in only one programme. The number of credits

required in each of these content areas appears in Appendix B.

The proportion of the total number of required credits which each content area represented was calculated. The mean percentages were calculated on the basis of N=9 so as to best reflect the relative importance of each content area across the entire population of graduate schools. Music therapy core courses represented from 16.7% to 77.3% of total required course credits. The mean percentage was 33.12%. One of the responses was not included in the calculation of the mean since the respondent stated explicitly that all music therapy core courses were, in effect, research courses, and a practicum was not required. This response was, therefore, included in the calculation of the mean percentage represented by research courses. Research represented from 4.1% to 53.3% of total required coursework, with a mean of 18.9%. Music courses represented an average of 12.94% of required coursework; the range was from 0 to 49%. Psychology courses accounted for an average of 9.52% of required coursework; the range was 0 to 30%. The percentage of the total required coursework accounted for by psychology of music/ acoustics ranged from 0 to 25%, with a mean of 8.48%. These two areas were combined because several respondents stated that they had included acoustics within psychology of music. Music education and special education courses represented an average of 3.33% and 2.27%, respectively, of the total

number of required credits. Sociology/anthropology and sciences represented an average of 1.14% of total required coursework. An "other" category was provided and areas listed represented an average of 10.3% of required coursework. Included in this area were required case conferences, workshops, and seminars. The actual content could not be determined from the responses.

Course Content

Since university catalogues tend to provide brief, general, and hence, vague descriptions of courses, a more thorough and specific investigation of content was undertaken. This inquiry focused on three major content areas, all of which were considered particularly relevant to therapy, per se, and these were: models of music therapy; models of therapy other than music therapy; and the therapeutic use of music in a variety of settings.

<u>Models of music therapy</u>. Models of music therapy were included in the required courses in 66.7% (n=6) of the Master's programmes. Of these six programmes, 100% included behavioural music therapy, developmental music therapy, and psychoanalytic based music therapy; 66.7% included guided imagery and improvisational-expressive music therapy; and 33.3% required students to develop their own models of therapy. The mean percentage of the students' total exposure to models of music therapy accounted for by each of the aforementioned models is presented in Table 4.

Although all nine Master's programmes had music therapy core courses as requirements, only in two-thirds of these programmes was the study of models of music therapy included within required coursework. The model which accounted for the largest percentage of the students' exposure to models of music therapy was the behavioural model. This emphasis on the behavioural approach is consistent with Brown's (1975) findings that behaviour therapy has had a major impact on the field of music therapy, and has been instrumental in shaping current music therapy techniques. It is also consistent with the conclusions of Jellison's (1973) investigation of research in music therapy. She found an increase in experimental research, in general, and in experimental behavioural research, in particular. She also found an increase in the reporting of behavioural techniques. It is not possible to determine whether the increase in the reported use of behavioural techniques resulted from an increase in the clinical use of these techniques relative to other techniques, or whether these techniques, because of their objective nature, lend themselves more easily to investigation and subsequent reporting. In parallel fashion, the emphasis on behavioural music therapy within Master's programmes may reflect on a clinical orientation or on a research orientation.

Of the six educators who did include models of music therapy in required coursework, two stated that they

encouraged students to do readings in those areas not included, two stated that they did not encourage students to do additional readings, and two did not respond. The three educators who did not require models of music therapy stated that readings in all models were encouraged.

Models of therapy other than music therapy. Models of therapy other than music therapy were included in the required courses in 77.8% (n=7) of the Master's programmes. Of these seven programmes, 100% included behaviour therapy; 85.7% included psychoanalytic therapy, gestalt therapy, and client-centered therapy; 71.4% included reality therapy, transactional analysis, psychodrama, and group dynamics; 57.1% included play therapy; and 42.9% included sensoryintegrative therapy. The mean percentage of the students' total exposure to models of therapy other than music therapy accounted for by each of the aforementioned models is presented in Table 6.

Although behaviour therapy did not represent as large a percentage of the total exposure to models of therapy other than music therapy as it did with models of music therapy, it represented a sufficiently large percentage (35.29%) to reaffirm the apparent trend toward a behavioural approach. The alliance of music therapy with the "activity therapies" was reflected in the large percentage accounted for by the "other" category (see Table 5). All of the models of therapy traditionally viewed as falling under the rubric of

psychotherapy individually represented under 8% of the students' total exposure to models of therapy other than music therapy.

Four of the seven educators who included models of therapy other than music therapy in required coursework encouraged students to do readings in those areas not covered. Two educators did not encourage readings and one did not respond. The two educators who did not include models of therapy other than music therapy stated that reading was encouraged in all models.

The therapeutic use of music. The therapeutic use of music in a variety of settings was included in the required coursework in 88.9% (n=8) of the Master's programmes. Two respondents did not specify which settings were included. Of those that did specify, 100% included the use of music in: adult psychiatry, the treatment of mentally impaired, special education, geriatrics, physical disabilities remediation, the treatment of emotionally disturbed and the treatment of developmentally disabled. The use of music in child psychiatry, in the treatment of addiction, and in palliative care were included in 83.3%, 66.7%, and 33.3% of the programmes, respectively. The mean percentage of the total coursework devoted to the therapeutic use of music accounted for by each of the aforementioned settings is presented in Table 8.

On the basis of percentages assigned, there seemed to

be no single setting which predominated this content area. In combination, however, adult and child psychiatry represented 28.3% of the total coursework devoted to the use of music in a variety of settings. The use of music in the treatment of the mentally impaired comprised the next largest percentage.

Specialization

Specialization in the use of music within one or several settings was possible in 55.6% (n=5) of the Master's level programmes in music therapy. In only one of these programmes were opportunities for specialization restricted to one specific type of setting, that being the treatment of the mentally impaired. In the remaining programmes, options were available. Of those programmes in which specialization was possible, 80% provided for specialization in special education, with the mentally impaired, with physical disabilities, with the emotionally disturbed, and with the developmentally disabled; 60% provided for specialization in geriatrics; and 40% provided for specialization in adult and/or child psychiatry and in addiction. Specialization in palliative care was possible in only one programme.

Specialization tended to be both clinical and theoretical in orientation and in only one programme was the clinical component not complemented by a theoretical component. Only three respondents specified the number of credits assigned

for specialization. The range was from 2 to 12 credits, with a mean of 7.4 credits. Since the response rate for this section of the question was so low, this mean might not accurately reflect the population mean.

Functional Music

A functional music course was required in 22.2% of the Master's level programmes. In an additional 55.6% of the programmes, students were required to demonstrate functional music skills. In an attempt to ascertain which specific music skills were commonly considered to be "functional music skills", a list was provided. Seven educators responded by selecting those skills which they emphasized. The ability to play one or several social instruments and the ability to sightread were included by 85.7% of the respondents. The abilities to transpose and to improvise, to match music to moods, and to express emotion through music were included by 71.4%, 57.1%, and 25.6% of the respondents, respectively. None of the respondents included the ability to perceive the meaning of emotion expressed through music in their definitions of functional music skills.

Assessment Methods

Formal assessment methods were taught in 88.9% (n=8) of the Master's programmes. In 50% of these programmes, assessment methods developed by music therapists and methods developed in other disciplines were utilized. In the

remaining programmes, the only assessment methods taught were those developed in other disciplines. There were no programmes in which music therapy assessment methods served as the sole assessment methods. The type of assessment method derived from a related discipline which was cited most frequently (n=5) was behavioural analysis. This finding was consistent with the trend toward behaviour therapy noted earlier. Psychological assessments were next in frequency (n=3), followed by art, dance, occupational therapy, educational, and mathematical, each of which were cited once.

Thesis

A thesis was required in 55.6% (n=5) of the Master's level programmes, but was optional in the remaining programmes. In those programmes not requiring a thesis, alternative replacements were required. In one of these four programmes, a thesis could be replaced by paper(s) and/or extra course(s). In the remaining three programmes, only one alternative to a thesis was provided. In one programme a paper(s) was required, in another programme extra courses were required, and in the third programme, a clinical alternative was required. The thesis was worth an average of 4.3 credits, with a range of 1 to 6 credits.

Less than 50% of the respondents considered philosophical and historical research to be acceptable types of research at the Master's level. All of the respondents (n=9)

considered experimental research to be acceptable and 77.8% considered descriptive research to be an acceptable form of research. It was assumed that the form of research most frequently used was also the preferred form of research. Experimental research was ranked as the most frequent form of research (Mdn=1, where 1 = most frequent), and descriptive research was second (Mdn=2). Experimental research was further subdivided into research in a laboratory setting and research in a clinical setting. The clinical setting was found acceptable by all respondents and the laboratory setting was found acceptable by 77.8% of the respondents. Experimental research in a clinical setting was more frequent than in a laboratory setting (Mdn=1 and 1.5, respectively). This finding might reflect a current movement toward research which is more practical in nature and, consequently, more relevant to the needs of music therapy clinicians.

Practicum

A practicum was required in 88.9% (n=8) of the Master's programmes. The number of credits assigned to the practicum ranged from 0 - 14 credits, with a median value of 2.83 credits. The minimum number of hours per week devoted to the practicum ranged from 2 - 20 hours with a median of five hours. The minimum total number of hours devoted to the practicum could not be computed because several educators did not respond and several others seemed to have misinterpreted the question.

All of the programmes in which a practicum was required offered a clinical practicum; 87.5% of the programmes offered both clinical and supervisory practica; and 25% of the programmes offered an administrative practicum in addition to the two aforementioned types of practica.

<u>Clinical practicum</u>. The types of facilities utilized for clinical practica were specified by six educators. Geriatric facilities was the only setting cited by all the respondents. Psychiatry, mental retardation facilities, special schools, and community mental health facilities were cited by 66.7% of the respondents, and facilities for the physically handicapped and for delinquents, prisons and general hospitals were each cited by one respondent.

Master's level students were involved in group and individual sessions in all but one of the programmes. In that programme, graduate students gained experience exclusively in one-to-one sessions. In none of the programmes were students required or encouraged to use media other than music. In 87.5% of the programmes, students were allowed to use other media, the most commonly specified media being, in descending order of frequency, art, movement/dance, and drama.

In only 25% of the programmes were students required, in the role of therapist, to utilize psychotherapeutic techniques such as verbal interpretation and reflection. In all the programmes, however, students were required to use formal assessment and evaluation tools.

In 62.5% of the programmes, Master's level students were supervised by members of the music therapy faculty and in 37.5% of the programmes, they were supervised by members of the faculty and by an on-site supervisor.

Supervisory practicum. Master's level students supervised both upper and lower division undergraduate students in 85.7% of the programmes which offered supervisory practica. In one programme, Master's level students were also responsible for supervising RMT-equivalency graduate students. Since experience beyond that required by the NAMT for the purposes of registration was not required for entrance into a graduate level programme in music therapy, it is possible that a large proportion of the Master's level students who supervise upper division undergraduate students have, in actuality, no clinical experience beyond the six-month internship. It is questionable whether this is a sufficient amount of experience to enable them to adequately supervise undergraduate students who are in their senior year.

Graduate students, themselves, were supervised primarily by members of the music therapy faculty.

Administrative practicum. This form of practicum was offered in only two programmes. One of the programmes used mental retardation and adult psychiatric facilities as the practicum site. The field supervisors' professions were not specified, but students were supervised by a music therapy professor. In the second programme, the university,

itself, served as the facility. A university administrator served as the field supervisor and graduate students were also supervised by the department chairman.

Supervisory methods. Videotape, process notes, and direct observation were methods employed for supervision in 100% of the Master's programmes which required a practicum (n=8). Students' verbal reports and audiotape were used in 87.5% and 50% of the programmes, respectively. These methods were ranked according to frequency of use. Based on the median of the ranks assigned, the method of supervision most frequently used was students' verbal reports (Mdn=2, where 1 = most frequently used), followed, in descending order of frequency, by written process notes (Mdn=2.25), direct observation by supervisor (Mdn=2.83), videotape (Mdn=3), and audiotape (Mdn=4). It is apparent that those methods utilized in the largest proportion of programmes were not used with the greatest frequency.

Minor Area

A minor area of study, i.e., a second area of concentration, was required in one-third of the Master's programmes. A minor was possible, although not required, in one additional programme, and in 55.6% of the programmes, it was not possible. The number of credits required for a minor ranged from 6 - 15 credits, with a mean of 11.1 credits.

The area which was most often recommended as a minor in three of the four programmes which required/allowed a

second area of concentration was psychology. In the fourth programme, special education was most often recommended as a minor area.

Goals of Master's Level Training

To ascertain the views of educators regarding the purpose of Master's level training in music therapy, a list of professional orientations was provided and respondents were required to rank them according to importance as goals of training. The median and range of ranks assigned to each professional orientation are presented in Table 10. Clinicians and researchers were included by 100% of the respondents; supervisors and educators were included by 88.9% of the respondents; and administrators was included by 66.7% of the respondents.

The importance attributed to the professional orientation corresponded to the frequency of inclusion. The training of clinicians was considered to be the most important goal of Master's level education (Mdn=1, where 1 = most important), and the training of researchers was second (Mdn=2). From the range it was apparent that there was greater agreement among educators on the importance of training clinicians than there was on the importance of training researchers. It is of note that whereas 100% of the educators perceived the training of researchers to be one of the goals of graduate education and ranked it second in

· 46

importance, only 55.6% of the Master's level programmes included a thesis as a requirement. Further research may reveal whether these findings are truly contradictory or whether the directors of Master's programmes believe that thesis writing is not an essential component of training in research skills.

Relationship of Music Therapy to Other Therapies

The perceived strength of the relationship between music therapy and various categories of therapy was determined through the use of ranks. The strength of the relationship, as measured by the median rank, corresponded to the frequency of inclusion of the various therapies. Behaviour therapy, which was included by 55.6% of the respondents, was considered most strongly related (Mdn=1, where 1 = most strongly realted). Activity therapy was included by 44.4% of the respondents and was rated the second most strongly related (Mdn=1.5). One-third (33.3%) of the respondents included psychotherapy and it was ranked third by two of these three respondents.

Degrees Granted

The titles of the Master's degrees conferred were investigated to determine whether they might be related to certain trends in curricular content or orientation. The data did not, however, reveal the existence of any relationship between the label of the degree and the orientation. This

was consistent with Braswell's findings (1979b) in relation to perceptions of various aspects of training.

Of the nine universities included in the sample, two conferred a Master of Music degree; two conferred a Master of Music Therapy degree; two conferred a Master of Arts in Music Therapy degree; one conferred a Master of Music Education degree; one conferred a Master of Music Education in Functional Music degree; and one conferred a Master in Creative Arts Therapy - Music Therapy degree. The two universities which conferred a Master of Music Therapy degree also offered a Master of Music degree.

Comparison of Graduate and Undergraduate Curricula

The purpose of this section is not to provide a detailed and comprehensive description of the content and structure of Bachelor's level programmes in music therapy. Descriptions have been elaborated elsewhere (e.g., Galloway, 1966 and Iley, 1976), and the NAMT has recently (in 1979) subjected the undergraduate curriculum to intensive investigation and has formulated a series of revisions which will take effect in September, 1981. The focus of this section is on specific aspects of the Bachelor's level curriculum as they compare to the Master's level curriculum.

Content Areas

Thirty-three directors of Bachelor's programmes specified which content areas were included in their programmes.

The percentages of Master's and Bachelor's programmes in which each of the content areas was required appear in Table 1 and the mean percentages of the total required coursework accounted for by each content area at both academic levels appear in Table 2.

The correlation between the distributions of proportions of Master's and Bachelor's programmes which required the content areas was very low (r = .32). Psychology of music/ acoustics courses and psychology courses, music courses, sociology/anthropology courses, sciences, and recreation courses were required in a significantly lower proportion of Master's programmes than Bachelor's programmes. The chi square values for these content areas were 16.2, p < .001; 15.9, p < .001; 26.7, p < .001; 27.8, p < .001; and 7.05, p < .01, respectively, for df = 1. Research courses were required in a substantially larger proportion of Master's programmes, but this difference was not statistically significant ($\chi^2 = 2.97$).

The distributions of proportions of the total required coursework accounted for by the content areas at the Master's and Bachelor's levels were not significantly correlated (r = .33). The Mann-Whitney U Test was utilized to determine the significance of the between-group differences in proportions for individual content areas. Since n was greater than 20, the normal deviate, z_u , was calculated. Music therapy core courses and research courses represented a significantly larger

Table	1
	_

Percentages of Ma	ster's and	Bachelor'	s Programmes
Requiring Cont	ent Areas a	and of Dire	ectors of
Bachelor's Pr	ogrammes E	pecting In	nclusion

	Pro	ogrammes	Directors
Content Areas	Master's ^a	Bachelor's ^b	Bachelor's ^C
Music Therapy Core	100	100	90
Research	100	63.6	100
Psychology of Music/Acoustics	55.6	100	65
Psychology	55.6	100	90
Music	44.4	97	55
Music Education	22.2	36.4	35
Special Education	22.2	48.5	75
Sociology/Anthropology	11.1	93.9	15
Sciences	11.1	97	35
Recreation	0	48.5	15
Other ^d	44.4	33.3	-

^a N = 9 ^b N = 33 ^c N = 20

.

^d Responses included: seminars, workshops, case conferences, philosophy, and supportive fields at the Master's level; a variety of subjects falling under Humanities at the Bachelor's level.

			<u> </u>
•		Actual	Proposed
Content Areas	Master's ^a	Bachelor's ^b	Bachelor's ^C
Music Therapy Core	33.12	15.03	23.84
Research	18.9	1.55	24.67
Psychology of Music/Acoustics	8.48	4.37	7.72
Psychology	9.52	11.43	18.37
Music	12.94	45.09	5.75
Music Education	3.33	3.03	3.00
Special Education	2.27	1.96	7.75
Sociology/Anthropology	0.45	5.61	1.25
Sciences	0.69	5.07	2.50
Recreation	0	1.26	1.15
Other	10.3	5.6	-

Percentage of Total Required Coursework Accounted for by Content Areas and Percentages Proposed by Directors of Bachelor's Programmes

Note: All entries represent mean percentages.

^a N = 9 ^b N = 33 ^c N = 20

Table 2

proportion of the total required coursework at the Master's level than at the Bachelor's level ($z_u = 3.08$ and 4.4, respectively, p < .01). Conversely, music represented a significantly larger proportion of the total required coursework at the Bachelor's level ($z_u = 3.98$, p < .01).

It is not surprising that a significantly larger proportion of the total required coursework be devoted to music therapy core courses and research courses at the Master's level than at the Bachelor's level. The combined percentage, 52.02%, conforms to the guidelines established by the NAMT for graduate programmes in music therapy, and supports the conceptualization of the Master's programme as the advanced level of training within the discipline. Given the curricular emphasis on research at the Master's level, however, it is difficult to explain Hanser and Madsen's (1972) failure to find differences in the research skills of undergraduate and graduate level students.

Course Content

The three areas of course content which were investigated were: models of music therapy; models of therapy other than music therapy; and the therapeutic use of music in a variety of settings.

<u>Models of music therapy</u>. Models of music therapy were included in required coursework in 66.7% of the Master's programmes and in 91.4% of the Bachelor's programmes. The difference in proportions, although substantial, fell short of statistical significance ($\chi^2 = 3.72$). This result obviated the testing of significance of the differences between proportions

Percentages of Academic Programmes Requiring Models of Music Therapy and of Directors of Bachelor's Programmes Expecting Inclusion

	Prog:	rammes	Directors
Models of Music Therapy	Master's ^a	Bachelor's ^b	Bachelor's ^C
Developmental	66.7	82.7	75
Guided Imagery	44.4	65.7	67.9
Behavioural	66.7	88.6	85.7
Improvisational-Expressive	44.4	68.6	71.4
Psychoanalytic based	66.7	42.9	71.4
Other ^d	55.6	. 42.9	-

^a N = 9 ^b N = 35 ^c N = 28

^d Responses included: developing own models, eclectic, and current trends at Master's level; Orff, Dalcroze, creative methods at Bachelor's level. for individual models because none of the individual differences exceeded the arithmetic value of 25%. The proportions of Master's and Bachelor's programmes in which each of the models was included appear in Table 3 and the percentages of the total exposure to models of music therapy accounted for by each model at both academic levels are presented in Table 4.

The distributions of percentages of Master's and Bachelor's programmes which required models of music therapy were not significantly correlated (r = .52). The distributions of percentages of the total exposure to models of music therapy accounted for by each of the models were significantly correlated (r = .87, p < .05). The difference between the percentages which developmental music therapy accounted for at the Master's and Bachelor's level was not significant ($z_u = 1.29$) and since the arithmetic difference for this model was greater than for all other models, it could be concluded that none of the differences were significant.

Models of therapy other than music therapy. Models of therapy other than music therapy were included in required coursework in 77.8% of the Master's programmes and 85.7% of the Bachelor's programmes. The proportions of Bachelor's and Master's programmes in which each of the models was included appear in Table 5, and the percentage of the total exposure to models of therapy other than music therapy accounted for by each model at both academic levels is presented in table 6.

The distributions of percentages of Master's and Bachelor's programmes which required models of therapy other than

Percentage of Total Exposure to Models of Music Therapy Accounted for by Each Model in Master's and Bachelor's Programmes

Models of Music Therapy	Master's ^a	Bachelor's ^b
Developmental	9.33	20.48
Guided Imagery	4.17	5.62
Behavioural	43.33	42.1
Improvisational-Expressive	10.83	11.18
Psychoanalytic based	11.67	10.52
Other	20.67	10.1

Note: All entries are mean percentages.

 $a_N = 6$ $b_N = 29$

Percentages of Academic Programmes Requiring Models of Therapy Other than Music Therapy and of Directors of Bachelor's Programmes Expecting Inclusion

	Pr	ogrammes	Directors
Models of Therapy	Master's ^a	Bachelor's ^b	Bachelor's ^C
Psychoanalytic Therapy	66.7	65.7	76
Gestalt Therapy	66.7	74.3	76
Reality Therapy	55.6	82.9	80
Client-Centered Therapy	66.7	71.4	80
Transactional Analysis	55.6	68.6	84
Psychodrama	55.6	40	80
Group Dynamics	55.6	68.6	92
Behaviour Therapy	77.8	85.7	88
Play Therapy	44.4	42.9	68
Sensory Integration	22.2	37.1	76
Other ^d	44.4	17.1	-

 $a_{N=9}$ $b_{N=35}$ $c_{N=25}$

^d Responses included: art therapy, dance therapy, occupational therapy, recreation therapy, and physical therapy at the Master's level; rational emotive therapy, family therapy, art therapy, dance therapy, and relaxation therapy at the Bachelor's level.

Percentage of Total Exposure to Models of Therapy other than Music Therapy Accounted for by Each Model in Master's and Bachelor's Programmes

Models of Therapy	Master's ^a	Bachelor's ^b
Psychoanalytic Therapy	7.57	7.48
Gestalt Therapy	5.43	9.07
Reality Therapy	3.29	10.37
Client-Centered Therapy	4.71	12.04
Transactional Analysis	3.29	6.74
Psychodrama	3.29	3.04
Group Dynamics	7.29	12.22
Behaviour Therapy	35.29	28.89
Play Therapy	1.85	3.41
Sensory-Integrative Therapy	0.85	3.96
Other	27.14	2.78

Note: All entries are mean percentages.

^a N = 7 ^b N = 27

music therapy were significantly correlated (r = .72, p < .02, df=9). The difference between proportions for reality therapy was not significant ($\chi^2 = 3.04$), and since this was the largest arithmetic difference between proportions, it could be assumed that the differences between proportions for the other models also were not significant.

The distributions of percentages of the total exposure to models of therapy other than music therapy accounted for by each model at the Master's and Bachelor's levels were significantly correlated (r = .61, p < .05, df=9). Clientcentered therapy and reality therapy represented a significantly smaller proportion of the total coursework at the Master's level than at the Bachelor's level ($z_u = 2.1$, p < .05 and $z_u = 3.08$, p < .01, respectively). Behavioural therapy accounted for a larger proportion of the total at the Master's level than at the Bachelor's level, but this difference was not significant ($z_u = .3^4$). Nor was the difference for group dynamics significant.

Therapeutic use of music. The therapeutic use of music in a variety of settings was part of required coursework in 88.9% of the Master's programmes and 100% of the Bachelor's programmes. The percentages of Master's and Bachelor's programmes in which each of the settings was required are presented in Table 7 and the proportion of the total coursework devoted to therapeutic settings accounted for by each setting at both academic levels is presented in Table 8.

There was a highly significant correlation (r = .925),

	Pro	ogrammes	Directors
Therapeutic Settings	Master's ^a	Bachelor's ^b	Bachelor's ^C
Child Psychiatry	71.4	64.5	95.5
Adult Psychiatry	85.7	83.9	95.5
Mentally Impaired	85.7	74.2	72.7
Special Education	85.7	93.6	86.4
Geriatrics	85.7	96.8	86.4
Palliative Care	28.6	12.9	77.3
Physical Disabilities	85.7	90.3	90.9
Emotionally Disturbed	85.7	80.7	95.5
Developmentally Disordered	1 85.7	83.9	95.5
Addiction	57.1	54.8	81.8
Other ^d	57.1	19.4	-

Percentages of Academic Programmes Requiring Therapeutic Settings and of Directors of Bachelor's Programmes Expecting Inclusion at Master's Level

^a N = 7 ^b N = 31 ^c N = 22

^d Responses included: juvenile offenders and preventive medicine at the Master's level; juvenile offenders, corrections, general hospitals, prevention, and vocational rehabilitation at the Bachelor's level.

Table 7

Та	b	1	е	- 8

Percentage of Total Exposure to Therapeutic Settings Accounted for by Each Type of Setting in Master's and Bachelor's Programmes

Therapeutic Settings	Master's ^a	Bachelor's ^b
Child Psychiatry	11.67	6.54
Adult Psychiatry	16.67	13.94
Mentally Impaired	15.5	11.43
Special Education	10.5	16.06
Geriatrics	11.67	14.9
Palliative Care	1.0	0.54
Physical Disabilities	6.83	10.65
Emotionally Disturbed	8.83 .	10.88
Developmentally Disordered	10.67	9.77
Addiction	2.66	3.61
Other	4.0	1.68

.

.

Note: All entries are mean percentages.

a_N = 6 ^b_N = 28

p < .001, df=9) between the distributions of percentages of Master's and Bachelor's programmes which included therapeutic settings. The distributions of percentages of the total coursework devoted to therapeutic settings accounted for by each setting were also significantly correlated (r = .763, p < .01, df=9). Although child psychiatry represented a larger proportion at the Master's level than at the Bachelor's level and the reverse was true for special education, the differences were not statistically significant ($z_u = 1.15$ and 1.36, respectively).

There was no single setting which predominated this content area at the Master's or Bachelor's level. In combination, however, adult and child psychiatry accounted for 28.3% at the Master's level and 20.5% at the Bachelor's level. The use of music with the mentally impaired comprised the next largest percentage at the Master's level, as did the use of music in special education at the Bachelor's level.

Specialization

Specialization in the use of music in one or several settings was possible in 55.6% of the Master's programmes and in 28.7% of the Bachelor's programmes. The difference between proportions, although substantial, was not significant $(\chi^2 = 2.32)$. Whereas at the Master's level specialization tended to be both theoretical and clinical, at the Bachelor's level it was predominantly clinical.

Functional Music

A functional music course was required in a significantly larger percentage of Bachelor's programmes than Master's programmes ($\chi^2 = 14.55$, p < .001). The percentages of directors of academic programmes who included specific musical skills in their definition of functional music appear in Table 9. The distributions of percentages of academic directors who included the musical skills were significantly correlated (r = .93, p < .01, df=5).

Ta	b	1	е	9
				_

Percentages of Academic Directors Including Skills in Definitions of Functional Music

Skills ability to:	Master's ^a	Bachelor's ^b
Play social instruments	85.7	100
Sightread	85.7	94.1
Transpose	71.4	88.2
Improvise	71.4	88.2
Match music to moods	57.1	50
Express emotion through music	28.6	44.1
Perceive meaning of emotion expressed through music	0	32.4

^a N = 7 ^b N = 34

. Assessment Methods

Assessments derived from other disciplines served as the sole forms of assessment in a significantly larger proportion

of Master's programmes than Bachelor's programmes ($\chi^2 = 4.33$, p < .05). Music therapy assessment methods constituted the sole assessment methods in 29.6% of the Bachelor's programmes. There were no Master's programmes in which only music therapy assessments were used. Behavioural analysis and psychology assessments were cited with the greatest frequency by directors at both levels as nonmusic therapy assessments which were taught.

Practicum

A practicum was required in 88.9% of the Master's programmes and in 100% of the Bachelor's programmes. The setting which was cited with the greatest frequency by directors at both academic levels as a site used for clinical practica was geriatrics. Special school settings were cited with equal frequency by directors of Bachelor's programmes. Psychiatry was cited by a substantially larger proportion of directors of Master's programmes (66.7%) than directors of Bachelor's programmes (39.6%). This difference was not, however, statistically significant ($\chi^2 = 1.5$).

The emphasis on geriatrics is consistent with the high proportion of programmes in which the study of the use of music in geriatric settings was required. The findings in relation to psychiatric settings, however, are not as consistent. Whereas psychiatry was required in approximately 78% of the Master's programmes and 73% of the Bachelor's

programmes and represented over 20% of the total coursework devoted to therapeutic settings at both levels, psychiatric settings were used for practica in 66.7% of the Master's programmes and in only 39.3% of the Bachelor's programmes. This apparent discrepancy between theory and practice may simply reflect the relative availability of settings such as special schools and nursing homes or, alternately, the rigidity of controls in psychiatric hospitals. The limited exposure to psychiatric settings prior to internship may contribute to the perceived status of music therapists within psychiatry (Braswell et al., 1979b).

In the majority of programmes at both levels, students were involved in both group and individual sessions. Students were restricted to individual sessions in one Master's level programme and to group sessions in 15.6% of the Bachelor's programmes.

Students were required/encouraged to use media other than music in a significantly larger proportion of Bachelor's programmes (44.1%) than Master's programmes (0%; $\chi^2 = 5.49$, p < .02). Students were allowed to use other media in an additional 51.4% of the Bachelor's programmes and in 87.5% of the Master's programmes. The most commonly cited media at the Bachelor's level were, in descending order of frequency, movement/dance and art. The order was reversed at the Master's level.

Students, in the role of therapist, were required to use
psychotherapeutic techniques in 25% of the Master's programmes and in 52.9% of the Bachelor's programmes. Although substantial, this difference was not statistically significant ($\chi^2 = 2.02$). Students were required to use formal assessment and evaluation tools in more Master's programmes (100%) than Bachelor's programmes (73.5%). This difference between proportions was not significant ($\chi^2 = 2.6$).

Videotape was employed for supervision in a significantly larger proportion of Master's programmes than Bachelor's programmes ($\chi^2 = 11.5$, p < .001). However, it was not very frequently used at the Master's level. The three methods used with the greatest frequency at both levels were students' verbal reports, written process notes, and direct observation by supervisors. Two of these three methods are, by definition, subjective in nature. Studies which have investigated methods of supervision in psychoanalytic training point to the limitations imposed by verbal reports and process notes on the supervisory process. Both have been found to be subject to distortions and omissions and have not been found to contribute substantially to student change (Matarazzo, 1978). In a study on the training of supervisors (Southard, 1973), it was found that a taperecording of interviews served as a helpful teaching device. Audiotape and videotape were not used with great frequency in the Bachelor's or the Master's level music therapy programmes despite their objective nature.

Minor Area

A minor area of study was required/possible in 44.6% of the Master's programmes and in 50% of the Bachelor's programmes. The area most often recommended at both levels was psychology, followed, at the Bachelor's level, by music education and special education.

Relationship of Music Therapy to Other Therapies

The perceived strength of the relationship between music therapy and various other therapies corresponded to the frequency of selection of those therapies for directors at both academic levels. The directors of Master's programmes considered behaviour therapy to be most closely related (Mdn=1, where 1 = most strongly related), followed, in descending order, by activity therapy (Mdn=1.5) and psychotherapy (Mdn=3). The directors of Bachelor's programmes considered behaviour therapy and activity therapy to be most, and equally, related to music therapy (Mdn=1), followed by psychotherapy (Mdn=2.7). More than twenty percent (22.2%) of the directors of Master's programmes and 7.4% of the directors of Bachelor's programmes considered music therapy to be not strongly related to any other therapy.

Comparison of Expectations of Directors of Bachelor's

Programmes and Content of Master's Programmes

The factual section of the questionnaire sent to directors of Bachelor's programmes contained several questions which were designed to obtain information regarding the directors' expectations of graduate training. Each of these questions corresponded to a specific question in the form sent to directors of Master's level programmes. This facilitated a comparison between the views held by directors of Bachelor's programmes and the actual content of the Master's programmes. The content of Master's programmes was considered to reflect, to some extent, the attitudes of directors of the programmes. The Pearson product moment correlation coefficient was used as a measure of the overall degree of relation and chi square was used to test the significance of the difference between proportions for individual items.

Content Areas

The percentage of directors of Bachelor's programmes who believed that the content areas should be required at the Master's level and the percentage of Master's programmes in which each area was required are presented in Table 1. The distributions of percentages of Master's programmes requiring, and of directors of Bachelor's programmes expecting, inclusion were significantly correlated (r = .865, p < .01, df=8). The proportion of directors of Bachelor's programmes who believed that psychology and special education courses

should be required at the Master's level was significantly greater than the proportion of Master's programmes in which they were required ($\chi^2 = 4.49$ and 7.13, respectively, p < .05). The difference between proportions for music courses was not significant ($\chi^2 = 2.77$). It was assumed, therefore, that for all content areas in which the difference between proportions did not exceed 10.6% that the difference between proportions did not exceed 10.6% that the difference included by at least 50% of the respondents in one group were not tested for significance.

The mean percentage of the total required coursework represented by each content area and the mean percentage projected by directors of Bachelor's programmes for the Master's programme are presented in Table 2. The distributions of percentages accounted for by the content areas within the Master's programmes and projected by the directors of undergraduate programmes were significantly correlated (r = .856, p < .01, N=8). Although music therapy core courses actually represented 8.5% more of the total required coursework than was projected and research represented 5.5% less than was projected, these differences were not significant (U=73, N=9, 18 and U=63, N=9, 20, respectively). The latter difference might have been artifactual in nature since directors of Bachelor's programmes were not instructed to include thesis requirements within the research category. The directors of Bachelor's programmes felt that a

significantly larger percentage of total required coursework should be devoted to psychology and special education than was actually true (U = 48 and 44.5, respectively, p < .05, N = 9, 20). Music courses actually represented more than double the projected percentage, but the difference was not significant (U = 100.5, N = 4, 11).

Course Content

The three areas investigated were models of music therapy, models of therapy other than music therapy, and the therapeutic use of music in a variety of settings.

<u>Models of music therapy</u>. The percentages of Master's programmes in which models of music therapy were required and of directors of Bachelor's programmes who felt that they should be required are presented in Table 3. The distributions of percentages were not significantly correlated (r = .62, df=3). There were no significant differences between proportions for individual models of music therapy.

<u>Models of therapy other than music therapy</u>. The percentages of Master's programmes in which models of therapy other than music therapy were required and of directors of Bachelor's programmes who felt that they should be required at the Master's level are presented in Table 5. The distributions of percentages were not significantly correlated (r = .382, df=8). The proportion of directors of Bachelor's programmes who believed that group dynamics and sensory-integrative therapy should be included in Master's programmes was significantly greater than the proportion of Master's programmes in which they were required ($\chi^2 = 6.05$, p < .05 and 8.1, p < .01, respectively). Since the difference between proportions for transactional analysis was not significant ($\chi^2 = 2.98$), it could be assumed that no other differences between proportions were significant.

<u>The therapeutic use of music</u>. The percentages of directors of Bachelor's programmes who felt that the settings should be required in graduate programmes and of graduate programmes in which the settings were actually required are presented in Table 7. The distributions of percentages of directors of Bachelor's programmes who believed that settings should be required at the Master's level and of Master's programmes in which they were included were not significantly correlated (r = .459, df=8). Although there were apparent arithmetic differences in the percentages for child psychiatry, addiction, palliative care, and the mentally impaired, the difference between proportions was significant only for palliative care ($\chi^2 = 5.58$, p < .05).

Although the overall distributions of percentages of directors of Bachelor's programmes who believed that content areas should be required at the Master's level and of Master's programmes in which they were required were not significantly correlated and, therefore, failed to reflect convergence of views among educators, there were very few specific areas in which the difference between proportions was significant.

Practicum

The proportion of directors of Bachelor's programmes who believed that an administrative practicum should be offered at the Master's level was significantly greater than the proportion of graduate programmes in which this type of practicum was offered ($\chi^2 = 13.8$, p < .001). Over twenty percent (21.2%) of the directors of Bachelor's programmes felt that a teaching practicum should be offered at the Master's level, but this type of practicum was not available in any of the graduate programmes.

The importance attributed to the various forms of practica by the directors of Bachelor's programmes, as measured by ranks assigned, corresponded to the actual frequency of inclusion of the practica in the Master's programmes. The clinical practicum was considered most important (Mdn=1.64) and was included in the greatest number of graduate programmes (100%); the supervisory practicum was considered second most important (Mdn=2) and was included in 87.5% of the Master's programmes; and the administrative practicum was considered least important (Mdn=3) and was included in 25% of the programmes. To the extent that inclusion reflects the attitudes of the directors of Master's programmes, one can conclude that music educators ascribe the greatest importance to the clinical practicum and the least importance to the administrative practicum.

Goals of Master's Level Training

The percentages of directors of Master's and Bachelor's programmes who selected the various professional orientations, the ranks assigned, and the ranges of ranks are presented in Table 10.

Although a greater percentage of directors of Bachelor's programmes than Master's programmes perceived the development of administrators to be a goal of graduate training, the difference between proportions was not significant ($\chi^2 = 3.39$).

The frequency of inclusion of the various professional orientations and the importance attributed to them corresponded quite well for directors of Master's and Bachelor's programmes. Directors at both academic levels considered the training of clinicians to be the most important goal of graduate education and the training of administrators to be the least important goal. This is consistent with the low proportion of graduate programmes in which an administrative practicum was offered.

Overall, there seemed to be more agreement among the directors of Master's programmes than Bachelor's programmes as reflected by the ranges of ranks assigned. The distributions of median ranks seem to reveal a better capacity among the directors of Master's programmes to view the various orientations as discrete. The lack of tied ranks seems to indicate that the directors of Master's programmes had more precise views regarding the goals of graduate training than did the directors of Bachelor's programmes.

Table 10

Percentages of Academic Directors Including Orientations, Median Ranks Assigned and Ranges

Orientations	Percen	itages	Media	n Ranks ^c	Ra	nge
	Master's ^a	Bachelor's ^b	Master's	Bachelor's	Master's	Bachelor's
Clinicians	100	100	1.0	2.0	1 - 2	1 - 5
Researchers	100	100	2.0	3.0	1 - 4	2 - 5
Supervisors	88.9	93.9	3.0	3.0	1 - 5	1 - 4
Educators	88.9	100	3•3	3.0	3 - 4	1 - 5
Administrators	66.7	0.06	4.9	4.5	4 - 5	1 - 6

a N = 9

p n q

N = 33

ပ

Ranks range from 1 - 6 (including "other" category), where

•

l = most important.

The correlation between the two distributions of rankings failed to achieve significance, but was, nonetheless, a high positive correlation ($\rho = .894$).

Despite the views expressed by Michel and Madsen (1969) that research is "the hallmark of graduate training" (p. 22), the directors of Master's programmes ranked researchers as the second most important professional orientation, and the directors of Bachelor's programmes ranked it equal in importance to supervisors and educators. It is of note that researcher was the only orientation which was not assigned a rank of one by any of the directors of Bachelor's programmes.

Comparison of the Attitudes of Directors of Master's

Programmes and Content of Master's Programmes

To measure the amount of congruence between the attitudes held by directors of Master's programmes and the actual content of the programmes, responses to questions in the attitude section (Section B) of the questionnaire were compared to responses in the factual section (Section A). Some comparisons involved one question from each section and others required the pooling of information from several questions. For all questions which required ranking, the correspondence between the frequency of selection and the rank assigned was investigated. 75

Relationship of Music Therapy to Other Therapies

The perceived strength of the relationship between music therapy and other forms of therapy, as measured by ranks assigned, corresponded to the frequency of selection of the forms of therapy. Behaviour therapy was considered most closely related, followed in descending order by activity therapy and psychotherapy. The correspondence between frequency of selection and ranks assigned did not hold, however, when directors of Master's programmes indicated which forms of therapy they felt contained elements most important in music therapy. The order of frequency of selection was consistent with that in the former question, but the rankings were not consistent. Although behaviour therapy was selected with the greatest frequency, according to the median rank it was considered to contain elements which were less important in music therapy than those of activity therapy and psychothera-(Refer to Table 11.) It is difficult to determine py. whether this discrepancy was simply artifactual and resulted from the differential wording in both questions, or whether it reflects an inconsistency based on a true divergence of views.

Academic Backgrounds

There was a consistent emphasis upon the role of the Master's programme in music therapy in the development of clinicians. The emphasis was apparent in the content of the Master's programmes as well as in the views expressed by the directors of these programmes. The opportunity for a clinical practicum was provided in 100% of the graduate programmes which offered practica, and the development of clinicians was perceived to be a goal of graduate training by all directors of Master's programmes. The background which was considered to be the one which would provide a music therapist with the best clinical skills was two years clinical experience and a Master's in music therapy. An equal amount of clinical experience with a Master's degree in another discipline and an additional year of clinical experience were not perceived as backgrounds which could furnish music therapists with clinical skills equal to those acquired during a Master's programme in music therapy.

The Master's in music therapy was ranked as the graduate degree which would best prepare a music therapist to teach music therapy at the university level. This finding was not consistent with the relative lack of importance attributed to the development of educators as a goal of graduate training. Based on the median rank assigned, educator was considered to be the fourth most important goal of graduate training. Although some directors of Bachelor's programmes expressed the need for a teaching practicum at the Master's level, there were no graduate programmes in which this type of practicum was offered and there was no evidence of a curricular focus on teaching skills. It is possible that the selection of the Master's degree in music therapy as the degree which would best prepare a music therapist to teach at the university

level indirectly reflects the views of educators regarding the distinctions between graduate and undergraduate training in music therapy. If it is assumed that a music therapist with a Master's degree in music therapy and one with a Master's degree in a related discipline differ primarily in their knowledge of music therapy, it can be concluded that educators do not consider the basic professional training in music therapy to provide sufficient understanding of the discipline to enable one to teach.

Verbal Therapy Techniques

Although 77.8% of the directors of Master's programmes believed that music therapists should be trained in verbal therapy techniques and 44,4% believed that this training should occur at the Master's level, students were required to utilize psychotherapeutic techniques in only 25% of the programmes which offered practica.

Specialization

Specialization was possible in 55.6% of the Master's programmes, but only 22.2% of the directors of Master's programmes expressed the belief that music therapists should specialize in the treatment of one or several patient populations.

One-third of the directors of Master's programmes believed that the working degree for psychiatric settings should be the Master's degree rather than the Bachelor's degree.

This was consistent with the finding that psychiatry was cited by a substantially, although not statistically significant, larger proportion of directors of Master's programmes than Bachelor's programmes as a site used for clinical practica.

Assessment Methods

The directors of Master's programmes were fairly evenly divided in their views regarding the necessity to have assessment tools specific to music therapy. Over fifty-five percent (55.6%) of the directors felt that it is necessary to have assessment tools specific to music therapy and 44.4% felt that tools developed in other disciplines adequately meet the needs of music therapists. The division in views was consistent with the division which characterized the actual use of assessment methods within graduate programmes. In 50% of the graduate programmes, the teaching of assessment methods was restricted to those methods developed in related disciplines, and in the remaining 50%, music therapy assessment methods were taught in addition to methods derived from other disciplines. There were no programmes in which music therapy assessments served as the sole form of assessment. This may be interpreted in two ways. Either educators believe that instruction in music therapy assessments does not suffice, or the music therapy assessment methods which presently exist are not considered to be sufficiently refined and, consequently, must be supplemented by other assessment methods.

Differences Between Music Therapists with Master's and Bachelor's Degrees

Sixty-two and a half percent (62.5%) of directors of Master's programmes indicated the same three music skills as being the most important for music therapists with Master's degrees and for music therapists with Bachelor's degrees. An additional 12.5% of the directors considered the two most important skills to be identical for music therapists with both levels of training. The lack of distinction made between music therapists with Master's and Bachelor's degrees on the basis of differential music skills was reflected in the significant correlation between the distributions of frequencies of selection of the various skills ($\rho = .731$, p < .01, N=12). It could be concluded that directors of Master's programmes did not believe that it is necessary for graduate students in music therapy to acquire new music skills. The majority of directors of Master's programmes (88.9%) failed to include musicianship among their selections of the three clinical areas in which it is most important for a music therapist with a Master's degree to possess greater skill than a music therapist with a Bachelor's degree. It would seem that not only did directors of Master's programmes feel that it is unnecessary to acquire new music skills during graduate training, but they also believed that music skills acquired during prior training need not be refined during the Master's programme. One can infer from these results that the directors

of Master's programmes believed that the music skills acquired during undergraduate training adequately prepare a music therapist to meet the musical aspects of the demands of the work situation. If the content of Master's programmes conforms to the attitudes of the directors of the programmes, one would assume that there would be no music requirements at the graduate level. This was not found to be true. Despite the directors' expressed view that musicianship was not an important parameter upon which to base a distinction between music therapists with Master's degrees and those with Bachelor's degrees, music courses were required in almost onehalf of the Master's programmes (44.4%) and represented, overall, 12.9% of required coursework. The contradiction between the expressed view and the actual programme content might be a manifestation of an ambivalent attitude toward the importance of providing graduate students in music therapy with music training beyond that acquired at the Bachelor's level. Alternately, it may be a product of requirements imposed by the department, rather than a reflection of the ambivalence of directors of music therapy. If the latter interpretation is correct, serious consideration should be given to Madsen's (1965) proposal that music therapy be moved out of music departments.

Although models of music therapy constituted part of the required coursework in 66.7% of the graduate programmes, only 33.3% of the directors of Master's programmes included

knowledge of models of music therapy among their selections of the three clinical areas in which it is most important for music therapists with a Master's degree to possess greater skill than music therapists with Bachelor's degrees. One must assume that the academic treatment of models of music therapy at the graduate level differs from that at the undergraduate level either in the addition of new models or in depth of analysis. It is, therefore, paradoxical that knowledge of the content area which characterizes the discipline was not perceived, by the majority of directors, to be an area in which it is important for professionals with Master's degrees to have greater proficiency than professionals with Bachelor's degrees. This finding also complicates further the interpretation of the expressed belief that a Master's in music therapy is the graduate degree which would best prepare a music therapist to teach at the university level. If the Master's in music therapy was not preferred to other related degrees on the basis of knowledge of music therapy, it is difficult to explain the selection.

Knowledge of models of therapy other than music therapy, group leadership, and assessment skills were the clinical areas cited with the greatest frequency as those in which music therapists with Master's degrees should possess greater skill than music therapists with Bachelor's degrees. The distributions of percentages of Master's and Bachelor's programmes which required models of therapy other than music therapy were

significantly correlated, as were the distributions of percentages of the total exposure accounted for by each model. There may well have been a difference in the depth with which the models were covered at the two academic levels, but this study was not designed to provide that information. On the basis of the data obtained, there is no evidence of a greater emphasis on models of therapy other than music therapy at the Master's level than at the Bachelor's level.

Group dynamics actually accounted for approximately 5% more of the coursework devoted to models of therapy other than music therapy at the Bachelor's level than at the Master's level. Because this difference was not statistically significant, one can safely conclude that there was no difference in the quantitative focus on group dynamics between the Master's and Bachelor's programmes. Clinical practica at both levels involved individual and group sessions and only at the Bachelor's level were students in some programmes restricted to group sessions. Although directors of graduate programmes expressed the view that music therapists with Master's degrees should possess greater skill in group leadership than music therapists with Bachelor's degrees, there is no evidence of a greater focus on these skills within Master's programmes.

Assessment methods derived from other disciplines served as the sole forms of assessment in a significantly larger proportion of Master's programmes than Bachelor's programmes.

Psychological assessments and behavioural analysis were the types of assessments most frequently used. Music therapy assessments served as the sole forms of assessment in a substantially, although not significantly, larger proportion of Bachelor's programmes. One may conclude that music therapists with Master's degrees do have greater exposure to nonmusic therapy assessments.

Comparison of the Attitudes of Directors of Master's

Programmes and Bachelor's Programmes

In this section, the attitudes of the directors of Master's and Bachelor's programmes toward certain aspects of the training and skills of music therapists were compared. Some questions were dealt with descriptively and others were subjected to statistical analysis. For all questions which required respondents to select three items from a list provided, Spearman's Rank Order Correlation Coefficient was used to determine the significance of the correlation between the distributions of frequency of selection. Chi square was utilized to test the differences between proportions for individual items. The correspondence between the frequency of selection and the ranks assigned served as an additional gauge of the convergence of views within groups.

Relationship of Music Therapy to Other Therapies

The frequencies of selection of the various forms of therapy and the median ranks assigned are presented in Table

11. The order of frequency of selection is almost identical

Table 11

Frequencies of Inclusion of Forms of Therapy and Median Ranks Assigned

Master's ^a 88.9	Bachelor's ^b 83.9	Master's	Bachelor's
88.9	83.9	2 0	·
		2.0	2.1
66.7	80.7	2.5	3.0
66.7	77.4	2.0	2.2
55.6	58.1	5.0	4.6
100.0	93.6	3.0	2.0
	66.7 66.7 55.6 100.0	66.780.766.777.455.658.1100.093.6	66.780.72.566.777.42.055.658.15.0100.093.63.0

^a N = 9 ^b N = 31 ^c A rank of l = most important.

for directors of Master's programmes and directors of Bachelor's programmes. Behaviour therapy was included by the greatest proportion of respondents in both groups as a form of therapy which contains elements important in music therapy. This finding supports the view that behaviour therapy has had a major impact on the field of music therapy (Brown, 1975). The correspondence between the frequency of selection and the importance attributed to the various therapies is not consistent for both groups of directors. Whereas there were no gross departures from correspondence between frequency of selection and importance attributed to forms of therapy for the directors of Bachelor's programmes, this was not true for directors of Master's programmes. Behaviour therapy was included by 100% of the directors of Master's programmes, but was ranked as containing the elements which were fourth in importance in music therapy.

Academic Backgrounds

The responses of directors of Master's programmes regarding which degree should constitute the working degree were evenly distributed across all three options which were: the Bachelor's degree for all settings; the Master's degree for all settings; and the Master's degree for some settings. The responses of the directors of Bachelor's programmes were somewhat more polarized. Fifty percent of the respondents in the latter group believed that the Bachelor's degree should be the working degree for all settings; 16.7% believed that the Master's degree should be the working degree for all settings; and 33.3% believed that the Master's degree should be the working degree for some settings. The setting cited with the greatest frequency by both groups of directors was psychiatry.

There was perfect correspondence between the percentages of directors of Master's programmes who included various backgrounds which would provide a music therapist with the best clinical skills and the median ranks assigned. Two years of clinical experience and a Master's in music therapy was included by 88.9% of the directors and was preferred to equal experience with a Master's in a related discipline, which,

in turn, was preferred to three years of clinical experience. The correspondence between frequency of selection and ranks assigned was not as exact for directors of Bachelor's programmes (see Appendix B). The academic background which was perceived, by directors of undergraduate programmes, to be the one which would provide music therapists with the best clinical skills was two years of clinical experience and a Master's degree in a related discipline. The disciplines cited with the greatest frequency were, in descending order of frequency, special education and psychology. The choice of disciplines was consistent with the expectations of graduate programmes which were expressed. The proportion of directors of Bachelor's programmes who believed that psychology and special education courses should be required at the Master's level was significantly greater than the proportion of graduate programmes in which they were required. The directors of Bachelor's programmes also felt that a significantly larger percentage of the total required coursework should be devoted to special education and psychology than was actually the case within Master's programmes. The devaluation of the ability of the Master's programme to provide music therapists with the best clinical skills was inconsistent, however, with the emphasis placed by the directors of Bachelor's programmes on the development of clinicians as a goal of graduate training.

The only three academic backgrounds which were selected by at least 50% of the directors of Master's and Bachelor's

programmes as being among those which would best prepare a music therapist to teach at the university level were a Master's in music therapy, special education, and psychology. The correlation between the overall distributions of frequencies of selection was highly significant ($\rho = .99$, p < .01, N=7). A significantly larger proportion of directors of Bachelor's programmes included special education among their choices $(\chi^2 = 3.88, p < .05)$. This was the only degree for which the difference between proportions was significant. The correspondence between the frequencies of selection and the ranks assigned was greater for directors of Master's programmes than for directors of Bachelor's programmes (see Appendix B). The Master's degree in music therapy was seen by directors of Master's programmes and directors of Bachelor's programmes as the degree which would best prepare music therapists to teach at the university level (Mdn=1, where 1 = best training).

Verbal Therapy Techniques

Almost four-fifths (77.8%) of the directors of Master's programmes and 93.3% of the directors of Bachelor's programmes indicated that verbal therapy techniques should be part of the training of music therapists. Although this difference between proportions was not significant ($\chi^2 = 3.32$), it was consistent with the finding that students were required to use psychotherapeutic techniques in only 25% of the graduate programmes, and in 52.9% of the undergraduate programmes.

Respondents were required to indicate at which level of training they felt verbal techniques should be taught. The Bachelor's programme, the six-month internship, the Master's programme and employment were included by 57.1%, 28.6%, 57.1%, and 42.9% of the directors of Master's programmes, respectively, and by 71.4%, 46.4%, 42.9%, and 39.3% of the directors of Bachelor's programmes, respectively. None of the differences between proportions were statistically significant. In order, chi square was .53, .73, .46, and .03.

Specialization

A significantly larger proportion of the directors of Bachelor's programmes than directors of Master's programmes expressed the view that music therapists should specialize in the treatment of one patient population ($\chi^2 = 8.03$, p < .01). Those directors of graduate programmes who believed that specialization should be part of training (22.2%) felt that it should occur only at the Master's level. Three-quarters (74.2%) of the directors of Bachelor's programmes believed that music therapists should specialize and their responses were fairly evenly distributed across three levels. The sixmonth internship, the Master's programme and employment were included by 47.8%, 52.2%, and 43.5% of the directors of undergraduate programmes, respectively. Only 4.3% of the latter group of directors included the Bachelor's programme as a level at which specialized training should occur. Specialization was possible, however, in 28.6% of the

Bachelor's level programmes. The same inconsistency was present at the Master's level. Although only 22.2% of the directors of graduate programmes believed that specialization should occur, specialization was possible in 55.6% of the Master's programmes.

Fidler (1979) proposed, in relation to occupational therapy, that debates regarding specialization be deferred until the generic knowledge base was clarified and the content of basic professional education was delineated. She suggested that emphasis on specialization prior to the development of a substantive base in occupational therapy would result in a focus on repertoire of techniques and an excessive reliance on related disciplines for a theoretical framework. She equated specialized training with the advanced level of training and stressed the importance specialization could have in the future for occupational therapy. The majority of directors of Master's programmes expressed the view that music therapists should not specialize, and those few who believed that there should be specialization, restricted it to the graduate degree. It is impossible to interpret the views of the majority of directors of Master's programmes regarding specialization on the basis of the results of the present study. Future investigations should focus on the assumptions underlying the expressed views.

Assessment Methods

Slightly over one-half (55.6%) of the directors of Master's programmes and 79.3% of the directors of Bachelor's programmes believed that it is necessary to have assessment tools specific to music therapy. The difference between proportions was not significant ($\chi^2 = 1.99$). Those directors who did not feel that it is necessary to have tools specific to music therapy cited psychology and special education as the two disciplines which have assessment tools which meet the needs of music therapists.

Although the skills and areas of dysfunction specified by the directors of Master's programmes as those which music therapists should assess did not reflect a dominant view, they did reflect a grasp of the concept of assessment. The skills and areas of dysfunction listed were: synchrony skills; nonverbal expressive and receptive skills; musicality; ability to produce, create, listen to, and move to music; vocal inflection; speech dysfluency; auditory acuity; gross and fine motor skills; perceptual motor skills; and developmental disabilities. It is immediately apparent that some of the areas listed overlap with other disciplines.

The responses of the directors of Bachelor's programmes to the sub-questions, rather than serving to elucidate and confirm the belief in the need for assessment methods specific to music therapists served primarily to obscure it and to render questionable the reliability of the expressed view,

.90

i.e., that there is a need for music therapy assessment methods. Respondents who believed that assessment methods are necessary were required to provide a list of skills and areas of dysfunction which they felt should be assessed by music therapists. Respondents who felt that the assessment methods in other disciplines meet the needs of music therapists were required to list the disciplines. Of the 23 directors of Bachelor's programmes who stated that assessment tools specific to music therapy are necessary, 21.7% did not provide examples of skills or areas of dysfunction to be assessed. An additional 8.7% did not provide examples of skills, but responded to the sub-question intended for respondents who believed that the assessment needs of music therapists were met by other disciplines. Some respondents (26.1%) responded to both antagonistic sub-questions. The remainder of the respondents (43.5%) responded appropriately. The responses fell into three major categories. The first category consisted of clear examples of skills and areas of dysfunction to be assessed. These included: perceptual awareness; localization; sequencing; recall; group functions; interpretive-expressive skills; coordination; discrimination; and motivational value provided by music for the individual. The responses in the other two categories were nonspecific in nature. The first of these categories included assertions that one should assess an individual in as many settings as possible, and hence, in a music therapy setting. The second category included responses which intimated that something

unique and special could be learned about an individual in a music therapy setting, but failed to define the special quality. These cryptic responses might well lead one to wonder what it is that constitutes assessment methods at the Bachelor's level.

Cohen, Averbach, and Katz (1978) stressed the importance of the role of assessment in ensuring that music therapy programming consists of clinical therapy rather than diversional activity. They also asserted that music therapy cannot achieve true professional stature until an assessment system which highlights the uniqueness of music therapy is developed. It would seem, based on the responses of educators, that either this system does not yet exist and consequently, there must be reliance on related disciplines for an assessment system, or the importance of such a system is not recognized. It is impossible to determine to what extent the views expressed by educators were influenced by an awareness of the present underdeveloped state of assessment methods within music therapy, and therefore, impossible to predict to what extent their views would change if an assessment system specific to music therapy were to be developed.

Differences Between Music Therapists with Master's and Bachelor's Degrees

The frequencies of selection of music skills considered to be the most important for music therapists with Master's and Bachelor's degrees and the ranks assigned by directors of

Master's programmes appear in Table 12. The corresponding data for directors of Bachelor's programmes appear in Table 13.

The distributions of frequencies of directors of Master's and Bachelor's programmes who selected music skills on the basis of their importance for music therapists with Master's degrees were significantly correlated ($\rho = .633$, p < .05, N=12). The frequency distributions in relation to music therapists with Bachelor's degrees were also significantly correlated ($\rho = .637$, p < .05, N=12). Both groups of directors did not differentiate between music therapists with Master's degrees and those with Bachelor's degrees on the basis of music skills. The distributions of frequencies of selection for directors of Master's and for directors of Bachelor's programmes were significantly correlated ($\rho = .731$ and .811, respectively, p < .01, N=12). The difference between the proportions of directors selecting inprovisation for music therapists with Bachelor's degrees was not significant $(\chi^2 = 2.18)$. Since the difference for this skill was the largest arithmetic difference, it could be assumed that none of the differences between proportions were significant.

The only skill which was selected by at least 50% of the directors of Bachelor's programmes was the ability to improvise. This was the skill which was also selected by the greatest proportion of directors of Master's programmes. The emphasis on improvisational skills is consistent with Galloway's (1966) finding that music therapists recognized

Table 12

Frequency of Selection and Median Ranks Assigned to Music Skills by Directors of Master's Programmes

		•		
.	Perce	entages ^a	Median Ranks ^b	
Skills	Master's	Bachelor's	Master's	Bachelor's
Ability to:				
Play instruments	62.5	50.0	3.0	2.8
Sing	50.0	50.0	2.0	2.0
Teach instruments	12.5	12.5	-	-
Improvise	75.0	87.5	1.8	2.0
Express emotion	12.5	0	-	-
Perceive emotion	25.0	0		- .
Sightread	12.5	37.5	-	2.0
Compose music	0	0	-	-
Direct groups	25.0	25.0	-	-
Arrange music	12.5	0	- .	-
Perform	12.5	37.5	-	1.0
Other	0	0	-	-

Note: All skills included by fewer than three respondents were not assigned median ranks.

a N = 8 ^b Rank of l = most important.

Г	a	b	1	е	1	3
						-

Frequency of Selection and Median Ranks Assigned to Music Skills by Directors of Bachelor's Programmes

	Perce	entages ^a	Median Ranks ^b	
Skills	Master's	Bachelor's	Master's	Bachelor's
Ability to:				
Play instruments	37.0	44.4	1.3	1.3
Sing	25.9	29.6	2.0	1.9
Teach instruments	25.9	29.6	3.0	2.2
Improvise	66.7	59,3	1.8	1.8
Express emotion	40.7	18.5	2.0	2.0
Perceive emotion	44.4	25.9	2.3	2.5
Sightread	18.5	25.9	3.0	2.0
Compose music	3.7	7.4	-	-
Direct groups	3.7	11.1	-	3.0
Arrange music	7.4	14.8		2.5
Perform	3.7	14.8	-	1.5
Other ^C	11.1	18.5	1.0	2.0

Note: All skills included by fewer than three respondents were not assigned median ranks.

a N = 27 b Rank of 1 = most important.

^c Responses included adapting skills to various populations and arranging musical environment. a need for increased training in functional music skills. It is not consistent, however, with the fact that the ability to improvise was not the music skill included by the largest proportion of directors when defining functional music (see Table 9). The correspondence between frequency of selection and ranks assigned was not assessed for directors of Bachelor's programmes since only one skill was included by 50% of the respondents. The correspondence for directors of Master's programmes was not exact.

The frequencies of selection and median ranks assigned to those clinical skills in which directors of Master's and Bachelor's programmes believed that it was most important for music therapists with Master's degrees to possess greater skill than music therapists with Bachelor's degrees are presented in Table 14.

The majority of directors of Master's programmes (88.9%) and Bachelor's programmes (96.9%) believed that music therapists with Master's degrees should possess greater skill in certain clinical areas than music therapists with Bachelor's degrees. The distributions of frequencies of directors selecting those clinical areas in which they believed it to be important that differences exist were not significantly correlated ($\rho = .636$, N=7). Although a substantially larger proportion of directors of Master's programmes selected models of therapy other than music therapy, the difference between proportions was not significant ($\chi^2 = 2.28$). It could,

Table 14

Frequencies of Selection and Median Ranks Assigned to Clinical Skills by Directors of Master's and Bachelor's Programmes

	Perce	ntages	Median Ranks ^C		
Clinical Skills	Master's ^a	Bachelor's ^b	Master's	Bachelor's	
Assessment	57.1	74.2	1.2	2.0	
Musicianship	14.3	9.7	-	1.0	
Group leadership	57.1	45.2	2.0	1.9	
Models of therapy	85.7	54.8	2.8	2.0	
Models of M.T.	42.9	41.9	2.0	1.5	
Psychopathology	28.6	51.6		2.1	
Other ^d	28.6	22.6	-	1.0	

 $a_{N} = 7$ $b_{N} =$

^b N = 31 ^c Rank of l = most important.

 $^{\rm d}$ Responses included research and administrative skills.

therefore, be assumed that none of the differences between proportions were significant. The correspondence between frequency of selection and ranks assigned, if restricted to those skills selected by at least 50% of the respondents, was quite good for directors of Bachelor's programmes. For the directors of Master's programmes, the frequency of selection had an inverse relationship to the importance attributed to the skills.

The two skills included by both groups of directors were assessment skills and knowledge of models of therapy other than music therapy. The third skill selected by at least 50% of the directors of Master's and Bachelor's programmes was group leadership and knowledge of psychopathology, respectively. There is no evidence, based on the content of programmes, of a greater quantitative emphasis within Master's programmes on models of therapy other than music therapy, group leadership, or knowledge of psychopathology. The evaluation of qualitative differences does not fall within the scope of this study but should be subjected to investigation in the future.

The study of psychopathology would normally fall within the area of psychology. The proportion of directors of Bachelor's programmes who felt that psychology courses should be required at the graduate level was significantly greater than the proportion of Master's programmes in which psychology courses were required. Directors of Bachelor's programmes

also believed that a significantly larger percentage of the total required coursework should be devoted to the study of psychology. Those directors of undergraduate programmes who believed that the Master's degree should be the working degree for some settings cited psychiatry with the greatest frequency. It is possible that directors of undergraduate programmes feel that to work effectively within a psychiatric setting it is necessary to have a good foundation in psychology and in the knowledge of psychopathology. If this emphasis is presently lacking within curricular content, it might, to some extent, explain Braswell's (1979) finding that music therapists working in mental retardation settings perceived their status to be higher than did music therapists working within psychiatry.

The frequencies of selection of professionals perceived to possess clinical skills most similar to music therapists with Master's and Bachelor's degrees and the ranks assigned by directors of Master's programmes are presented in Table 15. The corresponding data for directors of Bachelor's programmes appear in Table 16.

One-quarter of the directors of Master's programmes and 21.4% of the directors of Bachelor's programmes did not differentiate between the two levels of music therapists when comparing them to other professionals. The two distributions of frequencies of selection of professionals compared to a music therapist with a Master's degree were significantly

Table 15

Frequency of Selection and Median Ranks Assigned by Directors of Master's Programmes to Professionals Considered Most Similar to Music Therapists

	Percentages ^a		Median Ranks ^b	
Professionals	Master's	Bachelor's	Master's	Bachelor's
Clinical psychologist	75.0	25.0	1.5	-
Occupational therapist	75.0	75.0	2.2	1.8
Recreational therapist	25.0	50.0	-	2.0
Child care worker	0	12.5	-	-
Music educator	25.0	37.5	-	2.0
Psychiatrist	0	0	-	–
Social Worker	12.5	25.0	-	-
Special educator	62.5	75.0	3.0	2.0
Psychiatric case worker	12.5	0	-	-
Other ^C	25.0	0	-	-

Note: All professionals included by fewer than three respondents were not assigned median ranks.

a N = 8 b Rank of 1 = most similar.

^c Responses included: resource consultant and art/dance/ psychodrama therapists.
Table 16

Frequency of Selection and Median Ranks Assigned by Directors of Bachelor's Programmes to Professionals Considered Most Similar to Music Therapists

	Perce	entages ^a	Median Ranks ^b					
Professionals	Master's	Bachelor's	Master's	Bachelor's				
Clinical psychologist	50.0	17.9	1.1	1.0				
Occupational therapist	42.9	53.6	1.7	2.0				
Recreational therapist	25.0	78.6	3.0	2.0				
Child care worker	0	0	-	-				
Music educator	32.1	60.7	3.0	2.0				
Psychiatrist	10.7	0	2.0	-				
Social worker	42.9	14.3	2.2	2.5				
Special educator	71.4	71.4	1.9	1.9				
Psychiatric case worker	17.9	3.6	2.0	-				
Other ^C	7.1	0	-	-				

Note: All professionals included by fewer than three respondents were not assigned median ranks.

a N = 28 b Rank of 1 = most similar.

^c Responses included: consultant and researcher.

correlated, as were the two distributions for a music therapist with a Bachelor's degree ($\rho = .721$, p < .05 and $\rho = .9$, p < .01, respectively, N=10). The within-group distributions of frequencies of selection were also significantly correlated for directors of Master's programmes and for directors of Bachelor's programmes ($\rho = .672$ and .689, respectively, p < .05, N=10). A substantially larger proportion of directors of Master's programmes included occupational therapist among their selections of professionals possessing skills similar to those of a music therapist with a Master's degree. This difference between proportions was not, however, a significant one ($\chi^2 = 2.57$). Since this was the largest arithmetic difference between proportions, it could be assumed that none of the between-group differences between proportions were signnificant.

The three professionals included by at least 50% of the directors of graduate programmes in comparison to a music therapist with a Master's degree were, in descending order, clinical psychologist, occupational therapist, and special educator. In comparison to a music therapist with a Bachelor's degree, the three professionals were, in descending order, occupational therapist, special educator, and recreational therapist. As the frequency of inclusion increased, there was a corresponding increase in the perceived similarity between that profession and music therapy.

There were only two professionals included by at least

50% of the directors of Bachelor's programmes in the comparison to music therapists with Master's degrees, and these were, in descending order of frequency, special educator and clinical psychologist. Based on the ranks assigned, however, clinical psychologists were seen as more similar (Mdn=1.1). There were four professionals included by at least 50% of the directors of undergraduate programmes in the comparison to music therapists with Bachelor's degrees, and these were, in descending order, recreational therapist, special educator, music educator, and occupational therapist. All four were perceived to be approximately equally similar (Mdn=2.0, 1.9, 2.0, and 2.0, respectively).

The perceived similarity between music therapists with Master's degrees and clinical psychologists is more easily understood in relation to assessment skills than in relation to knowledge of psychology and psychopathology. There was a widespread reliance upon psychological assessments and behavioural analysis as assessment methods within Master's programmes. The emphasis on psychology, however, was relatively limited. This limited emphasis on psychology within Master's programmes was consistent with the low frequency of inclusion of psychopathology among the clinical areas in which it was considered important for music therapists with Master's degrees to possess greater skill than music therapists with Bachelor's degrees.

SUMMARY AND CONCLUSIONS

The purpose of the present research was to investigate the content and structure of graduate level training in music therapy, to differentiate between advanced and basic professional training, and to assess the degree of convergence of views among educators regarding advanced training and the differential skills of music therapists with Master's degrees and music therapists with Bachelor's degrees. It was expected that there would be a strong emphasis on music therapy core courses and research courses at the graduate level. This expectation was confirmed in one sense since both content areas were included in 100% of the Master's programmes and represented the largest proportions of required coursework. It was surprising, however, to find that models of music therapy were required in only two-thirds of the programmes and a thesis was required in only 55.6% of the programmes. One would expect that knowledge of models of music therapy would be considered to contribute substantially to scholarship in the discipline and would, therefore, be stressed in all graduate programmes in music therapy. Since theses were not required in almost one-half of the programmes (44.4%), it must be assumed that directors of Master's programmes perceive thesis writing to be only one, and perhaps, not the preferred, method of developing research skills. Clinical specialization

has been strongly identified with advanced professional training in other disciplines (for example, Fidler 1979) and within music therapy there has been some evidence that specialization is associated with Master's level training (Galloway, 1966). Specialization was possible in slightly over one-half (55.6%) of the Master's programmes and, therefore, did not seem to be a major focus of graduate training. A practicum was required in a majority of the Master's programmes (88.9%); clinical and supervisory practica were the most commonly offered forms of practicum. This was consistent with the rating of clinicians by directors of Master's programmes as the most important goal of graduate training.

Psychology of music/acoustics courses, psychology courses, music courses, sociology/anthropology courses, sciences, and recreation courses were required in a significantly greater proportion of Bachelor's programmes than Master's programmes. Most of these areas represent basic education and, therefore, these findings were not surprising. It is difficult, however, to explain the discrepancy between the proportions of schools at both levels which required psychology courses. It would seem that it has been accepted that a certain amount of basic psychology is necessary in the training of music therapists, but there is no consensus among directors of Master's programmes as to whether it is necessary for graduate students to acquire more advanced knowledge in psychology. A significantly larger proportion of

required coursework was devoted to music therapy core courses and research courses at the Master's level than at the Bachelor's level and a significantly smaller proportion was devoted to music courses. The distributions of proportions of Master's and Bachelor's programmes in which models of therapy other than music therapy and therapeutic settings were required were significantly correlated. This was not true, however, for models of music therapy. Client-centered therapy and reality therapy represented a significantly smaller proportion of coursework at the Master's level than at the Bachelor's level. These were the only models for which there was a significant difference. A functional music course was required in a significantly larger proportion of Bachelor's programmes than Master's programmes. The distributions of frequencies of selection of the component skills of functional music were significantly correlated. Assessment methods derived from other disciplines served as the sole forms of assessment in a significantly larger proportion of Master's programmes than Bachelor's programmes. This greater reliance on related disciplines was reversed in relation to media used in therapy. Students were required/encouraged to use media other than music in their clinical work in a significantly larger proportion of Bachelor's programmes than Master's programmes. This was consistent with the directors' of Bachelor's programmes rating of activity therapy as equally related to music therapy as behaviour therapy, whereas directors of Master's programmes rated activity therapy second, following behaviour therapy.

The directors of Bachelor's programmes believed that there should be a greater emphasis on psychology and special education at the graduate level than was actually reflected in the content of the Master's programmes. The proportion of directors of Bachelor's programmes who believed that group dynamics and sensory-integrative therapy should be required at the Master's level was significantly greater than the proportion of Master's programmes in which they were required. Although the distributions of proportions of directors of Bachelor's programmes who believed that various models and settings should be required at the Master's level and of Master's programmes in which they were actually required were not significantly correlated, and, hence, did not reflect convergence of views, there were few specific models/settings in which significant differences between proportions were found. The importance attributed to the various forms of practica by directors of Bachelor's programmes corresponded to the frequency of inclusion of the different types within the Master's programmes. Although the proportion of directors of undergraduate programmes who believed that an administrative practicum should be offered was significantly greater than the proportion of graduate programmes in which it was offered, it was ranked as the least important type of practicum. Directors at both academic levels considered the training of clinicians to be the most important goal of graduate education. It is of note that researcher was the

only professional orientation which was not assigned a rank of one (where 1 = most important) by any of the directors of Bachelor's programmes.

There were a few areas in which there were discrepancies between the attitudes expressed by directors of Master's programmes and the implied attitudes as reflected in the programme content. The proportion of directors who believed that graduate students should be trained in verbal therapy techniques was substantially greater than the proportion of programmes in which students were required to utilize these techniques. The reverse relationship was found in relation to specialization. The proportion of programmes in which specialization was possible was substantially larger than the proportion of directors who believed that music therapists should specialize. Despite the failure of directors of graduate programmes to differentiate between music therapists with Master's degrees and music therapists with Bachelor's degrees on the basis of music skills and the low frequency of inclusion of musicianship among their selections of those clinical areas in which it was considered important for music therapists with Master's degrees to possess greater skill, music courses were required in almost one-half of the Master's programmes and represented 12.9% of total required coursework. The proportion of programmes in which models of music therapy were required was substantially larger than the proportion of directors of Master's programmes who included knowledge of

models of music therapy among their choices of clinical areas in which it is important for music therapists with Master's degrees to possess greater skill than music therapists with Bachelor's degrees. There was also little evidence within the curricula to support the hypothesis that there was greater emphasis at the Master's level than at the Bachelor's level upon those clinical areas which were selected with the greatest frequency as areas in which it is important for music therapists with Master's degrees to possess greater skill.

There was considerable agreement in the attitudes expressed by directors of music therapy programmes regarding certain aspects of the training of music therapists and the differential skills of music therapists with Master's and Bachelor's degrees. There were, however, certain areas of disagreement. Whereas the directors of Master's programmes rated two years of clinical experience and a Master's degree in music therapy as the background which would provide music therapists with the best clinical skills, the directors of Bachelor's programmes ranked it second to equal experience and a Master's degree in a related discipline. The apparent devaluation of the capacity of the graduate degree in music therapy to provide music therapists with superior clinical skills was consistent with the findings of a survey conducted by Braswell et al. (1979b). It was found that music therapists did not feel that a Master's degree

in music therapy would enhance their professional skills or status. In relation to differences between the Master's and Bachelor's level programmes, the present study focused primarily on the respective quantitative emphases on various content areas. It is important that future research focus on the qualitative differences, that is, on the differences in the depth with which content areas are presented at both academic levels. This additional information could only serve to enhance our understanding of the true differences between graduate and undergraduate training in music therapy.

A significantly larger proportion of directors of Bachelor's programmes than directors of Master's programmes included a Master's degree in special education among their selections of degrees which would best prepare a music therapist to teach at the university level. The orientation toward special education was also evident in the directors' of undergraduate programmes expressed expectations of Master's level programmes. A significantly larger proportion of directors of undergraduate programmes believed that music therapists should specialize in the treatment of one patient population. The two clinical areas in which it was considered important for differences to exist between music therapists with Master's degrees and music therapists with Bachelor's degrees which were selected by the greatest frequency of respondents were assessment skills and knowledge of models of therapy other than music therapy. The third area selected by

directors of Bachelor's programmes was knowledge of psychopathology. This was consistent with their expressed view that psychology should be emphasized more at the Master's level than is currently true.

It would seem, based on the results of the present research, that convergence of views regarding the graduate training of music therapists and the differential roles and skills of music therapists with basic and advanced training is not yet a reality within music therapy. Whether or not this implies that music therapy still lacks status as a true profession is a moot question. It is apparent, from the literature, that music therapists are not the only professionals engaged in attempting to define the basic theoretical framework of the discipline, the skill base, and the scope and content of the basic and advanced professional training. Further research may supply some of the required definitions and may also determine the necessity for the degree of convergence postulated by Schein (1972).

LIST OF REFERENCES

•

•

·

LIST OF REFERENCES

- The American Occupational Therapy Association. Guide for graduate education in occupational therapy leading to the Master's degree. <u>American Journal of Occupational</u> Therapy, 1979, 33 (9), 590-599.
- Barnard, R.I. The philosophy and theory of music therapy as an adjuvant therapy. In E.G. Gilliland (Ed.), <u>Music</u> <u>Therapy 1952</u>. Lawrence, Kansas: National Association for Music Therapy, 1953.
- Braswell, C. Education and research in music therapy. In E.H. Schneider (Ed.), <u>Music Therapy 1960</u>. Lawrence, Kansas: The Allen Press, 1961.
- Braswell, C., Maranto, C.D., & Decuir, A. A survey of clinical practice in music therapy Part I: The institutions in which music therapists work and personal data. Journal of Music Therapy, 1979, 16 (1), 2-16.
- Braswell, C., Maranto, C.D., & Decuir, A. A survey of clinical practice in music therapy Part II: Clinical practice, educational and clinical training. <u>Journal of Music</u> Therapy, 1979, 16 (2), 50-69.
- Brown, N. An invesitgation of the influence of behaviorism and existentialism on music therapy as found in selected literature. Unpublished Master's thesis, University of Kansas, 1975.
- Cohen, G., Averbach, J., & Katz, E. Music therapy assessment of the developmentally disabled client. Journal of <u>Music Therapy</u>, 1978, <u>15</u> (2), 88-99.
- Davis, M. The practice of social work in hospitals. <u>Hospital</u> Progress, 1971, <u>52</u>, 61-62.
- Eliason, M.L., & Gohl-Giese, A. A question of professional boundaries: implications for educational programs. <u>American Journal of Occupational Therapy</u>, 1979, <u>33</u> (3), 175-179.
- Fidler, G.S. Specialization: implications for education. <u>American Journal of Occupational Therapy</u>, 1979, <u>33</u> (1), <u>34-35</u>.

- Galloway, H.F. Articulation problems in the academic and clinical training of music therapists. Unpublished Master's thesis, Florida State University, 1966.
- Gaston, E.T. A symposium on research: factors which underlie the development of a research program. Journal of Research in Music Education, 1955-1956, 3, 21-22.
- Gaston, E.T. Developments in the training of music therapists. Journal of Music Therapy, 1964, 1 (4), 148-150.
- Gaston, E.T. Man and music. In E.T. Gaston (Ed.), <u>Music in</u> therapy. New York: MacMillan Co., 1968.
- Gilfoyle, E.M., & Hays, C. Occupational therapy roles and functions in the education of the school-based handicapped student. <u>American Journal of Occupational Therapy</u>, 1979, <u>33</u> (9), 565-576.
- Hanser, S.B., & Madsen, C.K. Comparisons of graduate and undergraduate research in music therapy. Journal of Music Therapy, 1972, 9, 88-93.
- Iley, D.J. <u>A curriculum study based upon Herbert Galloway's</u> <u>articulation problems in the academic and clinical train-</u> <u>ing of music terapists</u>. Unpublished Master's thesis, Florida State University, 1976.
- Jellison, J.A. The frequency and general mode of inquiry of research in music therapy, 1952-1972. <u>Bulletin of the</u> Council for Research in Music Education, 1973, 35, 1-8.
- Lurie, A. Staffing patterns: issues and program implications for health care agencies. <u>Social Work in Health Care</u>, 1976, 2 (1), 85-94.
- Madsen, C.K. A new music therapy curriculum. Journal of Music Therapy, 1965, 2 (3), 83-85.
- Matarazzo, R.G. Research on the teaching and learning of psychotherapeutic skills. In S.L. Garfield A.E. Bergin (Eds.), <u>Handbook of psychotherapy and behavior change</u> (2nd ed.). New York: John Wiley and Sons, Inc., 1978.
- Michel, D.E. Professional profile: the NAMT member and his clinical practices in music therapy. Journal of Music Therapy, 1965, 2, 124-129.
- Michel, D.E., & Madsen, C.K. Examples of research in music therapy as a function of undergraduate education. Journal of Music Therapy, 1969, 6, 22-25.

- National Association for Music Therapy. <u>A career in music</u> <u>therapy</u>. Lawrence, Kansas: National Association for Music Therapy, 1978.
- National Association for Music Therapy. <u>Guidelines for es-</u> <u>tablishing master's degree programs in music therapy</u>. Lawrence, Kansas: National Association for Music Therapy.
- Regan, J. Differential utilization of manpower. <u>Health and</u> Social Work, 1976, 1, 113-124.
- Reilly, M. The educational process. American Journal of Occupational Therapy, 1969, 23 (4), 299-307.
- Rogers, J.C. Design of the Master's programme in occupational therapy, Part 1. A logical approach. <u>American Journal</u> of Occupational Therapy, 1980, 34 (2), 113-118.
- Rogers, J.C. Design of the Master's degree in occupational therapy, Part 2. An empirical approach. <u>American Journal</u> of Occupational Therapy, 1980, 34 (3), 176-184.
- Ruud, E. Music therapy and its relationship to current treatment theories. Unpublished Master's thesis, Florida State University, 1973.
- Schein, E.H. <u>Professional education some new directions</u>. New York: McGraw-Hill Book Co., 1972.
- Schneider, E.H. The status of music therapy. Journal of Music Therapy, 1965, 2 (4), 105-106.
- Sears, M. (Ed.). <u>Member newsletter</u>. Lawrence, Kansas: National Association for Music Therapy, December 1979.
- Sears, W. Processes in music therapy. In E.T. Gaston (Ed.), Music in therapy. New York: MacMillan Co., 1968.
- Shatin, L., Douglas-Longmore, G., & Kotter, W. A quantified criterion for evaluating the music therapist. <u>Journal of</u> Rehabilitation, 1963, 29 (1), 18-19.
- Southard, S. The process of student supervision. Journal of Music Therapy, 1973, 10, 27-35.
- Thompson, M.F. The function of the music therapist. In E.H. Schneider (Ed.), <u>Music Therapy 1960</u>. Lawrence, Kansas: The Allen Press, 1961.
- Warwick, D.P. The Sample survey: theory and practice. New York: McGraw-Hill Book Co., 1975.

Wattenberg, S.H. & O'Rourke, T.W. Comparison of task performance of Master's and Bachelor's degree social workers in hospitals. <u>Social Work in Health Care</u>, 1978, <u>4</u> (1), 93-105.

Young, P. <u>Scientific social surveys and research</u> (4th ed.), Englewood Cliffs, N.J.: Prentice-Hall, 1966.

.

APPENDIX A

QUESTIONNAIRES

DOUGLAS HOSPITAL CENTRE



Adult Services Services aux Adultes Telephone: 761-6131 Children's Services Services aux Enfants Telephone: 761-6131

6875 BOUL LASALLE BLVD., MONTREAL QUE, CANADA H4H 1R3

April 9, 1979

Dear Music Therapy Educator:

You will find enclosed two questionnaires. The first seeks factual information regarding the structure and content of the Master's level program in music therapy at your university, as well as your views on certain aspects of the training and clinical practice of music therapists. The second questionnaire focuses on the Bachelor's level program in music therapy at your university.

The two questionnaires have been constructed to provide 4s detailed and comprehensive a description of music therapy training at your university as possible, while maintaining the anonymity of the respondent. Hence, the length of the questionnaires could not be reduced further without resulting in a loss of potentially valuable information. It would be appreciated if you would respond to the Master's level questionnaire first, and refrain from signing either form.

This survey is directed only at music therapy educators in NAMTapproved colleges and universities, and therefore, the limited number of potential respondents makes every response an important one. Since the questionnaires constitute one part of a Master's level research thesis requirement in music therapy, your full and prompt attention would be greatly appreciated. Results of the study will be made available to all those from whom information was requested.

I trust that you will respond at your earliest convenience, preferably prior to May 30, 1979 and I thank you in advance for your time and cooperation.

Sincerely,

C. Jauley - Lya Connie Isenberg-Grzeda KNT

Connie Isenberg-Grzeda Clinical Training Director Graduate Student - Michigan State University

CIG/s

THIS SECTION OF THE QUESTIONNAIRE SEEKS FACTUAL INFORMATION REGARDING THE STRUCTURE AND CONTENT OF THE MASTER'S LEVEL PROGRAM IN MUSIC THERAPY. ALL QUESTIONS REFER ONLY TO THE MASTER'S LEVEL PROGRAM UNLESS OTHERWISE SPECIFIED. SPACE HAS BEEN PROVIDED AT THE END OF THIS SECTION FOR ADDITIONAL INFORMATION REGARDING THE PROGRAM AND/OR FOR ELABORATION ON, AND CLARIFICATION OF, RESPONSES. 1. For entrance into the graduate program, post-RMT experience is required (answer la) encouraged (answer la) not required or encouraged (go to #2). a)Indicate no. of years of post-RMT experience required/encouraged. 2 years l year more than 2 years 2. Indicate whether the program is a semester system term system. 3. The minimum no. of credits to obtain the Master's degree is _____. The minimum no. of credits for required courses is _____ . Of The minimum no. of credits for elective courses is _ these, how many credits must be within the music department? How many credits may be within the music department? Yes No 5. Is a thesis required? Yes ____(if yes, answer 5c and 5d) No ____(if no, answer 5a) a)Is a thesis optional? Yes ____(if yes, answer 5b,5c and 5d) No ____(if no, answer 5b) b)To replace a thesis, students must complete one of the following: paper(s) _extra course(s) ____other, specify:__ c) The thesis is worth (no.) credits. d)Indicate acceptable research type(s), and if more than one type is acceptable, rank according to frequency (l≠most frequent). ____philosophical ____historical ____descriptive (e.g.survey) ____experimental: ____laboratory setting _____clinical setting

M.T. Questionnaire P. 2 6. Is a practicum required? Yes ____(if yes, answer 6a-6e) No ____(if no, go to #7) a)No. of credits:___ b)Minimum no. of hours per week: c)Minimum total no. of hours required:____ d)Rank the following methods employed in supervision according to frequency (l=most frequent). ____videotape ____students' verbal reports ____written process notes ____other,specify and rank:___ _____direct observation by supervisor audiotape e)Indicate type(s) of practicum offered. (i) <u>Clinical</u>: Type(s) of facility: group Sessions are: _____one-to-one Are students required, in the role of therapist, to utilize psychotherapeutic techniques(e.g. verbal interpretation, reflection)? Yes _____ No ____ Indicate (by circling) whether students are: required/ encouraged / allowed / not allowed / to use media other than music. If other media are used, specify:___ Are students required to use formal assessment and evaluation tools? Yes ____ No Graduate students supervised by: (e.g. M.T. professor) (ii) Supervisory: Type(s) of facility: Student supervises: lower division undergraduates upper division undergraduates Graduate students supervised by: (e.g. M.T. professor) (iii) <u>Administrative</u>: Type(s) of facility:_ Field supervisor's profession(s):_____ Department(s) used for placement:_____ Graduate students supervised by: (e.g. M.T. professor) (iv) <u>Other</u>, specify: 7. In the program, students are trained to be the following (rank by importance, l=most important). ____researchers _____clinicians ____supervisors ____educators

___administrators ____other(s), specify and rank:___

M.T. Questionnaire P. 3 8. Do the required courses at the Master's level include specific Yes ____(if yes, answer 8a and 8b) No ____(if no, answer 8b) models of M.T.? a)In the students' total exposure to models of M.T., indicate what percentage of the total is accounted for by the following. Percentage (1)Developmental M.T. (4) Improvisational-Expressive(Nordoff and Robbins) . . (6)Other, specify: =100% b) If not included in required courses, is reading in some of the above-mentioned models (8a) encouraged? Yes ____ If yes, specify models using nos. in 8a:___ No 9. Do the required courses at the Master's level include models of therapy other than M.T.? Yes ____(if yes,answer 9a and 9b) No ____(if no,answer 9b) a)In the students' total exposure to models of therapy, indicate what percentage of the total is accounted for by the following. Percentage (6)Psychodrama (11)Other, specify:__ =100% b)If not included in required courses, are some of the abovementioned models (9a) available in elective courses? Yes _____ If yes, specify models using nos. in 9a:____ No

M.T. Questionnaire P. 4

•

.

10. Do the <u>required</u> courses at the Master's level include the therapeutic use of music in a variety of settings? Yes(if yes, answer 10a and 10b) No(if no, go to #11)
a)In the students' total exposure to the therapeutic use of music in a variety of settings, indicate what percentage of the total is accounted for by the following.
Music in: <u>Percentage</u>
(1)child psychiatry
(2)adult psychiatry
(3)treatment of mentally impaired
(4) special education
(5)geriatrics
(6)palliative care
(7)physical disabilities remediation
(8)treatment of emotionally disturbed
(9)treatment of developmentally disordered
(10)treatment of addiction
(11)other, specify:
b)Is specialization in one of the above-mentioned areas (10a)
No(if no, go to #11)
No(if no, go to #11) c)Specify possible areas of specialization using nos.:
No(if no, go to #11) c)Specify possible areas of specialization using nos.: d)Indicate whether specialization is:clinicaltheoretical
No(if no, go to #11) c)Specify possible areas of specialization using nos.: d)Indicate whether specialization is:clinicaltheoretical e)How many credits are available for specialization?
No(if no, go to #11) c)Specify possible areas of specialization using nos.: d)Indicate whether specialization is:clinicaltheoretical e)How many credits are available for specialization? 11. List total number of required credits in the following greas.
No(if no, go to #11) c)Specify possible areas of specialization using nos.: d)Indicate whether specialization is:clinicaltheoretical e)How many credits are available for specialization? 11. List total number of <u>required</u> credits in the following areas. M.T. core courses (including practicum)
No(if no, go to #11) c)Specify possible areas of specialization using nos.: d)Indicate whether specialization is:clinicaltheoretical e)How many credits are available for specialization? 11. List total number of <u>required</u> credits in the following areas. M.T. core courses (including practicum) credits Research (other than thesis)
No(if no, go to #11) c)Specify possible areas of specialization using nos.: d)Indicate whether specialization is:clinicaltheoretical e)How many credits are available for specialization? 11. List total number of <u>required</u> credits in the following areas. M.T. core courses (including practicum) credits Research (other than thesis) Psychology (other than psychology of music)
No(if no, go to #11) c)Specify possible areas of specialization using nos.: d)Indicate whether specialization is:clinicaltheoretical e)How many credits are available for specialization? 11. List total number of <u>required</u> credits in the following areas. M.T. core courses (including practicum) credits Research (other than thesis) Psychology (other than psychology of music) Music (instrumental.history.theory.etc.)
No(if no, go to #11) c)Specify possible areas of specialization using nos.: d)Indicate whether specialization is:clinicaltheoretical e)How many credits are available for specialization? 11. List total number of <u>required</u> credits in the following areas. M.T. core courses (including practicum) credits Research (other than thesis) Psychology (other than psychology of music) Music (instrumental, history, theory, etc.)
No(if no, go to #11) c)Specify possible areas of specialization using nos.: d)Indicate whether specialization is:clinicaltheoretical e)How many credits are available for specialization? 11. List total number of <u>required</u> credits in the following areas. M.T. core courses (including practicum) credits Research (other than thesis) Psychology (other than psychology of music) Music (instrumental, history, theory, etc.) Special education
No(if no, go to #11) c)Specify possible areas of specialization using nos.: d)Indicate whether specialization is:clinicaltheoretical e)How many credits are available for specialization? 11. List total number of <u>required</u> credits in the following areas. M.T. core courses (including practicum) credits Research (other than thesis) Psychology (other than psychology of music) Music (instrumental, history, theory, etc.) Special education Acoustics
No(if no, go to #11) c)Specify possible areas of specialization using nos.: d)Indicate whether specialization is:clinicaltheoretical e)How many credits are available for specialization? 11. List total number of <u>required</u> credits in the following areas. M.T. core courses (including practicum) credits Research (other than thesis) credits Research (other than psychology of music) Music (instrumental, history, theory, etc.) Music education Acoustics Psychology of music
No(if no, go to #11) c)Specify possible areas of specialization using nos.: d)Indicate whether specialization is:clinicaltheoretical e)How many credits are available for specialization? 11. List total number of <u>required</u> credits in the following areas. M.T. core courses (including practicum) credits Research (other than thesis) Psychology (other than psychology of music) Music (instrumental, history, theory, etc.) Special education Psychology of music Psychology of music Recreation
No(if no, go to #11) c)Specify possible areas of specialization using nos.: d)Indicate whether specialization is:clinicaltheoretical e)How many credits are available for specialization? 11. List total number of <u>required</u> credits in the following areas. M.T. core courses (including practicum) credits Research (other than thesis) Psychology (other than psychology of music) Music (instrumental, history, theory, etc.) Music education Special education Psychology of music Recreation
No(if no, go to #11) c)Specify possible areas of specialization using nos.: d)Indicate whether specialization is:clinicaltheoretical e)How many credits are available for specialization? 11. List total number of <u>required</u> credits in the following areas. M.T. core courses (including practicum) credits Research (other than thesis) credits Research (other than psychology of music) Music (instrumental, history, theory, etc.) Music education Special education Recreation Sciences (e.g.physiology neurogratomy.etc.)

.

•

•

.

.

M.T. Questionnaire P. 5 12. If M.T., as taught, is considered to be strongly related to any of the following therapies, indicate which one(s), and if more than one, rank according to strength of relationship(l=most strongly related). Behavior Therapy Psychotherapy ___Other, specify:___ Activity Therapy _____not strongly related to any other therapy 13. Is a minor area of study, i.e. a second area of concentration, required? Yes ____(if yes, answer 13b and 13c) No ____(if no, answer 13a) a)Is a minor area of study possible? Yes ____(if yes,answer 13b,13c) No ____(if no,go to #14) b)How many credits are required in the minor area? c)List area(s) most often recommended as a minor. Most recommended _____ 2nd_ 3rd_ 14. Are students required to take a functional music course(s)? Yes ____(if yes, answer 14b according to skills taught) No _____(if no, answer 14a) a)Are students required to demonstrate functional music skills? Yes ____(if yes, answer 14b according to which skills are demonstrated) No ____(if no,go to #15) b)Functional music skills include ability to: ____play one or several social instruments _____sightread _____transpose _____improvise ____match music to moods _____express emotion through music ____perceive meaning of emotion expressed through music emotion expressed through music ____other, specify:___ 15. Are formal assessment methods taught? Yes ____(if yes,answer 15a) No ____(if no, go to #16) a)Indicate assessment methods used: assessment methods developed in other disciplines.

16. Please use available space for additional information, elaboration and/or clarification of responses.

assessment methods developed by music therapists

Specify disciplines:

DOUGLAS HOSPITAL CENTRE



Children's Services Services aux Enfants

Telephone: 761-6131

Adult Services Services aux Adultes Telephone: 761-6131

6875 BOUL LASALLE BLVD. MONTREAL QUE, CANADA H4H 1R3

CENTRE HOSPITALIER DOUGLAS

April 9, 1979

Dear Music Therapy Educator:

The enclosed questionnaire seeks factual information regarding the structure and content of the Bachelor's level program in music therapy at your university/college, as well as your views on certain aspects of the training and clinical practice of music therapists.

The questionnaire has been constructed to provide as detailed and comprehensive a description of music therapy training at your university/college as possible, while maintaining the anonymity of the respondent. Hence, the length of the questionnaire could not be reduced further without resulting in the loss of potentially valuable information. It would be appreciated if you would refrain from signing the questionnaire.

This survey is directed only at music therapy educators in NAMTapproved colleges and universities, and therefore, the limited number of potential respondents makes every response an important one. Since the questionnaire constitutes one part of a Master's level research thesis requirement in music therapy, your full and prompt attention would be greatly appreciated. Results of the study will be made available to all those from whom information was requested.

I trust that you will respond at your earliest convenience, preferably prior to May 30, 1979 and I thank you in advance for your time and cooperation.

Sincerely,

C. Janling - Syrala, XMT

Connie Isenberg-Grzeda Clinical Training Director Graduate Student - Michigan State University

CIG/s

THIS SECTION OF THE QUESTIONNAIRE SEEKS FACTUAL INFORMATION REGARDING THE STRUCTURE AND CONTENT OF THE BACHELOR'S LEVEL PROGRAM IN MUSIC THERAPY, AS WELL AS SOME OF YOUR VIEWS ON MASTER'S LEVEL PROGRAMS. ALL QUESTIONS REFER ONLY TO THE BACHELOR'S LEVEL PROGRAM UNLESS OTHERWISE SPECIFIED. SPACE HAS BEEN PROVIDED AT THE END OF THIS SECTION FOR ADDITIONAL INFORMATION REGARDING THE PROGRAM AND/OR FOR ELABORATION ON, AND CLARIFICATION OF, RESPONSES. 1. Indicate whether the program is a semester system term system 2. The minimum no. of credits to obtain the Bachelor's degree in M.T. is • The minimum no. of credits for required courses is _ The minimum no. of credits for elective courses is . Of these, how many credits must be within the music department? How many credits may be within the music department?_____. 3. The degree conferred is If other than B.M., does the university/college offer a B.M. degree? Yes ____ No 4. Is a practicum (other than internship) required? Yes ____(if yes, answer 4a-4f) No ____(if no, answer 4f) a)No. of credits:_____ b)Minimum no. of hours per week:____ c)Minimum total no. of hours: d)Rank the following methods employed in supervision according to frequency (l=most frequent). _videotape _____direct observation by supervisor _students' verbal reports ____audiotape written process notes other, specify and rank: e)Type(s) of facility: __group Sessions are: ____one-to-one Do students observe other students? Yes _ No Are students required, in the role of therapist, to utilize psychotherapeutic techniques (e.g., verbal interpretation, No reflection)? Yes Indicate (by circling) whether students are: required / encouraged / allowed / not allowed / to use media other than music. If other media are used, specify: Are students required to use formal assessment and evaluation tools? Yes No Students supervised by:__________(e.g.,M.T.professor, graduate students)

M.T. Questionnaire P. 2

.

4 .	f)Indicate by rank which of the following types of practica you feel should be offered at the Master's level (l=most important type of practicum).
	clinicalsupervisoryadministrativeother,specify:
5.	In your opinion, a Master's program in M.T. should be training students to be which of the following (rank by importance, l=most important):
	researchersclinicianseducatorssupervisors
	administratorsother, specify and rank:
6.	Do the <u>required</u> courses include specific models of M.T.? Yes(if yes, answer 6a,6b and 6c) No(if no, answer 6b and 6c)
	a)In the students' total exposure to various models of M.T., indicate what percentage of the total is accounted for by the following.
	Percentage
	(1)Developmental M.T
	(2)Guided Imagery (Bonny)
	(3)Behavioral M.T
	(4) Improvisational-Expressive(Nordoff and Robbins)
	(5)Psychognalytic based
	(6)Other, specify:
	b)If not included in required courses, is reading in some of the above-mentioned models (6a) encouraged? YesIf yes, specify models using nos. in 6a: No
	<pre>c)Indicate, using nos. in 6a, which of the models you feel should be included in a Master's level program(even if they are included in the undergraduate program)</pre>
7.	Do the <u>required</u> courses include models of therapy <u>other than M.T</u> .? Yes(if yes, answer 7a,7b and 7c) No(if no, answer 7b and 7c)
	a)In the students' total exposure to models of therapy, indicate
	what percentage of the total is accounted for by the following.
	(1) De la contage
	(1) Psychoanalysis
	(2)Gestalt Therapy
	(3)Reality Therapy
	(4)Client-Centered Therapy

.

.

124 .

.

.

•

M.T. Questionnaire P. 3

.

ζ.	a)ca	ont	' d	•																									Pe	rc	ente	ge
((5)Tı	ran	sa	cti	ion	al	A	na	ly	si	s			•	•	•							•	•				•		_		
((6)Ps	syc	ho	dre	na	1			•					•	•	•	•	•	•	•			•	•	•	•	•	•				
((7)G1	rou	p I	Dyr	au	ic	5		•					•	•	•		•		•		•					•	•				
((8)Be	aha	vi	or	Th	er	ap	У	•					•	•	•	•			•				•	•	•	•					
((9)PI	lay	т	hei	:ap	y	•		•	•	•		•	•	•	•		•		•		•	•	•	•		•	•		_		
()	10)Se	ens	ory	y-1	[n t	eg	ra	ti	ve	T	'h e	rc	1p	y	•	•	•	•	•				•	•	•	•	•	•		_		
(:	11)01	the	r,:	spe	ci	fy	:	_					_														_			_		
																														=1	00%	
	b)Ii me Ye No	fn ent es	ot 10	ir hec If	ncl m F y	ud Iod Yes	ed el	s sp	.n (7 9ec	re a) if	qu a y	ii vo mo	i.	d la el	co bl s	UI e Us	ir ir	95 1 9	él n	ar ec os	e ti	so ive ir	הכ פ ו	e co 7a	of ur :_	: 1 : 5 e	:ho s	• ?	a bo	~ •	-	
	c)Ir be ir	ndi i ncl	ca nc ud	te, luc ed	, u ded in	si i t	ng n he	0 0 1	nos Ma Ind	st er	in er gr	7 • • •	7a Ju	le st	wh ve e	ic 1 pr	h pi		f gr am	th am).	•((e)	od ve	el n	s if	y c 1) :h	f ey	eel ar	8	hou.	ld
8.	Do 1 a va	the gri	et;	equ Y C	<u>vir</u> of	ed se	tt	in	ITS Igs	es ?	i Y N	nd 'es	:10	ud	• _{	th if if	e) ;	t /e:	he s,	ra a an	pe na sv		ti er	c 8 8 f	U 1 0)	an	о. d	f 8	mus b)	ic	in	
	a)Ir ir ii		he vi cci	st sri sur	tud iet nte	len y id	ts of fo	r	to et by	ta ti t	l ng he	e) 5 ,	rpo Fo	0s in 11	ur di ow	e co in	to ite		th wh	e at	tł F	ie: Del	ra rc	pe en	u t ta	i d ige	: (; (us of	e o th	f	musi tota	ic 1
	Mu	Jsi	c :	in:	:																								Pe	rc	ente	ge
	(1))ch	il	dβ	osy	ch	ia	tı	y	•	•	•	•	•	•	•	•	•	•	•		•	•	•	•	•	•	•		_		
	(2))ad	ul	tβ	osy	ch	ia	tı	y	•	•		•	•	•	•	•	•	•	•		•		•	•	•	•	•		_		
	(3))tr	ea.	tme	en t	: o	f	a e	nt	al	ly	' i	i m į	pa	i r	ed	I	•	•	•		•	•	•	•	•	•	•		_		
	(4))sp	ec:	ial	L e	du	ca	ti	on	•	•		•	•	•	•	•	•	•	•	•		•	•	•	•	•	•		_		
	(5))ge	ri	atı	ric	: 5	•	•	•	•	•		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•		-		
	(6))pa	11	iat	tiv		ca	re	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•		-		
	(7))ph	ys:	ico	1	di	s a	ы	.li	ti	e s	1	:er	7 e (di	a t	ic	n	•	•	•	•	•	•	•	•	•	•		-		
	(8))tr	ea.	tme	n t	•	f	• 11	ot	io	na	11	y	d	i s	tu	rt)e(d	•	•	• •	•	•	•	•	•	•		_		
	(9))tr	ea.	tme	en t	0	f	de	ve	10	pm	er	nte	1	ly	d	lis	10	rd	er	ec	1.	•	•	•	•	•	•		-		
	(10))tr	ea	tme	en t	0	f	ac	ldi	ct	io	n		•	•	•	•	•	•	٠	•	•	•	•	•	•	•	•		-		
	(11))ot	hei	Γ,	sp	ec	if	y :			_			_					_			_	_		_	_				=	100	Z
	b)Is po	3 3 3 5 5 5	pe ib	cid le?) ?	za Ye No	ti s	.on		n if if	on y n	e 10,	0' ; (f ai an:	th ns sw	e wa ei	ak r E	8 8 8 f	, , ,	-m 8d	er ,8	nti Be	io a	ne nd	ه 8	ai f)	ed	3 S	(8	- a)	200/	
	- C / J P			7 F	- V 8			-	44	au	3	91		• P '	ب ا ک	.	-	. 41	46	10	••	03	-	۰g	n	US	•	•				

.

-

.

M.T. Questionnaire P. 4 d)Indicate whether specialization is: ____clinical ____theoretical. e)How many credits are available for specialization? f)Indicate, using nos. in 8a, which of the settings you feel should be included in a Master's level program (even if they are included in the undergraduate program). 9. List total no. of required credits in the following areas. (3)Psychology (other than psychology of music) . . . (5)Music (instrumental, history, theory, etc.) (10)Sociology/Anthropology (11)Sciences (e.g., physiology, neuroanatomy, etc.) . . . (12)Other, specify:__ a)Indicate what percentage of the total required course work in a Master's program you feel should be in each of the above-mentioned areas (9a). 10. If M.T., as taught, is considered to be strongly related to any of the following therapies, indicate which one(s), and if more than one, rank according to strength of relationship (l= most strongly related). Behavior Therapy Psychotherapy Other, specify: Activity Therapy _____Other, speci _____not strongly related to any other therapy ll. Is a minor area of study, i.e. a second area of concentration, required? Yes ____(if yes, answer llb and llc) No ____(if no, answer lla) a)Is a minor area of study possible? Yes ____(if yes,answer llb,llc) No ____(if no, go to #12) b)How many credits are required in the minor area? c)List area(s) most often recommended as a minor. Most recommended 2nd 3rd

M.T. Questionnaire P. 5 12. Are students required to take a functional music course(s)? Yes ____(if yes, answer 12b according to skills taught). No ____(if no, answer 12a) a)Are students required to demonstrate functional music skills? Yes _____(if yes, answer 12b according to which skills are ______demonstrated) No ____(if no, go to #13) b)Functional music skills include ability to: _____play one or several social instruments _____sightread ______press emotion through music _____perceive meaning of emotion expressed through music ______other, specify:______ 13. Are formal assessment methods taught? Yes ____(if yes, answer 13a) No ____(if no, go to #14) a)Indicate assessment methods used: ______assessment methods developed in other disciplines.

assessment methods developed by music therapists

14. Please use available space for additional information, elaboration and/or clarification of responses.

SECTION B

.

THIS SECTION OF THE QUESTIONNAIRE SEEKS YOUR VIEWS ON CERTAIN ASPECTS OF THE TRAINING AND CLINICAL PRACTICE OF MUSIC THERAPISTS. SPACE HAS BEEN PROVIDED AT THE END OF THIS SECTION TO ENABLE YOU TO EXPOUND ON THE OPINIONS EXPRESSED.
 Which of the following therapeutic modes contain(s) elements that you consider to be important in music therapy? If more than one, rank order according to importance (l=most important).
Activity TherapyPsychoanalytic TherapyPsychotherapyBehavior TherapyBehavior Therapy
 Indicate which of the following most closely reflects your views. The working degree for all clinical settings should be the Bachelor's degree.
The working degree for all clinical settings should be the
The working degree for some clinical settings should be the Master's degree.
If the latter, specify settings:
 Indicate by rank, which three of the following backgrounds you feel should provide a music therapist with the best clinical skills (l=superior clinical skills).
2 years clinical experience 2 years clinical experience and a Master's in M.T. 2 years clinical experience and a Master's in another discipline. Specify discipline:
3 years clinical experience
4. Do you believe that verbal therapy techniques should be part of the training of music therapists? Yes(if yes, answer 4a) No(if no, go to #5)
 a) Indicate at which level you think training in verbal therapy should occur.
during undergraduate academic program during 6-month internship during Master's level academic program during employment
5. Do you believe that music therapists should specialize in the treatment of one patient population? Yes(if yes,answer 5a) No(if no, go to #6)
a)Indicate at which level you think specialization should occur.
during undergraduate academic program during 6-month internship during Master's level academic program during employment

.

.

•

· .

•

.

.

.

.

.

.

M.T. Questionnaire P. B2

.

:

•

feel should be assessed by music therapists that are not covered in psychiatric, psychological, occupational therapy and social work assessments.
b)Specify disciplines that have assessment tools which meet the needs of music therapists:
7. A clinical music therapist must possess a variety of music skills. Indicate by rank, the skills which you consider to be the <u>three</u> most important for a music therapist with a Bachelor's degree and for a music therapist with a Master's degree (l=most important).
Ability to: <u>Bachelor's</u> <u>Master's</u>
play a variety of instruments
express emotion through music
perform on a major instrument
8. Do you feel that music therapists with a Master's degree should possess greater skill in certain clinical areas than music therapists with a Bachelor's degree? Yes(if yes,answer 8a) No(if no, go to #9)
a)Indicate by rank the <u>three</u> areas in which you feel it is most important for differences to exist between Master's and

.

.

.

.

.

.

M.T. Questionnaire P. B3

9. In your opinion, the clinical skills of a music therapist with a Master's degree are most similar to those of a (rank the three most similar, l=most similar) clinical psychologist _psychiatrist ______ occupational therapist ______recreational therapist <u>social</u> worker special educator psychiatric case worker child care worker ____music educator other, specify: 10. In your opinion, the clinical skills of a music therapist with a Bachelor's degree are most similar to those of a (rank the three most similar, l=most similar) _____clinical psychologist _____occupational therapist ____psychiatrist ____social worker _____recreational therapist special educator ______child care worker _psychiatric case worker music educator other, specify: 11. Given equivalent post-RMT experience, indicate by rank the <u>three</u> graduate degrees which you feel would best prepare a music therapist to teach M.T. at the university level (l=best training). Master's in Social Work Master's in Psychology Master's in Counselling Master's in Music Therapy Master's in Music Education Master's in Special Education

12. Use the space provided below to elaborate upon opinions expressed.

Other, specify:

APPENDIX B

MEANS AND RANGES OF REQUIRED CREDITS IN CONTENT AREAS IN MASTER'S PROGRAMMES; FREQUENCIES OF SELECTION AND MEDIAN RANKS ASSIGNED TO BACKGROUNDS CONSIDERED TO BEST PROVIDE CLINICAL AND TEACHING SKILLS

.

Table A

Mean and Range of Required Credits in Content Areas in Master's Programmes in Music Therapy

Content Areas	Mean ^a	Range
Music therapy core courses	8.67	0-17 ^b
Research	5.0	2 - 16
Psychology	3.3	0-12
Music	4.06	0-16
Music education	1.0	0-7
Special education	0.5	0-3
Psychology of music/acoustics	1.89	0-4
Recreation	-	-
Sociology/Anthropology	0.22	-
Sciences	0.33	-
Other ^C	3.44	0-15

Note: All content areas for which ranges have not been specified were required in only one programme or were not required in any of the programmes.

 $a_N = 9$

^b One response was included under research.

^c See Table 1 for responses included.

щ
Ð
Ĥ
۾
EH

Frequencies of Selection and Median Ranks Assigned to Backgrounds Considered to Provide Best Clinical Skills by Directors of Master's and Bachelor's Programmes

	Percer	itages	Median	Ranks ^c
Backgrounds	Master's ^a	Bachelor's ^D	Master's	Bachelor's
2 years clinical experience	25.0	10.3	1	2.0
<pre>2 years clinical experience and Master's in music therapy</pre>	100.0	68.9	1.1	1.3
<pre>2 years clinical experience and Master's in another discipline</pre>	62.5	62.1	2.0	1.0
3 years clinical experience	50.0	62.1	3•0	2.5
Note: All hackgrounds included hv	fawan than th	nebnonser een	ts were not	assioned

-0 υ 20 D n na n TOMOT ר כ Ĥ, ALL DACKBI-UUIUS median ranks.

c Rank of 1 = provides superior clinical skills. 29 11 Z a ω 11 a N

Table C

Frequencies of Selection and Median Ranks Assigned by Directors of Master's and Bachelor's Programmes to Master's Degrees Considered to Provide Best University Teaching Skills

	Percei	ntages	Media	Median Ranks ^C						
Master's Degrees	Master's ^a	Bachelor's ^b	Master's	Bachelor's						
Music Therapy	100.0	83.3	1.1	1.0						
Music education	25.0	13.3	-	2.5						
Special education	62.5	90.0	2.0	2.0						
Social work	12.5	10.0	-	3.0						
Psychology	50.0	66.7	2.5	2.4						
Counselling	37.5	36.7	3.0	2.0						
Other ^d	12.5	-	-	-						

Note: All degrees included by fewer than three respondents were not assigned median ranks.

 $a_N = 8$

^b N = 30

^c Rank of 1 = best training.

^d Response was Master's in occupational therapy.