Family-centred early intervention: music therapy in the playgroup program

Helen Shoemark, B.Mus., MME, RMT
Music Therapist, Royal Children's Hospital, Melbourne, Victoria

Abstract:
This article describes the inclusion of music therapy in a family-centred playgroup program within an early intervention setting. The purposes of the playgroup were to provide an introduction for the family to the formal and informal networks which it could use, and to offer support for the early development of healthy family relationships. The purpose of the music therapy program within this, was to nurture creative expression in each family member, and assist in their enjoyment of each other. Song was the primary vehicle used because of its accessibility to the group members. The value of the music session was enhanced by the use at home of an audio-cassette of the songs and a lyrics book. Verbal and written feedback indicated that music was able to support families in developing skills which would enhance their relationships.

Introduction
Music therapy has recently moved into the area of family-centred early intervention. Family-centred programs are those which consider the family to be the unit for intervention, rather than the individual child. Whilst music therapists have worked with young children in education settings, few have worked in a developmental setting which addresses the family as the on-going unit for intervention. This article describes one aspect of family-centred early intervention — a playgroup program — and the inclusion of music therapy as part of that service.

Research about families
The recent development of working with families as a unit for intervention is not evident in traditional special education/early intervention research. Research for many years focused on pathology and dysfunction. Stoneman (1993) stated that early research focused on populations drawn from clinical programs, thus skewing results towards families experiencing difficulties. Without comparison groups, these families were compared with some ideal family and any problems being experienced were attributed to pathology rather than other possible causes. This also occurred, and still does, in day-to-day relationships with professionals. Gartner, Lipsky and Turnbull (1991) suggested that an informal “social pathology paradigm” evolved to describe parental behaviour rather than viewing their behaviour as rational responses to ignorance, insensitivity, or lack of social and economic supports.

By the 1980s, research shifted in focus to the strengths and norms of family life. The commonalities between families with and without a child with disabilities were identified. Gallimore, Weisner, Bernheimer, Guthrie and Nihira (1993) reviewed accommodations made by 102 families which include a child with additional needs
in order to sustain a daily routine. They found that families’ accommodations were generally not unusual, deviant or so-called pathological. These families employed strategies that allowed them to go on and live daily life.

**New models for early intervention**

The research of the 1980s and ’90s combined with practices from other human services produced positive models for service delivery to families. These models had their roots in The Head Start program (USA) which was founded on the premise that without healthy patterns of parental care and nurturing, poor children would not maximize a system of services (Halpern, 1990).

The adaptation of such a model was pursued by several researchers in early intervention (Simeonsson and Bailey, 1992). Dunst, Trivette and Deal (1988) adopted a family systems model. This model embraces a social systems perspective which views the family as a unit “embedded within other formal and informal social units and networks”. The social networks are inter-dependent, where “events and changes in one unit resonate and in turn directly and indirectly influence the behaviour of individuals in other social units” (p. 5). Within this model, intervention includes both the formal and informal support given to the family. Recognition of the family and not just the child, as their intervention unit, improves the chances of making a positive impact on all the family members. Success is determined not only by the individual child’s progress but by the way in which the family develops. Dunst et al. (1988) noted “It is not just an issue of whether needs are met, but rather that manner in which mobilisation and support occurs that is a major determinant of enabling and empowering families” (p. 44).

**Family-centred services**

Within this family systems model, Dunst, Johnson, Trivette and Hamby (1991) proposed a continuum of family-centred services. There are four models along this continuum which are all active in family/special education services in Australia (see Figure 1).

<table>
<thead>
<tr>
<th>professional-centred</th>
<th>professional is seen as expert who determines the needs of the family from his/her own perspective</th>
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<tr>
<td>family-allied</td>
<td>family is agent of the professional enlisted to implement interventions that are deemed necessary for the benefit of the family</td>
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<tr>
<td>family-focused</td>
<td>family and professional collaboratively define what the family needs to function effectively; family is encouraged to use primarily professional networks of service to meet its needs</td>
</tr>
<tr>
<td>family-centred</td>
<td>family’s needs and desires guide all aspects of service delivery and services aim to strengthen the family’s capacity to meet its own needs</td>
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It must be acknowledged that not all families want, or feel able, to take the responsibility indicated in the family-centred model, and so partnerships are formed with a balance of professional/family input that is comfortable for each family.

It is not surprising to find music therapy in family-centred early intervention as music therapy is already a client-centred practice and therefore a much smaller leap than for those professions which remain professionally-centred. Given that the playgroup was designed to include infants, it automatically ensured the presence of at least a mother-child dyad as a client unit for the actual session. The shift for the music therapist then was in supporting each member of the family, and their relationships, both within and outside of the actual music therapy session.

The playgroup embraced the method of working with families as partners, as described by Dunst et al. (1988). Working in partnership gives balance and direction to the process of families growing day by day. The acknowledgement that information may be sought and given by both partners encourages open and clear communication.

The playgroup program
Families were referred to the program by Health and Community Services (state department), infant welfare nurses, and health professionals in the region. It was available to families with an infant or toddler who was likely to eventually attend the centre on his or her own.

The program was funded by the main budget of the early intervention centre. The music therapy program was funded by an allocation from the annual fundraising profits, and a successful submission by the music therapist for a Community Arts Grant from the local government authority.

The playgroup was founded on the principles of family-centred practice, within which each family's preference for the balance of roles between themselves and the professional team was respected. The relationships were not static however, and the balance of input between family and professionals fluctuated and evolved.

The professional team worked in a trans-disciplinary manner, and therefore all staff were involved with the overall needs and processes of the family. Staff included a special education pre-school teacher, speech pathologist, a volunteer (who was a retired early intervention specialist) and the author as music therapist. The music therapy program was included upon an unsolicited proposal from the music therapist. The music therapist had a pre-existing relationship with the facility as an external supervisor for music therapy students.

The purposes of the playgroup were to provide an introduction for the family to the formal and informal networks which it could use, and to offer support for the early development of healthy family relationships. It was initiated by experienced staff members who realised that the needs of families begin with, or prior to, a diagnosis, and that much could be done to support and inform families prior to the child commencing an education program on his/her own. The playgroup was offered to families which included an infant diagnosed with a condition which was likely to precipitate a developmental delay. The children presented with the following diagnoses: Down Syndrome, chromosomal abnormality, cerebral palsy,
mild trich-thio dystrophy, Prader Willi Syndrome, Mosaic Down Syndrome, eating disorder/cardiac problems, 'low muscle tone', 'communication difficulties'. The impact of these diagnoses on child and family varied greatly.

The program was held at the early intervention centre. It took place for two hours, one morning per week, for approximately 8 weeks in each school term over one year. The morning included a play time, which provided opportunities for families to utilise the equipment and activities at their own pace. This was a free-play time to begin the program, and many mothers took the opportunity to chat with each other and staff, while also assisting their children to play. A morning-tea time prior to the music therapy session offered further opportunities for sharing, particularly concerns about feeding/eating. The music therapy time was the only whole group activity, at the end of each session.

Over the year, eleven families participated in the program, with an average of five families attending each week. The regular attendants of the program were mothers with their pre-school children and infants. Other family members were welcome and often at least one family would also bring a member of the extended family (these included mothers' spouses, parents, grandparents, sisters, school-aged children and nieces/nephews). Hence the group could be as small as three or four people (particularly during winter), or as large as 16 to 18 people. Other family members were invited to share in the enjoyment of this relaxed and supportive time (a valuable aspect of informal networking). It was common for grandparents to take the opportunity to speak directly to staff, not only about the grandchild with additional needs, but also about the child's mother and/or partner. This open communication both supported and gave further insight into the informal network of the family.

Within the family-centred approach these aspects were given priority. The first of these was the opportunity for families to develop informal networks for themselves. Shulman (1992) suggested a group such as the playgroup, creates mutual helping relationships and a sense of not being alone. When Whaithe and Ellis (1987) surveyed families which included a child with additional needs, parents said that the best source of information and support was other parents in the same situation. The context of the playgroup provided an opportunity for sharing information, developing the sense of 'being in the same boat', problem-solving and mutual support. This was demonstrated in conversations about medical procedures, regional services, family issues and more.

The second aspect given priority was the support of siblings and their relationship with other family members. In the family context, the focus of parents is often with the infant who has a recently diagnosed condition and giving priority to the sibling can be difficult to achieve. Professional staff gave priority to the evolving relationship between parents and all siblings present. They offered mothers the opportunity to focus on the sibling, while the child with additional needs was attended to by a staff member. The music therapy component (outlined below) played a significant role in this area.

The third aspect given priority was the cultural backgrounds of families. These included Greek, Irish, German, Italian, Chinese, Thai, Vietnamese, and Australian.
Scibilia and Sharples (1991) noted that parents whose first language is not English are further isolated from community support than other parents with a child with disabilities. They maintained that there is a loss of extended family in their own country which is not replaced in their 'new' country. This is a lack of understanding from others about their culture, and its implications for the family. When possible the playgroup offered access to other families that shared culture and/or language. If not within the immediate group, then professional staff made suggestions about access to informal support as appropriate (such as another family in the centre). Such connections offered key support to mothers in need of sharing experiences with other women who understood the cultural implications of this situation.

The music therapy program

The purpose of the music program was to nurture creative expression in family members and assist enjoyment of each other. This stemmed from the common need for families to share positive experiences, as observed by the professional team over many years. The purpose of the playgroup was to introduce informal and formal structures, of which music was one. Additionally it sought to support the early development of healthy family relationships, and it was considered by the professional team that musical experiences would offer an active, easily-accessed and positive experience to be shared.

The philosophy of many music therapists is that we believe “all individuals, regardless of age or musical background have a basic capacity for musical expression and/or appreciation” (Bruscia, 1991, p. 9). In this instance, it was first acknowledged that this group of mothers lacked confidence in creating any kind of music. In the first session, the mood was reserved and participation very quiet. Therefore, the music therapist began with the recreative technique of song-singing which was familiar to the mothers and only required the renewal of an existing skill — singing — without the development of new music skills. This was also appropriate to the pre-school siblings who attended. Improvisation using musical instruments was not used as it was not suitable until very late in the year, by which time closure had commenced and therefore a new activity was not appropriate.

Songs could be recalled at different times, in many contexts. Song formats also meant that for families which had a language other than English as their first language, ‘rehearsal’ was easy and quickly fruitful. In the initial stages, the music focused on well known children’s repertoire, as this was an acceptable starting point for most group members. The favourite songs that the mothers knew (regardless of cultural background) were Twinkle, Twinkle Little Star, Humpty Dumpty and Hey-dee-ho. The children also knew songs from well-known television programs such as Bananas in Pyjamas. Other songs were chosen for their potential to encourage actions such as bouncing, patting body parts, or rocking from side to side. Songs such as Hap Palmer’s Sammy, and various body songs provided easily learnt material that could be created in many family contexts (see Appendix A).

The songs did not overtly acknowledge the different cultural backgrounds. The songs reflected current kindergarten and pre-school repertoire. Other music such as relaxation music focused on the mother/child relationship through such styles
as lullabies. The culturally shared characteristics of lullabies were demonstrated by Trehub, Unyk and Trainor (1993) in a study where subjects were asked to listen to pairs of songs from 30 different cultures. They were asked to identify the lullaby in each of the 30 pairs (the alternative being an adult folk-song), which they did to a high degree of significance. The lullabies shared the key characteristics of repetition (43%), soothing quality (38%), softness (28%), simplicity (28%), and slow tempo (25%).

The 'quiet music' for the playgroup was composed to reflect the lullaby key criteria (Trehub et al., 1993). The melody was initially hummed (and thus became known as the Humming song), and later was also sung with open vowel sounds ('ooh' and 'ah'). The humming was both less threatening for mothers than actual singing, and also avoided language considerations. This humming tune offered a peaceful closure to each session (see Figure 2).

![Figure 2. Humming Song for 'quiet music' time. © H. Shoemark, 1994.](image)

**Session format**

Everyone was seated in a circle on the floor, with infants and children either on adults' laps or seated beside adults. The session commenced with familiar up-tempo songs to engage and build the level of arousal for participation. This was maintained with a variety of action songs and varied as needed with songs without actions. Requests were sung on demand and the session concluded with quieter, slower material.

The music therapist led the singing. Keys were selected to support the mothers' voices, as their confidence was a central issue in the program. The indefinite pitching ability of the children (oldest 3.5 years) meant that they sang happily despite any key selection. The songs were accompanied on an electric keyboard. The 'voices' used included the piano, electric piano, brass ensemble, and bells. The sustain function was used during the 'quiet music' (see Figure 2). The accompaniment style reflected the pre-school song repertoire. It was rhythmically simple, and harmonies other than I, IV and V were used to 'colour' the potency of the music and/or lyrics.

The singing style of the music therapist was playful and attempted to model how voice could be used creatively. Confidence and creativity in vocal play is valuable for others (in this case the primary care-givers), who are largely responsible for
encouraging their infants’ pre-speech vocalisations. The song Music sounds like this, was used as a constant vehicle to encourage this playful creativity in mothers and children. At the beginning of each verse, the music therapist sought a conclusion for the lyric “Music sounds like this ............” (repeated four times). The sound offered was then used by the whole group for the remainder of the verse. After modelling from the music therapist and other staff, they were asked for sounds which included ‘errgh’, ‘wee’, ‘pitt’, ‘brrr’ and many more. These developmentally appropriate sounds enabled most children to participate. For some mothers this helped to broaden their perceptions of what their children could “do”, at a time when much focus was given elsewhere to what the child could not do. Without the restricted expectation of a sound like singing, everyone joined in with relaxed singing. Other family members attending were often surprised by the jocularity of this segment.

Once group members (including staff) seemed at ease with the content and format of the session, improvised song material was also included to suit the level of concentration and ability of the people present. Improvised song was often a tool of re-direction, averting the need to halt the flow of the session to verbally redirect individuals or dyads. The songs usually began as single phrases which reflected, supported, extended or directed activity. For example:

During an early session, an infant was bothered by her mother patting different parts of her body during a body-action song called This is my Body. Tension between mother and child was increasing, as the mother attempted to maintain the action. The music therapist removed the source of the child’s aggravation by improvising a new song in which the action was to pat alternating hands on the floor. As the mother stretched her arms around the child to move them up and down on the floor, it created a bouncing action which pleased the infant very much. The mother relaxed, and enjoyed her child’s pleasure. At the same time, the transition from body patting to floor patting, offered the rest of the group an accessible extension of activity.

While the purpose of the activity was development of body image, the improvised song accommodated the immediate needs of the mother–child dyad. The song subsequently became a regular part of the program, with the lyrics evolved by participants each week. Sometimes the group would “bounce bounce bounce on the floor” and sometimes “rock from side to side”.

The mothers in the group were initially very focused on their own children. Because the children enjoyed the music, they were relaxed and participated fully which brought joy to the mothers who could view their child being stimulated and responsive. The weeks passed and they began to see the progress not only in their own children but in others too. As the group was seated in a circle, adults across the circle sometimes saw more than the child’s own mother, who was seated behind or next to the child. It was common to hear mothers comment on how beautifully a child had sung, or how well a child had concentrated. The delight of all the mothers in the new skills the children acquired, was a rich acknowledgement for each family and offered the informed support of which Whaitie and Ellis wrote (1987).
Staff supported mothers in balancing attention between siblings during music time. They made sensitive suggestions based on their observations, and always made themselves available when their assistance was requested. One mother explained that one of the main reasons she came was because her older daughter (aged 3) loved to come and play and have music. At the beginning of the year her younger daughter (with Down Syndrome) was only five months old and often slept through music time allowing the mother to share this time with the sibling. In the latter part of the year, the infant participated with smiles, and actions and singing as she was fully familiar with the material that her sister had enjoyed so much.

The opportunity to choose a song for the whole group was offered to each child as appropriate. The performance of that song offered instant gratification which could be sustained by the music therapist through additional verses, for as long as needed. Likewise, it could be kept short if another child was in need. The improvised or favourite song served individual children in the moment, and beyond.

One family included an older brother, aged four. He was a boisterous and happy boy, who occasionally would present with some anger. At the end of one session, he demanded a song about a monster, and the music therapist promised to write him his own monster song for the following week. A major consideration in writing the song was that it had to be appropriate for the younger children in the group, while being true to the needs of the four-year-old boy. The resulting song *Monster in my garden* had the monster stomping flowers, eating all the food, using all the soap, and sleeping in bed — plenty of scope for over-the-top four-year-old actions, while not being scary for the younger children. It also included rehearsal of the signs for *wait*, *stop* and *no* — very useful for all members of the family! He loved the song and it was sung in each session for the remainder of the program.

**Listening**

Apart from the use of song, listening was also encouraged. Listening was the main avenue for the smaller infants who were too young to be engaged in the prescribed action. In a family where this was the case, the infant was often cradled in the mother’s lap while the mother shared actions with the older sibling, thus providing stimulation and/or response for both.

The idea of listening to pre-recorded music at home for quiet times or relaxation was discussed over three weeks with mothers, early in the program. At that time, the mothers and infants came in for some quiet music while the older siblings played elsewhere. They were offered a selection of ‘relaxed’ music (*Enya Shepherd’s Moon*; *Pachelbel’s Canon in D*; *Carol King Way over yonder*) and its qualities were discussed. As this aspect of the program was minor, the music therapist decided to offer one ‘rule of thumb’ technique for selecting ‘relaxing’ music for home. Two broad categories of ‘relaxing’ music were described: that which is predictable and regulated by pulse, and that which is organised in phrases. Discussion included information about specific recordings and people’s own preferences. Different preferences between spouses and children were quickly identified, and noted as a possible source of stress.
Extension of program

In the context of the playgroup, music therapy formed a positive time for those who attended. To extend the professional support to those family members who could not attend, an audio-cassette and book were produced.

Audio-cassette

Songs were recreated for the audio-cassette by the music therapist alone. The songs that did not have several verses were repeated two or three times. The cassette concluded with the humming song. Each family had a cassette which they used wherever they wanted — car, bath, bed, etc. Mothers were initially surprised and delighted at the concept, and reported very favourably. The music therapist added new songs once per term.

The continuity of the music through the week contributed to the familiarity with material, and the subsequent meeting each week provided new stimulation for using the songs at home. The cassette therefore, played a key role in helping mothers become confident in requesting favourite songs and asking for new songs about particular topics.

One family had extended family in Asia. When the program began, the grandparents were visiting for several months and often came to playgroup. When they went home, their grandchildren missed them and it was suggested that a song about grandparents could be useful. The music therapist wrote I love my grandma. The lyrics say:

I love my grandma, I give her a hug and a kiss,
I love my grandma, I give her a hug and a kiss.
And when she’s not at my house
I call her on the telephone and say,
I love you Grandma, I give you a hug and a kiss.

Sign language was used as the signs are strongly representative of the words, and gave younger children visual cues and actions. This song became popular at home with all the families, and the word ‘grandma’ was translated into all relevant languages, and transferred to grandpas and other family members too. It was one of the most shared songs in the home.

Lyrics book

The final aspect was the book into which copies of the original lyrics were pasted. This was an easy reference when lyrics were forgotten or when a family member wanted to clarify a word the child was singing. It was simply an exercise book with the family’s name written brightly in the front. As songs were added to the repertoire, the music therapist produced lyrics sheets on computer, often with a graphic or picture to cue the pre-verbal children to the page, and these were given to parents to paste into the book.

The worth of the book was demonstrated when a mother commented that her five-year-old daughter had found it after school one day and gleefully told her that she knew lots of those songs and could teach them to her whole family. Another mother brought it each week and with each song she turned immediately to the page and would say “oh this is one of our favourites!”.
Evaluation
The purposes of the playgroup were to provide an introduction for the family to the formal and informal networks, and to offer support for the early development of healthy family relationships. The supporting purpose of the music program was to nurture creative expression in group members and their enjoyment of each other. The music component was evaluated by debriefing sessions with the professional team, a survey of the families, and spontaneous comments from families.

The survey was brief and sought information suitable for a report to the city council which had funded the project under its community arts scheme, and for refining the program the following year (see Appendix B). Of the seven families who received the survey, three replied. Other families offered verbal comments. Some observations from the actual program have already been noted above. The most supportive comments were given about the cassette/book which offered an evolving positive experience to enhance the family relationships:

• "... they [the family] love it. When playing the tape at home, L. and I can show Dad and other family members how we use music therapy at playgroup."
• "P. [father] got to learn the songs we play at [the centre] and had fun listening to them with H. [child]."
• "My husband loves it. We know it off by heart. It really keeps us going; I'd be lost without it. When H. is upset, I say 'Do you want your tape?'""

One family shared this family highlight:

We had a family gathering when our two-year-old son was singing and bopping along to our tape with his four-year-old cousin. We were laughing so hard we had tears rolling down our faces; but then we couldn't resist joining in too. When more guests arrived at the door, they told us they could hear us singing from the street!

The music sessions did change how music was used in some homes:

• "I play the tape a lot at home, and listen to more music."
• "It's helped to show me how to participate and get L. to participate, when singing and playing to music."

When asked for additional comments, these were offered:

• "Music plays a great part in H.'s growing up."
• "Music therapy has helped bring fun and joy to L.'s daily pleasure. Before this therapy, he was very frustrated, but since, he has been a very different child."

These comments indicate that the purposes of the music program were being met.

The staff acknowledged the uniquely engaging quality of a music program provided by a music therapist. They had included music in the previous year's program, but suggested it had far less impact on the wider purposes of the program. The aspect of the music program most often commented upon, was the moment by moment flexibility of the activities provided. Within this flexibility, the presence of improvised and original songs was a new experience for staff, which they greatly appreciated for its immediacy. They also commented that the presence of a strong role model in using voice creatively, offered significant support to the mother's attempts to be creative.
It was agreed, that for one family the presence of a therapist was significant in creating musical experiences which were accessible and useful in wider contexts. The child's love of music was used to aid in the development of his tolerance for transition, and subsequently easing an anxiety in the family's lifestyle:

The family included parents, and 'David', a two-year-old child with severe epilepsy, which required almost 24-hour supervision, frequent hospitalisation, and medication in high doses. The severity of his condition, and ensuing behaviour difficulties meant that the quality of family life was compromised (as stated by the mother). One of the significant daily problems for the mother, was that David did not tolerate transition from one activity to another. Each time she wanted him to finish what he was doing, he would scream and physically resist being moved. This was observed at playgroup when it was time to finish playing outside and move into morning-tea. David would not be placated by his mother and she became increasingly upset. His mother agreed with the teacher that as he enjoyed music it might motivate him to move into the next activity (the group music session). By this point, the mother was visibly upset, and one staff member offered to take David into music while the teacher stayed with her outside, looking through the one-way mirror.

As David heard the keyboard being played (I IV V improvisation), he momentarily quietened. Without information about his repertoire, the music therapist decided to begin with Twinkle, Twinkle Little Star, which he recognised, and during which he again quietened. The song was repeated, and he sat and listened. It was necessary to uphold the now expected routine of the session, for the remainder of the group. Therefore, an original song well known to the group was shared next, and with the shift out of familiar material David quickly became agitated again. It was clear that his difficulty with transition extended to the change in song material, and only familiar music would support him. Well known early childhood repertoire therefore was interspersed with the customary repertoire of the session. This enabled David to tolerate this initial experience with moments of genuine pleasure. It also meant that the rest of the group was able to enjoy their customary music session and model the 'fun' of actions and sounds for him.

After the session the mother apologised to other families for the inconvenience, to which they replied with stories of their own children's behaviour and comments and gestures of support.

The following session again began with David in a highly agitated state, but this time he quickly calmed down, as he recognised not only the very familiar repertoire, but also some of the 'fun' actions and sounds he had enjoyed the preceding week. For the third session, David recognised the music therapist seated on the floor with the keyboard, and seated himself ready to begin. His mother joined him for this session and they enjoyed the 'fun' together. From this time on, the mother knew that there was at least one time in the week where she and her son could relax and enjoy an activity with other people. Music was only a starting point, as he accepted other transitions during the morning.
The cassette and book became valuable sources of enjoyment for this family. The cassette became an important tool for helping him to settle to sleep at night. Six months after this program concluded it was still being used, and while he happily listened to other music, his mother maintained the playgroup cassette was his firm favourite.

Conclusion

In the wider context of the playgroup, music therapy was an active, enjoyable highlight. It provided families with valuable insights about the children, vehicles for development, avenues for family-sharing, time for each of the siblings, and time for mothers to share with mothers. Comments from families suggest that the purpose of assisting enjoyment of each other was readily met, both during the sessions, and in the wider home context. The nurturing of creative expression was only documented for those present in the music therapy session. The participants were all able and willing to initiate songs, actions, sounds and comments. Verbal reports and written feedback since the end of the program indicates that music continues to enjoy a high profile in the homes of the families involved. The on-going presence of music in the lives of families is a strong indication that the music therapy program offered the opportunity to develop skills and knowledge that have become part of their daily relationships.

Music therapy within family-centred early intervention, provides an opportunity for families to be active, extended and acknowledged. Beyond the bounds of the session, the accessible nature of music-making makes it an ideal medium to be shared within the family. There is real potential for music to become a positive and potent resource, which in turn offers valuable support to the daily life of the family.

References


**Appendix A – Songs used in the program**

Baa Baa Black Sheep (trad.)
Hey-dee-ho (trad.)
Humpty dumpty (trad.)
Old MacDonald (trad.)
Twinkle Twinkle Little Star (trad.)
Wheels on the bus (trad.)
I love my Grandma (1994) (H. Shoemark)
Monster in my Garden (1994) (H. Shoemark)
Music sounds like this (1994) (H. Shoemark)
Pat on the floor (1994) (H. Shoemark)
Thanks for all the fun (1987) (H. Shoemark)
This is my Body (1986) (H. Shoemark)
Bananas in Pajamas (Useful Book, Sydney: Australian Broadcasting Corporation)
Spot song (Useful Book, Sydney: Australian Broadcasting Corporation)
Get in the Bath (Playalong Songs, London: Hamish Hamilton)
Sammy (Hap Palmer 1981) (Favorites, Van Nuys, CA, Alfred)
When I have a shower (Sing 80, Sydney: Australian Broadcasting Corporation)

**Appendix B – Survey distributed to families**

1. How important is the music part of the playgroup for you and the children you bring? Put a cross on the line:

- don't care about it
- most important part of morning

2. What has been good about making music at playgroup?
3. What could have been better?
4. Would you like more information about recorded music for your own relaxation?
5. Was the song tape useful? How did you use it?
6. Was the book useful (songs words)? How did you use it?
7. Has the music at playgroup changed how you use music at home? (e.g. do you sing more, clap more, use tapes, etc.?)
8. Has the music had any impact on the family members who don't come to playgroup (e.g. dads, older brothers and sisters, grandparents, etc.)
9. Any other comments?