Music Therapy for Children with Severe and Profound Multiple Disabilities: A Review of Literature

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The purpose of this literature review is to identify goals and methods of music therapy for children with severe and profound multiple disabilities, and to clarify the various orientations used by clinicians. The general goals described have been identified by different music therapists and chosen for their representativeness and breadth of application. The orientations which clinicians take in their work with these children are described according to the practices outlined by Bruscia (1989).

While many examples from the literature for adults with severe and profound multiple disabilities are also relevant for children, they have not been included in this review because of the school age focus (approximately 3 to 18 years). As such, this includes the work of Wigram (1988), Hughes (1995) and Schalkwijk (1994), among others. Further, while much of the music therapy literature for children with autism shares similarities in orientation, goal(s) and methods, it has also not been included unless there is a clear indication that the author is referring to work with children who are severely or profoundly multiply disabled.

Identifying the Population

Children who are severely and profoundly multiply disabled have a combination of physical and intellectual difficulties which, although caused by similar conditions, create unique qualities and characteristics. These disabilities generally lead to severe limitations of movement, communication and socialization. Such children may require total care and be medically at risk. Epilepsy is common, and often not completely controlled by medication (Orelove and Sobsey, 1991). These children may have other impairments, such as hearing and vision loss. They vary considerably in their ability to understand and communicate information. Some use simple language or symbolic communication (such as gestures or picture symbols) while others may be unable to communicate needs or responses effectively. Their physical abilities also vary considerably, from well developed fine motor skills such as reaching or grasping, to a complete lack of independent physical movement. Sometimes these children will be unable to comprehend or adapt to unfamiliar environments and events, and this may cause difficulty in transitions, particularly from familiar to unfamiliar environments. Similarly, these children may not show recognition of familiar people, including family, teachers and therapists.

In educational settings, the needs of each child are generally outlined in an Individual Educational Program (I.E.P.) wherein goals are set by parents, educators, therapists and care staff. These goals are usually organized in areas such as auditory, visual, tactile, perceptual, sensori-motor, communication, cognitive, social and emotional development, and are then addressed by various

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disciplines (Boxill, 1989). Alley (1979), Codd (1988) and Jellison (1988) have reviewed various ways in which music therapy interventions have addressed the needs of people with disabilities, and this also includes children with severe and profound multiple disabilities.

General Music Therapy Goals
A number of interrelated goals have been identified by music therapists working with these children. These general goals may singularly, or in combination, provide the focus of a program.

The first and most primary goal is fulfilling the child's basic needs. For Alvin (1976), this involved creating an emotionally stable and predictable environment that fostered feelings of security, love and acceptance along with finding ways of self expression. She felt that only then could the child relate and develop. For Nordoff and Robbins (1971, 1977, 1983), fulfilling the child's basic needs involves 'meeting the child musically', where the therapist matches the child's inner condition with the music. As Bruscia (1987 p. 46) has indicated, this serves three main functions: to create an accepting, responsive environment; to make musical contact with the child; and to build trust and lessen resistiveness.

The second goal found throughout the literature is developing the child's sense of self. Alvin (1976) discussed this in terms of "relating self to objects" (Bruscia, 1987 p. 91), where the main aim was to enable the child to develop relationships with instruments, music, and the therapist. "In order to form these relationships, developmental growth must take place in the physical, intellectual, and social-emotional domains" (Bruscia, 1987 p. 91). For Nordoff and Robbins (1971, 1977, 1983), self-image is built by developing exploration and creativity. This is fostered by supporting the child's music making, acknowledging, and developing the inner "music child". Boxill (1985) discusses self image as built through a cycle or continuum of awareness, where the therapist approaches treatment with "a view to awakening, heightening, and expanding [the child's] awareness" (Boxill, 1985, p. 75). Two main strategies are used: reflection, a mirroring technique; and identification, a musical representation of the client and therapist.

The third general music therapy goal is establishing or re-establishing interpersonal relationships. For Boxill (1985; 1989), this meant developing the child's ability to understand and be understood by others through verbal and non-verbal means, where relationships may develop between the child, therapist or other person, or child's, therapist's or other person's music. Typically, this is developed through the contact song (Boxill, 1985, p. 80), an improvised or composed song which serves to affirm the therapeutic relationship, and enable interaction. Nordoff and Robbins (1983) felt that developing interpersonal relationships was achieved by developing expressive freedom, where musical options brought about increased possibilities for interaction and the realization that music can be "interresponsive". Alvin (1976) discussed this general goal as a two fold process: firstly, by establishing a relationship with the music therapist through self awareness and exploration; and secondly, by transferring the model of the therapeutic relationship to significant relationships in the child's life (for example, parents, siblings, peers) outside the immediate therapy environment. Agrotou (1993) felt that one way interpersonal relationships were established and developed was through ritualized
play, the “creative rhythmical formalisation of certain patterns of interaction” (Agrotou, 1993 p. 183). The basic qualities of this play are as follows: that each player’s output is regular in length and falls into a predictable regularity of tempo; and that each player’s contribution is called a turn and that a pair of turns constitutes a round, the building blocks of ritualized play.

Developing specific skills is the fourth general goal. There are two distinct ways of thinking about this goal area. Firstly, developing specific skills can be part of the therapy process concerned with “developing the music child” (Nordoff & Robbins, 1977) or developing “self awareness” (Boxill, 1985, 1989). In these orientations, skills are developed in order to increase expressive and interactive opportunities that foster the child’s development and self-esteem. Secondly, developing specific skills can mean focusing on the acquisition or development of competencies which enable the child to function with greater independence. This may include physical, emotional, cognitive, social or communicative development such as increasing the quantity, quality or duration of a skill. When this orientation is taken, the acquisition of the skill often becomes the central focus of the therapeutic process. For example, skills may include increasing eye contact (Kroot, 1987), using a switch toy (Holloway, 1980) or reaching for and touching objects (Saperston, Chan, Morphew & Carstrud, 1980), where musical activities provide a context, motivation or reinforcement for the development of the skill.

The fifth general goal is dispelling pathological behaviour. For Nordoff and Robbins (1971; 1983), dispelling pathological behaviour involves decreasing the incidence of maladjusted or unhealthy behaviour and developing healthy ways of expressing needs, emotions and responses to both people and the environment. For Alvin (Bruscia, 1987), this involves developing a level of awareness that goes beyond sensorimotor experiences in order to resolve conflicts that lead to pathology and isolation. For Boxill (1985), this involves increasing the child’s self-awareness in order to free “misused, misdirected, unused [or] unoriented energy.” (Boxill, 1985, p.73). Agrotou (1993) believes that fixated and repetitive behavior(s) is a form of communication associated with grief or loss. Through the establishment of ritualized patterns of communication and intervention, she provides a reliable and predictable environment for working through these behaviors. Dispelling pathological behavior may also include decreasing self-stimulatory behaviour (Kroot, 1987) or cueing other behaviours (Hanser, 1987).

The sixth and final general goal is developing an awareness and sensitivity to the beauty of music (Pfeifer, 1982). This involves “cultivating an awareness of, appreciation for, and satisfaction from beauty through experiential involvement with music” (Pfeifer, 1982, p.5). As Salas (1990, p.5) discussed, this experience may lie in intramusical structures and relationships, or in music’s ability to connect with human emotion, “giving voice to currents of feelings far beyond what is expressible in language”.

Orientations to Practice
When addressing these goals, music therapists take a number of orientations to practice. An orientation is defined by a therapist’s stance or theoretical approach to clinical work. This includes their beliefs about music, their role, and their relationship to the child. It is represented by the type of goals and methods used.
in working with these children and the meaning given to the therapy experience. Bruscia (1989) describes a number of areas of practice, and the following orientations are based on his categorization.

These examples are meant to be illustrative and not a comprehensive categorization of all music therapists working with this client group. Further, there is no intention to imply that the examples given are the therapist’s only orientation to practice.

Recreational Orientation
When music therapists take a recreational orientation, they are concerned with providing musical experiences for entertainment, recreation, diversion and leisure (Bruscia, 1989). These experiences can include concerts, plays, or special events where children perform music, perform with music (for example dancing), or where music performance is a shared experience that unites all members of the event (for example singing hymns at a church service). In these situations, the music therapist usually acts as coordinator, either of the musical portions or the entire event. Sometimes this requires writing or arranging music, creating a play, or preparing taped music to be used at the event. For example, Shoemark (1988) and Coull and Meadows (1990) created and produced plays with music as special events in a school setting. In doing so, they focused on the following: providing performance oriented opportunities for children to demonstrate skills that they had developed (Coull & Meadows, 1990; Shoemark, 1988); providing an opportunity for a school to join together in community (Coull & Meadows, 1990); providing enjoyment for family and friends (Shoemark, 1988); and, maintaining the dignity of children by involving them appropriately by age and ability (Shoemark, 1988).

Behavioral Orientation
When music therapists take a behavioral orientation, they are concerned with “the influence of music [on children] to increase, decrease, modify, or reinforce carefully designed targeted behaviors” (Bruscia, 1989 p.114). From the literature reviewed, music therapists typically place less emphasis on the dynamics of the therapeutic relationship and are more concerned with changes in the child’s behavior to meet an identified goal(s). As such, programs are developed with specific goals in mind and structured interventions formulated to meet these goals. For example, Wolfe (1980) used selected recorded music attached to a mercury switch to increase the head control of children with cerebral palsy. Music acted as a reward for these children, which they were able to hear when keeping their heads in an upright position. In another study designed to reinforce behavior, Holloway (1980) used both passive (contingent music listening) and active (instrument playing) music reinforcers to increase the pre-academic and motor skills of children in an institutional setting. Other examples of behavioral interventions include programs designed to elicit responses such as reaching for and touching objects (Saperston, Chan, Morphew & Carsrud, 1980), following directions (Dorow, 1975), and changing activity level (Dorow & Horton, 1982; Kaufman & Sheekart, 1985; Reardon & Bell, 1970).

Educational Orientation
In adopting an educational orientation, the music therapist "places an emphasis on curricular or developmental goals . . ." (Bruscia, 1989 p. 70). In the literature
reviewed in this discussion, two distinct orientations can be found. This first,
described by Bruscia (1989) as music therapy in special education, focuses on the
use of music to gain nonmusical skills and knowledge. The second, described as
developmental music therapy, focuses on a broader range of goals that address
delays or obstacles to developmental growth in all areas of the child’s life (e.g.
sensory, cognitive, communicative, social, emotional, affective). Each will be briefly
discussed.

When music therapists focus on the use of music to develop non-musical skills
and knowledge, they are typically concerned with reinforcing and maximizing the
educational goals of a child’s I.E.P. For example, Alley (1977, 1979), Jellison
(1977, 1979), Krout (1987) and Presti (1984) describe the role of the music
therapist in an educational setting as one who provides a systematically structured
program of activities to meet educational/curricula goals. In meeting these goals,
Jellison (1979) describes how the music therapist should derive a sequence of
short term objectives or behavioral tasks, determine an acceptable performance
criteria for their achievement, and then implement a series of activities to meet
these criteria. As such, the music therapist takes on an instructional role in the
child’s development, focusing on overt behavior and functional adaptation.

Some music therapists take a broader approach to the child’s development,
incorporating sensorimotor, communicative, cognitive, affective, interpersonal and
interpersonal needs in an integrated way. This approach, which Bruscia (1989)
calls developmental music therapy, “is concerned with autobiographical material,
family background, private emotions, and personality development” (Bruscia, 1989
p. 74) in ways that help children overcome delays and accomplish tasks that meet
their unique needs. Examples of this approach include the work of Agrotou (1993),
Alvin (1976), Boxill (1985, 1989), Howat (1995), Nordoff and Robbins (1971,
(1971, 1977, 1983), therapy involves three interrelated stages: meeting the child
musically, where the therapist’s music creates an accepting environment; evoking
musical responses, where the therapist stimulates the child to explore and create
music, both instrumentally and vocally; and developing musical skills, expressive
freedom and interresponsiveness. In this approach, both recreative and improvisa-
tional techniques are used. An increased emphasis is placed on the dynamics
of the therapeutic relationship, and while sessions may have a structure or plan
prior to each session, the therapist is likely to spontaneously respond to the child,
altering the content of the session accordingly. Further, the therapist places an
emphasis on self-inquiry as a way of understanding the therapy process.

Healing Orientation
Music therapists that adopt a healing orientation use “musical experiences and
the relationships that develop through them to heal the mind, body, spirit, to induce
self-healing, or to promote wellness” (Bruscia, 1989 p.93). In this orientation,
primary value is placed on the music therapist’s experiences of the child(ren) as
part of understanding the therapy process, and self inquiry is central to this. The
work of Nordoff and Robbins (1971, 1977, 1983) falls into this category because
the therapeutic experience allows the child to heal and change from within,
activating the child’s ‘inner resources’. As Bruscia (1989 p. 94) discusses, Nordoff

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and Robbins give the music therapist as healer four main functions: “1) to accept the [child] with respect and reverence, 2) to work through various relationships that develop through the music, 3) to create music that will activate the [child’s] inner resources, and 4) to continually develop one’s own musical life”.

**Major Treatment Methods**

When these orientations are taken to meeting the general goals previously described, music therapists use both active and receptive treatment methods in individual and group settings. Both of these methods will be discussed separately.

Active methods refer to the therapy that “takes place within and through the [child’s] efforts to perform, improvise, or create music, either alone or with others. Here the active experience either provides therapeutic benefits directly, as the main stimulus for change, or it leads to a response process that parallels or triggers a therapeutic change experience” (Bruscia. 1991, p. 65). Active methods include instrumental activities, improvisation, vocal activities and movement.

**Instrumental Activities**

An instrumental activity involves the child manipulating an instrument in order to produce some kind of sound. Typically, instruments that are used include hand held percussion, drums, cymbals and xylophones. Sounds can be “organized or unorganized, consist of random groups of sounds, short series of pulses, intermittent or prolonged beating, or rhythmic patterns of varying length and complexity” (Bruscia. 1987, p. 48).

Instruments are typically selected according to the child’s ability and interest, and may be adapted to maximize success and independence. In adapting instruments, the music therapist may position them for the child’s easy access and provide splints and grips in order to grasp smaller instruments and mallets. Instruments may be physically altered or other devices, such as levers or frames may be built. For example, Clark and Chadwick (1980) and Elliott, Mack, Dea and Matsko (1982) describe a range of adaptations to instruments designed to maximize the child’s access and independence. Music technology, such as computers and synthesizers, has also been adapted to utilize the synthesizer’s touch sensitivity and potential to produce a wide variety of sounds using similar movements (Meadows, 1991).

**Evoking Instrumental Sounds**

There are several reasons why music therapists use instrumental activities. The first of these is to evoke sound or music making responses from the child. Here, the music therapist helps the child to produce sounds through the exploration of instrument timbre, texture and shape (Pfeifer, 1989). Sometimes adapting the instrument or providing physical assistance is necessary. When the child explores an instrument, it is a way of stimulating them, making contact, establishing intent and engaging them in the therapy process. This goal is particularly important for the child with a physical disability because such activities physically stimulate them and assist them in understanding and controlling their bodies.

Nordoff and Robbins (1971, 1977) evoke musical responses by engaging the child in music making on instruments through modeling, verbal encouragement or instruction, and/or physical assistance. Once the child begins to play, the therapist
concentrates on the way the sound is produced, responding to the dynamics, timbre, melody and level of organization the child shows. In this way, the therapist begins from the child’s music, and engages the child by imitating, contrasting, pausing or structuring the musical experience in certain ways. These techniques apply more readily to children who are physically capable of using instruments, where the process centers around developing ways to express feelings, explore, or participate in instrumental activities.

*Developing Instrumental Skills*

The second goal is to develop instrumental skills. Two types of skills are emphasized, the first of which is to develop an expressive musical language. Here the music therapist fosters the child’s ability to express personal feelings, explore and create sounds, and interact with others through the playing of an instrument(s) (Alvin, 1976; Boxill, 1985, 1989; Nordoff & Robbins, 1971, 1977).

In developing expressive music skills, a common intervention is improvisation, where the therapist and child spontaneously make music together. This may comprise the child and/or therapist improvising with piano, voice, guitar, melodic or percussive instruments, either alone or in combination. Improvisations can vary in their complexity from simple sound forms to multi-dimensional compositions. For example, Nordoff and Robbins (1971; 1977) discuss developing expressive musical skills through improvisation in terms of ‘expressive freedom’ and ‘interresponsiveness’, where developing a musical language gives the child new or improved expressive options and choices. Other examples include the work of Alvin (1971), Boxill (1985), Howat (1995), Nordoff & Robbins (1971, 1977, 1983), Shoemark (1991) and Wigram (1992).

The second area is developing specific music skills, and involves the child learning and playing an instrumental part in a composition. Typically, this is structured around recreational activities, where the child rehearses and performs their part. While a number of therapeutic objectives, such as attending to the task and behaving appropriately, are implied in this activity, the emphasis remains on music making. The therapist may write music for specific goals (Levin, Levin & Safer, 1974; Purvis & Samet, 1976), adapt it from existing literature (Boxill, 1985, 1989), or write it specifically for the child, type of activity or goal (Boxill, 1985, 1989; Nordoff & Robbins, 1971, 1977).

*Developing Music-Related Skills*

The third goal area is developing music-related skills. Typically, goals focus on either those non-music skills developed in the process of music-making, or the non-music skills developed where music is used to motivate or reinforce specific skills. Bruscia (1991) has outlined a number of general objectives, which include “developing sensorimotor skills, learning adaptive behaviours, maintaining reality orientation, mastering different roles, identifying with the feelings of others, and working co-operatively toward a common goal” (Bruscia, 1991, p. 7). This goal area shares many similarities with the previous goal (developing instrumental skills). The main difference is in the emphasis placed by the music therapist. In this particular goal area, the emphasis is placed on the skills (for example behavior, motor skills or attention) associated with the instrumental activity. In the previous goal area, the emphasis was placed on the process of music making.
A wide range of music related goals have been addressed in the literature (Alley, 1977; Hansen, 1987; Pfeifer, 1982). These include developing eye-hand coordination and motor skills such as shaking, striking and grasping (Pfeifer, 1982; Krout, 1987), imitative behaviour and turn taking (Boxill, 1985), and following directions (Lathom & Eagle, 1982). Typically, these goals share a close relationship with the child's I.E.P., where the music therapist specifically addresses one or more of these goals in the child's music therapy program.

**Vocal Activities**

A vocal activity is one which is focused on the child producing any sound that can be made orally. Vocal sounds can be “sustained or unsustained, pitched or unpitched, verbal or non-verbal. They may be unrelated single tones, short motifs, melodic patterns, or short phrases” (Bruscia, 1987 p.47). Nordoff and Robbins (1983) and Boxill (1985) discuss singing as a direct and intimate self-extension, with the potential to integrate perceptual, cognitive and expressive capacities. As with instrumental activities, goals for vocal activities can be divided into three main areas: evoking vocal responses, developing vocal skills, and developing music-related skills.

**Evoking Vocal Responses**

In evoking vocal responses, the music therapist helps the child to produce any vocal sound in a musical context. This goal is usually most relevant in three specific situations. Firstly, for children who have profound disabilities as a way of stimulating a response or fostering interaction (Boxill, 1985; Cunningham, 1975; Johnson, 1975; Nordoff & Robbins, 1971, 1977). Secondly, for children with physical disabilities which impede their ability to produce vocal sounds. And thirdly, for children who are withdrawn or lack self confidence and need specific vocal support and encouragement (Nordoff & Robbins, 1971, 1983).

Nordoff and Robbins (1977, 1983) use a number of techniques to elicit vocal responses. These include improvisational techniques such as a) making vocal sounds while musically reflecting the child's emotional state, b) singing phrases that describe what the child is doing, feeling or experiencing, and c) imitating the child's vocal sounds or words, matching the musical and emotional qualities. Recreational techniques include a) presenting material the child is able to copy, add to or develop, b) introducing a familiar song or tune and encourage the child to sing along, and c) varying the instruments used in accompaniment. Techniques that can use either method include a) providing opportunities to complete phrases, add sounds, syllables or words, and b) combining vocalizing with movement or instrument playing.

**Developing Vocal Skills**

Developing vocal skills involves the therapist increasing the range, length, type, accuracy and/or quality of the child's vocal sounds. Two types of goals are emphasized in the literature: developing an expressive vocal language, and developing music-related skills.

In developing an expressive vocal language, the music therapist is primarily concerned with stimulating, supporting and developing the child's vocal expression(s). These include both verbal and non-verbal expressions of the child's here-and-now
experience with the therapist, either in group or individual sessions. Boxill (1985) gives the example of an agitated, hyperactive person, “when encouraged to hum a melody, may create his or her own sense of calm through the vibratory effect of the music, as well as the emotional gratification it affords” (Boxill, 1985, p. 101).

For Nordoff and Robbins (1983), developing an expressive vocal language involves presenting a variety of songs with different emotional qualities that gives the child a range of emotional experiences. In so doing, the child’s personality can become integrated in the act of singing and is functionally organized by the musical structure and content of the song itself. “Such a variety of emotional experience is vital to music therapy for it enhances responsiveness . . . and simultaneously fosters the personal development of (the child)” (Nordoff & Robbins, 1983, p. 32).

**Music-related Skills**

Developing vocal skills comprises many music-related skills. Typically, these are either the non-music skills developed in the process of singing and music making, or the non-music skills developed where singing is used to motivate or reinforce specific skills. These include the broad categories of receptive language, expressive language and academic skills (Pfeifer, 1982). For example, vocal activities can address the child’s ability to attend (Wylie, 1983), turn take, listen, and make eye contact (Kroot, 1987). Songs can reflect a skill or knowledge that is learnt in the classroom. For example, songs can describe colours and seasons (Purvis & Samet, 1976), providing a learning context for the child.

**Movement**

Movement activities focus on the physical well-being and development of the child. As an active method, movement activities are those where the child moves their body independently in a musical context. This includes gross motor activities, basic locomotor activities, structured and free psychomotor movements, and perceptual motor activities (Boxill, 1985), where the music therapist plays or selects music which supports and stimulates the child’s movements.

In movement activities, two main goals are emphasized: maintaining or increasing gross and fine motor skills (Robbins & Robbins, 1988); and educating the child to physically interact with the environment in ways that help them to learn about themselves, the environment and others around them (Boxill, 1989). More specific goals include increasing body awareness (Boxill, 1985), identifying body parts (Levin, Levin & Safer, 1984), increasing muscle control (Latham & Eagle, 1982; Robbins, 1988), maintaining range of movement (Robbins & Robbins, 1988) and integrating movements (Kroot, 1987; Levin, Levin & Safer, 1984).

Typically, movement programs are designed for groups, where children have similar needs, and may be coordinated with physiotherapists (Robbins & Robbins, 1988). Live or recorded music may be used, chosen specifically for the type of activity or experience undertaken. Live music can be improvised from an established song repertoire (Robbins & Robbins, 1988; Wagland, 1992). For example, improvised music can support or imitate the movement(s) undertaken. Songs can describe the movement (for example stretching), the context of the movement (for example, identifying body parts), or be a medium by which the movement occurs (for example, the child spontaneously responding to the music).
Receptive Methods
The second major area of interventions for children with severe and profound multiple disabilities are receptive methods. As Bruscia (1989 p. 43) describes, receptive methods refer to "the therapy that takes place when the child listens to, takes in, or receives the music itself". Three main receptive methods can be identified in the music therapy literature. These are sensory stimulation, movement, and contingent listening.

Sensory Stimulation
Sensory stimulation refers to the therapist’s use of musical and other media to arouse, excite and activate the child. In all interventions, the emphasis is on engaging the child in any type of response that will foster activity and awareness of themselves, objects and others. For example, this can include singing or playing to the child in order to change affect (e.g. eye contact) or manipulating the child’s arms and hands to explore an instrument, watching for changes in awareness and activity.

Typically, there are three elements to this type of intervention, and they can be used separately or together when working with a child. The first element is auditory stimulation, or the therapist’s efforts to stimulate the child by improvising (Johnson, 1975), singing songs (Dorow & Horton, 1982; Kaufman & Sheckart, 1985) or playing pre-recorded music (Wigram, 1981). Secondly, this can involve the use of textures, fabrics and other materials to physically stimulate the child. For example, fabrics can be gently rubbed over the child’s arms, hands or feet, while textures can be placed in the child’s hand(s) or between fingers. Thirdly, the therapist can physically stimulate and manipulate the child’s body by touching, massaging or carefully moving body parts. For example, the therapist may massage the child’s arm and hand as a way of making contact or building trust. Alternatively, the same technique may be used as a preparation for instrument playing, stimulating the child’s body and then placing the instrument so that the child can explore it, either independently, or with assistance.

Movement
As a receptive method, movement activities refer to the therapist’s caring and purposeful manipulation of the child’s body in a musical context to meet his/her physical well-being and development. These activities are specifically designed for children who have little or no voluntary control over their bodies, or lack the understanding to move in purposeful or controlled ways (Weigall & Meadows, 1995). These programs are usually designed and run with physiotherapists because of the high level of expertise required in understanding the physical makeup of children and limitations to their movements. Programs are usually run for groups, and there is generally a very high student staff ratio as children require individualized attention.

The music therapist has two main functions in these programs. Firstly, to provide the structure of the sessions, or secondly to work with a child providing physical intervention. Providing the structure to sessions includes both musical and verbal elements. Musically this involves selecting songs (both live and recorded) and improvising to connect, support, and facilitate the child’s movement experience.
Verbally, it means acting as a guide to staff members throughout the session. Providing physical intervention means working with a child while recorded music is played.

These movement programs have three related elements. The first of these is to focus on maintaining the child’s physical functioning, including range of movement, muscle tone, and body symmetry (for example, maintaining posture). Secondly, an emphasis is placed on the quality of the interactions between therapist and child. As these children usually receive constant physical handling, care is taken to make the interaction as positive and sensitive as possible. Thirdly, while the adult moves the child’s body, independent movement is encouraged and supported at all times.

**Contingent Listening**

*Contingent music listening* refers to the therapist’s application of live or recorded music to reinforce or reward appropriate non-musical behavior. Typically, the music therapist will identify, shape, reinforce and reward a desired behavior(s), with the music functioning in the last two elements of the sequence. For example, contingent listening has been used to reinforce imitative behavior (Meltzer, 1974), reaching and touching objects (Saperston, Chan, Morphew, & Carstaud, 1980), head positioning (Wolfe, 1980), motor skills (Dorow, 1975; Holloway, 1980) and foster positive interactions and acceptance among students in a mainstream music classroom (Jellison, Brooks & Huck, 1984).

**Summary**

One way of presenting the music therapy literature for children with severe and profound multiple disabilities is by goal, orientation and method. This gives an indication of the ways music therapists work with these children, showing both the diversity and similarities in overall approach.

Given the diverse goals of music therapists, there seems to be many similarities in the methods used. For example, instrumental and vocal activities were used to meet all the general goals identified in this review. It appears, therefore, that it is not so much the methods that are different as the meaning given to the therapy experience. For example, when a child first plays an instrument independently, it can be framed in two entirely different ways. From a behavioral orientation, it may be an example of following directions and playing attention to the task. From a broader educational perspective (developmental music therapy) on the other hand, it may be the child’s first communication of intent or interaction.

It follows that the general goals identified earlier in this review are not really ‘general’ at all. They reflect an orientation or orientations to practice by music therapists that value certain types of goal(s) for these children. For example, the first goal of fulfilling the child’s basic needs reflects a developmental music therapy or healing orientation that places an emphasis on the quality of the therapeutic environment and the relationship with the therapist. It has not been identified as a goal when working from other orientations.

Taking another perspective, the general goal of developing specific skills means different things in different orientations. From a behavioral orientation,
ing skill means targeting and systematically working toward the mastery of a specific skill, task or behavior that was identified by the therapist to meet adaptive or educational needs. Typically, music listening is used to reward or reinforce the child and the music therapist takes an instructional role. From a healing orientation, developing skills means fostering, allowing and encouraging the child to develop his/her own unique ways of communicating and interacting to become whole. As such, sessions take place spontaneously and develop in unique and unpredictable ways. A central focus is placed on the music as a representation of the process, perhaps without necessity for interpretation or explanation. Further, the therapist uses his/her own experiences to further understand this process.

In closing, while music therapist’s goals and methods give an indication of the ways in which therapy is approached with these children, it is the therapist’s orientation to practice which gives meaning to the experience.

Notes
1 This goal was originally identified by Gaston (1968).
2 Pfeifer cited Eagles (1978) as the primary source for this goal. However, as this is acknowledged as a personal communication (Pfeifer, 1982 p.32), Pfeifer is used as the source.
3 Performance can take place either within the therapy session or to peers, family and/or others.

References


