Approaches to music and movement for children with severe and profound multiple disabilities

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Abstract

Four approaches to music and movement for children with severe and profound multiple disabilities are outlined and discussed in terms of goals, activities, the role of the music therapist, the role of the physiotherapist, and the role of music. Elements that music therapists consider when designing music and movement programs for this population are also identified. The article is informed by a literature review and the author's clinical experience.

Introduction

Music and movement programs are often a core responsibility of music therapists who work with children who have severe and profound multiple disabilities (Meadows, 1997). Typically, they are designed and implemented in collaboration with physiotherapists. While these programs have a longstanding tradition in educational settings (Alvin, 1976; Nordoff & Robbins, 1971; Wigram & Weekes, 1983), there have been no attempts to identify and summarise the various approaches that have been taken. This may be of assistance to music therapists, particularly students, because there are differences in their design and implementation, and this in turn affects the movement experiences of the children. This article will review four approaches to music and movement programs, based on a review of the literature and the author's clinical experience. Each approach will be discussed in terms of goals, activities, the role of the music therapist, the role of the physiotherapist, and the role of music.

Movement Needs of Children with Severe and Profound Multiple Disabilities

Before discussing these approaches in detail, a brief description of children with severe and profound multiple disabilities is warranted. As previously described by Meadows (1997), based on Orelove and Sobsey (1991), these children have a combination of physical and intellectual difficulties which, although caused by similar underlying medical or genetic conditions, create unique qualities and characteristics. Typically, the medical or genetic conditions encountered include cerebral palsy, scoliosis, and unspecified forms of brain damage that lead to increased or decreased muscle tone, loss of range of movement, and loss of ability to coordinate movements. As a result of these conditions, some children may have little or no independent movement, and show no apparent awareness of their body, while others have well-developed fine motor skills, and can move many parts of their body independently.

It is important to note that some children with severe and profound multiple disabilities find touch or physical movement painful and/or stressful. As these children are often handled extensively by adults, they can develop a resistance, sometimes even an animosity, to being moved. For this reason, it may be difficult to engage them in any kind of movement, even though movement is essential to their well-being. This issue will be further discussed as it relates to the different music and movement approaches.
Defining Music and Movement Programs

Music and movement programs are designed to implement movement experiences in conjunction with music. No matter what the approach, the focus of sessions is on some aspect of the children’s physical development and/or well-being. The types of movement experiences include gross motor activities, basic locomotor activities, structured and free psychomotor activities, and perceptual motor activities (Boswell & Vidret, 1993; Boxill, 1985; Wigram, 1992). Music and movement programs are usually developed for groups of six to eight children (typically between 5 and 17 years of age), although this number varies. While instrumental and vocal activities may be incorporated into sessions, the main purpose is always to address a motor goal (Robbins & Robbins, 1988).

As previously identified by Meadows (1997), the overall goals of music and movement programs for children with severe multiple disabilities are: (a) to maintain or improve motor skills (Robbins & Robbins, 1988; Wigram, 1992); and (b) to educate children to physically interact with the environment in ways that help them to learn about themselves, the environment, and those around them (Boxill, 1985). More specific goals include increasing body awareness (Boxill, 1985), identifying body parts (Levin, Levin & Safer, 1984), increasing muscle control (Lathom & Eagle, 1982), maintaining range of movement (Robbins & Robbins, 1988), improving rhythmic skills (Boswell & Vidret, 1993), improving speech sounds (Boswell & Vidret, 1993), integrating movements (Levin, Levin & Safer, 1984), and improving circulation and respiration (Wigram, 1992).

Sessions usually take place in a room with mats and other physical aids, although other settings are not uncommon (e.g., a hallway or common space). Each child is taken out of his/her wheelchair and placed on a physiotherapy mat (padded or cushioned mat). Physical devices such as wedges and rollers may be used to facilitate movements. Sessions usually last between 30 and 60 minutes, depending on the needs of the children and the goals addressed. They are usually conducted on a weekly basis, although multiple sessions in a week are not uncommon.

Most of these programs (e.g., Robbins & Robbins, 1991; Weigall & Meadows, 1994; Wigram, 1992) call for a high adult to child ratio, approaching one to one. This is because the children require so much support that anything less would limit the effectiveness of the program. The adult helpers are usually classroom teachers, teaching aides, physiotherapists, physiotherapy aides, nursing staff and/or volunteers. Their role in sessions is to structure a child’s movements, move the child when he/she is unable, and generally provide support to the child during the session.

There are two distinct ways of implementing music and movement programs with this population, depending on the physical abilities of each child (Meadows, 1997). For those children who can move their bodies independently, or move with minimal assistance, activities are designed to maintain or increase the ability to move spontaneously and independently, and all adult interventions are centred on supporting such efforts. For example, if a child is able to raise his/her arms above his/her head, then the goal of such a movement may be to increase the range of the movement, its fluidity, or the number of times the child is able to make the movement.

A different approach is required for children with very limited motor abilities, or children who cannot move their bodies at all. In this approach, the adult helper plays a very active role in manipulating the child’s body through a sequence of movements that: (a) maintain and/or increase range of movement (and physical well-being); (b) stimulate spontaneous movement; and (c) develop self awareness. Many sessions combine both approaches, as children are usually mixed in their abilities or have some independent movement in certain limbs/areas, but not in others. In such cases, the same activity may be presented with the expectation that some children will respond
independently or with assistance, while others will be moved by an adult helper.

Another characteristic that is important to the definition of music and movement programs is the relationship between the music therapist and physiotherapist. In some situations, the physiotherapist takes full responsibility for the program, while the music therapist provides the music. In other situations, the music therapist and physiotherapist work collaboratively, in equal roles. And finally, in some programs, the physiotherapist acts as a consultant while the music therapist takes full responsibility for the design and implementation of the program. It is important to note that music and movement programs are not a replacement for physiotherapy. Instead, they provide a valuable supplement to physiotherapy goals and procedures by addressing them in the context of musical experiences.

One more defining characteristic of music and movement programs is that they usually call for a high level of communication among staff members in designing, implementing and evaluating the program. Because of the number of staff involved, and the overlap in professional knowledge, regularly scheduled meetings usually take place (particularly between the music therapist and physiotherapist) in order to evaluate the effectiveness of the program and address the specific needs and responses of children as they arise.

The Role of the Music

As previously described by Meadows (1997), music and movement programs use live and/or recorded music, chosen specifically for the type of activity or experience undertaken. Live music can be either improvised (Robbins & Robbins, 1988), or from an established song repertoire (Wigram, 1992). For example, improvised music can support or imitate the movement undertaken. Song lyrics can describe the movement (e.g., stretching), the context of the movement (e.g., identifying body parts), or be a medium in which the movement occurs (e.g., the child spontaneously moving his/her body in response to a song that is familiar and/or motivating). Little has been written about the use of recorded music, and the limited discussion focuses mostly on its basic lack of flexibility (e.g., can't adjust the tempo to match the group) (Wigram, 1992). In the author’s clinical experience, recorded music has been used successfully to create a transitional space at the beginning and end of sessions, to broadly contextualise movement(s), and to vary the music used in sessions.

Music helps address movement goals with this population by: (a) stimulating the children and motivating them to move (Wigram, 1992); (b) being a cue to the movement, and a context in which to move (Robbins & Robbins, 1988); (c) organizing the children's movements and helping to coordinate muscle patterns (Robbins & Robbins, 1988; Streeter 1993); and (d) providing predictability in sequencing activities which can reduce anxiety associated with being moved (Wigram, 1992).

Many of Wigram's (1992) comments about his work with multiply handicapped adults are relevant to children. According to Wigram (1992), rhythm and tempo can provide motivation to move, melody and harmony sustain interest and awareness in sound, while style and timbre support and encourage relaxation and stimulation as required in the session. Based on his clinical experience, Wigram felt that the tempo of the music often needed to be slow, with an emphasis on strong beats. This best facilitated the movement undertaken, allowing the clients suitable time to adjust to and embrace the movement.
Wigram (1992) also referred to “bathing” his clients in music, which can be interpreted as a way of creating a musical environment in which the movements take place. This is an important concept in music and movement programs because it emphasizes the dynamic interaction between the music therapist and his/her clients. When the therapist attempts to “bathe” clients, he/she is creating a musical experience that structures the clients’ movements, actively responding to what is happening in the group. For example, the music therapist may improvise at the piano in a manner that reflects a perceived emotional and/or energy level in order to empathize with the group and/or shift the group to a different place. The music facilitates this experience and transition.

In some of the approaches discussed below the concept of “bathing” in music is central (e.g., improvised music and movement), whereas in others it is not important at all (e.g., physiotherapy with music).

Approaches to Music and Movement

Based on a review of the literature and the author’s clinical experience, four approaches to music and movement can be distinguished, including (a) physiotherapy with music, (b) structured music and movement, (c) improvised music and movement, and (d) music therapist directed music and movement. Music therapists may use all of these approaches effectively. The extent to which each approach is used depends on the setting in which the music therapist works, the clinical orientation of the music therapist and physiotherapist, the goals of the program, and the physical needs of the children. They will be discussed in turn.

Approach 1: Physiotherapy with Music

In physiotherapy with music, the music therapist provides music for a physiotherapy program. The physiotherapist designs the movement program and leads the session, while the music therapist designs and implements the music to support the activities. In this approach, music is incorporated into physiotherapy goals and methods. The purpose of the music is to provide structure, context and/or motivation for the desired movement.

These sessions can be designed for either individuals or groups of children. The format of sessions may vary. In some instances, the music therapist will only follow the physiotherapist, presenting and repeating musical activities “in vivo”, according to the physical therapist’s goals. In other situations, the music therapist will move through a pre-arranged sequence of songs and activities that incorporate movements designed by the physiotherapist.

In these sessions, there is usually a high level of structure and the expectation that children will move in certain ways and at certain times. In some situations, movement activities are repeated until children reach a specific goal. Programs usually address educational goals, or facilitate developmental sequences. Examples include the work of Robbins and Robbins (1988), who worked collaboratively with physiotherapists to design and implement musical activities to match physiotherapy goals and activities in a school setting, and Levin, Levin and Safer (1984), who designed various musical activities to meet motor goals.

This approach has been successful when the physiotherapist wanted to maintain control of the session, yet can see the appropriateness of music in enhancing the children’s physiotherapy program. Another situation in which this approach may be successful is when the music therapist works with a wide range of clients and has limited time to work closely with particular children and staff. In this situation, the music therapist can enhance a child’s physiotherapy without having to take additional time and responsibility to design and co-ordinate the entire program.
Approach 2: Structured Music and Movement

In structured music and movement, the music therapist designs the movement program and leads the session. The program is designed in conjunction with the physiotherapist, who is always present in sessions. While the physiotherapist remains responsible for ensuring that the physical needs of the children are appropriately met, the music therapist may structure the session with both physical and musical considerations in mind. Some of the dimensions considered by the music therapist may include musical structure (e.g., what is the most appropriate musical activity to meet or incorporate the movement?), sequence (e.g., how can the movements be arranged musically?), contour (e.g., how does the musical sequence affect the children’s level of engagement?) and flow (e.g., can the children and/or adult helpers physically manage the sequence within the musical structure?). This is an important distinction from the first approach because the music therapist incorporates musical ideas that a physiotherapist may not consider.

This approach is identified as structured because there is usually a high level of structure in the movement activities, with the expectation that children will move in certain ways according to a predetermined sequence. Typically, these sessions follow a similar pattern from week to week, because repetition and familiarity may reduce anxiety associated with being moved (Wigram, 1992). Repetition may also promote predictability which, in turn, leads to anticipation and then to children initiating the movement(s) themselves. A predictable structure also permits easy evaluation of the program by providing clear reference points for comparing responses over time.

One such approach to structured music and movement, based on the author’s clinical experience, is outlined below.

1. Preparation. Children and adults enter the room and are positioned comfortably on mats. The adult helpers then wait with the children until the greeting song begins. The music therapist may be improvising on the piano as the children and adults enter, or may be playing a specially selected CD. The purpose of this music is to create a suitable atmosphere from which to begin the session.
2. Greeting song / orientation to session. The music therapist plays piano or guitar and sings a song to the children and adults, welcoming them and orienting them to the session. The music therapist may elicit specific responses from children.
3. Whole body awareness (e.g., stroking the child’s body). The adult helpers stimulate the children’s bodies by massaging body parts with the intent of increasing body awareness and preparing the body to move. The music therapist improvises music to match the interventions of the adult helpers, and may additionally direct the adults to work on specific body parts, or with a particular kind of touch (e.g., light touch vs. firm stroking).
4a. Gross motor activity (e.g., hip extension and flexion). The adult helpers assist the children to rotate their hips and extend and flex their legs. Some children may do this independently, while others may require assistance. The music therapist may sing a song that describes the movement or improvise music to match the kinds of movements undertaken.
4b. Gross motor activity (e.g., feet stomping). This is a natural extension of the previous activity, in that the rotation naturally leads to another type of lower body movement such as feet stomping. Again, the music therapist may sing a song that describes the movement, or improvise music to match the kinds of movements undertaken.
5. Arm stretch, elbow and wrist rotation. After lower body work, upper body work may be undertaken. Again, the adult helpers work with the children to maintain or increase range of movement in these body parts. The music therapist may sing a song that describes the movement or improvise music to match the kinds of movements undertaken.
6. Hand and finger massage. This is a natural extension of the previous activity. The music therapist may sing a song that describes the movement or improvise music to match the kinds of
movements undertaken.

7. Moving while sitting on a roller or other aide. After working with specific areas of the child’s body, this activity incorporates whole body movements such as rotation at the hips, reaching forward and stretching back, and touching body parts. Reaching to touch other children may also be incorporated. The music therapist is likely to use songs that describe the movement(s), whether they be specifically written for the activity, or from the existing literature. Three or four activities may occur in this position, depending on the abilities of the children.

8. Massaging the children’s bodies. The children are helped back down to the mats, and placed in a comfortable position. The adults begin stretching and massaging the children’s bodies. The children receive this without the necessity to respond. It is a way to finish the session, while simultaneously relaxing the children and working toward even muscle tone and symmetrical body position. The music therapist may improvise music or select a piece from a CD. The purpose of the music is to mirror a quiet, peaceful place.

9. Closure. Sessions may end after activity 8, or may move to a closure song (typically a good-bye song). The purpose of this song is to bring the session to a close and alert the children to an immanent change (i.e., change of position, room, etc.).

There are a number of examples of this approach in the literature. Wigram (1992) described a similar approach in which he organized sessions into various movement activities and matched songs and improvised music to the movements. Boswell and Vidret (1993) divided sessions into four components, including (a) focusing attention and securing eye contact, (b) performing passive movements, (c) performing imitative active components, and (d) performing original movement sequences. They developed specific movement activities for each stage, and used the same sequence throughout the program. Boswell and Vidret’s approach differs in that they were also focused on developing rhythmic and vocal skills in sessions, which they felt were a natural extension of the movements undertaken.

Approach 3: Improvised Music and Movement

In improvised music and movement, the music therapist designs the program and leads the session. The program is designed in conjunction with the physiotherapist, who is usually present in sessions, and the physiotherapist remains responsible for ensuring that the physical needs of the children are appropriately addressed. But in this approach, the music therapist follows the children and adult helpers. The overall structure of the session, and specific movements undertaken, are developed spontaneously as the children and adult helpers interact, based on the children’s physical and emotional needs at the time. In this way, sessions are improvised.

This improvised approach to music and movement, which developed from the author’s clinical experience with profoundly disabled children (Weigall & Meadows, 1994), emerged naturally out of Approach 2 as the clinical team began to see the limitations of working in a predetermined sequence of movements. Many children, particularly those who had little self-awareness, or were particularly sensitive to touch, tended not to respond well to structured forms of movement, especially when those movements did not reflect their emotional state. The adult helpers began working more spontaneously with these children, trying to engage them in movement experiences based on their immediate needs.
There were usually three interrelated goals in this approach. The first was to reduce tension and anxiety that the adult helpers could see/feel in the children. This would commonly include interventions such as massaging the children’s body parts, moving different body parts for the children, and allowing time for no movement. Working toward this goal often took a major part of the session for the most severely disabled children. The second goal was to maintain physical well-being, by moving the child through various physical activities, as described in Approach 2. The third goal was to increase awareness of self and others. As the adult helpers worked with the children, they assessed the children’s awareness and responded accordingly. If children began moving their bodies independently, vocalizing, and/or making eye contact the adults responded to them. These three interrelated goals and the corresponding interventions provided the basic structure for each session. Although improvised sessions tended to be more spontaneously created, they also utilized various elements from Approach 2, particularly the actual movement activities incorporated into sessions.

In order to address the change in emphasis from predetermined structure (Approach 2) to an improvised approach, the physiotherapist began a new form of training with staff members, to attune them to the children so they could work on a broad range of physical goals, but only as these naturally arose within the session. As a result of the training, staff members developed a repertoire of movements that could be used with specific children. In some sessions, they worked through seven or eight different movements whereas, in others, they only worked on one, depending on the children’s emotional and physical state at the time. As the physiotherapist was always present in sessions, she could be called upon to clarify a movement, or could be asked for additional ideas about how to work with a child. Not surprisingly, a key component of this approach was the continuity of the staff-child relationship. In order for this approach to be successful, the same adult and child worked together for an extended period of time.

In the improvised approach, the role of the music therapist shifted considerably. No longer concerned with maintaining a structured sequence of activities, the music therapist’s main role was to create music that matched the “felt experience” of the session. This “felt experience” was similar to “bathing” the clients in music, as previously described by Wigram (1992), in that the music therapist tried to musically express and respond to the emotional state of the children. The music used in sessions tended to be more improvisational, and based on the piano, although musical activities (e.g., greeting songs and action songs) were sometimes incorporated. Recorded music was also used because the purpose of the music was to match an overall feeling, rather than to facilitate a specific movement.

There were several observed advantages to this approach. The children tended to experience movement differently, in that the adults were responding to them “in the moment,” rather than trying to work through a predetermined series of physical movements. This, in turn, sometimes appeared to assist in reducing stress associated with being moved. The adults tended to be more closely attuned to the children and felt that they had a more active role in determining the flow of each session. They also became more active in suggesting helpful changes to be made in the overall organization of the program (e.g., which types of music might better support the children in a particular movement and/or emotional state).

There are several references to this type of approach in the music therapy literature. Wigram (1992) discussed adapting the music used in sessions based on the mood of the clients and therapists. Robbins and Robbins (1988) discussed improvising music and creating specific songs to match children’s movements in a physiotherapy program. They were particularly careful to adapt the various characteristics of the music used (e.g., tempo and phrasing) to match each movement. The improvised approach described above appears to differ from these approaches in that the entire
session is improvised. It does not incorporate specific music during movement activities.

**Approach 4: Music Therapist Directed Music and Movement**

In music therapist directed music and movement, the music therapist takes full responsibility for the design and implementation of the music and movement program. The physical therapist acts only as a consultant, and is usually not present in the session. Typically, the music therapist takes Approaches Two or Three (Physiotherapy with Music; Structured Music and Movement), or a combination of both.

This approach may also be used to supplement other music and movement programs that do involve physiotherapists. Some children may need extra attention, and/or may respond particularly well to the music used in sessions to an extent that may warrant additional therapy. Thus, this approach may be appropriate for individuals as well as groups of children. In fact, the music therapist could potentially use recorded music and work with the child him/herself.

The music therapist directed approach has been discussed by Boswell and Vidret (1993). In addition to running weekly group music and movement programs with a movement specialist, they worked with individuals from the same group three times a week, using a similar format to the group sessions.

Caution is advised when taking Approach Four. Music therapists are not trained in physiotherapy and, if they choose to direct a program themselves, they must have had adequate training from a physiotherapist, must know the children very well, and must have easy access to a physiotherapist for regular consultations.

**Discussion of the Approaches**

Four approaches to music and movement with children who have severe and profound multiple disabilities have been discussed, focusing on similarities and differences in goals, procedure, role of music, role of music therapist, and role of physiotherapist. In practice, the music therapist may take a number of these approaches in one setting (e.g., Robbins & Robbins, 1988), or combine several approaches while working with one group (e.g., Boswell & Vidret, 1993), according to client needs and therapist availability.

The approaches are distinguished from one another in several ways. First, they differ in the relationship between the music therapist and the physiotherapist. In Physiotherapy with Music (Approach 1), the music therapist takes a secondary role in sessions, following the physiotherapist’s lead, while in others (Approaches 2, 3 and 4), he/she takes primary responsibility for the design and implementation of the program. Further, in Approach 1 the music therapist provides music according to the needs of the physiotherapist whereas, in others, he/she takes full responsibility for the presentation and sequencing of the music.

Second, the approaches call for differing degrees of structure and freedom. In other words, they provide different guidelines for determining how children’s movements should be structured, both within the session (how should activities be sequenced?) and over time (in what way(s) should sessions be the same from week to week?). In Physiotherapy with Music and Structured Music and Movement, more structure is provided both within the sessions and over time, while Improvised Music and Movement tends to base the structure on what happens in each individual session. Music Therapist Directed Music and Movement varies in the amount of structure and freedom provided in sessions, depending on the goals of the session, the abilities and needs of the children, and whether the session is for an individual child, or group of children.

Third, different approaches call for differing roles of the adult helpers in relation to the children. In Physiotherapy with Music and Structured Music and Movement (Approaches 1 and 2),
the primary focus of the adults tends to be on structuring the child’s activities and assisting him/her to move through sequences of movements. In Improvised Music and Movement, the adults tend to focus on the emotional needs of the children during the sessions, with movements organized accordingly. This is not to say that when Approaches One or Two are taken the adults are not concerned with the emotional well-being of the children, rather that the primary focus is on moving the children through a pre-determined sequence of movements. Music Therapist Directed Music and Movement varies in the role the adult takes in relation to the child, again depending on the goals of the session, the abilities and needs of the children, and whether the session is for an individual child, or group of children.

Finally, music is used differently in the different approaches. Physiotherapy with Music, Structured Music and Movement and, sometimes, Music Therapist Directed Music and Movement, use songs and other structured musical activities, whereas Improvised Music and Movement and, sometimes, Music Therapist Directed Music and Movement, rely more on improvisation. The use of recorded music also varies, according to the goals of the session and the degree of structure or improvisation necessitated.

Several elements are common to all four approaches. All use music to supplement and enhance physiotherapy movements. All focus on the physical needs and well-being of the children. All require an adult helper for every, or almost every, child. And all require collaboration between the music therapist and physiotherapist.

When all the approaches are reviewed, five elements can be identified that music therapists consider when designing and implementing music and movement programs for severely and profoundly disabled children. These elements are summarised in Table 1.

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<th>Elements</th>
<th>Characteristics of Element</th>
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<tr>
<td>1. Establishing contact and developing empathy</td>
<td>The adult helper comes into contact with the child. By empathising, he/she establishes a way of physically interacting with the child according to the goals of the program, the emotional needs of the child, or a combination thereof.</td>
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<td>2. Reducing tension and anxiety</td>
<td>Having established contact, the adult helper works toward reducing any tension and anxiety in the child. The aim of this stage is to move the child into a calm, alert state.</td>
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<td>3. Maintaining physical well-being and developing self awareness</td>
<td>The adult helper moves the child through a range of movements that maintain physical well-being, while observing whether the child is aware of the movements, and/or initiates the movement him/herself.</td>
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<td>4. Developing independent movements</td>
<td>The adult helper allows the child to move independently, providing any assistance necessary.</td>
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<td>5. Developing awareness of others</td>
<td>As the adult helper moves the child through various movements, he/she observes whether the child is aware of others in the session, including the helper himself/herself. If the child shows awareness, then the helper responds to acknowledge this, and supports any interactions that take place, whether vocal or physical.</td>
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Some approaches emphasise certain elements more than others. For example, Physiotherapy with Music and Structured Music and Movement tend to emphasise elements three, four and five, whereas Improvised Music and Movement tends to emphasise elements one and two. These elements can also be viewed as general goals for all of the approaches.

Conclusion

Four approaches to music and movement for children with severe and profound multiple disabilities have been identified and described in terms of their goals, activities, the role of the music therapist, the role of the physiotherapist, and the role of music.

While distinct in many ways, these approaches may be used in a variety of ways by music therapists. In some situations, the music therapist may only use one approach, whereas in others he/she may use a variety of approaches in any one setting, or with any one group. In fact, these approaches could be seen as a continuum of practice, in which one approach is used after the other in order to meet the children’s needs. For example, Improvised Music and Movement may precede Structured Music and Movement for children who need to develop an emotional readiness to move/be moved. Conversely, for children who need structure in order to move, they could benefit from Structured Music and Movement, but then move to Improvised Music and Movement as they develop the capacity to move. The purpose of moving to an improvised approach would be to allow spontaneous and free movements to develop and evolve, these being so vital to the developing child.

It appears that the approaches to music and movement reflect both a clinical and philosophical orientation to developing movement programs as well as a response to specific goals and client needs. The choice of approach appears to depend largely on the beliefs of the clinician, combined with the philosophy of the setting, clinical team, goals, and needs of clients. It is by weaving these elements together that these approaches to music and movement have been developed, and through which they are implemented.

References


