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Music Therapy and Social Skills in Young Children with Disabilities: A Survey of Music Therapy Practitioners

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MUSIC THERAPY AND SOCIAL SKILLS IN YOUNG CHILDREN WITH
DISABILITIES: A SURVEY OF MUSIC THERAPY PRACTITIONERS

by

Sayaka Abe

A Thesis
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Master of Music
School of Music

Western Michigan University
Kalamazoo, MI
April 2004

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2004

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Sayaka Abe

MUSIC THERAPY AND SOCIAL SKILLS IN YOUNG CHILDREN WITH DISABILITIES: A SURVEY OF MUSIC THERAPY PRACTITIONERS

Sayaka Abe, M.M.

Western Michigan University, 2004

Music therapy services have been utilized as one of the related services that may be necessary to assist young children with disabilities in the accomplishment of their educational goals. The purpose of this study was to examine (a) how music therapy services are used in early childhood settings and (b) how music therapy interventions aid in the development of social skills in young children with disabilities. An original survey instrument was sent to music therapists who were members of the American Music Therapy Association and had indicated that they worked in early childhood settings. The survey was sent to 423 music therapists; responses were submitted by 115.

The survey was designed to learn the demographic information about the respondents and their clients, the role of music therapy as a discipline (i.e. collaboration and consultation with other professionals), problematic social skills associated with this population, and music therapy techniques used to develop the social skills of clients with various diagnoses. The results indicated that a variety of music therapy interventions are used to promote social skills development in young children with disabilities.

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CHAPTER I

INTRODUCTION

Early childhood intervention/early childhood special education has made remarkable progress over the past 20 years. There is a vast amount of literature supporting the benefits of special education programs for young children in regard to educational, nutritional, child-care, and family support. Such programs also help to reduce the effects of disabilities or prevent the occurrence of developmental problems later in life for children with special needs. Research has documented the positive benefits of special education services in addressing physical, cognitive, language and speech, social competence, and self-help skills development. Early childhood special education programs can also help to prevent secondary disabilities, and reduce family stress (Heward, 2003).

Currently, there is a movement and philosophical shift from child-centered to family-centered education among early childhood professionals (Humpal, 2002; Rupport, 1998; McWilliam, Ferguson, Harbin, Porter, Munn, & Vandiviere, 1998). Family-centered education programs include each child and his/her family in the design of a plan to meet the educational, social, and emotional goals identified by teachers, parents, and other service providers. Those goals and plans are documented on the Individualized Education Program (IEP) or the Individualized Family Service Plan (IFSP). The IFSP is used for children from birth until three years of age and includes both child-related goals and family-related goals based on the needs of the child. The power of

decision-making is shared between the multidisciplinary team members and the family members in order to reflect the child's needs within the family context ((Furman, 2002; McWilliam, et al. 1998).

Music therapy services have been utilized as one of the related services for young children in special education for many years. Music therapy services are often a part of the multidisciplinary team approach. The music therapist determines goals and procedures with other professionals, such as classroom teachers, early intervention specialists, speech and language pathologists, occupational therapists, physical therapists, and adapted physical education instructors (Humpal, 1990; Humpal, 2002). Music therapy can address several goals associated with early childhood education such as building individualization within the group interaction, developing communication skills and social interaction skills, and supporting cognitive and emotional development (Standley & Hughes, 1996).

Several researchers (McClelland, & Morrison, 2002, Craig-Unkefer & Kaiser, 2002, Humpal, 1991) have emphasized the importance of developing appropriate social skills in early childhood education. Children with disabilities often have more difficulty in the acquisition of social competence skills than do typically developing children. Through social interaction with peers, young children learn such concepts as sharing, friendship, negotiating rules, exchanging ideas, and replying aggression (Odom, McConnell, McEvoy, Peterson, Ostrosky, & Chandler, 1999). McClelland and Morrison (2002) report the importance of social and emotional competence in preschool children with disabilities in order to have a successful transition into kindergarten. In addition, the acquisition of peer-related social competence is a fundamental step in early childhood special education for

preschool children (Odom, et al., 1999).

Music therapy interventions can be one tool for improving social skills in early childhood settings (Humpal, 1991). According to Boxill (1985), music provides an experiential context for learning and developing children's personal and group skills. Humpal (1991) investigated the effect of integration with social skills in early childhood among children with disabilities and typical peers in a music mainstreaming program. The results of her study showed that a music mainstreaming program promoted positive interaction between non-disabled and disabled peers, improved students' ability to follow group direction, provided positive peer role models, increased social skills, and increased acceptance of handicapping conditions by non-disabled peers (Humpal, 1991).

The Research Proposal

Need for the Study

Young children who have disabilities frequently require therapy interventions to address their specific deficit areas. Music therapy services are often utilized as one of the related services in order to assist young children with disabilities in the accomplishment of their educational goals. Therefore, it is important to clarify and describe how music therapy is currently practiced in early childhood settings. In particular, there is limited music therapy research available related to social skills development among young children with disabilities even though acquisition of social skills is a primary goal in early childhood educational

programs (Furman, 2002; Humpal, 1991).

Statement of the Problem

The purpose of this study is to determine music therapists' perspectives of the efficacy of music therapy interventions to promote social skills development in early childhood. By surveying music therapists who have clinical experience with young children with disabilities, the findings from this study may help the music therapy professional to better understand (a) what music therapy interventions are used in early childhood settings, (b) how music therapy services are documented, and (c) in what way do music therapist collaborate and consultant with other discipline.

Research Questions

The specific questions to be answered in this study include:

1. How is music therapy practiced in early childhood settings?
2. How do music therapists address collaboration in early childhood settings?
3. How do music therapists participate in assessment and treatment programming in relation to federal and state law?
4. How do music therapists address consultation in early childhood settings?
5. What are the most common problematic social skill areas and how does

music therapy address these deficits?

Assumptions

This study assumes that the music therapists who indicated they work with the early childhood population have sufficient experience to determine the needs of young children with disabilities, the efficacy of music therapy interventions, and the importance of the development of social skills and their relationship with music therapy interventions.

Delimitations

The participants this study are limited to music therapists who are members of American Music Therapy Association and who indicated they work in early childhood settings.

CHAPTER II

REVIEW OF LITERATURE

Early Childhood Intervention/Early Childhood Special Education

The fields of early childhood intervention and early childhood special education have changed over the past 20 years. The number of early childhood programs for children with disabilities and family-centered early intervention programs increases each year. The early childhood literature generally refers to early childhood educational services involving only infants and toddlers from birth to age two. In contrast, early childhood special education includes educational services to preschoolers age three to five (Heward, 2003). The federal government started to fund early childhood special education under P.L. 99-457. The Education of the Handicapped Act Amendments passed in 1986 state that a free and appropriate public education must be provided in the least restrictive environment to preschool children. P.L. 99-457 was retitled as the Individual with Disabilities Education Act (IDEA) in 1990. The availability of educational services for infants and toddlers with disabilities and their families was clarified in Part C of the Individual with Disabilities Education Act (IDEA) of 1990 (Bondurant-Utz, 2002). Most children who are eligible for early intervention/ early childhood special education services are now covered under the federal law. However, the exact definition of eligibility and designation of the diagnostic instruments procedure is executed by each state or territory (Bondurant-Utz, 2002).

During the 2000-2001 school year, 598,922 preschoolers and 230,418 infants and toddlers were receiving special education in the United States (Heward, 2003). According to the U. S. Department of Health & Human Services (2003), the Head Start education program fosters child development by providing services to children from birth to age five, pregnant woman, and their families with the goal of increasing the school readiness skills in young children with low-income families. IDEA requires that early childhood intervention/early childhood special education services are provided in natural environments such as the same home, same school, and community settings as typically developing children (Sandall & Ostrosky, 2000). Early childhood intervention is usually provided at hospital settings for infants and newborns with disabilities. Otherwise, most early childhood special education is provided at the child's home, center or school based facility, or in a combination of both settings (Heward, 2003). Odom et al. (1997) identified six different preschool programs for children with disabilities: (1) community based childcare that is provided in profit and non-profit programs that are not based in public school buildings; (2) non-public-school Head Start; (3) public-school Head Start (4) public-school-early childhood education which is a government funded program for typically developing children and is operated by public school; (5) public-school childcare without government funding (parents of typically developing children pay tuition); (6) dual enrollments(p.96). According to Wolery et al. (1993) preschoolers with disabilities are enrolled in 94% of the Head Start education programs, 82% of the kindergarten programs in public schools, 73% of the public school kindergarten programs, and 59% of the community childcare programs.

The goals of early childhood intervention/early childhood special education programs are designed in collaboration with families to assist children with disabilities. Educational services are provided to minimize the impact of the disabilities on children and their families (Heward, 2003). Specifically, Wolery & Sainato (1993) mention that the goals of early childhood education for students with disabilities are promoting child engagement, independence, and mastery such as the skills of participation, choice making, age-appropriate abilities in many normalized situations, and autonomy. During their early childhood years these children need a successful educational program to develop in all domains; cognitive, motor, communication, social, and emotional.

There is substantial evidence available in the extant literature supporting the importance of early childhood education. The National Center for Early Childhood Development and Learning (NCEDL) (2003) reports that young children who spent time in high-quality educational programs demonstrated higher social skills and academic skills in the early elementary years than children from lower-quality educational programs. During the 1970s, the Milwaukee Project attempted to reduce the incidence of mental retardation through a program of parent training and infant stimulation. The children were considered to be at risk for related development delay because of the parents' level of intelligence (IQ score below 70). In the process, the mothers received training in childcare and learned how to interact and stimulate their children through play. Beginning before the age of six months, the children also received an infant stimulation program by trained teachers. By the age of three and a half years the experimental children showed an average gain of 33 IQ points over the control group (Garber & Heber, 1973).

Many elements influence children's development and learning. These include their genetic predisposition, the status of their central nervous system, their health and physiological functioning, and risk and opportunity variables in their families and communities. Infants' and preschoolers' learning styles were seen as emerging from biological maturation due to environmental factors, their experiences, their social and physical environments and their opportunities for learning. (Garber & Heber, 1973; Sameroff & Fiese, 2000).

The U.S. Department of Education (2002) reports the characteristics of infants, toddlers, and preschoolers who are served under IDEA. Their data reveal that the number of infants, toddlers, and preschoolers who receive educational services under IDEA has continued to increase each year. All infants and toddlers are entitled to receive early intervention services if they demonstrate developmental delays in one or more areas of cognitive development, physical development, social, or emotional development. They may also be eligible for services if they show physical or medical diagnose conditions that indicate a high probability of development delay, or if they have environmental risk conditions related to poverty (U. S. Department of Education, 2002) .

All children with disabilities from age three to age five are entitled to receive special education services. The U.S. Department of Education records the disabilities categories of preschoolers who are served under IDEA. In 2001, children with speech and language impairments were the largest group (55%) followed by children with developmental delay (24%). The category identified as development delay includes disabilities such as mental retardation or orthopedic impairments. According to federal regulations, states are not required to identify

and report existing diagnosed categories for preschoolers (Odom et al., 2002).

Individualized Family Service Plan (IFSP)

Early intervention programs reflect the shift in the delivery of supports and services from the child-centered approach to the family-centered approach. The family-centered approach emphasizes collaboration with the parents and multidisciplinary team. The Individual Family Service Plan (IFSP) is the tool for planning and supporting services within the family system. The IFSP is also required to address the needs of young children (birth to age three) who are at risk for development delay(s) and their families as legislated by the Education of the Handicapped Act of 1986. The IFSP process includes providing evidence of participation by families in the assessment of the child's strengths and needs. Opportunities for decision-making regarding the child's educational program must also be shared with the family members (Minke & Scott, 1995). In addition to addressing the present level of the child's development (physical, cognitive, communication, and social/emotional development), the IFSP also includes a statement for the family's support and needs on the child's education, a statement of the major goals expected of the child and family, a statement of the specific services that meet the unique needs of individual child, frequency and intensity of the services, and a statement of the process for successful transition to the preschool or other appropriate services (P.L. 105-17, IDEA Amendments, 1997). In 2002, the average age of the child receiving the first IFSP was 17.1 months with 64% of the children receiving early intervention because of a development delay

after 21 months of age (U.S. Department of the Education, 2002).

Individualized Educational Program (IEP)

The Individualized Educational Program is an annual document for development and implementation for a child with disabilities between the ages of three and twenty-one. The IEP is also required by the IDEA so that all children with disabilities are assured of receiving a free and appropriate public education. The members of the IEP team must include the child's parent(s), at least one special education teacher, at least one regular education teacher (if the child participates in the regular education environment), an agency representative, any individuals who can interpret the implications of evaluation outcomes, and other individuals who have knowledge or special experience with the child, such as related service personnel (Bondurant-Utz, 2002). The IEP addresses the child's present level of functioning by assessments, observation, standardized tests, and the IEP team members. It also includes the child's measurable annual goals, short-term objectives, the specific special education and related services, the extent that a child will participate in the regular educational program in the future, and a statement of the child's progress toward the annual goals (Davis, Kilgo, & Gamel-MacCormick, 1998). Although the IFSP and IEP have several similarities, the major underlying difference is that the IFSP is family-centered and the IEP is more focused on service delivery in a child's area of need. Since collaboration between families and professionals will result in a better understanding of the child, it will become more the foundation for both the IFSP and the IEP and assure the

child's long-term goals of development (Bondurant-Utz, 2002).

Interagency Individual Intervention Plan (IIIP)

The purpose of the Interagency Individual Intervention Plan (IIIP) is to provide better coordination of the practicing services and supports in school, home, and community from at least one other public agency for children with disabilities up to 21 years old. The IIIP combines all of the elements of IEP, as well as the other agency's plan(s) it replaces. Other agencies include publicly funded special education, social services, health/mental health, development disabilities, medical assistance, rehabilitation and Head Start programs and services (PACER center, Inc., 2003). IIIP is utilized only in Minnesota at the present time (Furman, 2002).

Social Skills in Young Children with Disabilities

Many researchers have shown the development of social skills should be a primary goal for early childhood educational programs (McClelland, & Mollison, 2002; Craig-Unkefer, & Kaiser, 2002; Humpal, 1991; Odom, McConnel, & McEvoy, 1992). Some infants and preschoolers with disabilities exhibit less interaction with peers, disrupt social relationships with their parents/caregivers, and are less socially accepted by peers than normally developing children. Research data also indicates that most preschoolers with disabilities have social delays that exceed their developmental delays (Odom & McConnell, 1989).

Gresham and Elliot (1984) describe social skills as those behaviors within

a given situation, predicting important social outcomes such as peer acceptance and others' social behavior known to correlate consistently with peer acceptance or significant other's judgments. Goldstein, Kaczmarek, & English (2001) define social skills for young children with disabilities as including learning to make friends, getting along with others, working in groups, managing frustration, and resolving conflict. Although most normally developing children learn such skills naturally, many children with disabilities show difficulty in acquiring these skills when simply playing with friends.

Since social skills are particularly salient needs for students with disabilities, some researchers have investigated the significance of deficits in social skills for students with specific learning disabilities. Such children frequently exhibit substantial deficits in social competence, such as interpersonal relationships with other children, their parents, and their teachers (Barkley, 1990; Guevremont, 1990; Landau & Moore, 1991). Whalen & Henker (1985) noted these children evoke and receive extremely negative responses from their peer group and teachers. Students with specific learning disabilities can have behavioral characteristics (e.g. impulsivity, inattention, and over activity) that can be perceived by their teachers and peers as annoying, boisterous, intractable, and irritating.

Palombo (1994) observed that most children with nonverbal learning disabilities desire and enjoy social interactions. Unlike children with autism, children with nonverbal learning disabilities try to relate intimately with their peers and other people and have difficulty in interpersonal behaviors involving social conversations, joining in communication to play, offering help, and apologizing. In addition, these children show difficulties in being empathetic to other people's

feelings, waiting their turn, listening, and following directions. Since nonverbal children with learning disabilities are unsure of how to express their frustrations and confusion, they can begin to exhibit aggressive behaviors.

Craig-Unkefer and Kaiser (2002) reported the significance of learning social communication skills for pre-school children with language delays and behavior problems. Young children with language delays frequently have difficulty engaging and interacting with their peers. The limited social communication skills result in decreased peer interactions, increased peer rejection, and increased aggressive and noncompliant behaviors.

Children with autism frequently have significant social deficits. Their behavioral characteristics include indifferent attention and being generally oblivious to others by avoiding eye contact and isolating themselves socially (Tsai & Scott-Miller, 1988). The major social skill goals for children with autism are increasing the ability to control and participate in their environments. Another goal is to develop their ability to make appropriate and functional social participations and responses correlating positively with long-term success in living and working in normalized environments (Neel, 1986).

There are four approaches that have commonly been utilized to develop social skills in children with autism: (a) Direct skill instruction: sequential teaching techniques of each of the task-analyzed steps, such as using modeling, repeated trials, prompts, and reinforcement with children in natural environments (Sasso, Melloy, & Kavale, 1990); (b) Antecedent prompting procedures: the technique to provide an initiation prompt by the teacher followed by reinforcement to the children with autism for successful social interactions with a peer (Fox, Shores,

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Linderman, & Strain, 1986; Odom & Strain, 1986); (c) Peer- initiated strategies: this process includes leading socially competent children to initiate interaction with children with autism (Ragland, Kerr, & Strain, 1978; Sasso & Rude, 1987); (d) Peer tutoring: this program increases social interaction between socially competent children and children with autism, and socially competent children learn how to interact effectively with their classmates with autism (Gayloard-Ross & Haring, 1987).

Some studies have investigated the most effective types of investigations to increase early childhood social skills. In their research (Vaughn, Kim, Slasn, Hughes, Elbaum, & Sridhar, 2003) reviewed the result of 23 studies of social skills interventions that involved 700 students with a variety of disabilities, whose ages ranged from three to five years. The authors concluded that the most effective social skills interventions were: (a) Modeling: normally developed children and teachers demonstrate specific desired social behavior to the children with disabilities; (b) Play-related activities: specific play activities assist to develop childrens' cognition, language, and social function skills; (c) Prompting: children with disabilities are prompted to display target behaviors; (d) Rehearsal and practice, children with disabilities practice the target behavior

Odom, et al. (1999) confirm that different approaches designed to promote peer-related social competence in a play-based format approach can be effective in providing opportunities for children to engage in positive social interactions with peers. Acquisition of peer-related social competence, such as sharing and exchanging playing ideas, are fundamental steps in early development. Such behaviors help children naturally acquire skills such as competent social

participation and acceptance by their peers.

Music Therapy in Young Children with Disabilities

Music therapy and music education, as well as the use of art therapies, were mentioned under the Public Law 94-142 in 1975:

The use of the arts as a teaching tool for the handicapped has long been recognized as a viable, effective way not only of teaching special skills, but also of reaching youngsters who had otherwise been teachable. The Committee envisions that programs under this bill could well include an arts component and, indeed, urges that local educational agencies include the arts in programs for the handicapped funded under this act. Such a program could cover both appreciation of the arts by the handicapped youngsters, and the utilization of the arts as a teaching tool per se. (Senate Report No. 94-168, 1975, p.13).

Music therapy services have been utilized as one of the related services for many years (Humpal, 1990). In the public school settings, music therapist can be a member of IFSP, IEP, and IIIP team. All children with disabilities have the right to receive the educational opportunities in the general curriculum. Therefore, the IEP goals also should be determined within the general framework as much as possible. Music therapy may be a related service if deemed to be necessary to assist in the accomplishment of educational goals for children with disabilities (Alley, 1979; Furman, 2002; Johnson, 2002, Humpal, 2002). For example, Snell (1996) reports

that primary music therapy goals and objectives on the IEP include the social/emotional with personal skills and interpersonal skills in her work setting. Another way of implementing IEP based music therapy in the school setting is as a part of the music education program. Ideally there should be a collaboration between music educator and music therapist within the development of IEP (Johnson, 2002).

Music therapy services in the school setting emphasize the functional use of music to achieve the academic, social, motor, or language goals of students with disabilities (Alley, 1979). Humpal (1990) states that music therapy applications for the goals of early children with special needs includes (a) cognitive domain, such as acquisition of counting and alphabet is taught by songs with these concepts; (b) motor domain: to improve coordination, flexibility, and dexterity of motor skills, playing rhythm instruments, clapping, and following directions with in visual and actual cues helps the development; (c) communication domain: using music provide the growth of receptive and expressive language skills, like uttering animal noise encourage early vocalization; and (d) personal/ Social/ Emotional domain: these goals should be the primary in the special education in early childhood, however, special educators should stress to investigate the strategies between the achievement of the goals and play settings. While music may provide to learn social interaction skills through music enjoyable games, movement, and turn-taking activities.

According to the American Music Therapy Association, (AMTA, 1999), the unique function of music therapy for young children includes the following:

- Music stimulates all of the senses and involves the child at

many levels. This “multi-model approach” facilitates many developmental skills.

- Quality learning and maximum participation occur when children are permitted to experience the joy of play. The medium of music therapy allows this play to occur naturally and frequently.
- Music is highly motivating, yet it can also have a calming and relaxing effect. Enjoyable music activities are designed to be success-oriented and make children feel better about them.
- Music therapy can help a child manage pain and stressful situation.
- Music can encourage socialization, self-expression, communication, and motor development.
- Because the brain process music in both hemispheres, music can stimulate cognitive functioning and may be used for remediation of some speech/language skills.

Furthermore, music therapy helps childrens’ families by providing enjoyable and purposeful music-based activities to share with their children (AMTA, 1999).

Music therapy techniques are specifically used with young children with special needs to encourage imitation; use prompts repetitively; use multi-sensory approaches; use a variety of modalities that adapted successfully to the children’s abilities; use gestures and signs; assisting the children’s experience of the music (such as moving, singing, playing, and exploring); use structures and

improvisational music interventions; using familiar or age appropriate music, encouraging rhythmic/vocal synchronization; and using various music and instruments etc (Humpal, 2002 ; Snell, 2002). Additionally, music therapy services can provide opportunities for integration of non-disabled children and children with disabilities. Both groups of children learn how to make friends, play together, and to accept differences and disabilities (Humpal, 1990).

Music Therapy in Collaboration and Consultation

Since collaboration and consultation have become a common and necessary component of special education, music therapy services are also connected with both processes. Collaboration is the time of cooperative practice between team members, such as a structure for addressing the issues of the child, opportunities of interpersonal communication within the team members, and sharing the power of decision making (Register, 2002, Hunt, Soto, Maier, & Doering, 2003). As a team member, the music therapist participates in the team meeting or IEP meeting and shares unique information about the childrens' music-related behaviors. The music therapist is the only team member trained to assess music-related behavior (Snell, 2002). Register (2002) found that 87.5% of the board certified music therapists who work at a variety of settings collaborate with others regarding treatment of clients. In her survey, she reported that 695 music therapists collaborated most often with parent/caregiver/other family, other related service provider (occupational therapists and speech therapist), medical personnel and educator in variety of settings. Register concluded that collaboration

for music therapists provides increased recognition of music therapy treatment information to other professionals and parents. Co-plan and co-lead therapy approaches are also part of the collaborative work. Furman (2002) described several examples of co-lead/integrated therapy sessions including (a) the occupational therapist and music therapist conducting joint sessions to increase the child's appropriate sitting skills, and (b) using music as a motivator for the child, as well as an additional adult, can provide support during the physical therapist's assessment of the child's jumping skills. Music also provides the opportunity to assess the child's functioning in a real life situation. For example, the speech and language therapist can observe the music therapy sessions to assess the child's language skill information (e.g. language imitation skills and spontaneous language skills).

Consultation involves providing information to an individual and/or group related to the child's educational program in order to educate or provide advice regarding educational procedures or a given issue. Music therapists primarily provide the consultation services to educators, parents/caregivers/other families, and administrators (Register, 2002). In special education settings there are six areas where that music therapist may be called upon for consultation. The first is support of planning music activities to meet IEP goals including leisure skills and social skill developments. The second area is training implementation of basic music activities to classroom personnel. Teaching music skills, such as simple accompaniment techniques is a third area. A fourth area is providing appropriate music resources to use in the classroom include song sheets, songbook, recording, and instruments. A fifth area is demonstrating appropriate music activities in order

to indicate appropriate expectations for the children. Finally, music therapists can be called upon to provide other support for classroom instruction (Johnson, 2003). According to Register (2002), the three most frequent subject areas cited by music therapists when they consult with other professions or parents relate to educational, communication, and socialization issues. She concludes that collaboration and consultation services are linked to the high instance of music therapy in educational settings.

CHAPTER III

METHODOLOGY

Participants

The initial population for this study was 423 board certified music therapists (MT-BC) who were members of the American Music Therapy Association and had indicated that they worked in early childhood settings. The researcher obtained their names and e-mail addresses from the 2003 Member Sourcebook published by the American Music Therapy Association (AMTA). Each music therapist who indicated working with young children was surveyed to obtain information regarding (a) how music therapy services are used in early childhood settings and (b) how music therapy interventions aid in the development social skills in young children with disabilities.

Instruments

A 29-question web-based survey was designed by the investigator to collect data in the following five sections: A. Demographics (i.e. the work settings, job title, common diagnoses of children that they work, and structure of music therapy sessions); B. Music therapy as a discipline (i.e. collaboration with other professionals, co-led, and reporting system); C. Music therapy and consultation; D. Music therapy and social skills (i.e. problematic social behavior and music therapy

techniques to develop social skills); E. Social skills and clients with various diagnoses. The survey questions were designed based on music therapy and early childhood special education literature. In addition, the thesis committee and three music therapists who are experts with early childhood population reviewed this survey before it was distributed to the participants. The web-based survey (Appendix A) was created with the help of an online company, SurveyMonkey.com®.

Consent and Approval

This research project was approved by the Western Michigan University Human Subjects Institutional Review Board. The Human Subjects Approval Form (See Appendix B) was reviewed by a subcommittee of the Board and found to be exempt.

Procedure

The initial step was to obtain a listing of names and email addresses of music therapists who currently work with the early childhood population. Using the 2003 Member Sourcebook published by AMTA, 423 music therapists were identified as meeting the selection criteria. Each music therapist was sent an email describing the purpose of the study, a statement regarding consent, and the survey. Participants were invited to complete the survey with the understanding that completion of the survey was considered as consent to participate in the study. The

web-based survey was made available to the participants for two weeks. The data from the survey was collected through SurveyMonkey.com® and later analyzed and downloaded to the investigator's personal computer.

Data Processing and Analysis

The data on the survey contained responses that could be tabulated and graphed by the survey providers, SurveyMonkey.com®. In addition, the descriptive responses (i.e., specific music therapy activities, interventions, techniques to increase social skills, and the name of the instruments that the music therapists use in their session) were also tabulated and compared.

CHAPTER IV

RESULTS

Of the 423 surveys that were sent to music therapists identified as working with young children, 89 were returned as undeliverable (i.e., user unknown, failed delivered, or mailbox unavailable). Four music therapists who did complete the survey indicated that they currently were not working in early childhood settings; therefore, those data were not considered in the analysis. Out of the possible 330 participants that received web-based surveys, 115 responded and their surveys were used in the data analysis. This resulted in a response rate of 35%.

Research Question 1

How is music therapy practiced in early childhood settings?

For this study a list of characteristics associated with music therapy practice in early childhood settings was developed including (1) city/state where the respondents work; (2) primary work setting; (3) public or private school; (4) job title; (5) age groups of children who receive music therapy; (6) percentages of time in group or individual settings; (7) common diagnoses that music therapists work with; (8) common diagnoses in group or individual sessions or both; (9) session times per week; and (10) length of session.

Table 1 lists the city and state where the participants reported they work. The largest single city that the participants indicated was New York City, NY (8)

followed by Cleveland, OH (5) and Houston, TX (5). The survey participants were also asked to indicate their primary work setting (See Table 2), public or private school whether their work is a (See Table 3), and their job title (See Figure 1).

Table 1

List of the Participants' City/ State and Survey Return Rate

CITY	STATE	RETURNED
Pasadena	CA	1
Los Angeles	CA	2
Boulder	CO	1
San Diego	CO	2
Denver	CT	2
Washington	CT	1
Wilmington	DE	1
Fort Lauderdale Miami	FL	1
Miami	FL	3
Tallahassee	FL	2
Quincy	FL	1
Atlanta	GA	3
Suwannee	GA	1
Des Moines	IA	1
Burr Ridge	IL	2
Dekalb	IL	1
Geneva	IL	1
McHenry	IL	1
Sterling	IL	2
Indianapolis	IN	2
Huntington	IN	1
Lawrence	KS	2
Shawnee Mission	KS	1
Quincy	MA	2

Table 1-continued

East Lansing	MI	1
Monroe	MI	2
Minneapolis	MN	1
St.Louis	MO	4
Fair Lawn	NJ	1
Albuquerque	NM	1
Geneva	NY	2
Middle Island	NY	1
New York	NY	8
Suffolk	NY	1
Poughkeepsie	NY	1
Warwick	NY	1
Yaphank	NY	1
Chapel Hill	NC	1
Cleveland	OH	5
Scranton	PA	1
Jackson	TN	1
Arlington	TX	1
Dallas	TX	3
Lewisville	TX	1
Houston	TX	5
Mansfield	TX	1
Missouri City	TX	1
Seguin	TX	1
Alexandria	VA	1
Seattle	WA	2
Madison	WI	2
Racine	WI	2
Wausau	WI	1
Other (Canada, Hong Kong, stated work in various city)		15
Not indicated		9
Total		115

According to data presented in Table 2, the primary work settings of the

majority of participants was either private practice/contractual (27.5 %) or “other” (26.6 %) followed by early intervention programs/centers (15.6 %), and preschool (11%). The majority of music therapists who work in school settings work in public schools (59.6 %), as compared to those employed by private schools (29.8 %) (See Table 3). A substantial number (86.2 %) of the respondents stated that their job title was Music Therapist (See Figure 1).

Table 2

Characteristics of Survey Participants

Primary work setting	%
Private Practice/ Contractual	27.5
Other*	26.6
Early Interventions program/centers	15.6
Preschool	11
Community-based facilities	9.2
Children’s hospitals or units	7.3
Children’s day care	2.8

*Out-patient center, Children’s therapy center, University music therapy center, Early Childhood School combined with Headstart, Elementary school, Homes of children, Inpatient psychiatric facility, Private therapeutic day school, Early Intervention non-profit preschool.

Table 3

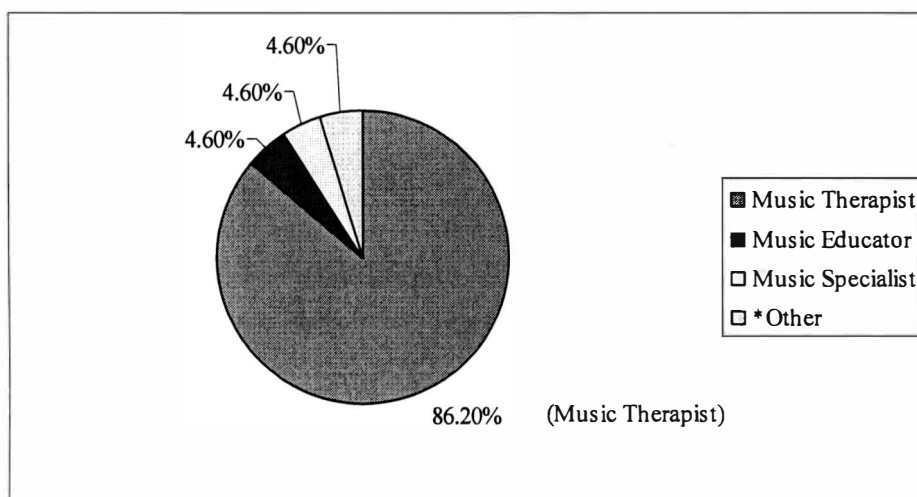
Public School or Private School

Public School and Private School	%
Public School	59.6
Private School	29.8
Other*	10.5

*Community music school, County MR/DD.

Figure 2 shows the age groups of the children seen by the participants. According to the data, the respondents most frequently worked with children who were 3-4 years (71 %), followed by 4-5 years (68.2 %), 5-6 years (52.3 %), 2-3 years (48.6 %), 1-2 years (20.6 %), and 0-1 year (20.6 %).

Figure 1. The participants' job title

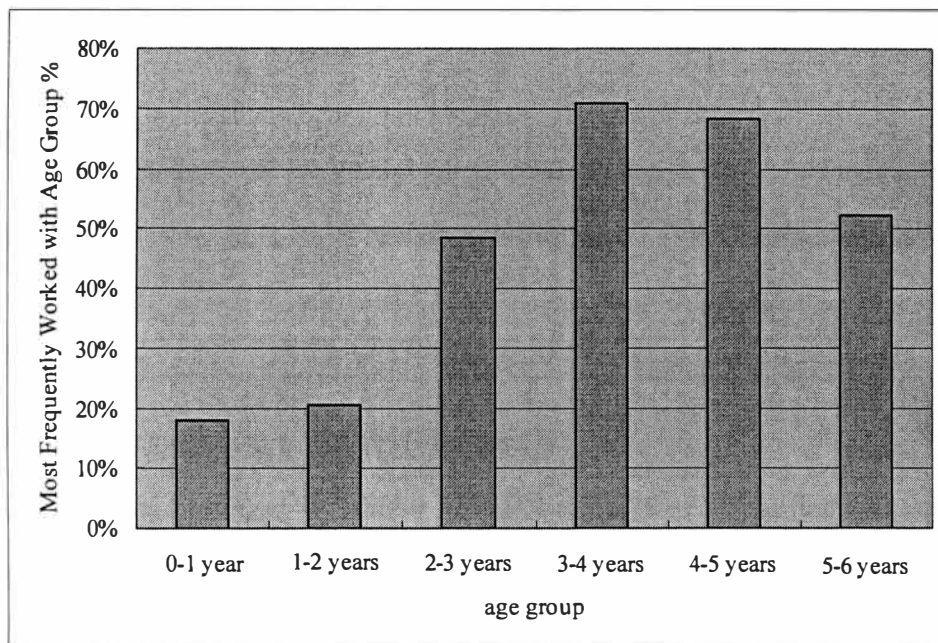


*Music instructor, Development/music therapist, Director of music therapy

program, Coordinator of training.

The participants were asked to indicate the percentage of time they work with their clients in either a group session or an individual session (total 100 %). The largest number of participants see children primarily in group settings (90%) [N= 25] and only infrequently in individual sessions (10%) [N= 26]. Seeing children equally in group (50%) [N= 15] and individual session (50%) [N= 14] was the second most frequent response followed by 10% for group [N= 13] and 90% for individual [N= 9] (See Figure 3).

Figure 2. Age groups of children that the participants frequently work with



When asked which diagnostic classification they work with, autism spectrum disorder (N=42) was indicated most frequently, followed by development

disability (including Down Syndrome) ($N=33$) (See Table 4).

Figure 4 reveals whether the respondents were more likely to see their clients in group or individual sessions or both. For the majority of diagnostic categories clients are more likely to be seen in both group and individual sessions or group session alone as compared to individual sessions alone.

Whether seen individually or in groups the majority of the participants reported that they work with children once a week (See Tables 5 and 6). The length of session time for individual session is likely to be 30-45 minutes in each session as indicated by 35.2 % of the participants and 30-45 minutes in each group sessions as indicated by 43.7 % of the participants (See Tables 7 and 8).

Research Question 2

How do music therapists address collaboration in early childhood settings?

In order to learn more about the relationship between the respondents and other professionals in their work settings, the respondents were asked to identify: (a) other professionals employed at their work site; (b) which, if any, they collaborate with, and (c) which, if any, they co-led sessions.

Data presented in Table 9 reveals that 66 % of the participants reported that their work settings employed occupational therapists, 65 % speech therapists and 62 % physical therapists. As seen in Table 10, 84 % of the participants reported that they collaborate with other professionals at their work settings. Specifically, 72.5 % of the participants reported collaborating with speech therapists, 68.1 % with occupational therapists, and 61.5% with physical therapists (See Table 11).

Figure 3. The percentage of time that the respondents work with clients in group and individual sessions (total 100%)

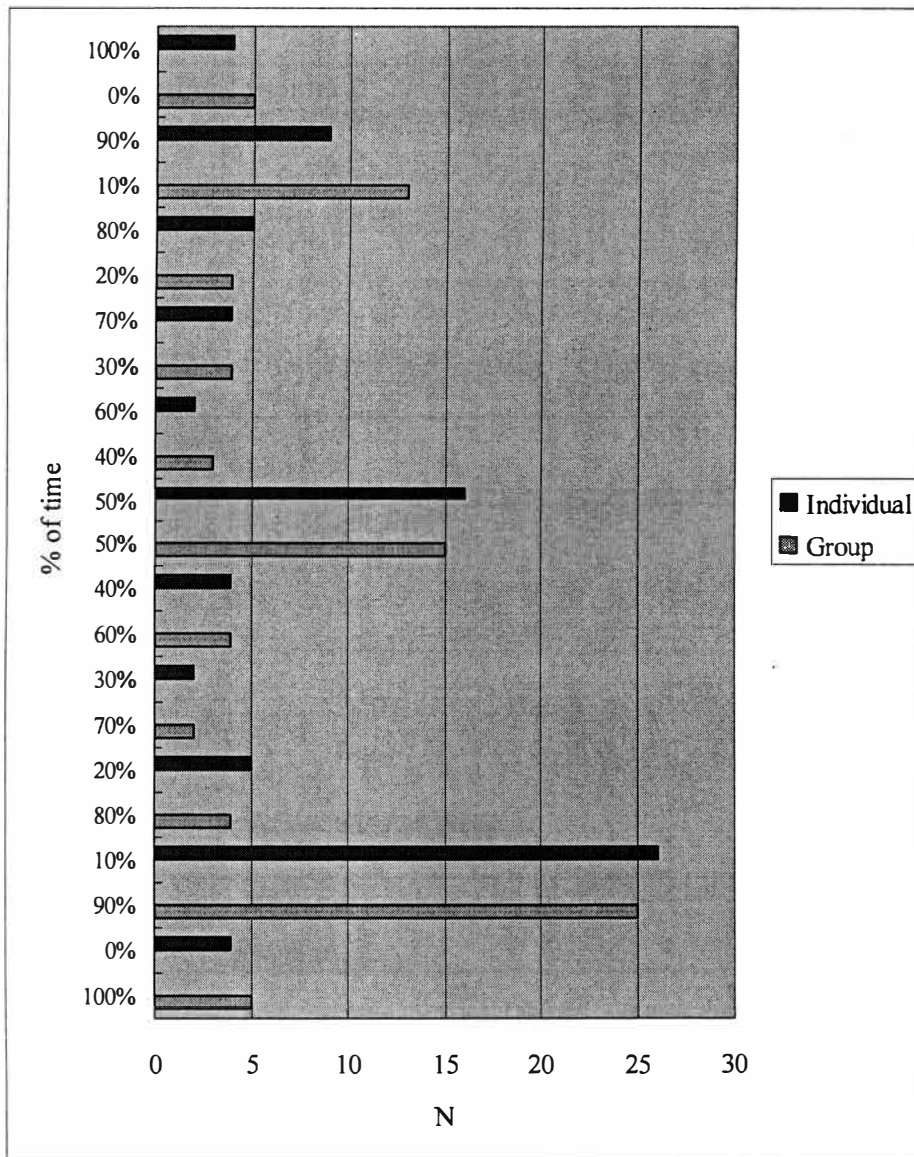


Table 4

The Most Common Diagnoses Reported by the Participants

Diagnoses	<u>n</u>
Autism spectrum disorder	42
Development disability	33
Speech or language impairment	31
Multiple disabilities	19
Behavioral/Emotional disorder	19
Not yet diagnoses	15
No disability	14
Cerebral Palsy	13
Learning disability	12
Specific development delay	12
Physical disability	8
Visual impairment	4
Hearing impairment	4

Table 5

Number of Individual Sessions Per Week

Sessions per week	%
Once	71
Twice	7
Three times	3
Four times	0
Five times	1
I don't see clients individually	15
Other*	3

*Once or twice a month, only for assessment

Figure 4. The number of respondents who see clients in individual or group sessions or both

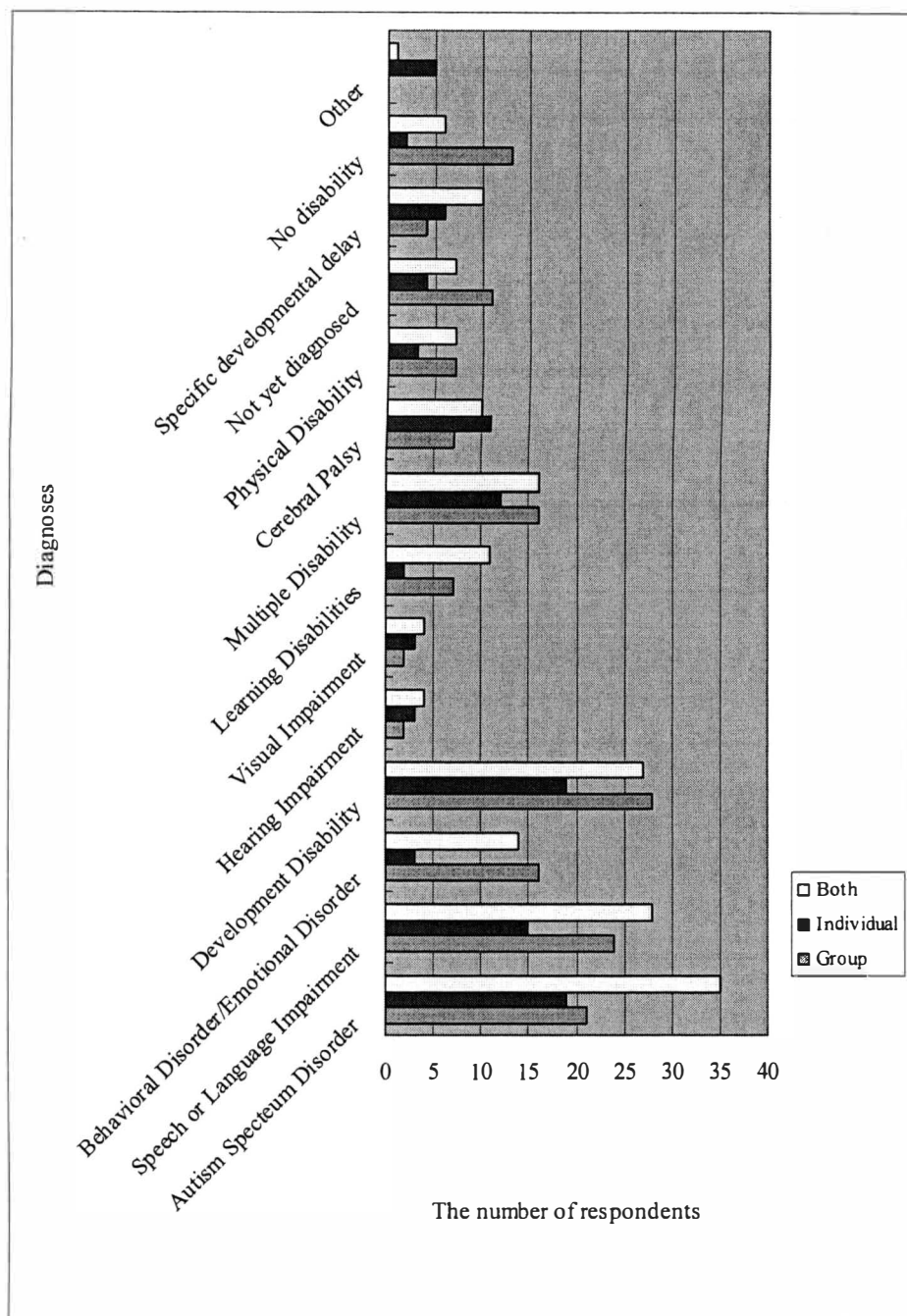


Table 6

Number of Group Sessions per Week

Sessions per week	%
Once	69
Twice	17.5
Three times	0
Four times	1
Five times	2.9
I don't see clients as a group	3.9
Other*	7.8

*Every other week, once a month, bi-weekly, once every 2 weeks.

Table 7

Length of Time in Individual Sessions

Length of Time	%
Less than 15 minutes	1
15-30 minutes	26.7
30-45 minutes	35.2
45-60 minutes	20
More than 60 minutes	0
I don't see clients individually	17.1

Table 8

Length of Time in Group Sessions

Length of Time	%
Less than 15 minutes	1
15-30 minutes	27.2
30-45 minutes	43.7
45-60 minutes	20.4
More than 60 minutes	2.9
I don't see clients as a group	4.9

Table 9

Other Professionals Employed

Other Professionals	%
Occupational Therapist	66
Speech Therapists	65
Physical Therapists	62
Educators	56
Early Childhood Special Educator	52
Medical Personnel (Nurses, Pediatrics)	52
Social Workers	49
Other Music Therapists	42
Other*	35
Music Educator	26
Physical Education Instructors	25
Adapted Physical Educator Instructors	23
Art Therapists	13

*Psychologist, Family facilitator, Behavioral Specialist, Vision Therapist, Early Childhood Educator, Child Life Specialist, Massage Therapist, Yoga Instructor,

Dance Therapist, Nutritionist, Researcher, Residential Staff, Parent Educator, Mobility Specialist, Audiologist, Sign Language Specialist, Drama Specialist.

Table 10

Collaboration within Work Settings

YES/NO	%
YES	84
NO	16

Table 11

Collaboration with Other Professionals

Other Professionals	%
Speech Therapists	72.5
Occupational Therapists	68.1
Physical Therapists	61.5
Early Childhood Educators	54.9
Educators	46.2
Other Music Therapists	38.5
Social Workers	36.3
Other*	33.0
Medical Personnel (Nurses, Pediatrics)	29.7
Adapted Physical Education Instructors	15.4
Art Therapists	14.3
Music Educators	12.1
Physical Education Instructors	5.5

* Psychologist, Parents, Vision therapist, Researcher, Child life specialist

Table 12 indicates that 62.6 % of the participants have co-led a session with other professionals. The greatest percentages of co-led sessions were with speech therapists (58.8%) and occupational therapist (47.1%), followed by other music therapists (38.2%) and physical therapists (36.8%) (See Table 13).

Table 12

Co-led

YES/NO	%
YES	62.6
NO	37.4

Research Question 3

How do music therapists participate in the assessment and treatment programming in relation to federal and state law?

To learn how music therapists working with young children report their findings to their employer, the respondents were asked to identify: (1) the requirements of documentation at their work site; (2) the specific reporting system used; (3) the non-musical goals and musical goals; and (4) the goal areas specified in agency documents.

Table 13

Co-led with Other Professionals

Other Professionals	%
Speech Therapists	58.8
Occupational Therapists	47.1
Other Music Therapists	38.2
Physical Therapists	36.8
Early Childhood Educators	23.5
Educators	14.7
Other*	13.2
Social Workers	11.8
Art Therapists	8.8
Adapted Physical Education Instructors	7.4
Music Educators	4.4
Medical Personnel (Nurses, Pediatrics)	4.4
Physical Education Instructors	0

*Vision therapist, Researcher, Yoga instructor, Early Intervention Specialist, Behavior Management Specialist, Child Life Specialist, Music Therapy Intern, Student Music Therapist.

Half of the participants (50%) mentioned that their agency required the reporting of children's development through some formal method of documentation. However, 50 % of the agencies did not require participants to report their findings in official documents such as the IEP (Individualized Educational Plan) or IFSP (Individualized Family Service Plan) (See Table 14). Table 15 shows the specific reporting systems that the participants used in their work settings. The majority (72.7 %) of the participants used IEPs, 36.4 % of the participants used IFSPs.

The information that the participants used in their documentation included the number of non-musical and musical goals. Thirty-seven percent of the participants described they established more than five non-musical goals and 33 % of the participants set three musical goals with young children (See Figure 5).

Table 14

Requirement of Documentation

YES/NO	%
YES	50
NO	50

Table 15

Specific Names of Reporting Systems

Reporting System	%
IEP (Individualized Educational Plan)	72.7
IFSP (Individualized Family Service Plan)	36.4
IIIP (Interagency Individual Intervention Plan)	1.8
Other*	18.2

*Individual Service Plan, TRIGR, music therapy annual report, therapy notes, quarterly progress reports, music therapy progress notes, general progress written updates.

When asked the three goal areas that appear most frequently on the

documents, 89.8 % ($N= 53$) of the participants stated the communication area (such as speech and language behavior) with 83.1 % ($N=49$) of the participants listing the social area such as peer interaction, sharing, and turn taking skills (See Figure 6).

Figure 5. The number of non-musical and musical goals reported by the participants to comply with agency documentation requirements

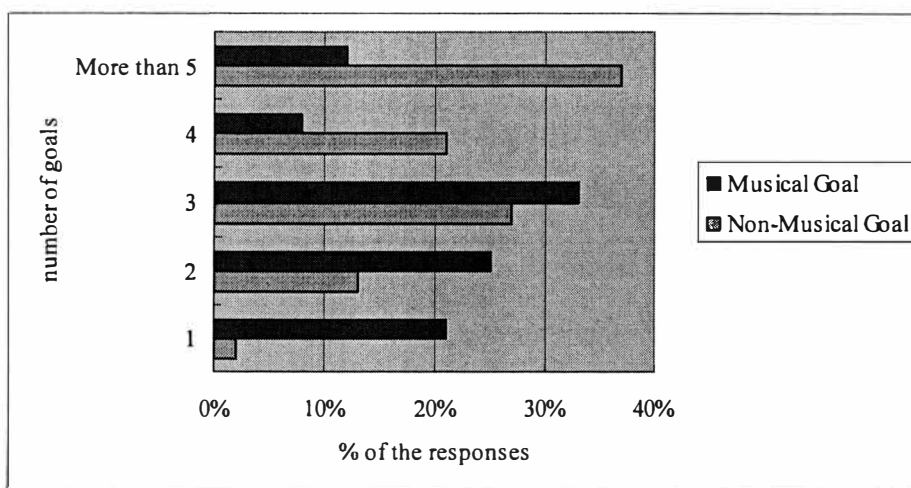
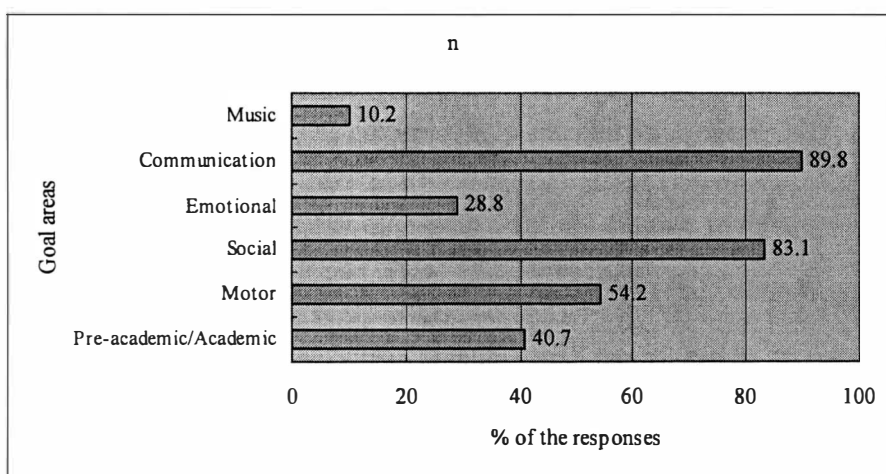


Figure 6. Goal areas that appear most frequently in agency documentations



Notes: Music (singing skills, playing instruments skills, etc)

Communication (speech, language behavior, etc)

Emotional (self-expression, self-regulation, etc)

Social (peer interaction, sharing, turn taking skills, etc)

Motor (fine and gross, motor development, coordination, flexibility, etc)

Pre-academic/Academic (readiness skills, math skills, reading skills, etc)

Research Question 4

How do music therapists address consultation in early childhood settings?

The participants were asked to provide information regarding their consultation services including: (1) service consultation; (2) the methods of consultation; (3) with whom they consult; and (4) topics discussed in the consultations.

The majority of the participants (75.9%) responded that they had provided consultation services within the last/current year (See Table 16). Of the different methods of the consultation services, 85.4% used direct consultation (i.e. dissemination of information to parents and teachers) and 84% used workshops and music therapy seminars to educate other professionals and parents (Figure 7).

According to the results of this survey, music therapists working in settings for young children consult with a variety of other professionals (See Table 17). Fifty-six percent of the participants reported that they consult with the early childhood special educator, which was the same percentage as all other educators. Fifty two percent of the participants reported consulting with the speech therapist. Figure 8 shows which topics the participants discussed during consultations with the other professionals. The majority of the participants indicated they discuss

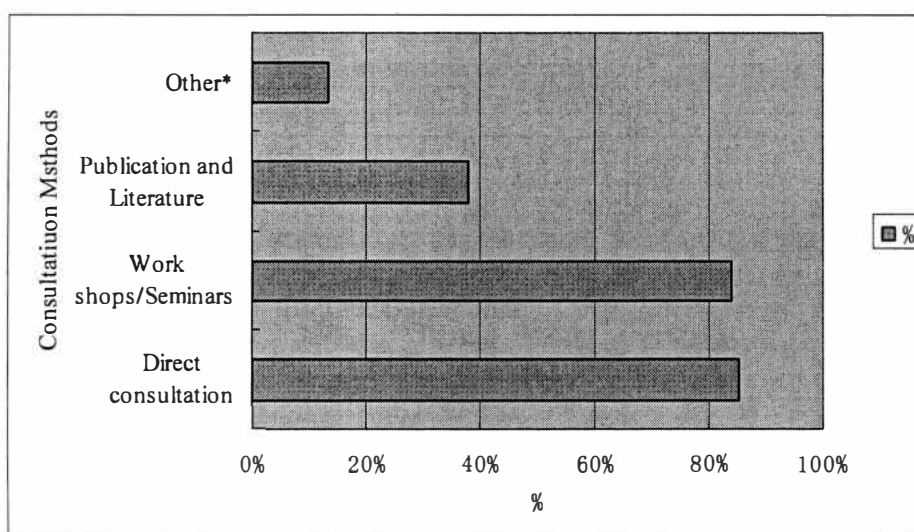
social skills (90.2%) and communication skills (90.2%) during consultation.

Table 16

Consultation

YES/NO	%
YES	75.9
NO	24.1

Figure 7. Consultation methods



*Interviews, “team” discussion and informally, assessment for music therapy services, building programs, consult to student model, creating CD with songs based upon music therapy goals, teacher training, study group.

Table 17

Consultation with Other Professionals

Other Professionals	%
Early Childhood Educators	56.1
Educators	56.1
Speech Therapists	52.4
Occupational Therapists	47.6
Other Music Therapists	45.1
Other*	41.5
Physical Therapists	32.9
Music Educators	32.9
Social Workers	30.5
Medical Personnel (Nurses, Pediatrics)	24.4
Art Therapists	4.9
Adapted Physical Education Instructors	4.9
Physical Education Instructors	0

*Parents, Special Educator, Special Educator, Sensory Integration Therapist, Caregivers, Massage Therapist, Families, Early Intervention Specialists and Administrators, Music Therapy Students, School Psychologists.

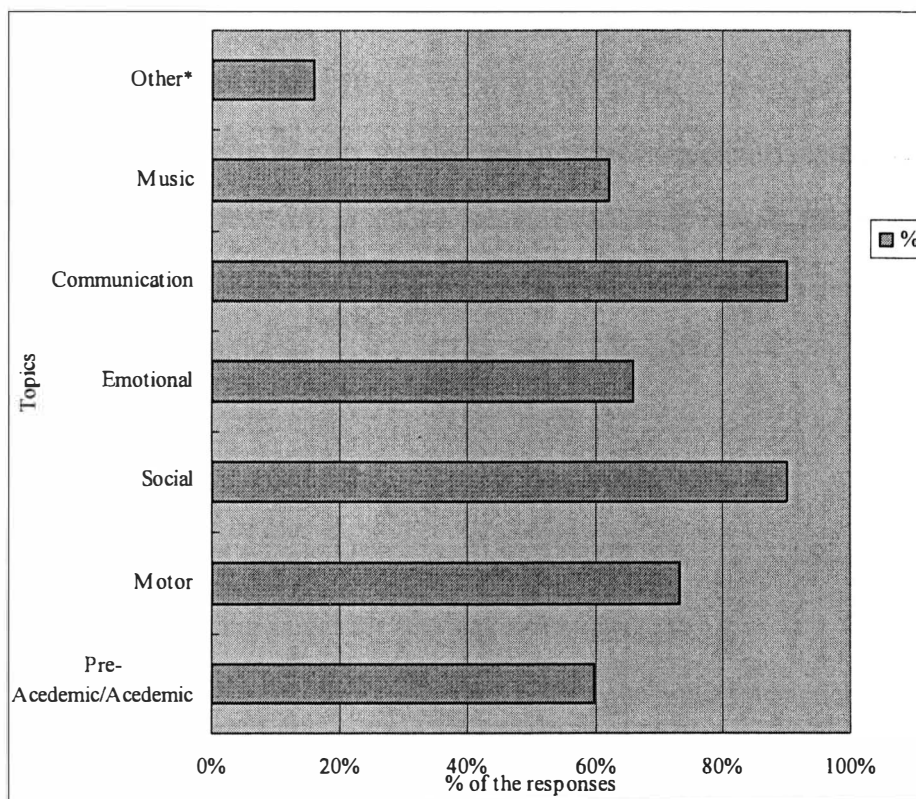
Research Question 5

What are the most common problematic social skill areas and how does music therapy address these deficits for various children with diagnoses?

The music therapy interventions for increasing social skills and specific problematic social skill areas with young children with various disabilities included in this investigation were: (1) problematic social behaviors for young children; (2)

music therapy techniques for developing social skills; (3) specific activities in music therapy sessions; (4) instruments used in music therapy sessions; (5) live or recorded music; (6) problematic social skills with various diagnoses.

Figure 8. Consultation topics



*Behavior management, Adaptation to music in music education, Sensory stimulation, Relaxation responses, Oral motor and sensory integration goals through music

Data presented in Figure 9 reveals that 49.4 % of the participants reported the most problematic social behavior for young children was difficulty playing

cooperatively (such as sharing instruments and materials) followed by 40.2 % of the respondents selecting difficulty in waiting for cues as the most problematic social behavior.

In order to develop children's social skills, the most frequently reported music therapy techniques described by the participants were using instruments in individual and group sessions (53%), and singing activities in individual and group sessions (49%) (See Figure 10).

The specific music therapy activities/techniques/interventions that the participants described are presented below. This listing reveals that a variety of techniques and objectives can be employed in the music therapy settings for young children with disabilities.

List of Music Therapy Activities/Techniques/Interventions

- Taking turns any instrument for waiting turn skills
- Instrument passing games for sharing instruments
- Pairing visual with auditory cues activities for eye-contact interaction
- Greeting music with using stretchy bands, parachute, and hoops for group coherence
- Ensemble playing for waiting turns skills and listening to friends in a quiet manner
- Music and movement activities for imitation skills
- Story songs that involve the use of nursery rhymes and stories improvisation-recitative, theme, conflict, variations and resolution through music drumming.

- Musical stages of speech that work with pre-verbal sound making from crying comfort sounds through first word
- Songs include a built in cue for a child to hit an instrument, interaction within peers, encourage sharing of ideas and emotions within the group.
- Partner activities
- Musical experiences which include the child's name to promote awareness of others and peer/group interactions.
- Musical experiences which provide for expression of feelings.
- Action songs that use interactive such as handshaking, tapping another finger, etc.
 - Encouraging joint attention that is very important to notice the child's interest/focus on a moment-to-moment basis and to be responsive to what they find important rather than following an adult-directed routine/game/play activity
- Leaving instruments on the floor until music starts to follow rules and increasing self-control.
- Group improvisation song writing and lyric analysis
- Using visual aids
- Non-verbal conversation between pairs using only instruments for communication
- Using Orff instruments to target specific skills of following directions, listening for cues, sharing instruments with other children, and taking turns
- Using a large gathering drum that all can get around to play on together and individually

Figure 11 reflects the most frequently used instruments that the participants reported using in their music therapy sessions and Figure 12 shows the instruments most frequently used by children in music therapy session. The guitar (80.5%) is the most frequently used instrument by the participants and the drum (64.2%) is the most frequently used instrument by the children.

Over half of the participants (57%) mentioned that they use live music in 75-100% of their sessions, while 64% of the participants reported they use recorded music in 0-25% of their sessions (See Figure 13).

The participants were asked to indicate the frequency of specific social behaviors demonstrated by children with various diagnoses. The frequency of behaviors was labeled W/E (Well established), I/E (Inconsistent or emerging) and N/O (Not observed). The twelve different diagnostic categories with young children linked on the survey were : Autism spectrum disorder, Speech or language impairment, Behavioral/Emotional disorder, Hearing impairment, Visual impairment, Learning disability, Multiple disabilities, Physical disability, Cerebral Palsy, Not yet diagnosed, Specific development delay, and No disability (Figure 14-25). Table 18 shows a summary of the most demonstrated social behaviors within W/E, I/E and N/O with each categories diagnoses.

As described by Figure 14, the most demonstrated W/E behavior in children with autism spectrum disorder was “Lining up”, and the most demonstrated I/E behavior was “Sitting appropriately.” The most common N/O behavior was “Understanding role as part of group”.

Figure 9. Problematic social behaviors for young children

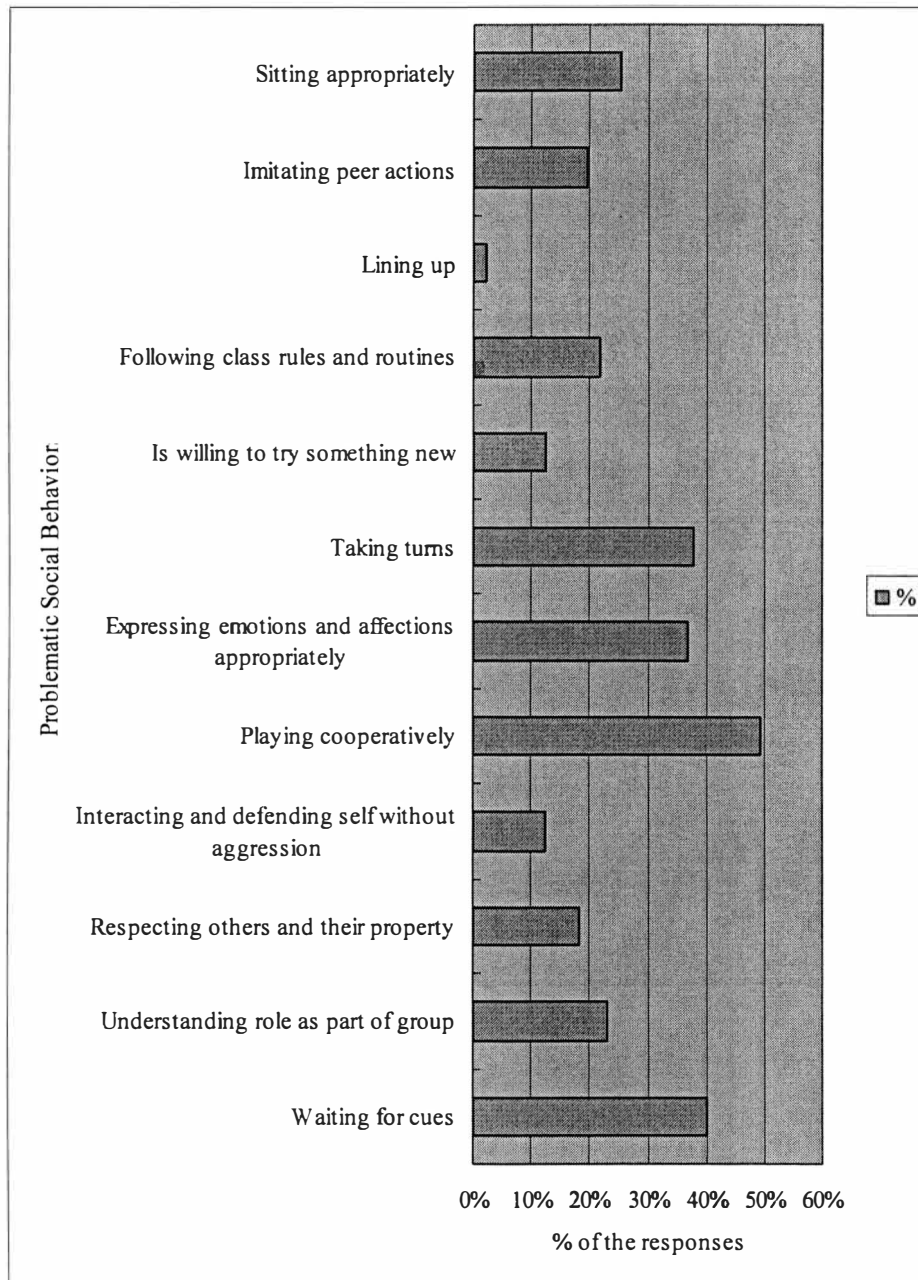
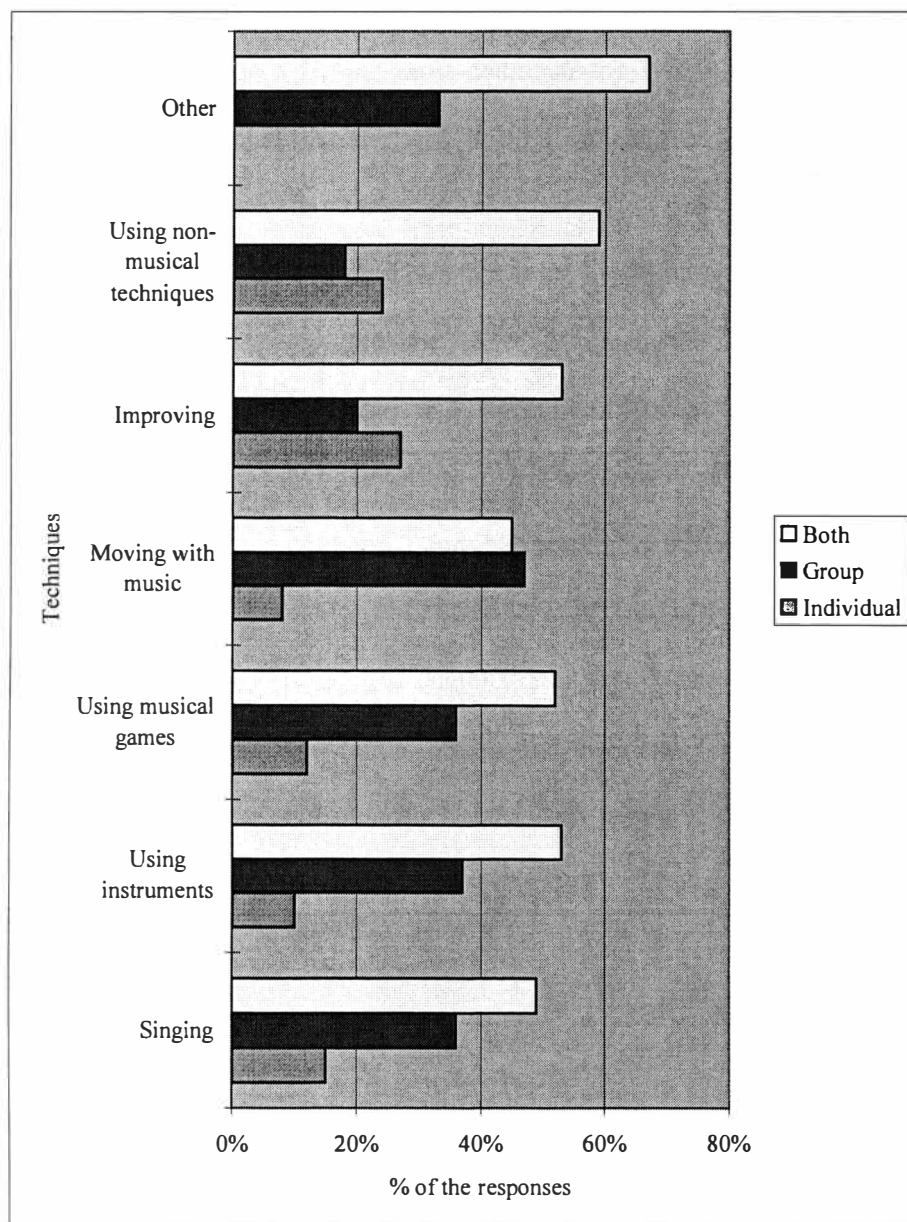


Figure 10. Music therapy techniques that the participants use most frequently to develop clients' social skills in individual or group session or both



The participants reported the most demonstrated W/E behavior in speech or language impairment was “Is willing to try new”, I/E behavior was “Playing cooperatively”, and N/O behavior was “Lining up” (Figure 15).

As seen in Figure 16, the most demonstrated W/E behavior in children with Behavioral/Emotional disorder was “Lining up”, and the most demonstrated I/E behaviors were “Respecting others and their property” and “Understanding role as part of group”. The most common N/O behavior was “Lining up”.

The participants reported the most demonstrated W/E behaviors in children with hearing impairment were “Respecting others and their property” and “Taking turns”, and the most demonstrated I/E behaviors were “Interacting and defending self without aggression” and “Expressing emotions and affections appropriately”. The most common N/O behavior was “Lining up” (Figure 17).

Figure 18 indicates the most demonstrated W/E behavior in children with visual impairment was “Respecting others and their property”; the most I/E behaviors were “Playing cooperatively” and “Turn taking”. N/O behaviors were “Waiting cues”, “Understanding role as part of group”, “Lining up”, and “Imitating peer actions.”

Figure 19 shows the most demonstrated W/E behavior in children with learning disabilities was “Is willing to try something new”, and the most I/E behavior was “Playing cooperatively”. The most frequently reported N/O behavior was indicated as “Lining up.”

Figure 11. Instruments used by the music therapists

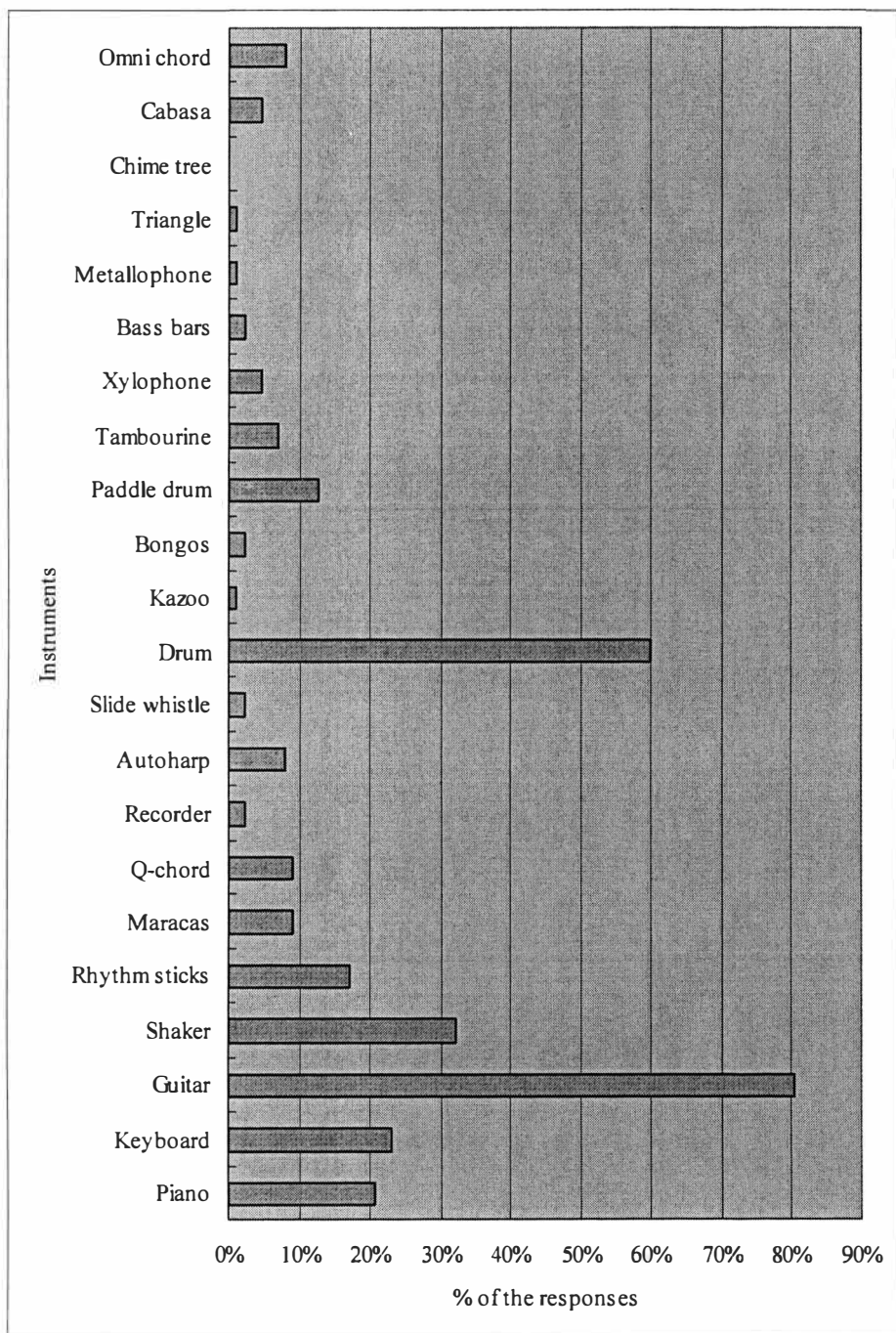


Figure 12. Instruments used by the children

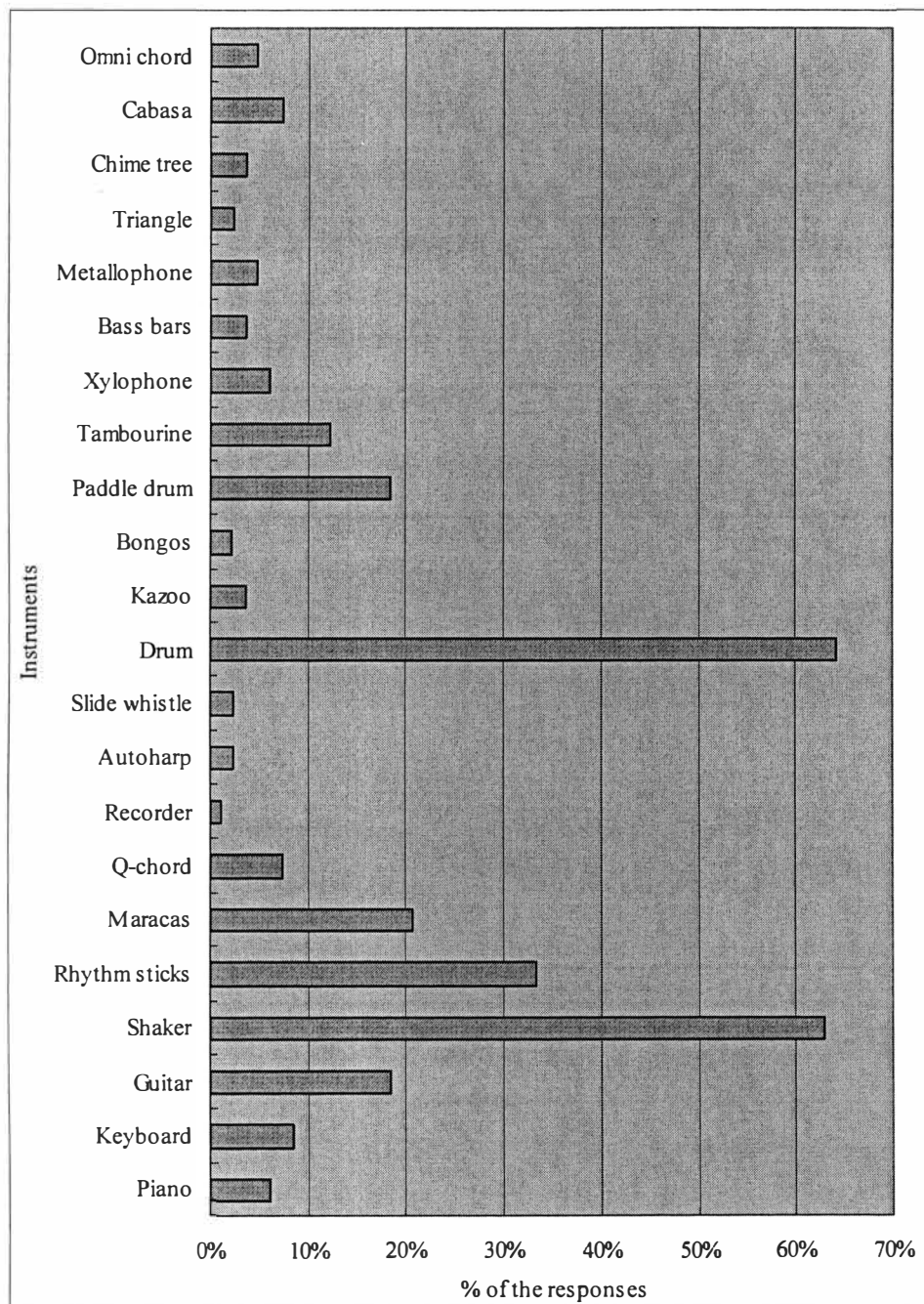


Figure 13. Live music and recorded music

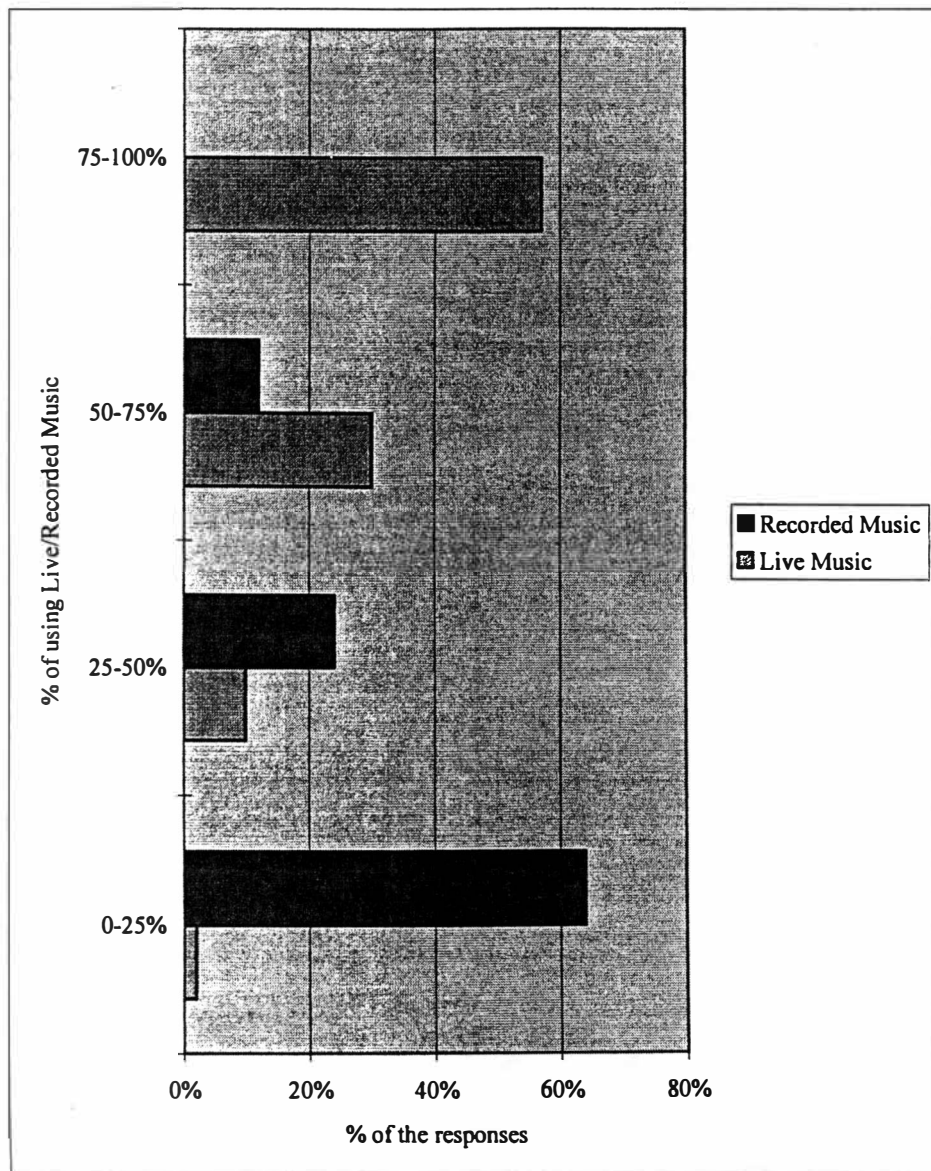


Figure 14. W/E, I/E, and N/O social behaviors within children with autism spectrum disorder

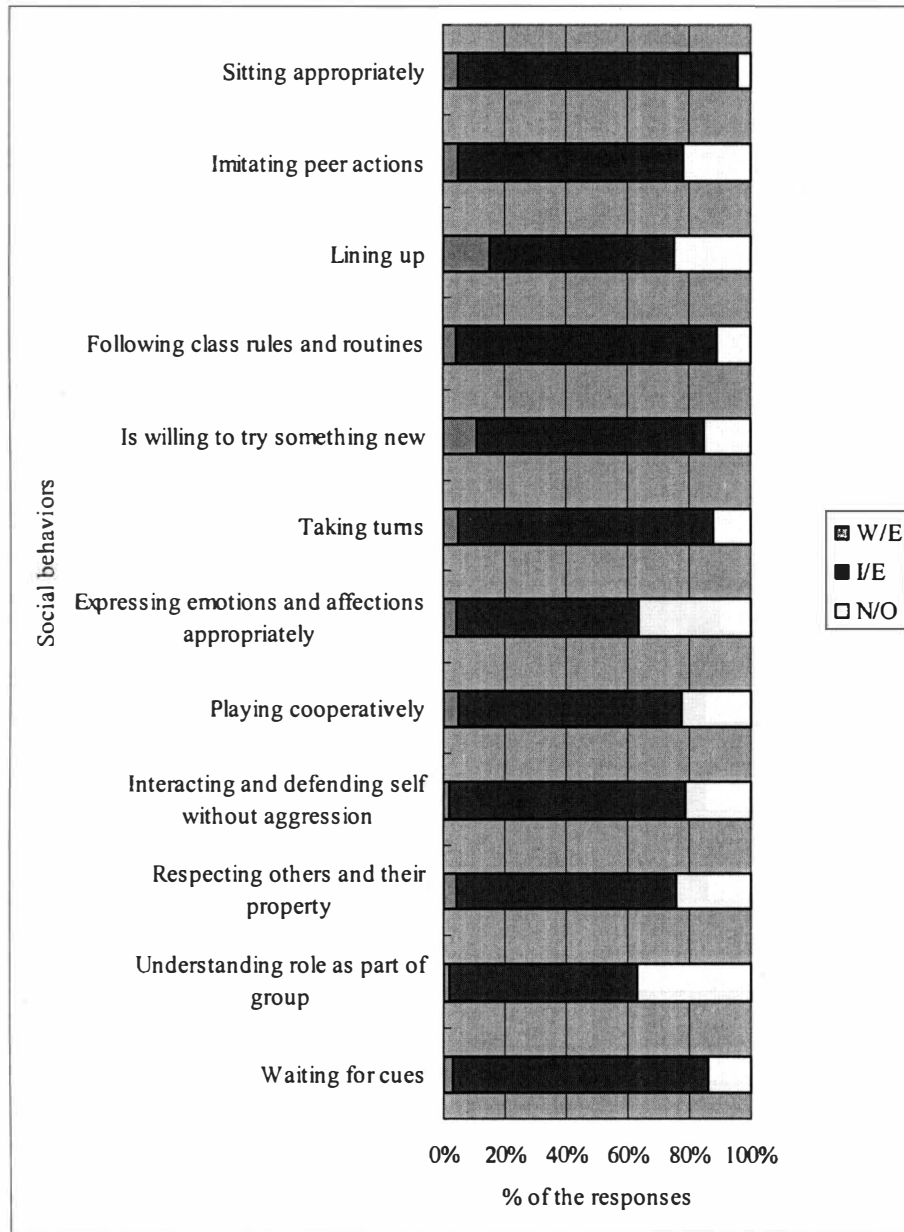


Figure 15. W/E, I/E, and N/O social behaviors within children with speech or language impairment

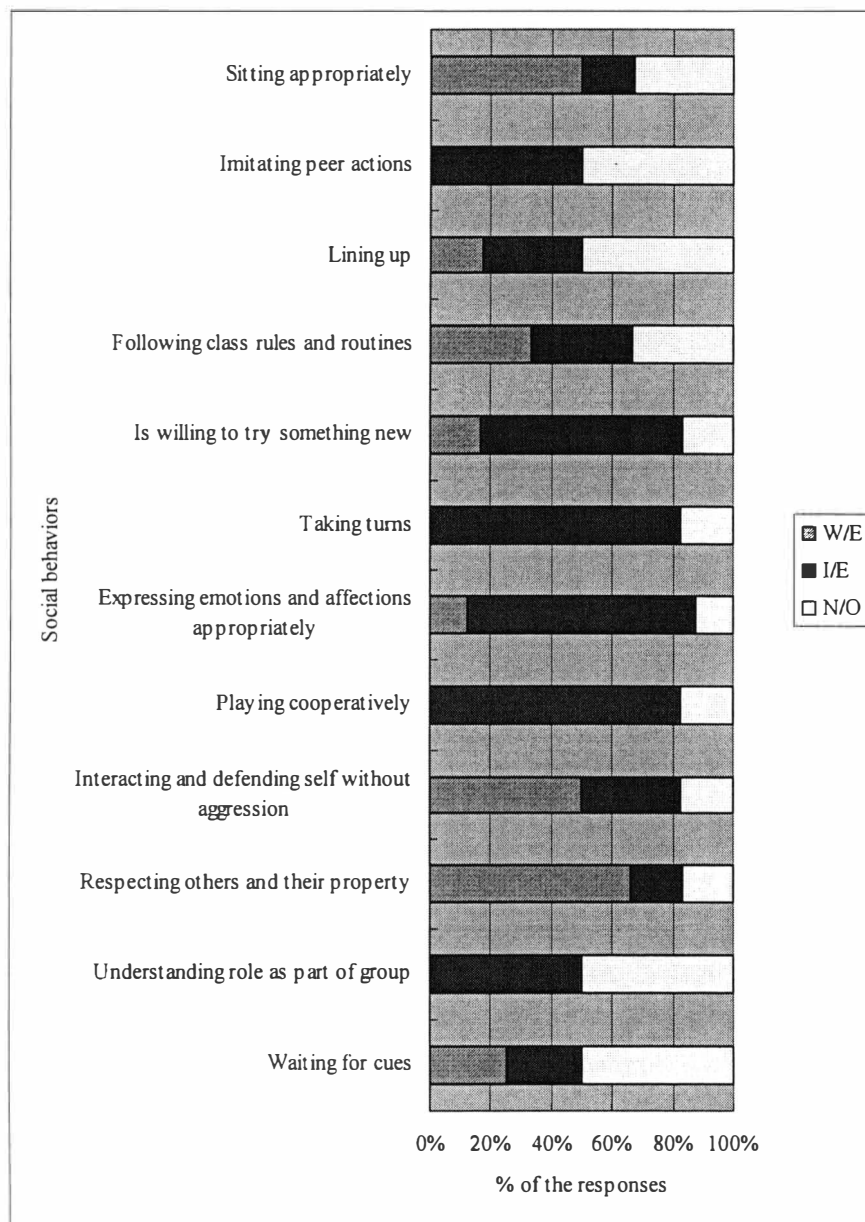


Figure 16. W/E, I/E, and N/O social behaviors within children with behavioral disorder/emotional disorder (or disability)

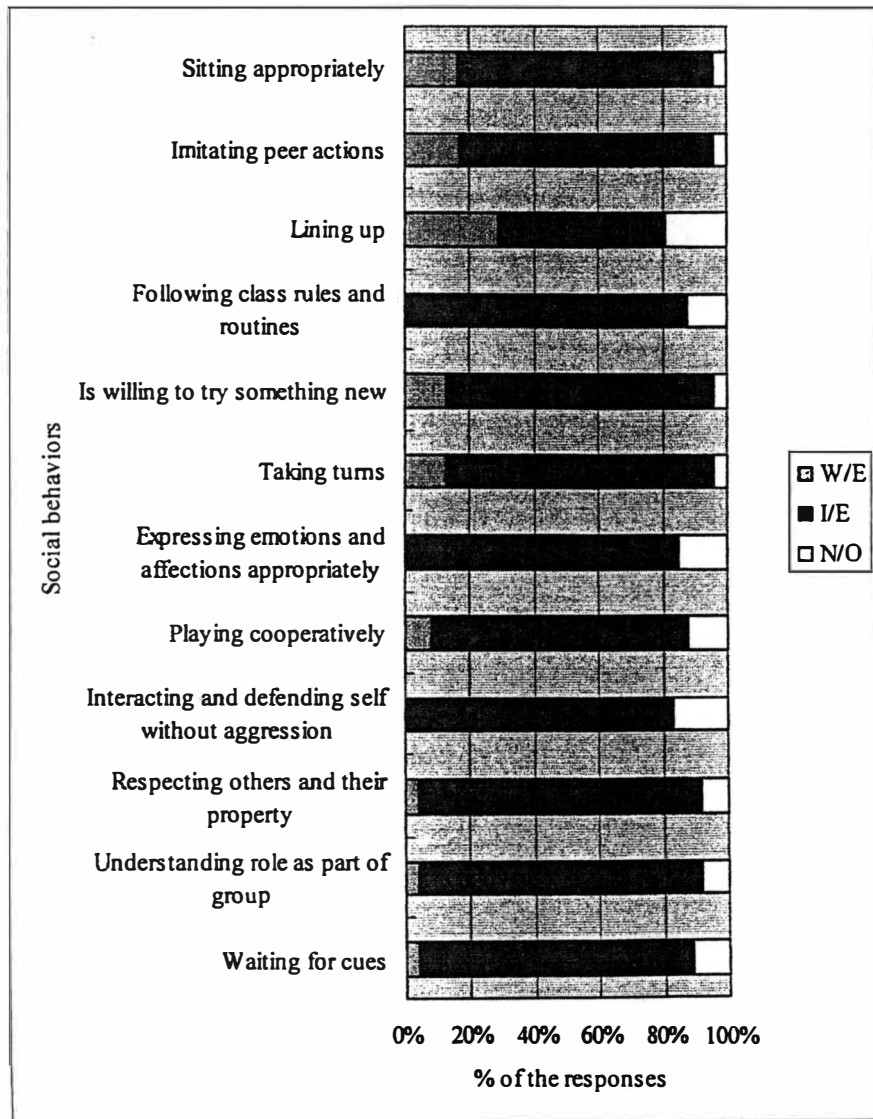


Figure 17. W/E, I/E, and N/O social behaviors within children with hearing impairment

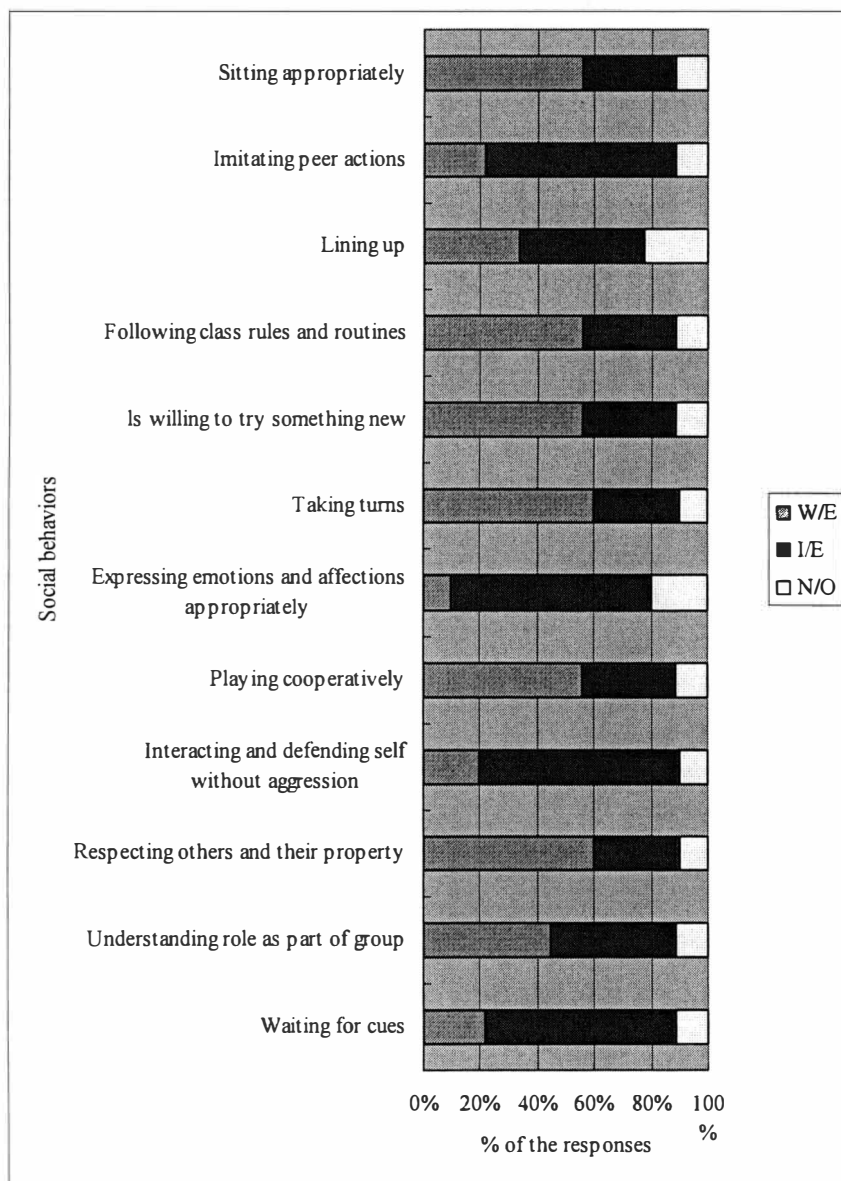


Figure 18. W/E, I/E, and N/O social behaviors within children with visual impairment

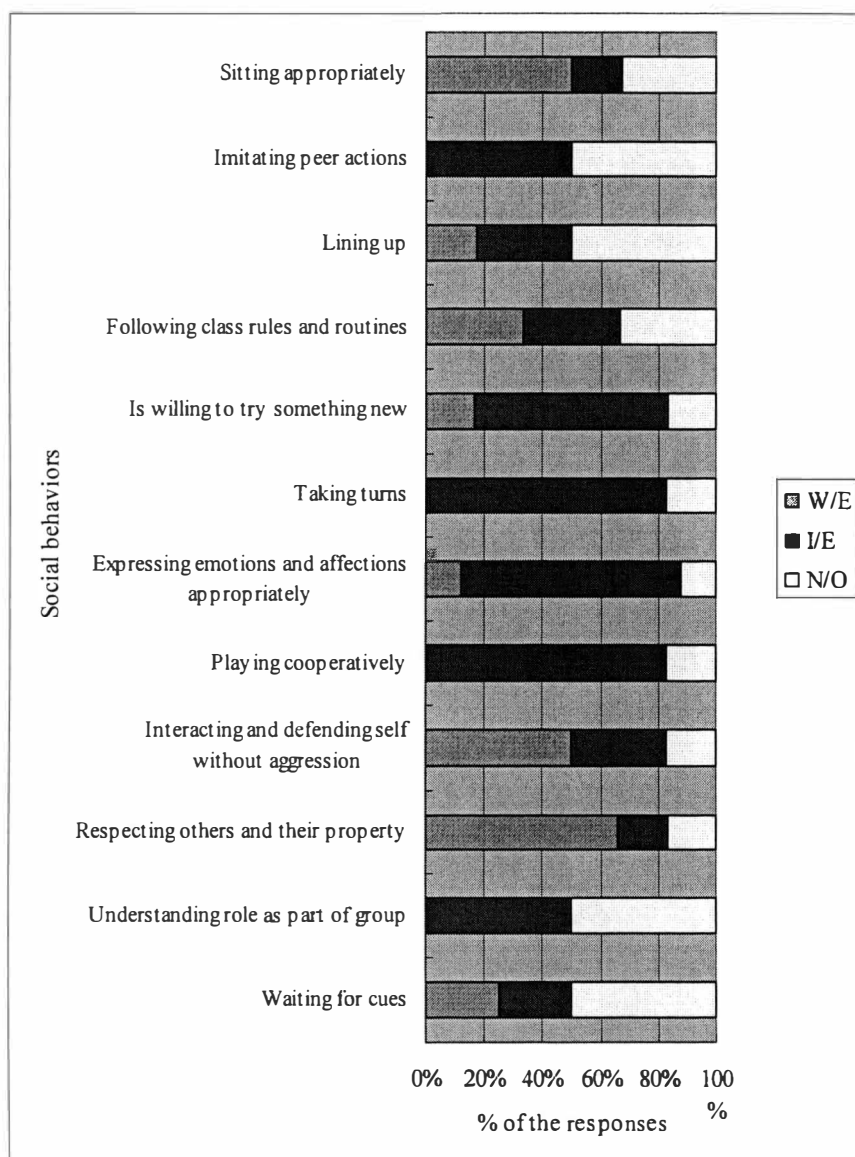
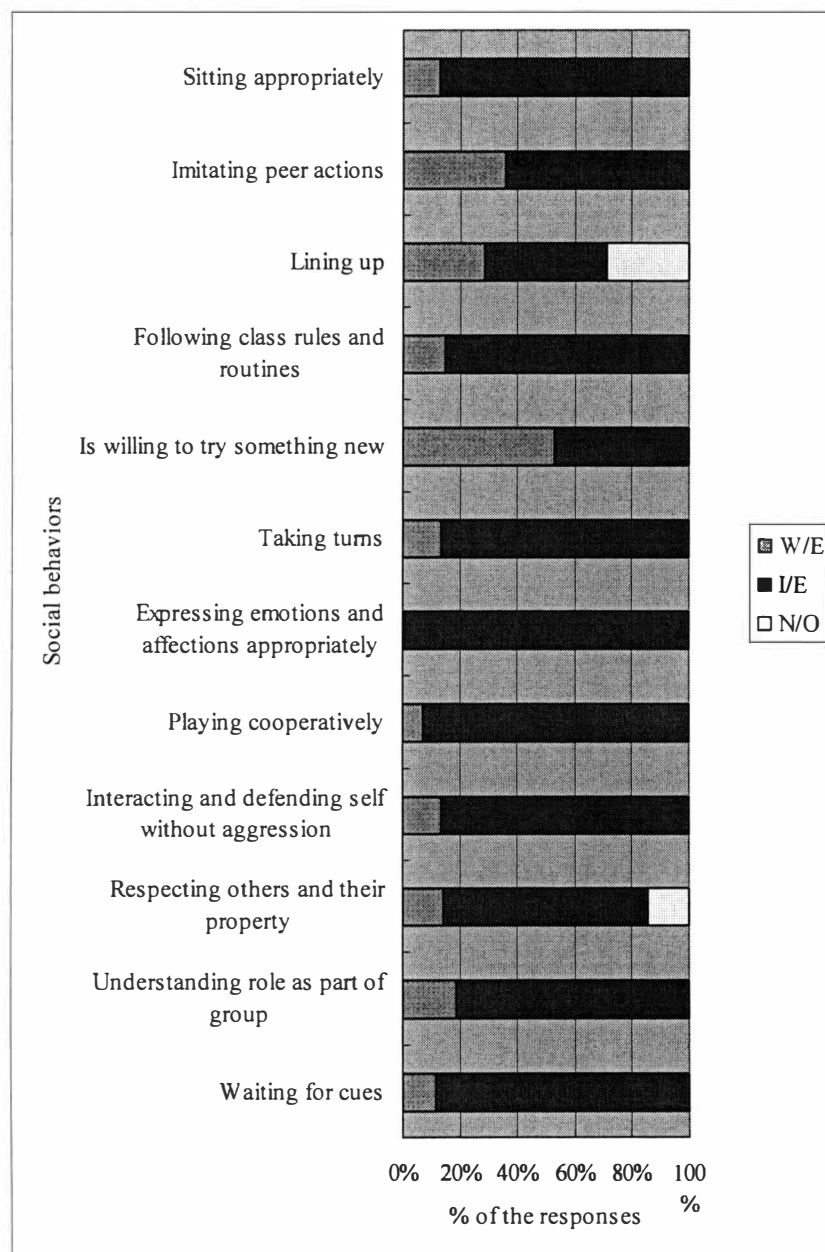


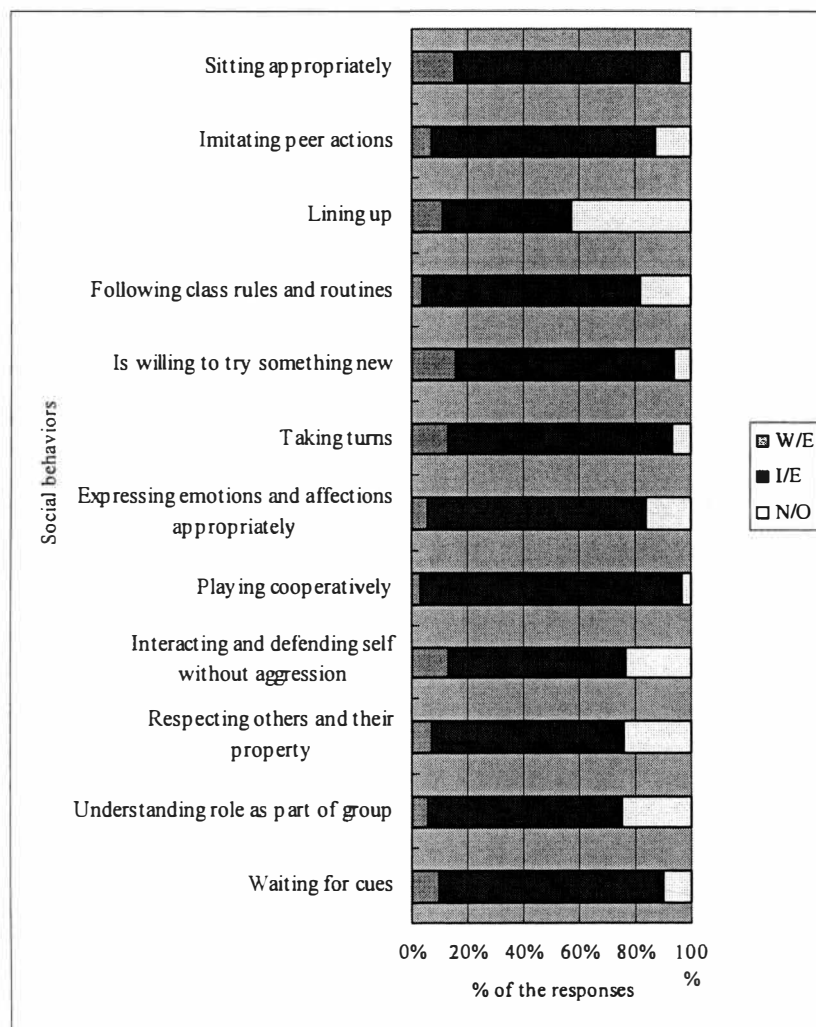
Figure 19. W/E, I/E, and N/O social behaviors within children with learning disability



As described in Figure 20, the participants indicated the most demonstrated W/E behavior was “Is willing to try something new”, and I/E

behavior was “Playing cooperatively.” The most often reported N/O behavior was “Lining up” in children with multiple disabilities.

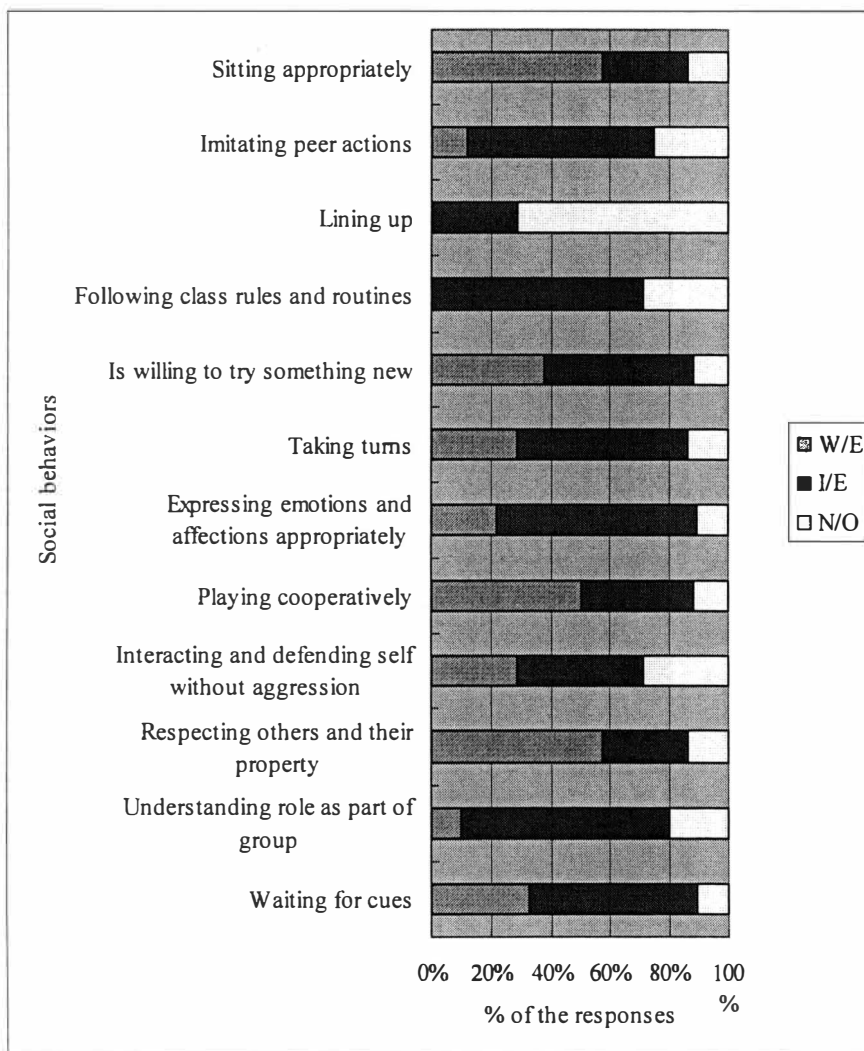
Figure 20. W/E, I/E, and N/O social behaviors within children with multiple disabilities



Data presented in Figure 21 shows the most demonstrated W/E behaviors in children with physical disability were “Respecting others and their property” and

“Sitting appropriately”, and I/E behaviors were “Following class rules and routines”, and N/O behavior was “Lining up”.

Figure 21. W/E, I/E, and N/O social behaviors within children with physical disability



Children with cerebral palsy category indicates that W/E behavior was “Is willing to try new”, I/E behavior was “Expressing emotions and affections

appropriately”, and N/O behavior was “Lining up” (Figure 22).

Figure 22. W/E, I/E, and N/O social behaviors within children with cerebral palsy

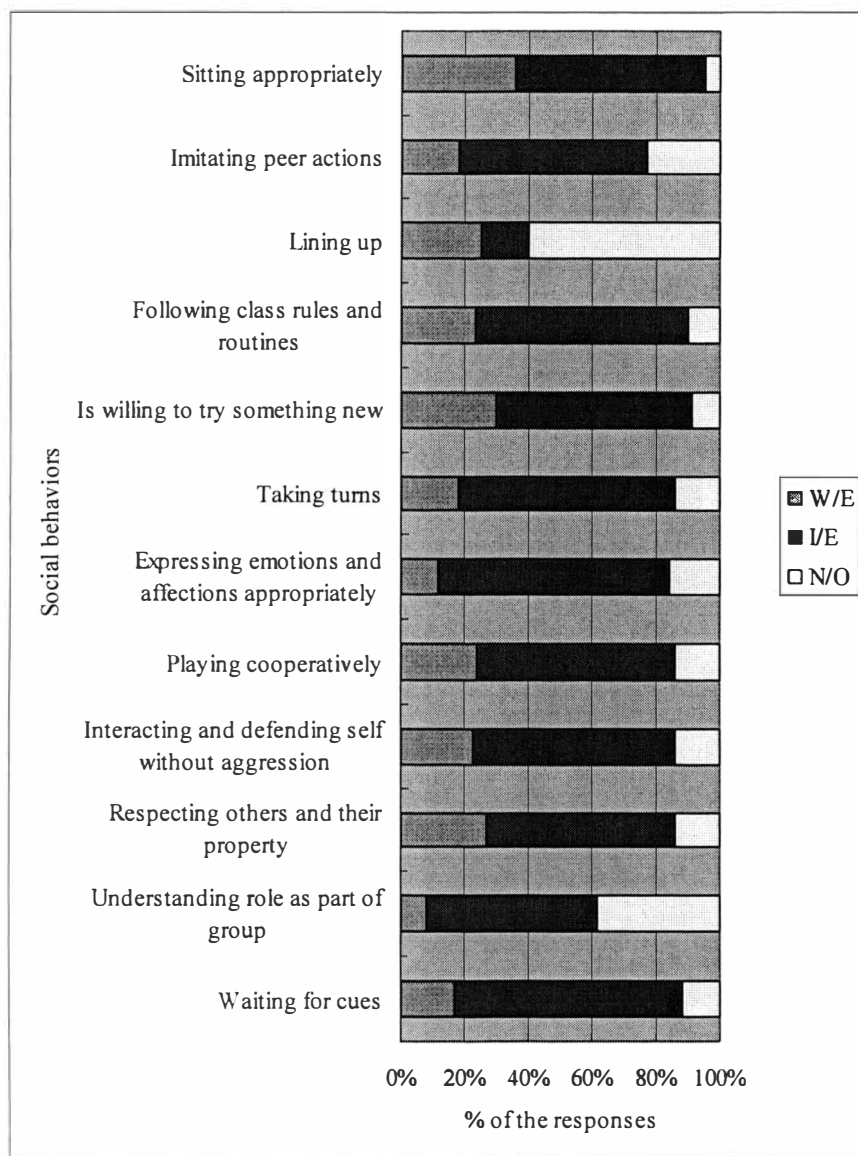


Figure 23 reveals that for the children who are not yet diagnosed the most frequently reported W/E behaviors were “Is willing to try new” or “Following class

rules and routines”, I/E behavior was “Expressing emotions and affections appropriately”, and N/O behavior was “Lining up.”

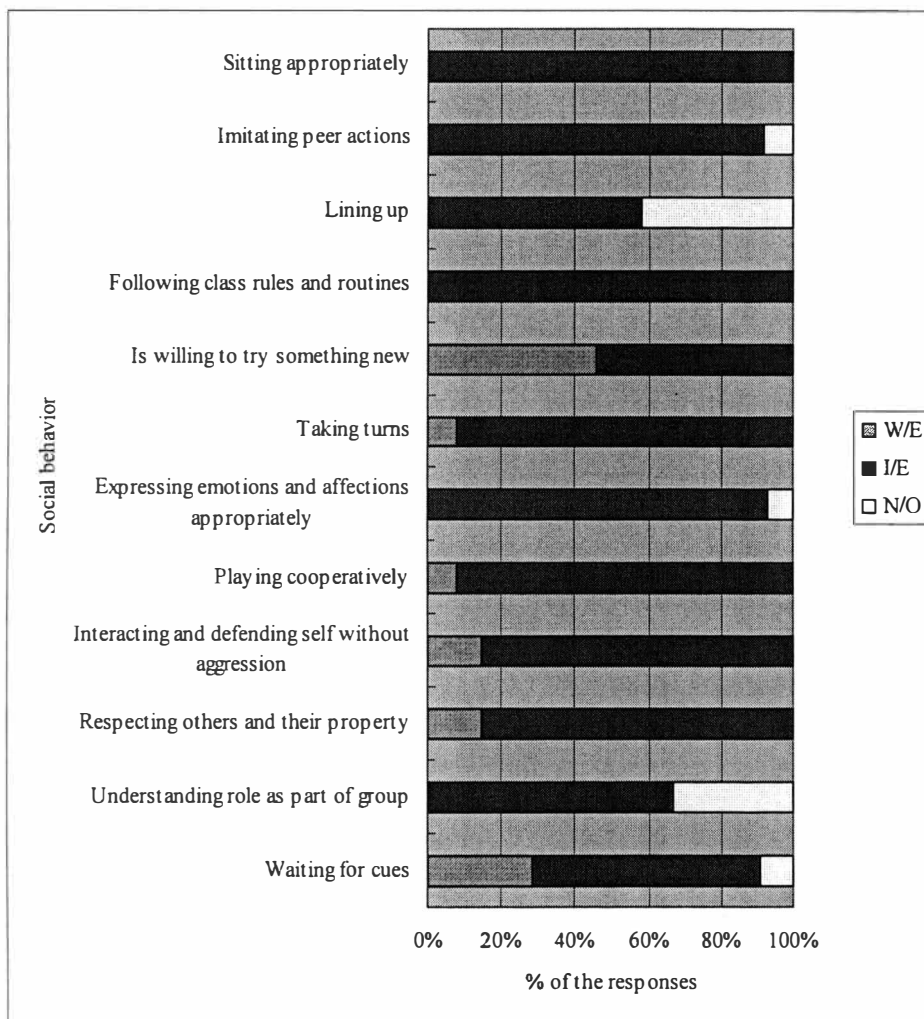
Figure 23 .W/E, I/E, and N/O social behaviors within children with not yet diagnoses



The participants reported the most demonstrated W/E behavior was “Sitting appropriately”, I/E behavior was “Expressing emotions and affections”,

and N/O behavior was “Lining up” in children with specific development delay (Figure 24).

Figure 24. W/E, I/E, and N/O social behaviors within children with specific development delay



Data presented in Figure 25, the participants reported the most demonstrated W/E social behavior was “Following classroom rules and routines”, I/E social behaviors were “Respecting others and their property” and “Taking turn”,

and N/O social behavior was “Lining up” in children with no disabilities.

Figure 25. W/E, I/E, and N/O social behaviors within children with no disabilities



Table 18

Summary of the Most Demonstrated W/E, I/E, and N/O Social Behaviors Listed by the Participants in Various Diagnoses with Children

Diagnoses	W/E	I/E	N/O
Autism spectrum disorder	"Lining up"	"Sitting appropriately"	"Understanding role as part of group"
Speech or language impairment	"Is willing to try something new"	"Expressing emotions and affections appropriately"	"Lining up"
Behavioral/Emotional disorder	"Lining up"	"Following class rules and routine"	"Lining up"
Hearing impairment	"Respecting others and their property" "Following class rules and routines" "Sitting appropriately"	"Waiting cues" "Interacting and defending self without aggression" "Imitating peer actions"	"Expressing emotions and affections appropriately" "Lining up"
Visual impairment	"Respecting others and their property" "Following class rules and routines"	"Interacting and defending self without aggression" "Taking turn"	"Lining up" "Imitating peer actions"
Learning disability	"Is willing to try something new"	"Expressing emotions and affections appropriately"	"Lining up"
Multiple disabilities	"Sitting appropriately"	"Playing cooperatively"	"Lining up"

Table 18-continued

Physical disability	"Respecting others and their property" "Sitting appropriately"	"Following class rules and routines"	"Lining up"
Cerebral Palsy	"Sitting appropriately"	"Waiting for cues"	"Lining up"
Not yet diagnoses	"Is willing to try something new" "Following class rules and routines" "Imitating peer actions" "Sitting appropriately"	"Waiting for cues" "Understanding role as part of group" "Expressing emotions and affections appropriately"	"Lining up"
Specific development delay	"Is willing to try something new"	"Following class rules and routines" "Sitting appropriately"	"Lining up"
No disability	"Following class rules and routines"	"Respecting others and their property" "Taking turn"	"Lining up"

CHAPTER V

DISCUSSION AND RECOMMENDATIONS FOR FUTURE STUDY

Discussion

According to the 2003 edition of the AMTA sourcebook, the total number of music therapists who indicated they work in early childhood settings was 423. Of that number 330 had valid email address and actually received the survey instruments were included in this study. The total number of usable surveys returned was 115 (35%). According to the results, the typical music therapist who works with young children is either in private practice or employed contractually. He or she is called Music Therapist and works with children ranging in age from 3-5 years. The typical music therapist is most likely to work with children with autism spectrum disorder, followed by development disability and speech or language impairment. He or she probably lives in a large metropolitan city like New York City. The participants were not asked their ages, highest degree that they held, or length of time practicing as a music therapist.

The participants described the most common diagnoses that they work with in early childhood setting was autism spectrum disorder. According to the DSM IV autistic disorder is usually diagnosed before the child reaches 30 months of age when children demonstrate problems with low developmental rates, responses to sensory stimuli, communication disorders, and cognitive deficits (Davis, Gfeller, & Thaut, 1999). This may be the reason for the relatively high

number of children with autism spectrum disorder seen by the respondents in this study. As previously stated, states are not required to identify and report existing diagnosed categories for preschoolers. Therefore, a substantial number of respondents indicated that the exact diagnoses were not yet known.

This study also investigated how music therapists address collaboration in their early childhood work settings. The results showed 84% of the participants collaborated with other professionals primarily speech therapists (65%) and occupational therapists (66%), in order to share in decision making, to solve problems, and to participate in interdisciplinary team meetings. These results coincide with the participants reporting of other professionals employed at their work settings. Most of the participants who responded “Other” were involved in collaboration with parents. The high percentage of collaboration with other professionals in early childhood settings was the most surprising outcome in this study.

In her recent research, Register (2002) investigated with whom music therapists collaborate in a variety of settings, such as geriatric facility, school, medical facility, psychiatric facility, etc. In her study, half of the music therapists reported that they collaborate with parent/caregiver/other family, 47.2% responded they collaborate with occupational therapist, and 44.6% of collaborate with speech therapists. These results would suggest that there are effective relationships and collaborations between music therapy and speech therapy/occupational therapy.

Sixty-two percent of the participants reported they have co-led a session with other professionals such as speech therapists (72.5%) and occupational therapists (68.1%). These findings may reflect the recognition that music-based

intervention can be affected in increasing children's speech development. For many years, music therapy and speech therapy has been coordinated for children with inadequate language development (Lathom, Edson, & Toombs, 1965).

How music therapists are involved in assessment and treatment programming of children's progress in relation to federal and state law was also examined in this study. Fifty percent of the participants reported that they document children's development on IEP (72.7%), IFSP (36.4%), IIP (1.8%) or other (18.2%). Nevertheless, half of the participants reported that they are not required to do any formal documentation. It is not known how these music therapists primarily those who worked in private practice, are sharing information or reporting their findings. IIP is only utilized in the state of Minnesota for children four years old and older (Furman, 2002). In their documentation, 37% of the participants stated they set more than five non-musical goals including the communication area (89.8%) and the social area (83.1%). From an examination of these results, it can be inferred that these two goal areas are probably emphasized by the educational team members when developing programming for young children with disabilities. In addition, music therapy services are used for increasing other non-musical goals such as cognitive/play, self-help, emotional, and gross/fine motor skills (Humpal, 2002).

This study also examined how music therapists address consultation in early childhood settings. Seventy-five percent of the participants that responded indicated that they served as consultants. The consultant methods include direct consultations (85.4%) and work shops/music therapy seminars (84 %). Register (2002) also investigated music therapy consultation with a diversity of clients. Her

findings indicate that less than half (44%) of the respondents served as consultants. Of that number the majority provided either workshops/seminars/in-services (72.6%) or one-to-one meetings (67.7%). It might be concluded that the reported high rate of direct consultation in early childhood settings indicates that there is need for consultations with childrens' parents or other professionals. For example, music therapists are available to respond to the requests of educators and other team members who may request ideas for music activities or parents who may want to borrow music resources to use in their home (Humpal, 2002).

Lastly, this study investigated problematic social skills in young children with disabilities and how music therapy services support the development of those skills. The participants who primarily work with children with disabilities age three to five years provided the results for this research questions. The lists of twelve social behaviors mentioned in this study reflect the skills necessary to have a successful transition from preschool to kindergarten (Bondurant-Utz, 2002). Half of the participants (49.4%) stated that the most problematic social behavior is playing cooperatively. It is assumed that this problematic behavior is the most conspicuous behavior in music therapy sessions. The reason for this may be that many music therapy activities require children to share instruments, play instruments cooperatively, and engage in a partner activity or group activity through music. Beyond that, it is widely recognized that functional social skills such as playing cooperatively are very important. Teachers in kindergarten or inclusive settings expect children to have functional social skills more than they expect academic skills (Walter, 1979).

Instruments used by the therapists and children were influenced by

whether live or recorded music was used in the music therapy sessions. The majority of therapists used a guitar and a drum rather than a piano or keyboard. It can perhaps be inferred that a guitar and a drum are more adaptable and adequate for the size of the room and are also at children's eye level.

The participants were asked to identify twelve categories of social skills that were either W/E (well established), I/E (inconsistent or emerging) or N/O (not observed) social behaviors across twelve different diagnoses or conditions of children. Five of the participants mentioned that this portion of the survey was confusing. Since children with disabilities usually have a variety of needs and abilities, it was difficult to identify them within the limited choices. Secondly, many children may demonstrate I/E in twelve categories of social behaviors in this age group (3-5 years). The reason for this may be their age and the newness of being in a group or school setting, their specific diagnosis, and their surroundings. It should be noted, however, that deficit in social behavior skills were noted by the participants across all twelve diagnostic categories.

Recommendation for Future Study

Future study is needed to confirm and further develop the findings from this study, particularly regarding the efficacy of co-led music therapy sessions with occupational therapy and speech therapy for young children with disabilities. More information is needed in order to determine how music therapy co-led sessions are implemented with occupational therapist and speech therapist.

Secondly, research is needed to clarify the specific social skill needs and

goals of young children with various diagnoses from the music therapist's perspective. This would involve designing more concrete research questions in the survey or other research method to examine a various level of abilities and needs for young children with disabilities.

Thirdly, more research is necessary to investigate the documentation system used by music therapist in private practice or other settings where they are not required to submit any reports.

Lastly, continued research is needed to clarify and describe music therapy techniques/activities and music styles that can be used successful in music therapy sessions with young children. In order to develop the quality of music therapy services for this population, it is important to investigate the awareness and satisfaction of the parents, teachers, and other professionals for participating music therapists in interdisciplinary team.

Appendix A
Survey and Cover Letter

SURVEY OF MUSIC THERAPY IN EARLY CHILDHOOD

Please complete the following questions.

A. Demographics

1. Please indicate the city/state where you work: _____

2. a. Please indicate which of the following is your primary work setting (i.e. where you spent most of your professional time working as a music therapist). (Choose only one)

- ☐ Early interventions programs/centers
- ☐ Children's day care
- ☐ Preschool
- ☐ Children's Hospitals or units
- ☐ Community-based facilities
- ☐ PPI classroom
- ☐ Private Practice/ Contractual
- ☐ Other _____

2. b. If this is a school setting, please indicate which setting. (skip to question #2.c, if your primary work setting is not a school)

- ☐ Public School
- ☐ Private School
- ☐ Both of the above
- ☐ Other _____

2. c. Please indicate your job title at your primary work setting.

- ☐ Music Therapist
- ☐ Activity Therapist
- ☐ Music Educator
- ☐ Music Specialist
- ☐ Recreation Therapist
- ☐ Special Educator
- ☐ Other _____

Considering the primary work setting that you indicated above, please respond to the following.

3. Please select the top three ages groups with whom you most often work:

- 0 year-1 year ☐
- 1 year-2 year ☐
- 2 years-3 year ☐
- 3 years-4 year ☐
- 4 years-5 year ☐
- 5 years-6 year ☐

4. Indicate approximately the percentage of time that you work with your clients in a group session and/or an individual session? (Total 100%)

Group session _____%

Individual session _____%

5. Please click on the most common diagnoses (up to 5) of early childhood clients that you service. Also, please indicate whether you are most likely to see these clients in a group or individual or both settings.

	<i>Group</i>	<i>Individual</i>	<i>Both</i>
<input type="checkbox"/> Autistic:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Speech or language impairment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Behavioral Disorder/ Emotionally Disabled	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Developmentally Disabled (Including Down Syndrome)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Hearing Impaired / Visually Impaired	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Learning Disabled	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Multiply Disabled / Physically Disabled	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Cerebral Palsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Not yet Diagnosed/Specific developmental delay	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Non-Disabled	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Other _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. If you see clients individually, what is the average frequency of individual sessions per client per week :

- ☐ Once
- ☐ Twice
- ☐ Three times
- ☐ Four times
- ☐ Five times
- ☐ Other _____
- ☐ I don't see clients individually

7. If you see clients as a group, what is the average frequency of sessions per group per week:

- ☐ Once
- ☐ Twice
- ☐ Three times
- ☐ Four times
- ☐ Five times
- ☐ Other _____
- ☐ I don't see clients as a group

8. What is the average length of each individual session:

- ☐ Less than 30 minutes
- ☐ 30 minutes
- ☐ 45 minutes
- ☐ 60 minutes
- ☐ More than 60 minutes
- ☐ I don't see clients individually

9. What is the average length of each group session :

- ☐ Less than 30 minutes
- ☐ 30 minutes
- ☐ 45 minutes
- ☐ 60 minutes
- ☐ More than 60 minutes
- ☐ I don't see clients as a group

B. Music Therapy as a Discipline

Considering the primary work setting that you indicated above, please respond to the following:

10. Please indicate any and all other professions employed at your setting.

- ☐ Other Music Therapist(s)
- ☐ Educator(s)
- ☐ Early childhood special educator(s)
- ☐ Speech Therapist(s)
- ☐ Occupational Therapist(s)
- ☐ Physical Therapist(s)
- ☐ Art Therapist(s)
- ☐ Social worker(s)
- ☐ Medical Personnel (Nurse(s), Pediatric(s))
- ☐ Others _____

11. Do you collaborate* with other team members at your setting?

- ☐ Yes
- ☐ No (If No, Skip to question #13)

* Collaborate: collaboration is the process of working with other professionals/parents to share decision making, problem solving, interpersonal communication within team members, etc.

12. If YES, with whom do you collaborate: (check all that apply)

- ☐ Other Music Therapist(s)
- ☐ Educator(s)
- ☐ Early childhood special educator(s)
- ☐ Speech Therapist(s)
- ☐ Occupational Therapist(s)
- ☐ Physical Therapist(s)
- ☐ Art Therapist(s)
- ☐ Social worker(s)
- ☐ Medical Personnel (Nurse(s), Pediatric(s))
- ☐ Parents/ Caregiver/ Other Family members
- ☐ Others _____

13. Have you co-lead* a session with another team member within the last/current year?

- ☐ Yes
- ☐ No (If No, Skip to question # 15)

*Co-lead: co-lead session is planned and implemented by two or more professionals/parents, etc.

14. If YES, with whom do/did you co-lead:

- ☐ Other Music Therapist(s)
- ☐ Educator(s)
- ☐ Early childhood special educator(s)
- ☐ Speech Therapist(s)
- ☐ Occupational Therapist(s)
- ☐ Physical Therapist(s)
- ☐ Art Therapist(s)
- ☐ Social worker(s)
- ☐ Medical Personnel (Nurse(s), Pediatric(s))
- ☐ Parents/ Caregiver/ Other Family members
- ☐ Others _____

15. Does your agency require you to report children's development in your primary work setting?

- ☐ Yes
☐ No (If No, Please skip following question # 16-18)

16. If YES, please click on the reporting systems that you use at your primary work setting?

- ☐ IEP (Individualized Educational Plan)
☐ IFSP (Individualized Family Service Plan)
☐ IIMP (Interagency Individualize Intervention)
☐ Other _____

17. Indicate the percentage of non-musical and musical goals that you report on the IEP, IFSP, or other reports for your clients?

- | | |
|--------------------------------------------------|----------------------------------------------|
| Non-musical goal: <input type="checkbox"/> 0-25% | Musical goal: <input type="checkbox"/> 0-25% |
| <input type="checkbox"/> 25-50% | <input type="checkbox"/> 25-50% |
| <input type="checkbox"/> 50-75% | <input type="checkbox"/> 50-75% |
| <input type="checkbox"/> 75%-100% | <input type="checkbox"/> 75%-100% |

18. Please click on the three goal areas that appear most frequently on the IEP, IFSP, or other reports for your early childhood clients.

- | | | |
|---------------|-----------------------|---------------------------------------------------------|
| Academics | <input type="radio"/> | (readiness skills, math skills, reading skills, etc) |
| Physical | <input type="radio"/> | (motor development, coordination, flexibility, etc) |
| Cognitive | <input type="radio"/> | (acquisition of counting and alphabet, etc) |
| Social | <input type="radio"/> | (peer interaction, sharing and turn taking skills, etc) |
| Emotional | <input type="radio"/> | (self-expression, self-regulation, etc) |
| Communication | <input type="radio"/> | (speech, language behavior, etc) |
| Music | <input type="radio"/> | (singing skills, playing instruments skills, etc) |

C. Music Therapy and Consultation

19. Have you served as a consultant* within the last/current year?

☐ Yes

☐ No (If No, Skip to D. Social skills and Children with various diagnoses)

*Consult: consultation is to provide music therapy information, to educate and advise within other professionals/parents, etc.

20. If YES, in what ways did you serve as a music therapy consultation (Click all that apply):

☐ Direct consultations (disseminate of information to parents, and teachers, etc.)

☐ Music Therapy In-services /Work Shops/ Seminars (to educate other professionals/parents/etc about music therapy, etc)

☐ Publication and Literature (delivery of music therapy information, through journals, articles, brochures, etc)

☐ Other _____

21. Please indicate which of the following individuals you have provided consultant services to within the last/current year. (click all that apply)

☐ Other Music Therapist(s)

☐ Educator(s)

☐ Early childhood special educator(s)

☐ Speech Therapist(s)

☐ Occupational Therapist(s)

☐ Physical Therapist(s)

☐ Art Therapist(s)

☐ Social worker(s)

☐ Medical Personnel (Nurse(s), Pediatric(s))

☐ Parents/ Caregiver/ Other Family members

☐ Others _____

22. Which of the following topics did you communicate about with the individuals indicated above? (click all that apply)

- ☐ academic
- ☐ physical
- ☐ cognitive
- ☐ social
- ☐ emotional
- ☐ communication
- ☐ music

If you work with children ages 3-5 in your primary work setting, please continue on to the following questions on the survey.

If you do not work with children ages 3-5 in your primary setting, the survey is concluded. Thank you for taking the time to provide this important information.

D. Music Therapy and Social Skills

Note: This section should be completed only by those who work with children ages 3-5 in their primary work setting.

Considering the primary work setting that you indicated above, please respond to the following:

23. Please click on the three most problematic social behaviors for children (ages 3-5) in your primary work setting.

- ☐ Waiting for cues
- ☐ Understands role as part of group
- ☐ Respects others and their property
- ☐ Interact and defends self without aggression
- ☐ Plays cooperatively; shares instruments and materials
- ☐ Expresses emotions and affections appropriately
- ☐ Takes turn; participates appropriately in music therapy activities
- ☐ Is willing to try something new
- ☐ Follows class rules and routines
- ☐ Lines up and waits appropriately
- ☐ Imitates peer actions
- ☐ Sits appropriately

24. Please click on the three music therapy techniques that you use most frequently to develop your clients' social skills. Please indicate whether you are most likely to see these clients in a group or individual or both settings.

	<i>Individual</i>	<i>Group</i>	<i>Both</i>
<input type="checkbox"/> Singing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Using instruments	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Musical Games	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Moving with music	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Improvisation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Non-musical techniques	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Other _____			

25. Please list up to two specific activities/techniques/ interventions that you think are most effective in increasing social skills of early childhood clients.

26. Please click on the three instruments you use most frequently in your sessions with early childhood clients.

☐ piano

☐ keyboard

☐ guitar

☐ Q-chord, omni chord, autoharp

☐ drum, bongos, paddle drum, tambourine

☐ Xylophone, bass bars

☐ metallophones, triangle, chime trees

☐ shakers, rhythm sticks, maracas, cabasa,

☐ recorder, slide whistle, kazoo

☐ Other _____

27. Approximately, what is the percentage of LIVE MUSIC or RECORDED MUSIC that you typically use in your sessions with early childhood clients?

Live music: ☐ 0-25%

☐ 25-50%

☐ 50-75%

☐ 75%-100%

Recorded music: ☐ 0-25%

☐ 25-50%

☐ 50-75%

☐ 75%-100%

E. Social skills and Clients with various diagnoses

28. Thinking about the diagnostic categories that you checked in Question 5, (that now appear below) indicate whether you believe the behaviors listed below are generally (1) well established: W/E (children demonstrate consistently); (2) inconsistent or emerging: I/E (children need physical/verbal supports and behavior is not consistent); (3) usually not observed :N/O.

☐ Autistic

W/E

I/E

N/O

(behavior well established) (behavior inconsistent or emerging) (behavior not observed)

	W/E	I/E	N/O
Waiting for cues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Understands role as part of group	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Respects others and their property	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interact and defends self without aggression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Plays cooperatively; shares instruments and materials	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Expresses emotions and affections appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Takes turn; participates appropriately in music therapy activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Is willing to try something new	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Follows class rules and routines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lines up and waits appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Imitates peer actions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sits appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

☐ Behavioral Disorder/ Emotionally Disabled

	W/E	I/E	N/O
Waiting for cues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Understands role as part of group	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Respects others and their property	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interact and defends self without aggression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Plays cooperatively; shares instruments and materials	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Expresses emotions and affections appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Takes turn; participates appropriately in music therapy activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Is willing to try something new	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Follows class rules and routines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lines up and waits appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Imitates peer actions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sits appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

☐ Developmentally Disabled (Including Down Syndrome)

	W/E	I/E	N/O
Waiting for cues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Understands role as part of group	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Respects others and their property	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interact and defends self without aggression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Plays cooperatively; shares instruments and materials	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Expresses emotions and affections appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Takes turn; participates appropriately in music therapy activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Is willing to try something new	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Follows class rules and routines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lines up and waits appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Imitates peer actions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sits appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

☐Hearing Impaired / Visually Impaired

	W/E	I/E	N/O
Waiting for cues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Understands role as part of group	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Respects others and their property	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interact and defends self without aggression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Plays cooperatively; shares instruments and materials	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Expresses emotions and affections appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Takes turn; participates appropriately in music therapy activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Is willing to try something new	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Follows class rules and routines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lines up and waits appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Imitates peer actions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sits appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

☐Learning Disabled

	W/E	I/E	N/O
Waiting for cues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Understands role as part of group	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Respects others and their property	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interact and defends self without aggression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Plays cooperatively; shares instruments and materials	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Expresses emotions and affections appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Takes turn; participates appropriately in music therapy activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Is willing to try something new	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Follows class rules and routines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lines up and waits appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Imitates peer actions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sits appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

☐ Multiply Disabled / Physically Disabled

	W/E	I/E	N/O
Waiting for cues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Understands role as part of group	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Respects others and their property	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interact and defends self without aggression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Plays cooperatively; shares instruments and materials	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Expresses emotions and affections appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Takes turn; participates appropriately in music therapy activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Is willing to try something new	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Follows class rules and routines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lines up and waits appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Imitates peer actions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sits appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

☐ Cerebral Palsy

	W/E	I/E	N/O
Waiting for cues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Understands role as part of group	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Respects others and their property	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interact and defends self without aggression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Plays cooperatively; shares instruments and materials	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Expresses emotions and affections appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Takes turn; participates appropriately in music therapy activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Is willing to try something new	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Follows class rules and routines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lines up and waits appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Imitates peer actions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sits appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

☐ Not yet Diagnosed/specific development delay

	W/E	I/E	N/O
Waiting for cues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Understands role as part of group	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Respects others and their property	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interact and defends self without aggression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Plays cooperatively; shares instruments and materials	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Expresses emotions and affections appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Takes turn; participates appropriately in music therapy activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Is willing to try something new	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Follows class rules and routines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lines up and waits appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Imitates peer actions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sits appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

☐ Non-Disabled

	W/E	I/E	N/O
Waiting for cues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Understands role as part of group	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Respects others and their property	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interact and defends self without aggression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Plays cooperatively; shares instruments and materials	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Expresses emotions and affections appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Takes turn; participates appropriately in music therapy activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Is willing to try something new	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Follows class rules and routines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lines up and waits appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Imitates peer actions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sits appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

☐ Other _____

	W/E	I/E	N/O
Waiting for cues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Understands role as part of group	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Respects others and their property	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interact and defends self without aggression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Plays cooperatively; shares instruments and materials	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Expresses emotions and affections appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Takes turn; participates appropriately in music therapy activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Is willing to try something new	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Follows class rules and routines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lines up and waits appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Imitates peer actions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sits appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Thank you for taking the time to provide this important information.

If you have any additional comments that you would like to make, please indicate them here.

Western Michigan University, Department of Music Therapy

Principal Investigator: Brian Wilson, M.M.

Student Investigator: Sayaka Abe, B.M.

Music Therapy and Social Skills in Young Children with Disabilities : A Survey of Music Therapy Practitioners

Dear Fellow Music Therapists:

You are invited to participate in a research study to examine how (a) music therapy services are used in early childhood settings and (b) music therapy interventions aid in the development of social skills in young children with disabilities. This research project is part of the Master's thesis requirement for Sayaka Abe, a music therapy graduate student at Western Michigan University. Your name and e-mail address were received from the American Music Therapy Association Member Sourcebook 2003. This survey will take approximately 15 minutes to complete. Results obtained from the survey may provide valuable information regarding the future development of music therapy services with this population.

Clicking on the link below will take you directly to the survey website. This site will be available to you until (February 18, 2004). This site is created through with the help of online company SurveyMonkey.com®.

<http://www.surveymonkey.com/s.asp?u=22797369103>

If you choose not to participate or to withdraw from the survey at any time, there will be no penalty. All information from the survey and your e-mail address will be kept confidential.

If any questions or concerns arise prior in completing this online survey, you may contact Sayaka Abe at Sayaka.Abe@wmich.edu, telephone (269) 387-5861 and my faculty adviser, Professor Brian Wilson at (269) 387-4724. If you have any questions or concerns about your rights as a participant in this research study, please contact Western Michigan University's Human Subjects Institutional Review Board at (269) 387-8928 or the Vice President for Research (269)-387-8298. This consent document has been approved for use for one year by the University's Human Subjects Institutional Review Board (HSIRB) on (January 26, 2004). You should not participate after (January 26, 2005).

Thank you for your time and willingness to assist me.
Sincerely,

Sayaka Abe

Appendix B
Human Subjects Institutional Review
Board Approval Letter



Date: January 26, 2004

To: Brian Wilson, Principal Investigator
Sayaka Abe, Student Investigator for thesis

From: Mary Lagerwey, Ph.D., Chair *May*

Re: HSIRB Project Number 04-01-18

This letter will serve as confirmation that your research project entitled "Music Therapy and Social Skills in Young Children with Disabilities: A Survey of Music Therapy Practitioners" has been **approved** under the **exempt** category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may **only** conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: January 26, 2005

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