PEDIATRIC MUSIC THERAPY

ABOUT THE AUTHOR

Wanda B. Lathom-Radocy, MT-BC, received Bachelor's, Master's, and Ph.D. degrees in music education and music therapy from The University of Kansas. Her professional positions included teaching elementary and junior high music in Clay Center, Kansas; Director of Music Therapy at Parsons (KS) State Hospital and Training School; and teaching assistant to Dr. E. Thayer Gaston, RMT. Dr. Lathom-Radocy initiated music therapy curricula at Montclair State University and The University of Missouri–Kansas City. She was president of the National Association for Music Therapy, wrote and co-directed a federal grant project to train music therapists to give information workshops to increase awareness of the role of music therapy in schools, and has clinical experience with many handicapped children. An honorary life member of both the Midwestern Regional Music Therapy Association and American Music Therapy Association, Dr. Lathom-Radocy has published numerous professional articles and given presentations at various national and international conferences. UMKC recognized her professional contributions with the designation of Professor Emerita.

PEDIATRIC MUSIC THERAPY

By

WANDA B. LATHOM-RADOCY, PH.D, MT-BC

Professor Emerita
University of Missouri–Kansas City

Charles C Thomas
PUBLISHER · LTD.
SPRINGFIELD · ILLINOIS · U.S.A.

Published and Distributed Throughout the World by

CHARLES C THOMAS • PUBLISHER, LTD.
2600 South First Street
Springfield, Illinois 62704

ISBN 0-398-07301-5 (hard)
ISBN 0-398-07302-3 (paper)

Library of Congress Catalog Card Number: 2002020688

With THOMAS BOOKS *careful attention is given to all details of manufacturing and design. It is the Publisher's desire to present books that are satisfactory as to their physical qualities and artistic possibilities and appropriate for their particular use.* THOMAS BOOKS *will be true to those laws of quality that assure a good name and good will.*

Printed in the United States of America
MM-R-3

Library of Congress Cataloging-in-Publication Data

Lathom, Wanda, 1936-
Pediatric music therapy / by Wanda B. Lathom-Radocy.
p. cm.
Includes bibliographical references and indexes.
ISBN 0-398-07301-5 (hard) -- ISBN 0-398-07302-3 (paper)
1. Music therapy for children. I. Title.

ML3920 .L38 2002
615.8'5154'083--dc21 2002020688

PREFACE

Public Law 94–142, passed in 1975, requires a free public education in the least restrictive environment for all handicapped children. This law later was changed, somewhat, and published as the Individuals with Disabilities Education Act (IDEA) (Public Law 101–476, 1990). These laws were passed to provide the services needed for a handicapped child to receive education in an environment as close to a "regular" school setting as possible, given the child's needs. This is called the "least restrictive environment" in the law. Many children who had been in residential care were returned to their communities to attend public school, where they were to receive the special services necessary for success. The law recognized that the family would provide the long-term support for a disabled child. Implementation of the law included providing funds, through the U.S. Department of Education, Office of Special Education, for training personnel and disseminating information regarding utilization of special services required in the education of handicapped children.

The National Association for Music Therapy received grant funds from 1979–1982 for a "Special Project: A National In-Service Training Model for Educational Personnel Providing Music Education/Therapy for Severely/Profoundly Handicapped Children" (Grant No. GOO 709 1336). A manual to conduct in-service training workshops for music educators, administrators, parents, and special educators was written for use by music therapists when giving in-service workshops. The music therapists who would be giving the workshops were then brought together for two train-the-trainer institutes held at Texas Women's University, Denton, Texas in 1980 and 1981. In addition to learning to use the training modules, each music therapist gave a presentation regarding treatment or training procedures, research, or special media regarding each of the handicapping conditions defined in PL 94–142. From these presentations, monographs were prepared, to make information available for each trainer to use in workshops (Lathom & Eagle, 1982). Thus, small teams wrote, prepared case history material, and searched for related literature and research related to each handicapping condition. Since the funding was relat-

ed to severely/profoundly handicapped children, the areas of learning disabilities and gifted were not included in the monograph series. Each monograph was extensively reviewed by Institute participants, outside evaluators, and other music therapists throughout the country. This book is not an attempt to make a later edition of the monographs, but is an independent book that covers characteristics of many of the same populations that were discussed in the monographs. It particularly includes literature since 1980, when the monographs were written.

An important part of the Institutes and monograph preparation was the search for related literature. Charles T. Eagle, Jr. Ph.D., RMT-BC, Director of Music Therapy at Southern Methodist University, served as Project Training Coordinator, and searched for bibliographic citations through the Computer-Assisted Information Retrieval Service System (CAIRSS) for Music (Eagle, 1982). Many citations were abstracted, and a 176-item annotated bibliography was prepared for use at the first Institute. By the second Institute, 501 items were annotated and provided to each trainer. This search was of value in preparing the monographs as well as preparation for workshops. Media presentations, in the form of a videotape and a slide show were prepared by the media team of the Institutes. These, too, were used in workshops.

Since the second Institute, a further annotating and indexing project extended the bibliography to 1000 items. This was conducted by Project Director Wanda Lathom, Ph.D., RMT-BC, Director of Music Therapy, University of Missouri-Kansas City with the assistance of many undergraduate and graduate students. This project was funded by a University of Missouri-Kansas City Faculty Research Grant. Dr. Eagle has continued the CAIRSS project and has provided additional annotated citations. This book's content reflects much literature appearing since the initial monograph publication. However, its primary emphasis is to provide information to help music therapists understand the characteristics of children seen in practice. Much available music therapy reference material is not included. If this book is used as a text, primary literature in the field of music therapy should be assigned to supplement the text. It is assumed that the music therapy students reading this book will have had some background in anatomy and physiology, psychology, and special education, since courses in these areas are required in a music therapy curriculum.

REFERENCES

Eagle, C. T. Jr. (1982). *Music therapy for handicapped individuals: An annotated and indexed bibliography.* Washington, DC: National Association for Music Therapy, Inc.

Lathom, W. B., & Eagle, C. T. Jr. (Eds.) (1982). *Music therapy for handicapped children* (Vols. 1–3). St. Louis, MO: MMB Music, Inc.

INTRODUCTION

While a free public education had been promised to all children in the United States for many years, children with disabilities often were unable to receive the necessary specialized services to allow them to benefit from education in their home community. Legal and philosophical developments during the past quarter century have had profound influences. Consider the case history of Laura:

> Laura is a ten-year-old girl with severe physical abnormalities, including two sets of eyebrows, severe hyperthyroidism, rudimentary ears, front nasal dysplagia, and malformations of the oral cavity. Her sight and hearing are impaired, as are her psychomotor abilities. Upon first observations, Laura spontaneously explores her environment, touching it and looking at it, or engages in self-stimulatory behavior, such as hand staring or finger-flicking.
>
> Group goals established for Laura's class are to increase environmental and peer awareness, increase awareness of causality, and develop imitative skills. Individual goals established for Laura are to develop self-awareness, extend her attention, and social skills. The service responsible for helping Laura achieve these goals is music therapy. Laura has been seen once weekly for group music therapy in the Day School Unit and twice weekly for group music therapy in the In-Patient Unit at the Mental Retardation Center. Her attendance has been good.
>
> Because of the physical abnormalities of her oral cavity, Laura currently is incapable of expressive speech. She does exhibit glottal vocalizations during group music therapy; these vary in quality and seemingly relate to frustration, anger, discomfort, or pleasure. Receptively, Laura follows simple verbal commands. Her expressive language is not commensurate with her receptive abilities. Laura exhibits adequate gross and fine motor coordination and balance for accomplishing music tasks. Her attention span seems short, and her ability to focus on a task is limited. However, Laura has shown progress in this area. Her treatment team felt that these abilities can be developed by interrupting inappropriate behavior and guiding her back to the task.

Some of the material in this Introduction and in Chapter 1 was included in Lathom, W. B. (1980) *The Role of the Music Therapist in the Education of Severely and Profoundly Handicapped Children and Youth*, a report prepared for use in workshops or seminars given as part of the National Association for Music Therapy "Special Project: A National In-Service Training Model for Educational Personnel Providing Music Education/Therapy to Severely/Profoundly Handicapped Children." Bureau of Education for the Handicapped, Grant Number GOO7091336.

> Laura explores music materials in a purposeful manner. For example, she spontaneously and discriminately locates specific music material on the equipment cart, such as a tone bell and stick beater, and hits the tone bell with the beater to produce sound. She usually holds materials close to her left eye, which affords her better vision. Laura occasionally has imitated a visual model by using music materials to demonstrate new methods of sound production. Her interaction with music materials is not directed toward self-stimulation but rather toward sensory input. Laura demonstrates knowledge of some spatial relationships related to music tasks and shows acquisition of self-help skills.
>
> In music therapy, Laura has shown the most growth, socially and affectively. Generally, she is a passive participant in all music activities in that she sits within the group and appears aware of her environment. However, she participates actively if physically prompted or if materials are placed close to her. Laura demonstrates development of interpersonal relationships by recognizing familiar authority figures, approaching them spontaneously, and holding their hand. She initiates physical affection such as hugging and sitting on laps, and she has begun "smiling" (upward twitches of sides of mouth) and laughing during pleasurable experiences and crying when gratifying materials are taken away or when she is physically hurt by one of her peers.
>
> Music therapy has been instrumental in Laura's social, emotional, and cognitive growth. The positive changes in these aspects of her behavior and levels of communication relate directly to the intervention of the music therapy program in which she participates. It is therefore recommended that Laura continue to be seen three times weekly for group music therapy sessions and that her program goals be continued.
>
> Laura is typical of a client who would have spent most of her childhood in an institution before PL 94–142 was passed. Now, she is most likely to remain in the community, attend a public school, and participate, to whatever extent possible, in social and recreational events enjoyed by all children. Her long-term expectation probably would be to live in a group home, participate in supervised employment, and have a level of independence that would have been considered impossible twenty-five years ago. Thus, the service delivery and goals in music therapy must be different, too.

The goals of education and therapy for this child ultimately are no different than for all others: to help the individual be the best he or she can be. Maslow (1971) states this concept:

> Stated simply, such a concept holds that the function of education, the goal of education–the human goal, the humanistic goal, the goal so far as human beings are concerned–is ultimately the "self-actualization" of a person, the becoming fully human, the development of the fullest height that the human species can stand up to or that the particular individual can come to. In a less technical way, it is helping the person to become the best that he is able to become. (pp. 168–169)

Thus, the goal for a college student, a client in a mental health facility, or a child with a disability is the same: to become the best that he or she is able to become. To be "fully human," it is important to experience the full realm of human expression. A handicapped child can experience all human feelings–joy, compassion, anger, and the insensitivity of others. Yet the child's lack of communication skills may make it difficult to express feelings. The

arts provide a vehicle to let all people "get in touch" with feelings and to communicate those strong emotions nonverbally. Sharing of human feelings in ways acceptable in one's culture is important for all children, but especially for a child who is limited in many other forms of communication. Almost all children respond to music, and most express great pleasure through participation. A child who is to "reach the fullest height" must be aware of the range of available feelings and must have a means of communicating them to others. Through the arts, this is possible, even for severely/profoundly handicapped children.

THE LEAST RESTRICTIVE ENVIRONMENT

The least restrictive environment clause of the law requires each state to establish procedures to assure all handicapped children receive a free appropriate education. "Appropriate" means that the child can benefit from the experience and can be expected to succeed and make progress toward acting independently. Unfortunately, this has not always been the case when children have been "mainstreamed." The term "mainstream" was never used in PL 94–142, nor has it been in the current version, called IDEA (Individuals with Disabilities Education Act, 1990). Rather, it was an attempt to express the desire to include handicapped individuals with those who were not handicapped, thus reducing the isolation and stigma that had resulted from institutionalization and a general misunderstanding of the capability of handicapped people. Safford and Rosen (1981) summarize the principle of mainstreaming when they note that "participation in educational programs with nonhandicapped peers, to the extent appropriate [for the child with a disability] is an essential aspect of an appropriate education" (p. 2). As a comprehensive official definition, the following was approved by the Council for Exceptional Children's Delegate Assembly in April 1976:

> Mainstreaming is a belief which involves an educational placement procedure and a process for exceptional children, based on the conviction that each such child should be educated in the least restrictive environment in which his educational and related needs can be satisfactorily provided. This concept recognizes that exceptional children have a wide range of special educational needs, varying greatly in intensity and duration; that there is a recognized continuum of educational settings which may, at a given time, be appropriate for an individual child's needs; that to the maximum extent appropriate, exceptional children should be educated with nonexceptional children; and that special classes, separate schooling, or other removal of an exceptional child from education with nonexceptional children should occur only when the intensity of the child's special education and related needs is such that they cannot be satisfied in an environment including nonexceptional children, even with the provision of supplementary aids and services.

Today, the term "inclusion" is used in addition to "mainstreaming." Inclusion means that the child's primary placement is in a regular classroom. The teacher may be assisted by specialists, but the majority of the child's time is with his or her class. Placement decisions are made by the team writing the child's Individualized Education Plan (IEP), which must include input from parents and even the child if he or she is capable of making decisions. Entering an IEP meeting with a preconceived program in mind, before any parental input, is against the law's intent. As administrators and attorneys are well aware, educators must avoid appearing to have any preconceived placement plans prior to hearing from parents in the context of a multidisciplinary staff meeting (Smelter, Rasch, & Yudewitz, 1994, p. 37). For IDEA money to fund music therapy, the IEP *must* include music therapy, and the parent must have input into the process of program determination. If the parent also is disabled, he or she may have additional rights under Section 504 of the Rehabilitation Act.

All 50 states have accepted funding under IDEA, so all are required to assure that all children with disabilities receive a free appropriate education. Both mainstreaming and inclusion may miss the linkage between "least restrictive environment" and "appropriate." Inclusion is done in the best interest of the child, but, as the literature suggests (e.g., Baines, Baines, & Masterson, 1994; Smelter, Rasch, & Yudewitz, 1994), ideology and parental demands may override educational and therapeutic considerations. Careful painstaking attention to details of goals, objectives, implementation of intervention strategies, and rationale for any particular course of action, supported by extensive documentation, is essential for building a case for particular actions.

"Mainstreaming" has been especially misused in music, art, and physical education classes, where children from special education classes are most often included with nonhandicapped children. If the child is unable to participate and is not provided with necessary supplementary services to help him or her gain the requisite skills to participate, this is not the least restrictive environment. It is inappropriate mainstreaming. Placing a child in band when he or she does not play an instrument is not appropriate. Placing a student in a choral ensemble when he or she cannot read the words or music is not appropriate. Placing a wheelchair-bound child in the back of the class to "watch" the fourth grade have music class is not appropriate. Yet, each of these examples have been reported many times. In the United States, schools must be responsible for demonstrating appropriateness of all educational experiences. One way to supplement the mainstreamed music class is to offer either alternative or supplementary special services by a music therapist or music educator with additional special education background. To the

greatest extent possible, handicapped children should participate with nonhandicapped children. Only when the child cannot achieve, even with supplementary aids and services, should separate classes be considered. Even then, placement close to his or her home should be provided. This concept was stated in 1973 in the Section 504 regulations of the Vocational Rehabilitation Act Amendment (PL 93–112), as well as in PL 94–142.

Some children's educational needs are best met in special education classes, special schools, or even residential facilities where 24-hour care and training can occur. The needs of each child must be considered and placement in the least restrictive environment must be made. Instruction in the home or hospital may be necessary, especially if the child has a health impairment that prevents him or her from attending classes. Music therapists can offer related services to help children benefit from education in regular classes, special education classes, resource rooms, special schools, hospitals, residential care, or home care. PL 94–142 recognized music therapy as a related service.

INDIVIDUALIZED EDUCATION PROGRAM

Each child who is a potential candidate for special services must be evaluated to determine need and appropriate placement in a special education program. The results of the initial evaluation are stated in the child's Individualized Education Program (IEP). Participation in the regular education program, *to the maximum extent appropriate*, depends on the child's particular needs. The IEP also lists the related services needed to assist the child to benefit from education, the initial goals and objectives, and time lines for their accomplishment. If music therapy is utilized as a related service, the music therapist should assess each child and state goals and objectives in the IEP. Each state has legislation relating to implementation of the federal law. Although PL 94–142 stated that music therapy was a recognized related service, funding often relates to the state legislation, which may not include music therapy. Thus, it is important for music therapists to inform legislators about their role, and to assure that music therapy appears on the IEP of each child they serve. Since the case load is often large, this requires much extra work for a music therapist. However, funding directly relates to the IEP, so it is very important to state goals and objectives for each child. The alternative is for the school district, hospital, or institution to hire a music therapist without receiving state or federal reimbursement. Although this is done in states where music therapy is not included in state legislation, it limits the number of positions available. Thus, children who could greatly benefit from music therapy as a related service may be denied the service.

FULL PARTICIPATION IN EDUCATIONAL OPPORTUNITIES

Arts programs should be a part of every child's education. One of the concepts basic to the public law is that handicapped children should have access to full participation in education. Part of PL 94–142 stated that "Each state and educational agency shall take steps to insure that handicapped children have available to them the variety of programs and services available to nonhandicapped children including art, music, industrial arts, home economics, and vocational education" (Section 121a23, Regulations). The rules and regulations governing this Act go on to say that artistic and cultural programs, arts, music, and dance therapy may be among the related services offered to handicapped children if they are required to assist the child in benefitting from special education (Section 121a23, Comment, Regulations).

Music therapy uses music to improve verbal and nonverbal communication and social, emotional, academic, and motor behavior. Music therapists are highly trained specialists who provide services to handicapped individuals of all ages and with all types of disabilities. The music therapist first observes and evaluates the child and then makes recommendations to all other personnel involved in the child's program. The result is an IEP specifying goals and objectives, personnel assigned to help meet these objectives, and the time needed to attain these objectives. A parent or guardian and the administrator then signs the IEP.

The music therapist establishes specific procedures and then initiates the service on an individual or group basis. Singing, moving, playing, listening, discussing, and creating are the types of activities the music therapist will use in the individual or group sessions. Frequent consultations with other involved personnel are necessary if the child's program is to be effective. In particular, the music therapist must consult the parents and keep them apprised of their child's progress and of how they can assist the child at home. All those involved in the child's education and/or treatment program should have access to documentation of services offered, further assessments made at time periods specified on the IEP, and information on subsequent changes in program or termination of services.

Seeking to define the tasks of a music therapist who worked with children, Lathom (1982), surveyed 164 music therapists working in settings with a special education component, including public and private schools or other special education facilities, residential facilities, and children's treatment centers. Two-thirds of the respondents had worked for one to five years in a facility with a special education department. The survey showed that music therapists spent a substantial amount of time (over 45%) in the following five activities:

1. Implementing music therapy programs in groups. Because music often requires more than on participant, it can be a very effective group activity. Experience in taking turns, considering other people, cooperating with others, and feeling responsibility to the group can all occur when children play musical games, sing, listen to music together, or play instruments in an ensemble. With praise and acknowledgment of these behaviors, there is considerable carryover to behavior in nonmusical groups. When carefully planned musical activities are performed successfully and applauded by the therapist/teacher or the other children in the group, a child can feel proud.
2. Implementing music therapy programs one to one. Some children need the therapist's full attention before they are ready for group activity. Thus, many effective programs start with individual sessions, move to a small group (two to four children) activity, and then expand to larger groups (an entire class or combination of several small groups). Sufficient time should be allotted for frequent contact with children who must start with one-to-one treatment/education programs.
3. Planning music therapy programs. Changing the child's behavior requires careful planning by the music therapist. For successful performance, musical activities must be within the child's skill and ability level. The child's ability to work with others in the group must be considered, as well as the ability to follow instructions, complete tasks, and maintain impulse control while waiting to be the focus of attention. The child's relationship with the therapist is an important consideration if praise and attention are to be used to reinforce the child's behavior.
4. Preparing music therapy goals/outcomes for the child's Individualized Education Plan. Music therapy should be based on objective observation and evaluation that is shared with others on the IEP team. It is best if the music therapist can attend the staffing conference with the child's teacher, the school administrator, the parent(s), and other who will contribute to the child's education and treatment. This staff conference can provide the music therapist with the information necessary to implement a program that will meet the child's special needs.
5. Preparing reports, letters, and filing. After preparing the initial evaluation report, the music therapist maintains daily progress notes which are summarized periodically and sent to others who work with the child. It is important that the therapist keep progress notes in a central file so that accountability of service provided can be documented. Although frequent contact with the parents is desirable, this is often difficult to arrange. If revisions in the initial IEP are required, the music therapist should inform the parents of their child's progress in writing. Other reports, such as those

stating reasons for termination or other recommendations, should also summarize progress in the child's treatment program.

Since the first task in service provision is to assess the child's abilities and needs, the first chapter of this book discusses assessment procedures for children in music therapy. The following chapter discusses typical goals and objectives for children with disabilities. Subsequent chapters discuss various disabilities and ways in which music therapy may serve children with these problems.

Music therapy may play a significant role in enhancing communication, academic achievement, motor skills, emotional expression, organizational skills, and social skills. The overall goal of all education and treatment is always to assist the individual to become an independent, productive member of society to the highest extent possible. This leads to a life of greater happiness and fulfillment than was possible when individuals with disabilities were viewed as a burden on society.

REFERENCES

Baines, L., Baines, C., & Masterson, C. (1994). Mainstreaming: One school's reality. *Phi Delta Kappan, 76*, 39–40, 57–64.

Lathom, W. B. (1982). Survey of current functions of a music therapist. *Journal of Music Therapy, 19*, 1982, 2–27.

Maslow, A. H. (1971). *The further reaches of human nature.* New York: Viking Press.

Safford, P. I., & Rosen, L. A. (1981). Mainstreaming: Application of a philosophical principle in an integrated kindergarten program. *Topics in Early Childhood Special Education, 1*(1), 1–10.

Smelter, R. W., Rasch, B. W., & Yudewitz, G. J. (1994). Thinking of inclusion for all special needs students? Better think again. *Phi Delta Kappan, 76*, 35–38.

Note: To obtain a copy of Public Law 94–142, The Education of Handicapped Act, 1975, or Public Law 101–476, The Individuals with Disabilities Education Act, 1990, write your U.S. representative or to one of your U.S. senators. The final regulations for Public Law 94–142 are published in the *Federal Register* for Tuesday, August 23, 1977. The final regulations for Section 504 of Public Law 93–112 are in the *Federal Register* for Wednesday, May 4, 1977. The *Federal Register* is available at most public libraries.

ACKNOWLEDGMENTS

This project has required research in several libraries. The author especially thanks the libraries at the University of Missouri-Kansas City; University of Kansas (both medical and campus facilities); and Dr. William Hipp, Dean of the School of Music at the University of Miami, for facilitating use of the medical and campus libraries at that university. Both professional associates and former students have provided encouragement and motivation to complete this book. The author is especially grateful to her husband, Rudolf E. Radocy, for his patience during the project as well as valuable editorial comments. Without this assistance, the book might never have been completed.

CONTENTS

PEDIATRIC MUSIC THERAPY

Chapter 1

MUSIC THERAPY ASSESSMENT OF HANDICAPPED CHILDREN

Assessment of every potential client is necessary to determine whether or not music therapy might be of use in his or her total program. If music therapy appears viable, a baseline description of the client's entering behaviors is important for subsequent evaluation of progress.

The evaluation should lead to a statement of recommendations. This is possible only if the therapist has elicited behaviors in several categories: Communication, Academic or Cognitive, Motor, Emotional, Organizational, and Social (CAMEOS) (Eagle, 1982, p. 21). The literature supports using music therapy in achieving goals in each of these areas. Determining the child's current level of functioning can reveal deficiencies, which lead to program recommendations. Of equal importance, assessment should reveal strengths. Helping children to be aware of strengths and use them effectively, while coping with remediating deficiencies, is essential to treatment through music therapy.

CONTENT OF THE ASSESSMENT SESSION

All evaluations should include demographic information: name, sex, address (classroom, home, location within a hospital, or wherever the child is currently residing), age, school, and grade. In some instances, it may be important to include the name of the person making the referral (physician, teacher, parent, other therapist, etc.). At times, it may be important to include a number to call in case of medical emergencies. This is especially important for children with health problems. The therapist writing the report should provide his or her name, and the date of the observation(s) and the date on which the report was written.

The first paragraph of an assessment should describe the child's appearance. "Billy is 4'3" tall, weighs about 50 lbs, has brown eyes, red hair, and freckles. He wears a baseball cap and is very reluctant to remove it." Such a description allows members of the treatment team to be sure they are speaking of the same child, or to refresh their memories if they are confused about names of several children who are being evaluated at the same time.

Salend and Salend (1985) caution observers to *describe* rather than *interpret* behavior. They further suggest that the examiner note the child's "approach to the testing situation, attention to task, idiosyncrasies, self-concept and response style" (p. 282).

This information may be included in the section on description of the child, or it may be more appropriate in later sections of the report.

To meet the requirements of PL 94–142, assessment must not be discriminatory regarding cultural or racial differences. Kratochwill and Cancelli (1982) observe that "The stigma attached to labeling a disproportionate number of culturally different individuals retarded and the perceived insulting nature of a premature conclusion that one group of people is less intelligent than another is not only cause for concern but to some, reprehensible" (p. 7). Whenever possible, children should be given instructions in their native language or preferred mode of communication. This is essential if standardized tests are used. There are cultural differences in learning style, desire for structure in presentation of materials, ability and willingness to reveal or discuss emotional issues, and differences in desired level of sound and light stimulation (Dunn & Griggs, 1995). Assessment by a multidisciplinary team helps insure that bias will be less than when decisions are made by any one individual. A variety of ways to obtain information about a child's ability leads to a much better assessment. In a music therapy environment, children may feel less threatened and be more likely to engage in activities they regard as play or fun than in more formal testing environments. Both are needed, since they supplement the information needed for a more complete and accurate assessment.

COMMUNICATION SKILLS

Assessment of communication should include observations of both verbal and nonverbal communication skills. Each of these categories should include receptive and expressive communication. While ability to read and write is important to communication, it is usually evaluated under the category titled "Academic/Cognitive Skills." Use of notation may be evaluated with music skills.

Verbal Expressive Skills

As the child enters the music therapy area, the therapist should initiate conversation. This establishes rapport and a relaxed, comfortable environment. Note any verbal responses made by the client. Is his or her speech understandable? If not, describe the problem: articulation error? Inappropriate loudness level? Substitution or omissions? Are complete sentences used? Is the grammar and word choice appropriate?

Verbal Receptive Skills

Next, give simple one-sentence directions to participate in a music activity: "Clap your hands." "Tap your toe." "Ring the bell." When you have observed these verbal receptive language skills, try two-sentence directions: "Choose an instrument from this box. Hold it, quietly, on your lap." "Stand and march in place." "Take hold of the parachute. Lift it to your waist." These instructions require knowledge of vocabulary. You should give the direction, *wait for the response*, and note which children can respond. When you give the directive, try not to model the behavior. If you do, you will be uncertain if the child responded to verbal or nonverbal content of your communication. After you have waited for an adequate time, if the child has not responded, repeat the verbal command. If there is still no response, model the behavior, and repeat if necessary. A last attempt is to hand-shape the behavior. Take the child's hand and gently assist him or her in making the desired response while pairing it with the verbal command.

It is essential that you exhibit patience in allowing the child adequate time to process the request and organize the response. Many children can respond if allowed enough time, but they quickly give up if they feel rushed. Rowe (1987) recognizes two types of classroom "wait time": time for students to respond to questions (wait-time I) and time for the teacher to respond to student answers (wait-time II). The second type of wait-time has had more research, since the response to the student's behavior may be reinforcing. Research suggests that if this delay is too long, other behaviors may occur and be accidently reinforced, thus producing an undesired response pattern (sometimes called superstitious behavior). Patience in wait-time I is likely to lead to a far better assessment, since many exceptional children require a longer time to process instructions and initiate a response. If the child is not responding, try waiting longer. Be careful not to create anxiety by the expectation that the child respond immediately or quickly. In music therapy, a more relaxed response time may be established by keeping a steady beat going and allowing the child to join in the task when he or she feels ready. A comfortable social climate, clear instructions in as few words as possible, nonverbal models of the expected behavior, if needed, and time for organizing and performing the motor response will lead to a better assessment of the child's highest level of behavior. Of course, there are some children who understand what you want them to do, but choose not to do so. This will become evident as the session progresses. However, there are so many ways to elicit behavior in a music therapy session that you can usually find a way to get a response, even from the most uncooperative child.

If you are uncertain if the child is following verbal instructions or imitating others, you may need to give different individualized instructions to each child. Imitation is an important skill, too, and should be noted. However, the intent in this part of the assessment is to test complex receptive verbal skills.

Many songs allow the child to fill in a blank in the lyrics: "My name is _____." "My favorite food is _____." To further test verbal skills, use songs which allow a single word response. Next, use an activity which requires the child to provide a phrase, then a complete sentence.

Communication skills can be further noted when you observe social skills. You may find that he or she talks freely with peers but will say nothing to adults (or vice versa). If a child is from a home where adults were punishing and older siblings provided protection, he or she may speak only to older children. A child who has been frequently hospitalized and requires close supervision when at home may have little experience with peers but will talk freely to adults. Both ability and style of communication should be recorded. Usually the treatment team is not interested in verbal content or a description of music procedures used to elicit these behaviors.

Nonverbal Expressive Skills

Be aware of facial expressions and other body language that the child uses to express feelings. How does he or she show pleasure? Anxiety? Frustration? Anger? Is this a child who is freely able to express feelings, or is he or she inhibited? If so, is the child indicating shyness, fear, or a lack of appropriate repertoire of nonverbal expressive behaviors? A nonverbal child may still be able to demonstrate expressive communication by using finger spelling, manual communication, or pointing to language boards. You may also include testing that allows "Yes/No" answers