# Music Therapy Groupwork with Special Needs Children

# MUSIC THERAPY GROUPWORK WITH SPECIAL NEEDS CHILDREN

## The Evolving Process

*By*

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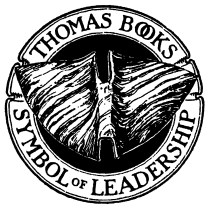


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*This book is written in honor of my parents,*
*Ruth and Daniel Goodman,*
*who continue to teach me love, optimism, and industry.*

# Preface

I write the preface to *Music Therapy Groupwork with Special Needs Children* after having written the book. Writing the book has crystallized my ideas after so many years of groupwork and yet raised more thoughts and even controversy. This is gratifying for it demonstrates that the material remains stimulating to me, even after so many years of practice.

I continue to be inspired by the moments of sheer joy while making music, my original impetus to enter the field of music therapy, and trust that you can provide some of these moments for your clients. I continue to be impressed with the value of the music itself in reaching children, and helping to mobilize a group

The field of music therapy continues to grow and, along with that growth, birth new applications of music therapy in groupwork. Whereas many therapists in the field began working with children of special needs, previously referred to as "handicapped," we also work with children in medical settings, in hospice, in dysfunctional families and in community crisis. Further, the move toward inclusion places many higher-functioning special needs children in the music room of the music educator where the music therapist frequently consults. These additional clinical settings are a statement about our added perspective in helping children as well as changes in society over the past decades. In writing the book, I found it difficult to delimit the focus. Nevertheless, I did. Therefore, please be certain that while the focus of the book is with children in self-contained educational settings and child psychiatric settings, this is a beginning, not an end. I chose to focus on these latter areas because, frankly, they are the areas of practice I spent so many years practicing.

In working effectively and thoughtfully with the children, I developed many concepts over the years and share these with you in the book. Since most of the book is not written in the first person, please understand that any idea that is not referenced in the book is an original idea on my part.

Above all, I hope to develop the therapist's sensibility *to work effectively toward the formation of a cohesive group with children who have different functioning levels, different temperaments and different musical preferences.* In order to achieve this end, *the therapist must employ different developmental expectations (goals and objectives) for each child, adaptation in the presentation of the music and varying methods while simultaneously encouraging the sense of group.* These con-

cepts stand in contrast to an approach where the clinician establishes the same generic goals for group members and presents material, without adaptation, on a uniform level with the hope that the group will become cohesive as time passes.

I have also made a concerted effort in the book to convey my integration of multiple approaches in music therapy. Music therapy, particularly in the group, can feel like a balancing act. The art and science of music therapy encourages the therapist to find a relationship-based approach with the children through making music, much of which is a creative spontaneous process. At the same time, we are called upon to structure and document changing behaviors, which allow the children to find increasing independence as they make their ways in the world. This balancing act, between structure and freedom, can call upon different approaches, approaches gleaned from the worlds of cognitive-behavioral, humanism, psychodynamic theory and group theory.

Throughout the eight chapters, I provide multiple clinical vignettes from my clinical work, which will serve to demonstrate my theoretical perspectives. Certainly the review of many years of my case notes has given me an additional opportunity to reflect on, and be thankful for my work.

The first chapter, "The Story of a Group," presents my thinking process as I proceed with a seemingly disparate group of children. This thought process brings the reader through the various stages of working with a group: assessment of individual children within the prospective group, considering the children as a potential group, organization of long-term goals, formulation of music therapy objectives, methods and materials for beginning sessions, considerations regarding how to evaluate the music therapy sessions and problem solving as sessions proceed over the following year. The first chapter, in effect, is the groundwork for all subsequent chapters.

The second chapter, on assessment, provides a healthy review of the literature. The area of assessment is one that has actually received a great deal of attention in the last two decades, more so than evaluation. Assessment works most effectively when the tool used is specific to the developmental level of the child and theoretical purpose of the music therapy work itself. Using published or previously published assessment tools, including an assessment I authored for disturbed children in 1989, casework is presented to demonstrate some of the very real questions about the efficacy of various assessment tools. The task of music therapy assessment for provision of services on the Individual Education Plan (IEP), a consulting role I am frequently asked to provide, is also discussed.

The third chapter, the writing that actually started the entire book, reflects on the clinician's choices in providing individual or group therapy. It explains the structure of the group in the special education and the child psychiatric settings, presents ideas regarding developmental prerequisites for

groupwork and helps the clinician consider what I term "core considerations in forming a group," including developmental appropriateness, sensory appropriateness, musical appropriateness, and last but not least, the practical realities of the facility.

The fourth and fifth chapters bring the reader through the process of long-term goal planning and short-term music therapy objective planning, a necessary process for many school systems and hospitals that hold the therapist accountable for progress. While these chapters may try the patience of the reader and seem contrary to an artistic process, they are necessary details toward the documentation of progress. They also demonstrate the variability of how goals were presented in the Individual Education Plan in the past versus the federal mandate for their presentation in the present. Although many therapists practice groupwork with generic types of goals for the children, the option to clearly conform to following the IEP goals, although problematic, is presented along with practical suggestions to simplify the process (i.e., Chapter 4 presents my suggestions for organizing the IEP goals and prioritizing them for use as group music therapy goals). Most importantly, music therapists, from the unique perspective of music therapy, have a role in changing or adding goals to the individual education plan; a seasoned clinician will exercise this prerogative.

The sixth chapter, "Materials," begins to introduce the reader to the myriad of possibilities for interventions through music, the primary tool of the music therapist or "musical therapist" as some innocently refer to us. The considerations in selecting and creating vocal, instrumental, movement and listening materials are presented to the therapist as part of an overall effort in the book to emphasize the thoughtful use of the music as a selective tool. As a practical measure, I include a listing of materials I used over a five-year period with multiply handicapped children. While it was not possible to detail all the ways in which I adapted almost all of the materials to suit the spontaneous reactions of the children in the group, I hope that the reader will, through a series of case examples in this chapter (see my "General and Specific Continuum of Music Response"), begin to understand the necessity for simultaneously using music with different expectations from members of the group, a necessity that requires musical reactivity and improvisation on the part of the therapist.

Chapter 7, "Methods," dense as it is, draws on possibilities which all involve basic principles of music therapy. In this chapter I identify and discuss all the variables that have to be considered as the therapist devises music therapy methods: 1) the space being used for music therapy; 2) the physical arrangement of the group; 3) activity levels consistent with developmental functioning; 4) diagnosis of the child; 5) goals and objectives for all group members; 6) how to incorporate other professionals into the music therapy session; 7) strategies promoting group process, 8) suggested session format;

9) adaptive nature of methodology; and 10) consideration of the therapist's knowledge base and philosophy of helping. Methods are as variable as the plethora of clinical situations we find ourselves in. Suggestions for the beginning therapist to detail method in a session plan are included in this chapter. This chapter will stimulate the clinician to think in terms of many kinds of challenging conditions requiring different emphases in methodology. The concept of working with the group as a group of children with individual needs is vital to understanding the juggling act of using different methods with different children in the group even while the children work together to become a group.

Finally, the eighth chapter reflects on evaluation, the objective and subjective pieces of this process, and the issues regarding documentation in a creative arts process. Evaluation is multifaceted and serves not only to keep track of how the children are doing in the session week-to-week but also to educate the clinician in a continuing effort for self-growth. The celebration of subjective evaluation in this chapter recognizes that part of evaluation that helps the therapist in terms of self-growth and examining the process of music therapy.

*Music Therapy Groupwork with Special Needs Children, The Evolving Process,* is broad in scope. Not only do the children in the group change as a result of the music therapy process but so does the therapist in understanding and adapting to the needs of the group. The book presents a combination of beginning, intermediate and advanced level concepts. Feel free to focus on the chapters that appeal to your level of training. It is an ideal resource for the student entering the field of music therapy (who will profit from the study guide questions at the end of each chapter), the beginning therapist beginning to cope with the demands of group practice, the seasoned clinician reconsidering long-standing ways of conducting the group and the allied professional working with the music therapist.

Writing this book has provided an opportunity to share, beyond my immediate classroom at Montclair State University, all the ideas I have formulated over the many years working with groups of children. I sincerely hope that the reader finds value in the ideas I present and uses these ideas to further the profession of music therapy.

KAREN D. GOODMAN
October 18, 2006

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- To the children I have been privileged to work with and learn from in the course of music therapy. You go unnamed but never forgotten.

# Contents

# Music Therapy Groupwork with Special Needs Children

Chapter 1

# The Story of a Group: Unanswered Questions

This first chapter orients the reader to the purposes and content of the book. In my teaching and practice of music therapy over the past 28 years, I have found that most music therapy literature addresses individual therapy. However, in both public and private schools, economic constraints demand group therapy practice. Group work poses particular challenges in terms of initial assessment, selecting the group members, establishing goals and objectives, setting up the sessions, methodology and product and process evaluation. No matter what philosophy of helping the therapist adopts, there are overlapping concerns in all of the aforementioned areas. There is an ethical need for educators to train students for group work as well as individual work and therefore help beginning therapists meet the realistic demands of clinical practice today.

## *INTRODUCTION*

The reader should feel free to indulge me as I write the first and only autobiographical chapter of this book. The name of this book, *Music Therapy Groupwork with Special Needs Children,* has personal significance. I began my journey in music therapy in the mid-seventies, a time when there were few books on the subject, a small number of training programs, very limited graduate studies in music therapy and little to no advertising of clinical positions. I had an undergraduate degree in English and enjoyed writing poetry and short stories. I was also a musician. My interest in the not so burgeoning field of poetry therapy turned to an interest in music therapy as I moved to Boston to work at a publishing firm and, in my free time, began to volunteer with two pioneering music therapists in the Boston area, Donna Madden Chadwick and Beverley Wilson Parry, therapists whose work would quickly become the subject of the music therapy documentary, "The Music Child." Their work at a developmental center, based on the principles of Nordoff and Robbins, led me to study with Vera Moretti, a former student of Paul Nordoff.

Following my music therapy training, I was fortunate enough to work with several important models and, in some cases, mentors, all of whom had the end result of enriching my background, propelling me to return to graduate school and stimulating my subsequent work. The first of these mentors was Dr. Silvano Arieti, a prominent and unorthodox psychiatrist whose psychotherapeutic approach with schizophrenics (Arieti, 1955) and understanding of the link between creativity and schizophrenia (Arieti, 1976) greatly affected my work with mood-disordered and schizophrenic clients at The Creative Arts Rehabilitation Center. My interests in psychiatry led to clinical work and qualitative research on music therapy with the suicidal child, stimulated by my working association with psychiatrist Dr. Cynthia Pfeffer at New York Hospital, Cornell Medical Center. These experiences allowed me to develop my interests in group work within an analytic model and the development of a projective music therapy assessment tool with the disturbed child (Goodman, 1989).

Further along, graduate studies in special education and child psychology solidified my understanding of child development and its overlap with music therapy, an understanding that was deepened by clinical work and descriptive research with psychiatrist Dr. Judith Kestenberg who, fortunately for me, phoned me one day, drawing me into work at her therapeutic nursery, a working laboratory for the worlds of early musical devel-

opment and musical attunement. Additional workshop training with Dr. Daniel Stern reinforced the interests I had in nonverbal attunement signals between mother and child, so important to nonverbal bonding through music. Finally, workshop training with Dr. Stanley Greenspan as well as my music therapy clinical work with several of the children he was seeing in treatment helped me bridge the gap between the developmental and psychoanalytic studies I had pursued and helped me gain a greater sense of perspective on sensory integration, an interest already stimulated by my graduate studies in neurology. Last but not least, the many years of teaching at Montclair State University I continue to enjoy today alongside clinical practice in psychiatric and school settings serve to remind me of the day-to-day reality of teaching and practicing group music therapy.

As I found myself getting increasingly excited about the field of music therapy, I also realized that I had to rely largely on myself to discover how to problem-solve the issues in doing music therapy. The leap from theoretical learning to applied practice looms large.

In presenting the process of a sample music therapy group to you in this first chapter, I offer my thinking process and therefore all the elements of how the group evolves: the initial composition of the group and its potential as a group, the assessment of the group members for intervention planning, the formulation of goals and objectives, the methods and materials that I use and the ongoing evaluation of the group. These are the elements of the chapters following this first group.

Now, flashback to September, 2000 to a working music therapy group at a large regional day school for multiply handicapped children. I am the music therapist there two days a week, simultaneously conducting music therapy and descriptive research in conjunction with my full-time university position at Montclair State University.

## *THE STORY OF A GROUP*

### THE SCHOOL

I have been working at this special education school for six years, conducting six groups a day twice a week. It is a regional day school, receiving 31 sending districts throughout the State of New Jersey. The school has a wide variety of about 80 disabled children, ages 3–21. I am the first music therapist to set up school-wide programming. It did not start out this way. . . . I was initially hired to do individual and small group music therapy with six children who had music therapy on their IEP. After six months, the new principal advised me that "this program is disbanding." After some of the parents filed a lawsuit which included objection regarding the dissolution of the music therapy services, the principal called me back two days before school was to begin. She felt that all the children in the school should get music therapy, not just those selected on the IEP She offered me a fulltime job. I was only available two days a week since I was teaching in and coordinating the programs at Montclair State University full-time. Based on my recommendation, she hired an additional therapist another two days a week to work with the older students in the school. I tell this story not only to emphasize how important parent advocacy is but also to point out the possible political difficulties of some children receiving music therapy on the IEP and others not from the administrative point of view.

My personal and professional goals in taking this position are to maintain standards of practicing music therapy. That includes assessment, suggestion as to individual and group therapy placements, team conferencing time, records review time and inclusion in the IEP process. My first principal was very supportive of the music therapy program although, as you will see as my story unfolds, I have to struggle just to try to do my job properly. Unfortunately, she retired after four years. The next principal was disinterested in the program and despite several invitations to visit my music room, he never came. The current principal is minimally supportive of my efforts. She refers to me as a music teacher, probably because public school districts do not recognize the music therapy certification in New Jersey. A public school district maintains this school. By law, all music therapists working in the schools must have a school certification. My certification is in special education

since I am a certified teacher of the handicapped in New York and New Jersey so I would more aptly, in this sense, be referred to as the special education teacher providing music. However, I am paid more than fairly as a music therapist and I think the constant efforts of music therapists to work with the politics of schools and state certification systems are difficult. My simple suggestion to others would be: do your job as well as possible, stick to your ethical and professional standards and try to get involved in state advocacy for creative arts therapy so your music therapy credentials are recognized.

In this school, transdisciplinary team members serve the facility from occupational therapy, physical therapy, music therapy, speech/language pathology, social work, psychology and special education. The administration of the school keeps changing and therefore my working space and assignments do as well. I have built a healthy respect for the work of music therapy with the special education teachers, other therapists and parents, to the extent where they are in the music room on a regular basis. I have to set up my meetings with other professionals informally; the extent to which professionals communicate with each other is not fixed by schedule and this, in my opinion, makes the implementation of goals more difficult. The only charge I have from the administration is to "provide music for the children." and share written session plans with the principal at the beginning of every week. My personal and professional goals exceed that simple directive. Whatever I learn from working with these children and the professionals in the school drives my teaching at the University level.

Now it is September again with the yellow school buses unloading at the front door, the leaves turning and a nip in the air. Even though many of the same children continue one year to the next, there are always those who come and go and there are always new classroom combinations, largely based on chronological age. I ask that I meet with the same six groups twice a week and that request is, thankfully, honored. Right now, I have my own music space which is a large classroom. I am pleased to tell you that everything I order is honored. As a result of this, I have a large and varied collection of instruments, a decent piano, sheet music and music posters on the walls.

The groups are chronologically ages 3–12, developmentally much younger and frequently medically fragile. They are, in effect, all the children from the sending districts who cannot be handled properly in the in-district self-contained classrooms. In that sense, they are very challenged children, requiring additional staff in each classroom (nurses, private aides, teacher assistant) and one-on-one programming much of the time. The notion of sending all the children as a group to "specials" of art, music and physical education is an educational norm. It remains a challenge for me to really conduct therapy with these children as a group and I have been compelled to find compromise solutions in order to do so. This group coming through the door of my music room is no exception.

## THE GROUP

These six group members, chronologically ages 7–9, range in developmental age from preschool to early grade school, with a variety of physical and attentional difficulties and all are multiply handicapped. I have already been in their classroom so I have had a chance to meet them prior to their first music group. They are blessed with an experienced and lovely special education teacher who also happens to be a musician and uses music frequently during class activities.

*Alexander,* age 8, a tall olive-skinned child, rolls himself in on his wheelchair with a sweet smile on his face. He is cerebral palsied, not able to care for his physical needs independently and physically compromised to the extent that he has to struggle with his expressive language and also utilize augmentative communication. Yet he is progressing with early academic skills, including math and reading skills. According to his teacher, when challenged with more demanding tasks, Alexander reverts to regressive emotional behavior such as fake crying or ignoring the speaker. This issue was not addressed in his I.E.P. but could be addressed as a new goal for building self-esteem through

music therapy since he seems very musical.

An aide wheels in *Simon,* age 9, a slight child with blonde hair and blue eyes. He is another physically compromised child, is wheelchair-bound, nonverbal and at an infant/toddler level in terms of developmental prowess. He uses picture exchange with verbal prompts and is beginning to make cause/effect connections.

*Keisha,* age 7, a petite and vivacious black girl, is eagerly pulling her assistant teacher by the hand as she enters the room laughing. She is visually compromised and impulsive in behavior, has weak oral motor control, an uneven gait pattern, and perseverative speech, reminiscent of a beginning talker.

*Terrence,* age 8, a muscular active black child with microcephaly, runs into the room in front of the other children. He is beginning preschool academic skills, such as identifying and sorting colors and shapes, attending to a simple story, preparing food, using simple computer operations, identifying numbers to 9 and counting. He speaks in 4–5 word sentences. His difficulty in controlling impulsive behavior remains a key behavioral issue.

*Maria,* age 9, a chubby strong looking child with black hair and dark eyes, pulls her Spanish-speaking aide along with her and plops into her seat with an air of finality. She is bilingual and understands one-step directions in both Spanish and English. She can approximate language and uses pictures for communication, especially for food-related activities. She can combine up to four signs/pictures to make requests but needs modeling first to help nudge her along. Since she likes music, she will use that sign as well as the sign for gym spontaneously and appropriately. Thus far, her medications have not solved any behavioral problems as far as mood swings and self-abusive and peer-abusive behaviors such as pinching, biting and slapping. She stares me down after she sits in the chair and then finally smiles at me.

Finally, *Linda,* age 9, comes in on her wheelchair. She is able to use simple signs and picture choices for communication and attempts some verbalizations for communication, all compromised by oral motor musculature issues, which result in excessive drooling. There is a need for hand-over-hand assistance on multiple tasks since her fine motor and gross motor skills are weak. At her highest functional level, she operates at an infant/ toddler level.

## ASSESSMENT

At this school I have been assigned back-to-back 45 minute groups with two preparation periods of 30 minutes each, one before the children arrive and one after the children leave. During my 30-minute lunch period, I struggle to take notes on the morning groups (three groups in the morning) while I eat my sandwich. After the children leave, I continue my note-taking on the afternoon groups (three groups in the afternoon). There is no downtime between classes. The notes are, at the beginning, based on generic types of developmental goals that I arrive at while I try to find the time upon arriving at school to read through IEPs. My efforts to read and educate myself about the six groups of children I am working with two days a week is, I think, minimal professionalism.

The possibility of assessment on an individual basis aside from group meeting times is impossible. Having done extensive literature reviews on assessment and having written an assessment myself (Goodman, 1989), I know that virtually all the literature on music therapy assessment is for individual students (see Chapter Two of this book) not group. This is not a school that will allow me to change the class schedule to accommodate individual assessment. With six groups of about six children in each group, individual assessment would take me a minimum of 36 clinical hours, or more than a week. Since my schedule is based around the classroom teacher taking a lunch break, I cannot break up the group. In a sense, my previous clinical work has spoiled me since, in virtually all previous jobs, I had free rein in conducting assessments and then setting up groups. With these children, I am going to have to assess on an ongoing basis, within the context of the group while using infant and early childhood milestones from the *Music Therapy Assessment Profile for Severely/Profoundly Handicapped, MTAP* (Michel and Rohrbacher, 1982). The concept of the MTAP,

written during my own professional participation as a member of the two week summer of 1978 "Training Institute for Music Therapy with Severely/Profoundly Handicapped" in dusty Denton, Texas is simple: devise music tasks that reflect developmental milestones within the domains of cognition, fine motor, gross motor, social-emotional and speech-language development. I can extend this concept through the use of other developmental resources like the *HELP Activity Guide* (Furuno, 2005), which now includes developmental milestones for ages three-six (Vort, 1995), the estimated developmental age range for Alexander and Terrence.

The purpose of the music therapy assessment will be to determine the level of functioning in developmental domains of motor, language, cognition and communication in music and compare that to the stated current levels of functioning and goals of the IEP for compatibility. Children can perform differently in music and new expectations can be determined. I have thought a great deal about the issues involved in assessment and this group will push me to another level of consideration (see Chapter Two).

## APPROPRIATENESS OF GROUP PLACEMENT

As I meet the children and work with them, I begin to think about their appropriateness and potential as a group. I started really trying to tease out what makes a group work about five years ago when I started my work at this school. The factors I consider are the following: 1) *The developmental level of the child;* 2) *The musicality of the child;* 3) *The sensory profile of the child;* and 4) *The practical consideration of the school setting.* As with other groups in the school, these children are *developmentally mixed.* Alexander and Terrence are on a preschool or beginning kindergarten level; Linda, Maria, Keisha and Simon are on an infant/toddler level. In this sense, they are all more like a family constellation, a heterogeneous sibling-like group. When I think about children beginning day care or preschool, I know that they do not relate to each other until they are generally past parallel play, or about 2.5 years old. On a practical level, then, with all the aides and teachers in this room of six children (a personal aide for Keisha, a personal aide for Maria, a private nurse for Simon, an assistant teacher, a visiting speech pathologist and myself), the ratio is 1:1, more like a "Mommy and me" play group. In effect, am I practicing individual therapy within a group context?

Terrence, Keisha and Maria are quickly starting to show signs of *strong musical preferences* in the first few sessions. Terrence loves his Sesame Street Songs, Keisha adores her finger plays and Maria is most responsive to simple Spanish folk songs. They all have to learn to take turns in sharing musical materials with each other and sometimes this is hard for them. In a group where there are overriding musical preferences and the children simply cannot wait, this would be an impossible situation for the music therapist. Fortunately for me, these children are able to wait their turn. However, it is a stretch for them to attend to favorite materials of other children. They are, rightfully so at their developmental ages, musically egocentric. In terms of *sensory profile,* the children are very different and I find myself continually observing their reactions to stimuli. I love reading the work of Dr. Stanley Greenspan because he offers so many perspectives on this. He talks and writes about the response of the child to varied stimuli. When I talk, what does the child hear? When I sing or play instruments, what does the child hear? When I use visuals in my presentation, what does the child see? When I touch the child in a firm way, how does that feel? When I touch the child with a light fleeting touch, how does that feel? I notice that practically all of the children take time to react. Do they all have auditory processing delays? When I try to assist them with hand-over-hand movement activities, Alexander is very spastic, his arms flail and they are tight. Simon and Linda are floppy, like rag dolls. Maria is rooted to the ground and resistant to movement. Keisha and Terrence are small and tight in their bodies, moving dysrhymically in their seats, impulsively calling out. Since the children present such a mixed picture developmentally, musically and sensorily, I am going to have to work at different levels simultaneously. Sometimes

I feel like a juggling act but at the same time, it is intellectually stimulating to be noticing all these different levels and reactions all the time. The *practical limitations of the school* put me in the position of only taking this group as they exist in the assigned classroom. I see this as a rigid arrangement. I am scheduled to cover the teacher preparation periods and that leaves me no flexibility in grouping. If I had the option, I would place Alexander and Terrence in a separate dyad since they are closer to each other in terms of developmental age and would complement each other with different musical interest. The other children would either be on an individual basis or together in a type of infant stimulation model. This group, as it stands, will be quite challenging. The variables involved in determining individual or group placement have been ones I have been fortunate enough to act on in previous clinical settings (see Chapter 3) but not here. How then will I make this group "work"?

## SETTING GOALS

### Generic Goals

#### *Phase One, Goal Setting*

Until I have a chance to wade through all the IEP reports, my goals are relatively generic and relate to various uses of music throughout the session.

Through a variety of songs I want to:

- Increase and evaluate expressive/receptive language
- Increase and evaluate socialization
- Increase and evaluate vocal projection
- Decrease auditory processing time
- Increase consistent response to one and two-step directions

Through a variety of instrumental activities, I want to:

- Follow one step and two-step directions,
- Decrease impulsivity,
- Have the children recall and follow sequence of directions,
- Create a sense of rhythmic control.

Through movement, I want to:

- Decrease impulsivity,
- Increase response to one step and two step directions,
- Increase social interactions,
- Reinforce a sense of rhythmic control.

### Reviewing the IEP

Setting goals for the music therapy session can be delimited to the simple expectation of the facility, in this case, "provide music for the children" or else live up to my own personal and professional expectations. As a therapist, I am not satisfied unless I can help the children progress developmentally. If I can fit into the team approach of the Individual Education Plan while using music to contribute a special context and meaning for completion of developmental goals, then I feel connected to the overall progress of the child. The federal mandate, IDEA, holds the special education teacher, occupational therapist, speech-language therapy, physical therapist, etc. responsible for writing observable measurable goals on the Individual Education Plan. Although, frankly, I am not a conformist, I decide to follow IEP goals as well as formulate music therapy goals and objectives as observable and measurable. It is not easy nor is it my natural bent. However, I think that music therapists will ultimately gain more recognition documenting the progress the children make than not. Therefore I am used to reviewing the goals of the IEP and seeing how they can be incorporated into my session planning. This is, in effect, a four-step process.

First, I *review the IEP goals and recent reports* (neurological, psychosocial, educational, psychological, occupational therapy, speech therapy, physical therapy) in a child's file. Second, after I have all this information on the children in a group, I create a table using the names of the children and *organizing the IEP goals into developmental domains*