Imagine: Early Childhood Music Therapy Online Magazine

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To improve access to and distribute knowledge and information about early childhood music therapy in clinical terms.

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Welcome to the second volume of imagine, AMTA’s annual online magazine dedicated to early childhood music therapy. imagine 2011 offers you 39 colorful articles, eight innovative podcasts, and four delightful photo stories featuring the work of our frequent contributors and newcomers from around the world. We also included new “teaching episodes,” expanded the “our favorite” section, updated the “event calendar,” and can now accept online submissions of your manuscripts on the imagine website.

As we reflected on the launching of imagine in 2010, the editorial team was very pleased with the positive responses and encouraging words from our authors and readers. Below are three examples of comments we received:

‣ The new online imagine is fabulous. What a fantastic major new contribution to the field. I was awed by the sophistication and wealth of info.
‣ I had a chance to look at imagine a bit last night. It is absolutely fabulous. Congratulations! I want to go back and read every word and watch every video.
‣ I just spent the whole morning exploring the imagine website...and I am inspired! Not just by the beautiful layout and design, but also by the amazing multimedia and quality of the content. I have forwarded it on to all my music therapy colleagues in South Africa and I am sure they will enjoy it just as much.

The interest in imagine is also evident by over 8300 worldwide visitors on the imagine website since September 2010 as well as numerous hyperlinks from related organizations and companies.

Over the past year, we reached out to build awareness of imagine as well as Early Childhood Music Therapy. For example, in October 2010, I was invited to speak on the Music Therapy Radio Show with Janice Harris and to introduce imagine to the readers of the ECMMA’s online journal, Perspectives. As a result of our fruitful collaboration with ECMMA, complimentary copies of selected articles from Perspectives are now available on the AMTA website’s “Member Only” section. Furthermore, we held roundtables at the 2010 AMTA
imagine 2(1), 2011

conference in Cleveland, Ohio where we shared reflections and ideas for AMTA’s new early childhood online magazine; at the World Congress of Music Therapy in Seoul, Korea, we featured our Asian Color of Us series authors. We also distributed imagine flyers at AMTA’s 2011 regional conferences and to colleagues abroad. During the International Society of Early Intervention (ISEI) conference in New York City (covered in this issue), we met with major players in the field of early childhood education. You can learn about additional initiatives in the reports by Angela Snell, Judy Simpson, and in a reflection on “Imagine why Music Matters: Advocacy for Music as an Essential Early Childhood Experience” by Dr. Dena Register.

Other features in this issue include a multimedia article by Noelle Pederson and Dr. Barbara Reuer, describing a solid early childhood music therapy training program for parents who use English as a Second Language (ESL) and whose children’s facilities follow an Even Start curriculum. Our new “research snapshots” section is presented by Dr. Blythe LaGasse, and Debra Gombert gives a brief research report on improving communication in young children with autism spectrum disorders.

Our Practice category features clinical work based on sound theories, recommended practice, and research. The wide variety of topics spotlighted by 15 authors include early music therapy interventions for language development with at-risk infants, clinical case vignettes with infants in an Australian hospital, the use of augmentative and alternative communication as well as “Words for Engagement” for children with autism spectrum disorders, a case report for a child with partial agenesis of the corpus callosum, new opportunities and requirements for attachment-based music therapy, music and literacy development in young children with hearing loss, cultural awareness related to family roles in bilingual music therapy sessions, reunifying families in crises through a music therapy intervention including Music Together® repertoire, understanding development in early child music therapy, and dancing poems.

In the Ideas section, our colleagues Beth McLaughlin, Laurel Rose-Weatherford, Margie LaBella, and Carol Ann Blank introduce music therapy interventions that can be easily implemented and adapted to your clinical practice. This year’s Color of Us series focuses on early childhood music therapy as practiced in Europe including Switzerland, the United Kingdom, France, Finland, Iceland, Poland, Hungary, and Latvia. In our Resources section, Ruthlee Adler introduces her favorite websites that are useful for music therapy practice with young children and families. Rachel Rambach shares valuable resources for building your own business, and I provide a short review of selected music apps for little ones.

Finally, I would like to introduce you to our new Wisdom section, which spotlights the knowledge, expertise, and insights of our senior colleagues who have worked throughout their entire lives with young children and their families. I am delighted that Marcia Humpal has pioneered this section this year. She is an incredible evidence-based practitioner, and has been a teacher, role model, and mentor for many of us. I also would like to thank her and Lisa Jacobs for their indispensable editorial assistance in getting this issue off the ground. My gratitude also is extended to our authors who shared their work plus their collegiality and friendly collaboration as we all explore this new way of publishing.

As we continue building a strong professional early childhood music therapy community, I encourage you to think about how you might contribute with your talents and make a difference in the lives of young children, their families, and our profession. I would like to leave you with John Lennon’s quote “A dream you dream is only a dream. A dream you dream together is a reality” and invite you to watch the beautiful performance of his song “Imagine” produced by the nonprofit organization Playing for Change. It is a great example of how we can be united in music and build community for change.

Happy reading, listening, watching, and reflecting!

Yours,

Petra Kern, Ph.D., MT-DMtG, MT-BC, MTA
Editor, imagine
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Carol Ann Blank

About the Color of Us Series

Switzerland
Friderike Haslbeck and Sandra Lutz Hochreutener

United Kingdom
Clare Flower

France
Adrienne Lerner

Finland
Kirsu Tuomi and Esa Ala-Ruona

Iceland
Valgerdur Jonsdottir

Poland
Krzysztof Stachyra

Hungary
Eszter Forgacs

Latvia
Mirdza Paipare

Tuning Into Technology
Ruthlee Figlure Adler

Building Your Own Business in Early Childhood Music Therapy
Rachel Rambach

Cool Music Apps for Little Ones
Petra Kern

Rounding With Medical Staff to Increase Music Therapy Awareness in the Neonatal Intensive Care Unit
Amy Robertson

Practicing Music Therapy in the NICU: An Interview with Kim Hawkins
Matt Logan

Constructing Meaning in Music and Text: Implications for Literacy Development in Young Children with Hearing Loss
Christine A. Barton

Lessons Learned in Least Restrictive Environments: The Role of Music Therapy in Preparing Young Children to Succeed in Inclusive Schools
Elizabeth K. Schwartz

Moving Beyond “Moo, Cow, Moo:” Targeted Song-Based Language Experiences for Young Children
Cathy Knoll

Seed Pod: Collaboration to Help Children Grow Through Music and Movement
Dorothy Simonis Denton

Laughter in Music Therapy and With Young Children
Kalani Das

Music Therapists Talk About Self-Care: A Video Interview
Kat Fulton

Publications 2010-2011
Petra Kern
10 tips for music therapists working with young children and their families

1. Be sensitive to the needs of the family as well as the child – you are part of a team.
2. Study and understand child development, developmentally appropriate practice and the unique way young children learn.
3. Be playful not only in your demeanor but in your music-making; children learn through play.
4. Arrange the environment for success – don’t have too many distractions or choices.
5. Be expressive – get up close, at their level and “in their face” (establish eye contact).
6. Pause and WAIT – give young children a chance to respond.
7. Repeat, repeat, repeat, repeat! Young children also learn through repetition.
8. Use music and songs to make transitions seamless and non-confrontational.
9. Know that you might not see immediate responses….they often appear later in a familiar and comfortable environment.
10. Share information, suggestions and musical strategies with the family and with other members of the interdisciplinary team.

Working with young children is like venturing into the fountain of youth – each time you share meaningful musical moments with these little ones, you are invigorated by their joyful wonder as you help them discover and expand their world through experiencing the power of music.

Marcia Humpal, M.Ed., MT-BC
Founder, Early Childhood Newsletter
Co-founder Early Childhood Network
American Music Therapy Association
imagine, Editorial Assistance
"Children are like snowflakes, each with their own pattern."

–Author Unknown
1. Welcome and Introductions. Dr. Petra Kern and Angie Snell, Early Childhood Network (ECN) Co-Chairs welcomed all those in attendance and gave time for everyone to introduce themselves. Attendees included 34 colleagues from 10 states (AL, CA, FL, IL, MA, MI, MN, NY, OH, VA). Dr. Kern thanked the AMTA conference planners and Special Target Populations chairs for arranging a larger meeting space for the ECN lunch. The number of participating members of the ECN attendees continues to grow each year as was evident at this meeting. Items handed out included: An attendance list, a presentations and publications list, a sign-up sheet for submissions to imagine 2011, a list to collect the group’s “favorite children books,” and an announcement of the imagine roundtable.

2. Info to EC Network

2.1. Inaugural Issue of imagine. Dr. Kern, Editor, shared that the issue of the Early Childhood online magazine, imagine, continues to receive a growing readership nationally and internationally from stakeholders inside and outside the field of music therapy. She thanked Marcia Humpal and Lisa Jacobs for their support as editorial assistants in publishing the inaugural issue of imagine as a multimedia online magazine for practitioners. She reviewed the goals of imagine, which focus on music therapy and young children (ages 0-5) in the following ways: Offer a reputable clinical publication forum, distribute knowledge and information in clinical terms inside and within the field, and improve access to knowledge and information on early childhood music therapy worldwide. Dr. Kern expressed gratitude to all those who contributed content to the first issue of the professional online magazine. The 2010 publication includes 50 submissions from colleagues living and working in 10 different countries. She also announced the successful February 2010 launching of the imagine website, which allows expanded use of interactive technology, hyperlinks, and information. Dr. Kern described the following innovative sections of the magazine: Photo stories, podcasts, teaching episodes, and favorites. She encouraged attendees to view the current multimedia magazine content and the guidelines for submissions at www.imagine.musictherapy.biz.

The next deadline for submissions is May 15, 2011. The meeting attendees applauded Dr. Kern for her dedication, passion, and commitment to this high quality and current media venue. The group discussed the importance of further development of this online resource.

2.2. Facebook Group. Currently, there are 171 Facebook Group members. All attendees were encouraged to sign up for the Early Childhood Music Therapy Network Facebook Group. Attendees discussed the importance of increasing participation and postings on the Facebook page. It was suggested that each attendee post items (such as related products, instruments, books, music) and comments after the conference.

3. Year 2010 in Review

3.1 Presentations/Institutes. A sample of professional presentations by ECN members for 2010 includes

- 2010 AMTA Conference. Darcy Walworth co-presented Developmental Music Therapy
Interventions for Infants and Toddlers: Evidence-Based Practices and Recommendations.

- 2010 AMTA Conference. Darcy Walworth co-presented the NICU Music Therapy Training CMTE with a panel of presenters.
- 2010 Fall Seminars at Western Michigan University and Eastern Michigan University. Angela Snell, Laurel Rosen-Weatherford, and intern Amy Foley presented on Autism and Music Therapy.
- 2010 AMTA Conference. Laurel Rosen-Weatherford, Jessica Kasprzyk, Angie Snell and Interns Amy Foley and Emily Carlson presented Community Connections: A Video Presentation of REAL WORLD School Music Therapy.
- 2010 Aicardi Family Conference. Becky Wellman presented Music Therapy.
- 2010 Illinois Association for Music Therapy Fall Training. Becky Wellman presented Building Our Practice.
- 2010 AMTA Conference. Becky Wellman presented at the poster session on Music Therapy with Osteodysplastic Primordial Dwarfism Type II.
- 2010 National Association for the Education of Young children. Kamile Geist and Eugene Geist presented Hitting the Right Note.
- 2010 Chaplains Association Conference and Staff Inservice. Dorothy Denton presented on Music Therapy and Hospice.
- 2010 International Society of Music Educators. Marta Hernandez presented Integration of Music and Physical Education.
- 2010 AMTA Conference. Petra Kern presented Inclusion 2010: Applying the DEC Definition to Early Childhood Music Therapy.
- 2010 AMTA Conference. Marcia Humpal was a co-presenter for the Institute: Music Therapy in Literacy Learning: Addressing Functional Outcomes and Advocacy.

Special Target Populations Network Session 2011

The next meeting will take place at the 2011 Annual AMTA Conference on Friday, November 18, 2011 12:30 - 2:15 PM Atlanta, GA

See you there!
### 3.2 Government Relations

Angie Snell reported the Department of Education provided updated clarification on music therapy as a related service through a new Question and Answers document on the DOE’s website. The document reiterates that music therapy can be a related service for a student with disabilities under Part B of IDEA if it is required for the child to receive a free and appropriate public education (FAPE). Attendees were encouraged to go to the website link to the Question & Answers section http://idea.ed.gov/explore/view/p/%2Croot%2Cdynamic%2CQaCorner%2C3%2C. The specific question about “artistic or cultural services, such as music therapy” can be found in section E. Attendees suggested that a link to this website be posted in imagine and on the ECN Facebook Group.

Beth Schwartz prepared information with Judy Simpson for a testimony in front of the U.S. Senate Health Education and Labor Pensions (HELP) Committee in May 2010. Beth Schwartz testified for the allotted three minutes time frame about the importance of related services and personnel under the Education and Secondary Education Act (ESEA).

### 3.3 Publications

- Darcy Walworth is preparing a book chapter on Autism Spectrum Disorders for a multidisciplinary text for the emerging treatments for ASD.
- Music Therapy with Premature Infants: Research and Developmental Interventions, 2nd Edition by Jayne Stanley and Darcy Walworth is now available through AMTA.
- The Music in Special Education, 2nd Edition by Mary Adamek and Alice-Ann Darrow is now available through AMTA.
- Petra Kern’s article “Evidence-based Practice in Early Childhood Music Therapy: A Decision-Making Process” is now available in Music Therapy Perspectives, 28(2), 116-123.
- Petra Kern was invited to introduce imagine in the Early Childhood Music and Movement Association’s (ECMMA) publication Perspectives 5(4), 19.
- Petra Kern and Marcia Humpal are in the process of editing a book on Music Therapy and Young Children with Autism Spectrum Disorders and Their Families with Jessica Kingsley Publishers.
- Attendees were also referred to pages 94 and 95 of the 2010 imagine magazine for additional 2010 publications.

### 4. Research Reports/Grand Opportunities

Dr. Walworth reported that the National Center of Autism is now listing music therapy as an “emerging practice” for ASD. She also highlighted NICU research that suggest differences in responses by gender and a new study that showed premature infants receiving music therapy were able to get off breathing supports sooner. Another highlighted study suggests that pianists who start lessons before the age of 7 have a larger corpus callosum (connects R/L sides of the brain). Recent research related to music therapy and early childhood can also be found in imagine1(1), 2010 on pages 32-43 related to Nordoff-Robbins Music Therapy, letter identification, and NICU.

### 5. Music and Product Sharing

Time permitted brief mention of music and products found in imagine including Helen Marlias’ Succeeding at the Piano series, a listing of online resources, songs, and several podcasts. Attendees were encouraged to share their favorite resources on the ECN Facebook page.

### 6. Related Organizations for Conference Attendance and Presentations

Dorothy Denton shared her work with the ECMMA. Denton is working to become a liaison between AMTA and this organization. As a new collaboration between ECMMA and AMTA, all AMTA members can now access one article per issue for free from Perspectives. The regional ECMMA conference is in Dayton, Ohio from July 15 to 16, 2011. Conference planners are recruiting presenters. Those interested should seek information from Dorothy Denton at dsd551@aol.com. The conference session topics tend to place emphasis on movement, however other topics are also included.

Dr. Kern refered to the forthcoming International Society on Early Intervention congress in New York in May 2011. Dr. Dena Register will hold a research symposium on music therapy and early childhood with Dr. Darcy Walworth, Dr. Deanna Hanson-Abromeit, and Dr. Petra Kern.

### 7. Other Topics of Interest

Attendees discussed issues related to non-music therapy companies or businesses and/or partnerships with music therapists. Members briefly explored the pros, cons, and ethical questions that can arise with these types of partnerships.

### About the Author

Angela M. Snell, MT-BC has specialized expertise in all areas of school music therapy, including assessment, program design, special education law, inclusion and community initiatives for Pre-K through Post-Secondary students. She is a local, regional, and national presenter, author, and advocate on related topics.

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Join us in Atlanta, GA for the 13th annual AMTA conference. Learn about advocacy and leadership as you expand your therapy skills when you attend the 2011 conference AMTA in the ATL: Advocacy, Therapy and Leadership. There will be many opportunities to learn and increase your skills in the area of early childhood music therapy. Here is a selection of the early childhood events at the 2011 annual AMTA conference:

**Institute**
- Focus on children from infancy through age five, examining their development across various domains. Co-chaired by Marcia Humpal, M.Ed., MT-BC and Rebecca Wellman, Ph.D., MT-BC Wednesday, November 16, 12:30–6:30 p.m.

**Pre-conference Training**
- Level III NICU Music Therapy with Jayne M. Standley, Ph.D., MT-BC; Andrea Cevasco, Ph.D., MT-BC; Lori Gooding, Ph.D., MTBC; Darcy Walworth, Ph.D., MT-BC; Natalie Wlodarczyk, Ph.D., MT-BC; Olivia Swedberg, MM, MT-BC; Miriam Hillmer, MME, MT-BC; Jessy Rushing, MM, MT-BC; Judy Nguyen Engell, MM, MT-BC. Wednesday, November 16, 2011, 9:00 am – 6:00 p.m.

**CMTs**
- Examining the Evidence-Base for Music Therapy with Children: Implications for Clinical Practice
- Preventive Music Therapy for Children Living in Poverty
- Music for Learning: Serving Young Children with Autism Spectrum Disorders
- NICU Music Therapy: The Development of Rhythm, Breath & Lullaby as Clinical Practice
- Assisting with Medical Procedures: Techniques and Tips for Success

**Concurrent Sessions**
- Licking the Drum: Recognizing Developmental Music Responses in Early Childhood
- Music Incorporated with ABA Verbal Behavior Training for Children with Autism
- Celebrate: Multi-cultural Songs for Kids from One to Twenty-one
- Special Music Education: Response to Intervention (RTI) and Implications for Music Therapy
- Using Video Modeling/Video Self-Modeling in Music Therapy: Enhancing Learning and Generalization
- Music Therapy in Atlanta’s Fulton County Schools: The Nuts and Bolts of Our Program
- Creative Interventions for Hospitalized Children: Improvisation to Music-Facilitated Dramatic Play
- Adapted Instruments for Children with Severe Disabilities: Benefits from Assessment to Implementation
- Music Therapy and the Music Educator: Working Together to Support Inclusive Classrooms
- Creative Expressions!
- Schoolhouse Stories: Making Sense Out of Music Therapy for Teachers and Parents
- Importance of Music and Movement for Preschoolers with Special Needs
- Modes, Meter, and Meaning: Composing Therapeutic Songs in Early Childhood
- A Continuum of Care: Family Music Therapy in Hospital, Community and Home
- A Different Look at Autism Spectrum Disorders: Considering the Research
- Comprehensive Literacy Learning: Addressing Child, Family, and School-based Needs with Music
- Mutually Responsive Orientation: Music Therapy as an Intervention Supporting Parent-Child Interactions
- Utilizing the Bright Start Curriculum as a Developmental Assessment
- Staying Informed: Online Resources for Autism Spectrum Disorders
As a service to members, AMTA frequently responds to questions regarding the recognition of music therapy within early intervention programs throughout the country. This recognition varies from state to state and often requires advocacy with state agency officials to increase awareness of music therapy as a possible service within the Individuals with Disabilities Education Act (IDEA) special education law. Communication with state officials has increased during the last year as AMTA continues to collaborate with the Certification Board for Music Therapists (CBMT) on implementation of the state recognition operational plan. Working together with music therapy state task forces, AMTA and CBMT provide technical support and guidance to related state agencies when questions arise about the application of music therapy in education and healthcare settings.

Our ultimate advocacy goal in early intervention is for each state’s special education regulations to specifically list music therapy as an early intervention service. Until that time, it is vital for clinicians to be able to successfully respond to questions regarding recognition of music therapy as a part of early intervention programming. Whether these questions come from the district or state level, music therapists should feel confident in providing information that reflects current practice. Understanding basic facts about special education statutes and regulations will assist music therapists better advocate for service provision for young children.

IDEA is the federal law that outlines special education services, with Part B focused on ages 3-21 and Part C focused on ages birth-three years. Regulations designed to help states and local education agencies implement the law are written for both Part B and Part C. Although regulations have not yet been finalized for IDEA Part C under the most recent IDEA Authorization, the U.S. Department of Education proposed regulations from 2007 clearly state that the list of early intervention services is not exhaustive and may include other services.

This same interpretation by the U.S. Department of Education issued a Questions and Answers (Q&A) document, which clarifies that music therapy can be a related service under the Individuals with Disabilities Education Act (IDEA).

This document replaces the clarification letter AMTA received from the U.S. Department of Education in 2000.

Two benefits of this updated clarification include: 1) it is posted on the U.S. Department of Education IDEA website for public use; and 2) it includes information from the most recent reauthorization of IDEA, including the IDEA Part B Regulations finalized in 2006. To review this resource for the music therapy profession, please visit the Department’s IDEA website at http://idea.ed.gov/explore/view/p/%2Croot %2Cdynamic%2CQaCorner%2C3%2C.

Although this document is focused on IDEA Part B, AMTA recommends that clinicians refer to this document when administrators question music therapy involvement in Individual Family Service Plans (IFSP) as well. As AMTA, CBMT, and the state task forces continue to work toward improved state recognition in all clinical areas, we encourage you to advise us of both challenges and successes in providing early intervention programming. Your input will support ongoing advocacy efforts to increase access to quality music therapy services for young children and their families.

About the Author

As AMTA’s Director of Government Relations, Judy Simpson represents the interests of members with state and federal legislators and agencies. Judy’s clinical experience has involved developing music therapy programs for clients of all ages in general hospital settings, including physical rehabilitation, oncology, labor and delivery, psychiatry, ICU, and general medicine.

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QUESTIONS AND ANSWERS ON INDIVIDUALIZED EDUCATION PROGRAMS (IEPS), EVALUATIONS, AND REEVALUATIONS

REVISED JUNE 2010 (p. 25-26)

Question E-1: Can artistic and cultural services, such as music therapy, be considered related services under the IDEA? If so, are there qualifications in the IDEA for personnel to provide such services as related services?

Answer: Related services means transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education. Related services can include artistic and cultural services that are therapeutic in nature, regardless of whether the IDEA or the Part B regulations identify the particular therapeutic service as a related service. The Department’s long-standing interpretation is that the list of related services in the IDEA and the Part B regulations is not exhaustive and may include other developmental, corrective, or supportive services (such as artistic and cultural programs, art, music, and dance therapy), if they are required to assist a child with a disability to benefit from special education in order for the child to receive FAPE. As is true regarding consideration of any related service for a child with a disability under Part B of the IDEA, the members of the child’s IEP Team (which include the parents, school officials, and whenever appropriate, the child with a disability) must make individual determinations in light of each child’s unique abilities and needs about whether an artistic or cultural service such as music therapy is required to assist the child to benefit from special education.

If a child’s IEP Team determines that an artistic or cultural service such as music therapy is an appropriate related service for the child with a disability, that related service must be included in the child’s IEP under the statement of special education, related services, and supplementary aids and services to be provided to the child or on behalf of the child. 34 CFR §300.320(a)(4). These services are to enable the child to advance appropriately toward attaining the annual goals, to be involved and make progress in the general education curriculum, and to participate in extracurricular and other nonacademic activities, and to be educated and participate with other children with and without disabilities in those activities. 34 CFR §300.320(a)(4)(i)-(iii). If the child’s IEP specifies that an artistic or cultural service such as music therapy is a related service for the child, that related service must be provided at public expense and at no cost to the parents. 34 CFR §§300.101 and 300.17.

Regarding the question about personnel qualifications for providers when an artistic or cultural service such as music therapy is considered a related service, Part B of IDEA does not prescribe particular qualifications or credentials for personnel providing special education and related services. Under 34 CFR §300.156(a), each SEA must establish and maintain qualifications to ensure that personnel necessary to carry out the purposes of Part B of the IDEA are appropriately and adequately prepared and trained. This responsibility includes ensuring that the qualifications for related services personnel and paraprofessionals are consistent with any State-approved or State-recognized certification, licensing, registration, or other comparable requirements that apply to the professional discipline in which those personnel are providing special education or related services. 34 CFR §300.156(b)(1). In addition, the SEA must ensure that related services personnel who deliver services in their discipline or profession meet applicable State qualification standards and have not had certification or licensure requirements waived on an emergency, temporary, or provisional basis. 34 CFR §300.156(b)(2)(ii). Therefore, if a child’s IEP includes an artistic or cultural service such as music therapy as a related service, the SEA would be responsible for ensuring that the child received that service from appropriately and adequately trained personnel, consistent with 34 CFR §300.156(b).
In May 2011, Dr. Michael Guralnick, Chair ISEI invited the international community on early childhood to gather at the third conference of the International Society on Early Intervention in New York City to network and share information and ideas. Numerous research symposia, paper sessions, and poster presentations reflected the current trends of early childhood intervention around the world. Included in the conference program were two music therapy symposia led by Dr. Dena Register (U.S.A.) and Anja Tait (Australia) respectively. These research symposia and in-depth conversations with early childhood professionals provided excellent opportunities not only to educate about the research-based benefits of music therapy interventions for young children and their families, but also to reflect on commonalities and prospective collaborations.

To echo the current trends in early child intervention, colleagues who have attended the conference summarized selected presentations. We hope that this will give the imagine readers some insights and inspiration for their own work.

**Symposium on the Impact of Music on Cognitive and Social Development in Early Intervention**

Darcy Walworth, Ph.D., MT-BC (USA); Deanna Hanson-Abromeit, Ph.D., MT-BC (USA); Dena Register, Ph.D. (USA); and Petra Kern Ph.D., MT-DMiG, MT-BC, MTA (USA)

Summarized by Dena Register

The Symposium on the Impact of Music on Cognitive and Social Development in Early Intervention was one of two music therapy presentations on the congress program. Moderated by Dr. Dena Register, this session was comprised of four distinct, but related, presentations on the use of music therapy to impact the lives of young
environments are natural and potent contexts for research, centers around three key ideas: 1) everyday vision for learning in the early years, in practice, policy and from our work in schools, libraries and communities, our case studies there was also diversity, of art forms, disciplines, the observable and the intangible, including interaction, and product. We are concerned with measuring impact, both in inclusion, e) collaboration, and e) reflection about process practice for adults, c) natural (everyday) environments, d) purposeful integrated.

The space between home, school, community and caregivers and peers, and opportunities to learn self-regulation. Video clips of each of the presenters’ clinical work provided clear demonstration of how music facilitates these skills in natural, playful ways and allows for high frequency and high quality interactions among children and adults.

One common thread among the four presentations was the idea that young children need experiences that facilitate child-centered communication, healthy attachment to caregivers and peers, and opportunities to learn self-regulation. Video clips of each of the presenters’ clinical work provided clear demonstration of how music facilitates these skills in natural, playful ways and allows for high frequency and high quality interactions among children and adults.

Re-imagining Learning in the Early Years with the Arts
Anja Tait, BMus(Therapy), PostGradDipPrimaryEducation, RMT (Australia); Edel Musco, BFineArt, M.Ed. (Australia); and Petra Kern Ph.D., MT-DMTG, MT-BC, MTA (USA)

Summarized by Anja Tait
In this presentation, we each discussed the theoretical frameworks that inform our practice of involving families with the arts, and how this work is situated in the liminal space: The space between home, school, community and playground. We believe the arts in early childhood are full of joy, action and reflection. Arts interventions can address communication, social functioning and emotional wellbeing, and elicit an experience of enjoyment. Arts interventions are flexible, responsive, inclusive, collaborative, interactive and integrated.

Across the three case studies there were commonalities, including a) intentional learning for children, b) purposeful practice for adults, c) natural (everyday) environments, d) inclusion, e) collaboration, and e) reflection about process and product. We are concerned with measuring impact, both the observable and the intangible, including interaction, connection, involvement, and commitment. Across the three case studies there was also diversity, of art forms, disciplines, environments, research methodologies and methods.

From our work in schools, libraries and communities, our vision for learning in the early years, in practice, policy and research, centers around three key ideas: 1) everyday environments are natural and potent contexts for implementing early childhood interventions, 2) arts interventions expand and enable learning opportunities for people of all ages, and 3) an interdisciplinary approach allows multiple perspectives and inventive collaborations that contribute new knowledge to the field.

This presentation was a bricolage, comprising three different but complementary perspectives that accommodate contradictions, and together create and present a rich picture of the field: The arts in early learning, early childhood development and early intervention.

Practice-Based Evidence: Exploring an Overlooked Issue in Evidence-Based Practice Discourse
Kofi Marfo, Ph.D. (USA); Christine Johnson, Ph.D.; and Helen Lunn, B.A. (Australia)

Reviewed by Deanna Hanson-Abrament
This symposium included three presentations. In Early Intervention’s Evidence-Based Discourse: Beyond the Obvious and the Oversimplified, Kofi Marfo, Ph.D., stressed the importance of being “confident in ourselves” as we become evidence-based practitioners. Using the West African word sankofa, which means “going forward by taking the best of the past with you,” Dr. Marfo emphasized the importance of evidence and rigor, but also the value of experience and knowledge to do the right thing, recognizing highly qualified practitioners as the key to new knowledge.

Christine Johnson, Ph.D. and Helen Lunn, B.A. addressed the characteristics of an expert clinician in Practice-Based Evidence: What Practitioners Say it Means. Knowledge base, cognitive processes, the ability to internally integrate processes, and interpersonal relationships may be qualitative differences that identify an individual as an expert practitioner. Moreover, differentiation of practice levels could inform changes to curriculum, documentation of quality practices, decision support tools, and participation in decision and policymaking.

In Charting New Waters through Acknowledging Expertise and Evidence, Helen Lunn encouraged the recognition and development of expert practitioners through adequate pay, implementation of formal mentoring and clinical supervision models, increased number of expert practitioners as managers, a culture of reflective practice, and a continuous collection of feedback from patients and clients.

Each of these presentations had relevance to music therapy. As the vision of music therapy research and practice expands, it is important to review the past for value and meaning within the context of new ways of thinking and working. In addition, as music therapy evolves, the continuum of practice levels will demand greater differentiation. Embracing reflective practice and proactive advocacy for the training, retention and acknowledgement of expert levels of practice will guide the profession into the future.
together to achieve optimal benefits for clients. The context of the music intervention services, it is encouraging to know there are four principles that music therapists can apply when designing and planning interventions. All six of the principles can be applied through targeted early intervention programs. This is compelling for music therapists providing early intervention services to infants and young children at risk of developmental delays from deprived environments. "Genetic Aspects of Recovery from Early Brain Injury", James Blackman, MD, MPH, explored the function of genetics in predisposition to survival, recovery from brain injury, and being at risk for diseases later in life. The ethical considerations for research designs surrounding knowledge of genetic predisposition for debilitating diseases were discussed. It was stressed that a nurturing and therapeutic environment enhances the outcomes of children and adults who experience traumatic life events with differing recovery trajectories due to the individual’s genes.

In *Six Principles for Rethinking Language Intervention*, Kathy Hirsch-Pasek, Ph.D., the tenets of language development in the context of the environment were discussed. All six principles addressed had relevance to music therapy interventions in early childhood: 1) The amount of language addressed to children matters; 2) Children learn words for events and things that interest them; 3) Children learn best in interactive and responsive environments where they participate in conversations; 4) Children learn in meaningful contexts; 5) Children need to hear diverse examples of words; and 6) Vocabulary and grammatical development are not divorced—even for infants.

When music therapists sing songs to children during interventions, all six of the principles can be applied. Through a large repertoire of songs children are exposed to varied language and a larger base of grammatically correct words than might be used in conversations (principles 1, 5 & 6). Children are naturally interested in music and typically have a desire to sing along and learn the words of the songs (principle 2). A music therapy session is intrinsically interactive and responsive with the child participating in conversations, both verbal and musical (principle 3). The context of the music therapy intervention is meaningful as the child is addressing goals targeted for skill acquisition across domains (principle 4). In summary, as music therapists design and plan intervention services, it is encouraging to know there are communication, emotional, and genetic factors all working together to achieve optimal benefits for clients.

**Virtual Home Visits: Providing Services to Children and Families via the Internet**

Barbara Fiechtl, M.S. (USA); Sue Olsen, M.Ed. (USA); and Sarah Rule, Ph.D. (USA)

Reviewed by Anja Tait

Utah State University reported on a two-year research study about the effectiveness of technology as a tool for providing access and support for families isolated by seasonal weather. Many families reported that virtual home visits were equivalent in impact to face-to-face visits provided by early interventionists (e.g., occupational therapy, physiotherapy and speech pathology). During virtual home visits families were involved in direct delivery of therapeutic interventions for their children’s learning and development. Over time, families developed their capacity to provide for their children’s special needs.

There were reported to be large start-up costs (computer equipment purchase and loan), but large cost savings (travel, personnel). I query how the computer literacy of participating practitioners and family members might have affected the perceived impact of the therapeutic interventions. Additional issues could be the stability of the software, and reliability of Internet connections.

The findings of the study reported in this presentation are relevant to my professional context, enabling access and support for staff in isolated locations in Australia. It was also relevant to initiatives in other remote locations, including families isolated by refugee status and location.

**The Roots Literacy: Play and Language**

Carol Westby, Ph.D. (USA)

Reviewed by Edel Musco

This presentation focused on the importance of play, emotional literacy and language development for very young children. Westby made the following key points: a) stories are natural extensions of children’s early experience of sharing of event structures, b) engaging in storytelling practices with the support of others enables children to develop understanding of what it is to act for a reason, c) competency with different types of oral narratives enables us to understand others in a variety of ways, and d) narrative training casually influences basic theory of mind skills.

Westby discussed strategies to help children who are ignored in social play. These include 1) support children to enter play, 2) support children’s communication, 3) and help children build self-confidence. She recommends supporting children to enter play by teaching them the skills needed to enter play, and helping them find appropriate roles in the play. Westby supports children’s communication by showing children how to get another’s attention, and helping children to give clearly communicated messages. These strategies build young
children’s self confidence by helping them build play and communication skills and experiences being acknowledged and valued in play contexts. The teacher’s role is to recognize the play initiations, to interpret the play initiations, and to respond to the play initiations.

In my professional context, working with children across the stages of schooling, the value and implications of children’s play styles is often overlooked, within the classroom and beyond.

Online Professional Development for Early Intervention
Peggy Miksch, M.Ed. & Vera Stroup-Rentier, M.Ed. (U.S.A.), Ann Turnbull, Ed.D. (U.S.A.); Caya Chiu, M.Ed. (U.S.A.); and Heather Aldersey, M.S. (U.S.A.)

Reviewed by Petra Kern
This symposium included four presentations introducing the new Early Years Professional Development Program at the Beach Center on Disabilities, University of Kansas. In Key Principles and Overview of Courses for Online Training, Peggy Miksch and Vera Stroup-Rentier presented the program’s five key principles: 1) family-professional partnerships, 2) natural environments, 3) cultural responsiveness, 4) service coordination, and 5) the primary provider model, which are reflected in each of the eight available courses. In Definition and Operationalization of Evidence-Based Practice for Online Training, Ann Turnbull demonstrated how user-friendly documents as well as audio and video clips featuring various stakeholders’ perspectives, and case vignettes guide the learner through the evidence-based decision-making process. In State-of-The-Art Technology for Online Training, Cay Chiu illustrated the latest instructional technology such as engaging activities, progress tracking for learners, and documentation of continuing education for administrators. Heather Aldersey addressed how the online courses can be modified to accommodate other states and countries in her presentation, Opportunities for Contextual and Cultural Adaptation for Online Training.

In general, an increasing number of organizations and governmental agencies seem to be offering online professional development services. A new component accompanying these online courses is onsite mentor-coaching programs supporting learners in implementing the content presented in the online courses via Skype and other online tools. It is obvious that the field is moving from a traditional direct service model to a more consultative approach of service delivery which recognizes the strength of children and families to identify and implement solutions with the support of experts. As music therapists, we will need to stay current and apply all types of service delivery models when working with young children with disabilities and their families.

Resources
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› Download the Congress Program

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Imagine Why Music Matters: Advocating for Music As An Essential Early Childhood Experience

Dena Register, Ph.D., MT-BC
University of Kansas
Regulatory Affairs Advisor, CBMT

Every state in the nation is currently handling financial crisis. Open your local paper or turn on the evening news and you are bombarded with stories about budget shortfalls, elimination of services, and stories of already underserved populations not getting what they need to support basic growth and development. As strange as this may seem, this is an opportune time for those working with young children to focus on what we are able to provide and what resources are most cost-effective and beneficial for our youngest generation.

An extensive body of research in the last twenty years has helped us define several critical needs for children under five, regardless of their developmental progression. We know that if we are able to provide children and their families with support for 1) safe, secure, and appropriate attachment to caregivers, 2) the ability to self regulate and cope with change, and 3) the ability to utilize communication in the highest form of which they are capable, then we set them on a road to success.

Additionally, the connection between these three essential factors is also evident in current literature regarding the variables, which help predict how children’s cognitive development and literacy acquisition might progress.

In an effort to find some common ground among these three factors, I immediately think of the critical role that parents and caregivers serve in a child’s life. It is the interactions that we have, including the frequency and magnitude, which play a vital role in developing these three essential skills. For those of you who are parents, you might remember either a general (or quite acute) sense of panic over giving your own children everything they need to succeed in life. This feeling can be compounded by any number of difficult circumstances that include economic, familial or educational limitations. Many families have great difficulty knowing what resources are available to them and/or accessing those resources. The result of these challenges and gaps are missed opportunities during a critical developmental period (from birth through age five) that set the stage for how development proceeds with children.

Imagine for a moment that instead of the perception that music is something “extra” or “just for fun,” music was seen as the place where all of the challenges
and needs described above could be met. Imagine that there was an understanding that in the course of music group, parents could see and practice positive interactions with their child and could model the use of music to help children self-regulate and communicate.

The use of music to facilitate communication and teach non-music related skills is well researched, including the use of music to facilitate speech and language and reading skills in young children. Furthermore, the areas of music-assisted communication and child-directed music and singing have been substantial investigated. However, the relationship of music use in the home environment with parent and family interactions and its effect on development of both the individual child and the family has not yet been fully explored.

Imagining this kind of integration and impact is not difficult for those working in early childhood music practices with children and their families. We each have a cadre of stories that illustrate the principles of change facilitated by meaningful musical play. For example, the mother of a four-year-old child with autism spectrum disorder who, when testifying before a room of State Agency administrators, summed up her child’s music therapy group by saying, “When my child is in music I have the opportunity to see them doing things that every other [typically developing] child can do.” With moments as poignant as these, why do we find ourselves fighting to keep jobs? In short, the answer is two-fold: Education and documentation. These two components are also essential in advocacy.

While many people hear the word ‘advocacy’ and immediately associate it in some way with politics, it truly stretches beyond the scope of any election or political party and gets right to the heart of the things for which we care most deeply. Advocacy is one’s ability to defend or plead the case for a particular cause or position. Advocacy is the job of everyone everywhere. In a world that is constantly shifting (economically and otherwise), advocacy is one of the best mechanisms for continuing to move forward.

In the business of our day-to-day schedules it is often difficult to think about how we might add one more thing to our schedules. Part of our difficulty as music therapy professionals working with young children is that we often view advocacy as “another thing” instead of something that is embedded in our daily existence. This is not to say that there aren’t times when we need to take the extra moments to write a letter to an elected official or that we shouldn’t make the extra time to support in-person advocacy events. Rather, we need to be intentional in our day-to-day practice and discover the moments of advocacy that present themselves to us through what we are already doing.

Here is an example of how some frustrating experiences and professional needs resulted in an opportunity for both education and documentation in my nearby, underserved community:

I was coordinating music therapy services and writing music therapy curricula for early literacy learning as part of a large, multi-year grant project funded by the Federal Department of Education. The grant was well-planned and we had an outstanding team of professionals working on components that included a variety of classroom services, literacy coaching support, frequent professional development, services for students with identified
special needs and emerging bilingual students and parent outreach.

While things were, for the most part, moving along quite smoothly, one of our continuing challenges was the parent/family outreach piece. How could we, efficiently and effectively, reach a large number of families (between 140-145 being served as part of the grant service area) without overextending our ever-present staff and budget limitations? Attendance at evening events scheduled at individual schools usually included only families from that particular school (though all participants were invited) and with nine different locations on our service roster we could realistically only get to each school once per year at the most.

As we began to work together on a solution to this issue, our team recognized that both the music and the non-music research literature exploring parent-child interactions indicated promising results and benefits for both children and their families. We decided to utilize the local (and centrally located) library to host a monthly “Sing, Move & Learn” event for parents and their children. Plans for the one-hour music and story time were organized around a different theme each month and included both music and book experiences that were structured to elicit parent and child interactions. Experiences included singing, movement, instrument playing and story reading and interaction. As an incentive for attendance, participants received a copy of the featured story for the evening and participating families from the Early Reading First grant received a featured instrument to take home. Because the event was held in a community venue it was free and open to the public. These cooperating agencies were responsible for advertising the events via flyer and in early childhood classrooms and business venues throughout the area as well as through various online sources.

The purpose of this study was to investigate the perception of music use in the home as reported by the family as well as the effects of informal, group instruction and practice of music experiences on the interactions of family members. The parents/caregivers completed the survey regarding music use in the home each time they attended. Surveys measured the self-report of how much music was used in the home. Surveys following the initial event also asked participants if they had attended a previous “Sing, Move & Learn” and what, if any, of the previous activities they used at home over the previous month(s).

In the first four months of the event, participation went from less than 20 people to more than 100. By the second year, average number of participants leveled off at nearly 160 and peaked at just over 200. Additionally, parents that attended two or more sessions reported increased use of music techniques learned at “Sing, Move & Learn.” The program has found sustainability beyond its initial grant funding from a variety of community partners that find this program a cost-effective way to support the needs of young children and families in their community.

This kind of advocacy-in-action is a prime example of educating and documenting results. Using music to structure parent/caregiver-child interactions helps us work towards the three fundamental goals of 1) providing children and their families with support for safe, secure, and appropriate attachment to one another, 2) modeling situations for children to self-regulate and cope with change and 3) offering play-based opportunities for families, particularly young children, to communicate in meaningful, positive ways.

If you are concerned about the lack of music offerings for young children and their families in your community, consider how you might harness the incredible power you have to educate and document the large and small ways that you are changing lives.

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**About the Author**

Dena Register, Ph.D., MT-BC, teaches music therapy at the University of Kansas. She presents nationally and internationally on her work and research in early intervention and literacy skill development and has published in the *Journal of Music Therapy and Music Therapy Perspectives*. Dr. Register also serves as the Regulatory Affairs Advisor of CBMT.

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Advocacy in Action

› **Know Your Stuff:** Be willing and able to talk to parents, lawmakers, or other professionals in specific, concrete but SIMPLE language about the effects that music has on the various developmental domains. Have examples (stories) that you can share about the kinds of music you would use and how you would use them to elicit change.

› **A Little Goes a Long way:** We often here decision-makers ask, “What about the research in this area?” Research plays a vital role in the development of best practices and helps us determine what is most effective for children or clients. However, this is a questions that many people have been conditioned to ask without REALLY understanding the interpretation of the results. Choose no more that two to three poignant research articles to help make your point. Follow this with an anecdotal example of watching the change occur in order to really illustrate your point.

› **Practice Self Promotion:** While it is difficult for some of us to speak up and draw attention to the work we are doing, this kind of attention is critical to our survival, particularly during a time when we are facing cuts of “non-essential” programs. Part of becoming an “essential” program in the minds of others is pointing out what you are doing, documenting the results you are achieving and sharing that information with as wide an audience as possible. You have to systematically talk non-musicians (and some musicians for that matter) through precisely what is happening, including the functions that music serves in helping the children reach their developmental goals.

› **Stay Connected:** None of us works alone, even though it might feel like it some days. One way to feel supported and to access information and suggestions that can help you be a better advocate is by involvement and membership in your professional organizations such as the American Music Therapy Association, Early Childhood Music & Movement Association, Certification Board for Music Therapists, the Council of Exceptional Children, and National Association for the Education of Young Children. In essence, your continued membership and patronage of these and other associations is a form of advocacy. Your dues dollars allow those organizations to increase program offerings, support services and education and documentation on a national level which, in turn, serve professionals nationwide.

› **Focus on What Is Important:** No matter how bad things get, financially speaking, we MUST keep our eye on the “prize.” That “prize” is the opportunity and privilege to serve as many families as possible with the highest possible quality of services. It is critical that reaching children in more areas, earlier in their development be the focal point of our conversations, with decision-makers. The job security and increased funding will follow if our integrity and commitment to serve are upheld.

From time to time I will hear music therapists become defensive at the suggestion of sharing their work environment with another music professional or those in other therapeutic professions. I find this fascinating as it seems to come from a mentality of fearing we will somehow run out of work. In contrast, I have witnessed hearings where both occupational and physical therapists have testified publicly to agency heads about the difference that having a music therapist on their team made in their treatment decisions, the responses they saw in their clients and the efficacy of their team work on helping children progress.
This featured article describes the expansion of Sound Minds and discusses how this early childhood music therapy program functions as a training tool within the Even Start curriculum for low-income parents who use English as a Second Language (ESL) and their families.

**Beginnings**

In 2009, Noelle Pederson, the Director of Education and Training at Resounding Joy®, presented the Sound Minds program and correlating clinical results at the Western Region Even Start Conference for approximately 150 early childhood and family literacy educators. After attending the presentation, Kelley Tennis-Flores, the Bilingual Liaison for the Even Start program in Placentia, California expressed interest in a staff and parent training of the Sound Minds program at her facility.

According to Ms. Tennis-Flores, Even Start serves parents who are English as Second Language (ESL) students and their families who might benefit from the Sound Minds program. Ms. Tennis-Flores remembers the first interaction with the Resounding Joy® music therapist as following:
When I saw Noelle get this room full of educators who were bored, half asleep, burned-out, and frustrated – she lit a fire under us and got us excited to jump up to sing and dance. It was definitely the highlight of the conference. It woke us all up, touched the warm part of us and reminded us of why we teachers do what we do when working with children. We know what works – when the kids AND the parents are having fun, we see a greater success.

“A parent is a child’s first and most important teacher.” This quote is commonly used by Even Start staff and functions as the underlaying philosophy of the program. The Even Start program at Ruby Drive Elementary in Placentia, California is funded by a federal grant that is designed to break the cycle of poverty by empowering parents with the knowledge and practice of literacy activities and teaching them how to develop essential relationships with their children. The main program goal is to help foster the bond between the parent and the child. Many of the parents have been raised with the idea of only giving directions to their children as opposed to relating to them – through touching, eye contact, and building trust. Activities such as music, playing, reading, or cuddling helps provide a solid foundation for the parents and their children. Even Start parents participate in literacy field trips to local community organizations and venues. They receive educational materials and resources to begin building home libraries and provide learning opportunities at home for their children.

Even Start participants make a significant commitment when enrolling in the program. For example, the program includes:

- Daily ESL classes
- ESL distance learning
- A minimum of 30 minutes daily Parent & Child Interactive Literacy Activities (PCILA)
- Attendance at weekly parenting education classes
- Attendance at daily preschool and childcare for children ages 0 to 7 years old, and
- Regular home visits.

In January 2011, Sound Minds staff held a five hours training at the school location for approximately 30 families and 20 local Even Start staff members. Table 1 outlines the training schedule.

**Table 1. Schedule of the Sound Minds Training**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:30-7:55</td>
<td>Pre Workshop Setup</td>
</tr>
<tr>
<td>8:30-9:35</td>
<td>Child-Parent Sessions</td>
</tr>
<tr>
<td>9:30-9:35</td>
<td>1) Infants/Mobile Infants</td>
</tr>
<tr>
<td>8:45-9:10</td>
<td>Toddlers</td>
</tr>
<tr>
<td>9:15-9:45</td>
<td>Preschoolers</td>
</tr>
<tr>
<td>10:00-11:00</td>
<td>Sound Minds Staff Training</td>
</tr>
<tr>
<td>10:45-11:00</td>
<td>1) Introduction of Sound Minds</td>
</tr>
<tr>
<td></td>
<td>2) Slideshow &amp; Interactive Experiences</td>
</tr>
<tr>
<td></td>
<td>3) Question/Answer Segment</td>
</tr>
<tr>
<td>11:00-12:00</td>
<td>Break -</td>
</tr>
<tr>
<td>12:00-12:15</td>
<td>1) Introduction &amp; Opener G</td>
</tr>
<tr>
<td>12:15-12:45</td>
<td>Hands-on Training</td>
</tr>
<tr>
<td>12:45-12:55</td>
<td>3) Homemade Instruments - where to local</td>
</tr>
<tr>
<td>1:00-1:10</td>
<td>Break -</td>
</tr>
<tr>
<td>1:10-1:40</td>
<td>4) Hands-on Training</td>
</tr>
<tr>
<td>1:40-2:00</td>
<td>5) Summary &amp; Q/A</td>
</tr>
</tbody>
</table>

Kelley Tennis-Flores, Even Start Bilingual Liaison reflected the initial training as follow:

“I was noticing lulls throughout the day, downtime that wasn’t being used – we need to make this fun for our families. We brought in teachers from four different ‘school readiness’ sites from the district, preschool teachers, infant childcare workers, and the Even Start director. Everyone enjoyed it and got excited; it was a great bonding experience for us as a staff.”

Watch Sound Minds and Even Start
-Kelly Tennis-Flores, Bilingual Liaison, Even Start
Language and Bonding Focus
The majority of the parents who attend the ESL program and Even Start in Placentia speak Spanish as their first language; some families come from around the world. Not speaking English and possessing poor literacy skills prohibits these parents from attaining jobs, resulting in low-income or impoverished situations. The main goal of the Sound Minds program is to encourage parent and child bonding through music while addressing developmental goals for the children. The focus of the program within the Even Start curriculum focuses on language development. Most of the songs and activities of Sound Minds use English as the main language with American Sign Language as gestural reinforcement. Some Spanish songs have been added to excite Spanish-speaking parents and their children about using their native language and to introduce other children to it since it is widely used within the community. Staff members of Resounding Joy® believe that it is important to incorporate at least one song of each parent/child that attends the group to encourage the acknowledgement and respect of their language, traditions, and culture.

Using Music in the Classroom
The early childhood educators attended a two-hour workshop, which included a 45-minute didactic presentation explaining the research behind using music to achieve developmental goals with children. Many of the classroom teachers spoke little English; a translator proved to be very helpful especially during the question and answer section. 75 minutes were allocated for actual experiential practice of singing typical children songs with sign language, movements, and gestures. Even Start staff voiced their concerns that they were intimidated to sing aloud, feared they would forget the lyrics, or that they felt uncomfortable or “silly.” By the end of the interactive practice session, the educators appeared more confident and were able to lead a few songs independently in front of the peer group.

Using Music Activities at Home
Prior to the Sound Minds Parent Workshop, parents created small musical instruments with the ESL teacher. Parents were eager to demonstrate their music products to the Sound Minds music therapist.

To evaluate how parents use music outside of the classroom environment with their children, Sound Minds staff applied a simple “Music Usage Survey” outlined in Table 2.

Table 2. Sound Minds “Music Usage Survey” for Parents

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
</table>
| In the last month, which of the following did you use music with your child? | Ultrasound Cheering  
Feeding  
Bed/Hug Time  
Play Time  
Car Rides  
Clean Up Time (e.g., toys)  
Bath Time  
Pacification (e.g., calming the child)  
Grocery Store/Shopping |
| How often did you use music with your child this last month? (e.g., 1x/day, 3x/week) |  |
| What kind(s) of background music do you play (if any) while your child is in the room? |  |

As an outcome of the informal survey, parents selected “pacification” most often and described that they sing an occasional lullaby to get their child to sleep. Others indicated that they play recorded music (e.g., from the radio – not necessarily children’s music) in the background throughout the day.

The Sound Minds staff discussed with parents how music might be used as a transition song, for play, and to provide general structure and fun to their children’s daily routine. Parents responded with confirming nods and took notes.

During a consultation visit three months later, the Sound Minds music therapist referred to the information from the initial
“Music Usage Survey” and asked again how the parents are using music at home with their children. Many of the parents excitedly replied with descriptions of music activities they do at home, what instruments they have created with their children, and the overall benefits they might have observed by using music with their children in everyday life. One parent said, “We like to be together more and I stop thinking about what am I going to do with them? We like playing together all the time.”

At the the next consultation visit, both parents and teachers reported that remembering all the components of the song was the most difficult piece to facilitate. This can be seen as progress considering that during the January 2011, training workshops the participants described the biggest challenge as “feeling too silly” to sing and engage in the activities. Not one parent or teacher described feeling that way any more. One parent said, “I just want to do it as perfect as I can for my kids, but they have fun no matter what I do.”

Sound Minds staff conducted a clinical post-training evaluation with Even Start parents and staff. In this evaluation, most parents requested a video with the songs’ melodies and actions. Hence, Sound Minds staff created a DVD with video excerpts featuring each song of the 30 songs used in the curriculum as well as explaining how to position the child for each music activity, modeling the movements, and providing the melody and lyrics.

Today, Even Start staff uses the DVD to practice so they can lead the parent-child groups and use them during the children’s morning music floor time. The music therapist of Sound Minds suggested that the instructional DVD be provided to every family who attends the Even Start program.

Future Perspectives
Since the beginning, Resounding Joy® has broadened the possibilities for education and bonding at Ruby Drive Elementary Even Start program. The Even Start program in Placentia, California has ordered USD $5,000 worth of instruments and equipment for the classrooms and “family kits” that the parents may take home and use with their children.

Resounding Joy® is refining Sound Minds to become a licensed training program to continue training early childhood development staff for programs like Even Start, Head Start, teen parent programs and so forth. The goal is to get music making and learning into the hands, hearts, and homes of teen parents, ESL parents, and their families. Some of these programs have funding in their curriculum budget to hire a certified music therapist, which allows the program to receive the highest quality of services. However, for the majority of early childhood programs who do not have available funding yet, other options need to be found.

Music therapists should be prepared to offer training and consultation to early childhood staff so that the interactive music-making programs continue within classrooms and parent/child groups. Sound Minds will continue to fine-tune this training program in order to provide other music therapists a more detailed concept of the curriculum and how to get such program started at other early childhood settings. Eventually, a formal program evaluation of Sound Minds will be warranted.

Resources
› Resounding Joy Inc.
› Even Start Network
› Position Statement Even Start
› Ruby Drive Elementary Even Start
› U.S. Department of Education Even Start

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With the current emphasis on evidence-based practice, music therapy clinicians that work with young children are encouraged to integrate research findings with their clinical expertise and client preferences (Kern, 2010). This review will demonstrate brain changes that occur as a result of music engagement and the use of music for skill acquisition in early childhood settings. There are exciting developments in music research, illustrating the powerful effect that music can have on child development.

**Early Brain Development and Music**

New brain imaging methods have allowed researchers to better document changes that occur in the developing brain. These advances have heightened our understanding of brain processes including cortical plasticity and critical periods. Cortical plasticity is the ability of the brain to change, to be flexible or “plastic” in response to its environment. As the young brain changes in response to the environment, there are thought to be “critical periods” or times where the brain is especially sensitive to environmental information/stimuli needed for development of different skills and functions. For example, there is a period in childhood where we appear to naturally learn language from our environment; however, after that period it can be much more difficult to learn a language (e.g., learning a new language as an adult vs. naturally learning language as a child). When there are difficulties in acquiring skills, music could be used to enhance or optimize learning during these more “plastic” periods (Healy, 2010).

The unique characteristics of music make it motivating and attractive to young children, and therefore the ability for music to facilitate brain changes has been the focus of some current research. When looking at adults who began music engagement in early childhood, researchers have found increased volume of the brain areas involved in:
An examination of research published in 2010 – 2011 demonstrates nonmusical skill acquisition in young children who are engaged in music therapy.

Music in the Neonatal Intensive Care Unit (NICU)
This research snapshot will provide a brief synopsis of current research in the NICU. In a study by Vianna et al. (2011), mothers who engaged in music therapy had a statistically significant increase of breastfeeding rates compared to mothers who did not receive music therapy sessions. Using the pacifier-activated-lullaby, Standley et al. (2010) demonstrated a statistically significant shortened gavage (tube) feeding in premature infants at 34-weeks adjusted gestational age. Furthermore, Standley et al. (2011) completed a recent post-hoc analysis of infants in the NICU who receive NICU music therapy. Results indicated that the smallest infants (low birth-weight) tended to be referred for services. Results also showed that infants receiving services tended to gain more weight and, for babies born very prematurely, be discharged earlier. These studies continue to show positive results for using music with children in the NICU. Music therapists are encouraged to receive additional training when working with this population in order to prevent any possible harm to the fragile developing system.

Speech and Language Development
A few recent studies have highlighted the impact of music therapy on the development of speech skills. Groß et al. (2010) investigated the use of creative music therapy (based on Nordoff-Robins) with eighteen children ages 3.5 – 6. Children showed positive gains in phonological memory for words and understanding sentences. The children also showed statistically significant gains in scores on intelligence. In another study, Lim (2010) researched the effect of music on the acquisition of target words in children with autism ages 3 – 5. This study randomly placed children in a music group, speech group, or control group. Results indicated that children in the speech and music conditions showed statistically significant verbal production improvements when compared to the control condition. Participants who were “low functioning” showed the greatest improvements in the music condition.

Early Learning Skill Development
Providing quality, art-enriched early intervention programs for “at-risk” children was the focus of a study completed by Brown, Benedetti, and Armistead (2010). These researchers found that children engaged in an arts-enriched preschool (early learning, music, visual arts, and creative movement) improved in language, literacy, mathematics, and science skills, regardless of ethnicity and economic disadvantage. This growth was in comparison with another “high-quality” preschool, suggesting that an art-focused program can enhance early learning goals.

Other important skills in the early childhood setting include social and imitation skills. A recent single-subject design study by Finnigan and Starr (2010) showed that music therapy was successful in increasing social responsive behaviors in a
preschool child with autism spectrum disorders. Increased behaviors included eye contact, imitation skills, and turn-taking skills. Nonmusical follow-up measures showed some carry-over in turn-taking skills. Furthermore, the client was engaged in the music therapy sessions, showing no avoidant behaviors during treatment.

The above studies highlight some current research in early childhood settings. Although more research is needed to show the efficacy of music therapy in early intervention/early childhood special education, the initial evidence indicates that music could be an extremely powerful tool in child development.

In order to provide readers with the opportunity to explore these studies further, the reference list below has direct links to the study abstracts via PubMed (http://www.ncbi.nlm.nih.gov/pubmed/) or the digital object identifier (DOI) number (http://www.doi.org).

References

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Possible Effects of Music Therapy on the Building Blocks of Communication
Debra Jelinek Gombert, MA, MT-BC

Almost every early childhood setting is concerned with teaching or improving communication. Communication includes the use of language, a range of verbal and nonverbal behaviors, and social communication: The skills of reading facial expressions, perceiving emotions, and using nonverbal communication. Deficits in these social communication skills are at the very core of the DSM-IV-TR (APA, 2000) definition of Autism Spectrum Disorders (ASD). Social play, imitation, and reciprocal turn-taking form the foundational building blocks for both social communication and language development.

This article describes how music therapy may help anchor and support these building blocks. Although the focus of the intervention was on children who have ASD, the theories and measures used may be of interest to those who work with a variety of early-childhood populations.

Theory
Speech language pathologist James MacDonald (2004) defines a child’s interactive life as having three components:

1. Social Play – interacting with another with no goal other than being with each other
2. Imitation – acting and communicating like others, spontaneously learning from the surrounding world, and
3. Reciprocal Turn-Taking – having the habit of give-and-take in a related meaningful manner.

He suggests that a child-led model is most effective for working with late-talkers, including children with ASD. MacDonald’s model encourages the adult to first build a relationship by meeting the child at his or her current emotional, communicative, and interactive level, and then, through matching the child in balanced and playful interactions, gradually bring him or her into the adult’s world. MacDonald’s speech pathology approach closely mirrors the humanistic approach to music therapy described by Boxill (1981), in which making contact with a child becomes the foundation for helping that child move from inner action to outer action. These two models share a goal of shifting a child from someone who operates primarily in his or her own world, to someone who actively interacts with the people around him or her. The following protocol was based on these theories of MacDonald and Boxill.

Protocol
Eleven male children, ages 36 to 66 months, took part in four one-on-one music therapy sessions. All children had been diagnosed with ASD. A parent was present during all of the music sessions, and was encouraged to participate and interact playfully with the child during the sessions. The weekly sessions were 30 minutes each. The following protocol was used to determine if music therapy could possibly facilitate positive change in each child’s interactive life.

In addition to a hello song and goodbye song, the protocol included four pre-composed songs. The songs involved actions with scarves, shakers or the drum, inviting and encouraging imitation of sounds, words, and actions in a musically engaging, natural, and enjoyable way. Some songs and adaptations naturally invited turn-taking with sounds, words, or movements; others encouraged playfully staying in extended exchanges with the therapist or parent.

Watch Music and Movement Actions

The music and activities were chosen to allow the therapist to 1) musically balance the amount of the therapist’s and child’s music, 2) musically match the child’s behaviors, 3) respond to the child’s feelings, actions, words, and preferences, 4) share control with the child, letting each partner affect the direction of the music and the session, and 5) be playful with the child (MacDonald and Stoika, 2007).
The protocol remained consistent for the four week period. However, the songs in the protocol were sometimes expanded or adapted to meet the child at his or her level. Although play was sometimes extended with a particular instrument or prop, no new instruments or props were introduced. For example, Q. seemed to be distressed at the sound of the guitar, so the melody of the hello song was sung with only the drum as accompaniment. The lyrics of a song were sometimes changed to reflect what the child was actually doing, rather than to name a desired activity. For instance, in W.’s case, this meant that instead of singing “Shake, shake, shake... turn around... and stop” to the shaker song, his father and the researcher sang “Dance, dance, dance.... run around... and stop.”

More time was sometimes spent on a particular song, depending on interest. For example, D. seemed to love the scarves and the scarf song, especially when we said “Wooo!” and threw the scarf up in the air. He began to imitate the sounds of the song. Later, the researcher interpreted his throwing the scarf down as a request to say “Wooo!” D. looked at his mother and signed “up.” His mother threw up the scarf; he smiled and repeated the sign and request several times.

Results

Although the I-ARM does not have established reliability, and has not been validated, it was chosen because it contains all of the elements that are foundational to a child’s interactive life and thus central to improving a child’s social communication and later language development. According to the trained observer, there was a statistically significant increase in interactive life as measured by the I-ARM (MacDonald, 2004) for all 11 participants (Gombert, 2010).

Furthermore, the music therapist reported the following observations:

W., who seldom made eye-contact, began to look at the music therapist in anticipation of the “stop” during the shaker song. He also began to make alterations to his energetic motions so that they more closely matched the adults’ running and dancing. W. did not ever seem interested in the shakers. It seems unlikely that he would have been engaged had he been asked to focus on the objects the therapist was interested in; rather his father and she joined him and labeled his actions. The result was that W. demonstrated a higher degree of imitation during the study than his father had previously seen.

D. engaged in extended social play with others during scarf time in his music session perhaps because the adults present spent a little more time on the song he loved, and expanded the activity accordingly. D.’s mother reported that it was rare for D. to make any request, and that prior to the study D. had never spontaneously requested “up” for anything except to request that he be picked up.

Several mothers wrote unsolicited comments after the final session. In some cases the comments reflected a change that the numbers did not capture. Without prompting, the mothers reported improvements in many areas targeted by the intervention.

X.’s mother saw an increase in her son’s interaction following music therapy sessions: “It has been taking much less prompting to have him answer people... He was seeking out interaction with his bus driver assistant more.”

Measures

The Interactive Life part of the Adult Child Relationship Map (I-ARM), a tool designed by MacDonald (2004), was used as the pre-test and post-test. The I-ARM has three main categories: Social Play, Imitation and Modeling, and Reciprocal Turn-Taking. The fourth section lists problems that are possible indications that a child does not want to interact (e.g., ignoring or avoiding people).

For this case, a parent completed the I-ARM before the first session and after the last session. In addition, a trained observer completed the I-ARM while watching videotapes of the first and last sessions for each child.
T.’s mother saw increases in recall and imitation, writing that T. “has shown two main areas of improvement as a result of music therapy – his recall of past events/ability to talk about them in the present – his inclination to imitate others.”

Two mothers wrote about an increase in turn-taking. X.’s mother wrote: “This music class [study] has been effective in forcing the wonderful and much needed eye contact when turn-taking and otherwise, versus playing a board game for example. He now wants to take a turn.” J.’s mother wrote: “J has a better understanding of turn taking... initiated a conversation with a stranger for the first time ever while in music class [this study]. It was a start to back and forth exchange initiated by him.”

J.’s mother also saw an increase in imaginative play, writing: “His imaginative play has become used more and to a larger scale. He had some great movements in class [the sessions] when he had the idea to paint the wall. ... I notice a more detailed imaginative play with him.”

Conclusions
The fact that a trained observer reported a statistically significant increase in interactive life suggests that this type of intervention might be useful in increasing interactive life in children who have ASD and other communication deficits. The observations from several mothers supported this (Gombert, 2010). Further study of and research utilizing the interactive portion and other portions of the Adult child Relationship Map (ARM) is needed to establish its use as a measure, and perhaps as assessment tool. A longer intervention period is also recommended, which may result in greater carry-over of the skills gained in music therapy, as well as closer agreement between the observer and parent’s reports. In addition, a mixed methods study is recommended, to include all parent’s written comments on the intervention.

References

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Debra Jelinek Gombert, MA, MT-BC works as a music therapist in both the public schools and private practice with preschool and school-age children who have multiple impairments or ASD. The study reported here was completed in partial fulfillment of her Master’s degree in Music Therapy at Saint Mary-of-the-Woods College.

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Early Music Therapy Intervention for Language Development with At-Risk Infants

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The ability to effectively communicate is a skill that is vital to healthy relationships, learning and development, and life-long success. When a child begins life at a disadvantage due to health or environmental risk factors, his or her ability to communicate with the world is affected. For these children, early intervention that begins during infancy can be a key factor in neurological development, thus creating a more cost effective intervention that has stronger and greater long term tangible outcomes than intervention that comes later in childhood (National Scientific Council on the Developing Child, 2007). Due to the similarities of how music and language are processed in the brain (Patel, 2008), music-based interventions can support language development in at-risk infants.

Naturalistic and constant exposure to language within the context of a meaningful relationship supports the acquisition and learning of language (Callander & Nahmad-Williams, 2010). It has been suggested that the early exposure to mother’s voice in particular may be important for the processing of language (Dehaene-Lambertz et al., 2010). However, children living in poverty may experience deficits in their language exposure thus impacting later cognitive development. A landmark longitudinal study, originally published in 1995, by Hart & Risley (as cited in 2002) demonstrated a vast discrepancy in language exposure to young children based on socio-economic status. Infants growing up in poverty heard on average far fewer words per hour (616 words/hour) than those growing up in working class households (1,251 words/hour) or those in professional households (2,153 words/hour) (Hart & Risley, 2002, p.32).

Language acquisition is cumulative and early experiences are critical to brain structure, thus lack of language experience early in life can negatively impact later developing higher cognitive functioning (National Scientific Council on the Developing Child, 2007) and psychosocial well-being into adulthood (Schoon, Parsons, Rush & Law, 2010). Therefore, early intervention that is immersed in naturalistic language should begin during infancy. Interventions that are designed to be appropriately stimulating to the neural circuitry of the infant brain may promote appropriate development adequately preparing the child for higher-level language learning (National Scientific Council on the Developing Child, 2007). Music-based intervention strategies can be intentionally designed to be infant directed, occur in a naturalistic environment, focus on hierarchical language acquisition skills, and promote meaningful relationships with the music, the therapist, caregivers and parents.

There is a large body of literature describing the similarities between speech and music in brain structure and function (Deutsch, 2010; Patel, 2008), providing a neurological basis for intervention. Infant-directed singing can be utilized as an intervention strategy to elicit, direct and sustain infants’ attention so that other developmental milestones can be addressed (de l’Etoile, 2006). The therapeutic function of music intentionally organizes the elements of music to address intervention objectives (Hanson-Abromeit, 2010), specifically the pre-linguistic aspects of language development such as gestures, babbling, and word utterances. Figure 1 illustrates an example of the therapeutic function of music specifically intended to be developmentally appropriate for infants and pre-linguistic acquisition. The music elements are intended to provide emotional regulation and sensory organization to support infant availability for learning, as well as language skills.

Directed interventions can be presented in a sequenced manner to mimic the developmental acquisition of language (e.g. gestures, vocalizations and words) as well as be cumulative in nature to reinforce repetition of language concepts. Music therapy services can be offered in a manner that is developmentally appropriate and in a naturalistic environment, such as home or day care. Replication by other
caregivers and parents would also ensure greater exposure of intervention strategies, raising the potency by creating a preventive intervention strategy that is integrated into all aspects of an infant’s environment. Early music therapy interventions have the capacity to create a bridge between music and relationships for at-risk infants who are living in poverty to facilitate reciprocal communication and language learning.

References

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Figure 1. Therapeutic Function of Music for Infant Language Interventions
Evidence-Based Interactions: 
Music Therapy with 3-12 Month Old Infants in a Hospital

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Abstract
There is an established literature base for music therapy with both hospitalized newborn infants and children. However, infants aged 3-12 months fall into a “gap” where the literature about premature infants does not acknowledge the infant’s social capacity for companionship, and the pediatric literature does not acknowledge the infant’s lack of autonomy. This article uses two clinical case vignettes to explore how the various research bases may be flexed to provide a coherent basis for meeting the needs of the infant. The clinical cases will be interpreted through the theoretical lens to indicate the potential for further clinical or research pathways for consideration.

The music therapy literature informs practice with critically ill newborn infants, and young children, but the subtle age group of infants aged three to twelve months is unrepresented in the literature. These infants are more mature than critically ill premature or newborn infants, but do not yet have the social or communication capabilities of the pre-school population. Therefore, there is a need to consider our capability to construct evidence-based interventions to meet their unique needs.

Literature Review
Hospitalization of an infant in the first year of life has the potential to involve unfamiliar people, invasive, potentially frightening procedures and an unpredictable, chaotic atmosphere. This may intensify feelings of stress and anxiety that infants and young children often experience when they are ill (Marley, 1996; Robb, 2008). The protective presence of parents sustains some normality for children (Shoemark & Dearn, 2008) but may be limited by their own stress response to the hospitalization or other obligations such as caring for other children, or work (Marley, 1996; Robb, 2008).

For both infants and children, music therapy serves to break isolation, develop feelings of control, reduce stress and facilitate growth, development and learning (Jacobowitz, 1992; Standley, 2003). The music therapist is trained to stimulate interaction in a safe and sensitive manner to support the infant’s sense of social effectiveness and importance in the world (Miller, Ables, King, & West, 2009). Music therapy for an infant in acute hospital care will most often include infant directed speech and singing (Courtnage, 2000). Infant directed speech (IDS) and singing is characterized by sustained vowels, slow tempo, gliding between pitch levels, high pitch level, simplified pitch contour and repetition (Courtnage, 2000; de l'Etoile, 2006). Arnon et al. (2006) also described the implementation of wordless, rhythmic, repetitive, soothing lullabies provided by a female voice, with the intention of replicating sounds infants are likely to have been exposed to in utero.

Shoemark (2011) uses the term contingent singing to acknowledge the conscious application of the intuitive infant-directed singing as a therapeutic intervention. Contingent singing is responsive, synchronous and reciprocal, providing opportunities for infants to learn that they can influence the social partner (O’Gorman, 2007; Shoemark, 2006).

The consistent and predictable nature of a song makes it an ideal method for the co-constructed experience of music therapy (Shoemark, 2006). Songs may include both pre-composed (to provide potential familiarity) and improvised songs (to respond to the infant in the moment). Lullabies serve to relax and soothe, focusing attention inwards, whereas play
Songs aim to attract an infant’s interest, focusing attention outwards towards the music therapist (Courtnage, 2000; de l’Etoile, 2006). This shared attention creates opportunities for meaningful interaction and communication with the caregiver (de l’Etoile, 2006).

Infants between the ages of 3 and 12 months are no longer neonates, but are still pre-verbal; they are socially available and able to engage, but are still infants. How then does the clinician construct an evidence-based approach to meet the fluctuating needs of the older infant in a hospital setting? The following case vignettes illustrate how an early career clinician rationalized method selection by matching behavioral status and familial context with the published literature for preterm infants and children in a hospital.

Case Studies
Two clinical cases are drawn from the clinical program undertaken by the first author under the supervision of the second author. The program focused on the infant aged 3-12 months in the General Medical ward of The Royal Children’s Hospital Melbourne, Australia. The infants presented with conditions such as failure to thrive, bronchiolitis, liver failure and respiratory complications; they received care over admissions from a few days to a few weeks. Referrals to the program were for infants who were expected to have a long admission, showed signs of distress, or lacked family support.

The music therapist first interacted with family members and nursing staff to establish the key foundation for commencement of the intervention—infant age, medical condition, presenting state and behaviors, availability of family, and the family and infant preferences for the intervention. The music therapist drew on the writings of Standley (2003), Walworth (2009), de l’Etoile (2006), and Shoemark in applying music for critically ill newborns and premature infants. The writings of Robb (2008) and Whipple (2005) provided key indications for live music serving to create a supportive and familiar atmosphere that promotes interaction with pre-school aged children, and Shoemark and Dearn (2008) provided guidance on music therapy in family centered care.

Case Study “Mary”
“Mary” (not her real name) was a 7-month-old infant with a pre-existing developmental delay involving restricted physical capabilities and complex medical issues which resulted in high levels of pain. Mary’s family was from the country so their presence at the hospital was limited. The nurse unit manager referred Mary because of her high levels of distress and limited social partners or opportunities for successful interaction.

After the referral discussion and initial fact finding, a brief interaction indicated that Mary presented as a critically ill infant with pain and related distress (cry face, sweaty skin, stiff arm movements, disengagement and escalated crying). Using the critically ill newborn literature, the music therapist (MT) selected live and possibly recorded music to reduce distress. The initial intention was to use IDS with a characteristic falling pitch to support Mary’s transition to a settled state (Courtnage, 2000; de l’Etoile, 2006).

Mary cycled through short periods of crying and being settled, so the MT paired IDS with tactile stimulation (simple patting of her arm in time with speech) to provide more affirmative support. The MT interpreted Mary’s extended periods in a settled state as a positive reaction, so she then expanded her vocal presentation to contingent singing to provide a more engaging focal point (Shoemark 2010). As the intention was to help Mary transition to sleep, a lullaby-like rendition of Twinkle Twinkle Little Star (familiar to her) was used to relax and soothe, and focus her attention inwards (Courtnage, 2000; de l’Etoile, 2006). Mary did settle and slept.

In contrast, the second session commenced with Mary in an alert and settled state. For this session the MT considered Mary as a socially available infant, and thus held her family in mind in approaching her as their developing daughter. Despite complex medical status and lack of family support, it was possible for Mary to engage in interaction that was responsive. The MT invited Mary into active interplay by using infant-directed speech with rising pitch, and used both pre-composed and improvised songs. Given that an improvised song can be used to respond to the infant in the moment (Shoemark, 2006), lyrics were improvised around the shapes that Mary was creating with her mouth and the saliva bubbles she produced with her breath. Mary reciprocated and responded to the animated facial expressions with increased smiles and vocalizations. Through this responsive and reciprocal interaction, Mary was able to have an impact on her environment, which may contribute to the development of a sense of self and freedom of expression.
**Case Study “Sarah”**

“Sarah” (not her real name) was 12 months old, awaiting a liver transplant, and had multiple admissions on the general medical ward. Sarah’s mother self-referred for music therapy, as she had found music therapy useful for positive interaction and sensory stimulation in previous admissions. In her initial interactions, Sarah was energetic and able to socially engage. Using the literature on hospitalized pre-school children, the MT aimed to re-engage Sarah in her environment, using age-appropriate songs and instrument playing to create a predictable environment, structure, autonomy support and involvement (Robb, 2008).

From the outset, Sarah was receptive to nursery rhymes and pre-school songs. She “danced”, vocalized and played instruments. She was active in shaping the session, using clear pointing actions and vocalizing open vowel sounds to indicate choice. Interactive music therapy sessions provided a safe and predictable environment in which Sarah’s preferences were honored and gave her some control over her environment. Her self-expression was acknowledged and her developmental needs met. Occasionally, Sarah’s presenting need was to transition to sleep. Rather than rescheduling or missing the session, the MT adjusted the work to focus on state transition (informed by the critically ill newborn infant literature). The method employed was gentle, repetitious singing of lullabies with light guitar accompaniment to support her transition to sleep.

As care was planned around the whole family, the other significant variation in sessions accommodated the changing needs of Sarah’s parents. In initial sessions, Sarah’s mother was actively involved, and thus the role of the MT was as a facilitator, providing the music that set the context for interactions between mother and daughter. Through established rapport and trust, Sarah’s parents began to also use the music therapy sessions as respite. They sometimes left the ward, knowing that Sarah was happily involved in appropriate contingent interaction. Other times they sat in the background of the session, taking the opportunity to see Sarah engaged in music with the therapist. Perhaps observing Sarah engaged in this context also may have had therapeutic benefits for the parents, as they could see their social infant able to interact, participate independently and have control of an activity she enjoys (Shoemark & Dearn, 2008). The needs of the parents were always held in mind, whether their participation was active or passive, or they were present or absent during the session (Shoemark & Dearn, 2008).

As the MT was only available for two active sessions each week, the role of music was extended by resourcing the family for other times. Active engagement with the family established their songs of kin (key songs with meaning for the family) (Loewy & Stewart, 2005) and produced an understanding of stylistic preferences. A recorded music library was established and maintained with variation in the music as needed. Music remained an important part of everyday life for this family, creating a safe, supportive and familiar atmosphere. Thus the music therapy program provided a continuum between the two current environments in family life, the home and the hospital.

The research basis provided a lens through which the music therapist filtered her interpretation of the child’s needs and thus her plans for pertinent methods.

**Conclusion**

The first twelve months provide one of the most significant periods of development in a child’s life. Music therapy evidence to support this time is lacking as this age group falls between the existing evidence bases for hospitalized newborns and pre-school aged children. Two case examples offered insight into the unique and varying needs of a 7 month and a 12 month old infant, and the process of using the literature to assess status and familial support prior to selecting music therapy methods. This work would be enhanced by research, explicating the processes which take into account the fluctuating needs of unwell, pre-verbal, socially available infants within the context of their families.

**Note**

This paper was originally presented to the 35th National Conference of the Australian Music Therapy Association, Sydney 2009. The work was completed while the primary author was on a clinical placement during her final year of study under supervision of the second author, at The Royal Children’s Hospital, Melbourne. Written consent was given by the families for the vignettes to be published.
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As soon as, or even before a human is born into the world, parents begin speaking to and attempting to communicate with their child. Communication builds relationships between humans, allowing them to interact in meaningful ways. Communication facilitates learning, enabling one to receive, process, and respond to information to develop cognitively and socially. Ultimately, communication is essential to function in society. Yet, many children and families are affected by autism spectrum disorders (ASD) and a primary characteristic of ASD is the lack of an effective means of communication (American Psychiatric Association, 2000; Centers for Disease Control and Prevention, 2010).

Communication, Language, and Speech
Communication involves receiving information from others (receptive communication) and expressing information to others (expressive communication). It is the process that people use to exchange concepts and ideas (Owens, 2001). To exchange ideas fluidly, the vast majority of all communicative acts involve language. Language is communication that is based on a rule-governed system (Owens, 2001). Within societies, rules are attached to the relationship among symbols to give people means to communicate with each other in an orderly and coherent fashion.

When language occurs in a non-print format, it typically occurs via speech. Speech is “a verbal means of communicating or conveying meaning” (Owens, 2001, p. 7). Though communication is not solely defined by the ability to speak, much focus is placed on speech from the day of one’s birth, since that is the primary mode of communication in our society.

The ability to communicate effectively with familiar and non-familiar people is essential to functional life. An effective communication system allows one to express needs and desires, interact with others, and engage effectively in a classroom or work environment. The ability to communicate is central to life quality. Unfortunately, deficits in communication are a hallmark feature of ASD and almost 50% of individuals with ASD do not have effective speech (National Research Council, 2001), putting them at grave risk for dysfunctional communication.

Communication and ASD
Treatment for communication needs of individuals with ASD can be found in various educational approaches and therapies, one of which is music therapy. Nine percent of board certified music therapists (MT-BCs) (443 of 4,764 MT-BCs) currently report working with clients with ASD (K. Howat of the Certification Board for Music Therapists, personal communication, August 14, 2009). In accordance with other therapies and treatments, communication is a primary treatment goal in music therapy sessions for persons with ASD (Kaplan & Steele, 2005). Though music therapists may work to achieve several communication goals in persons with autism, the central focus of the treatment plan is the facilitation of a functional, accessible, and competent communication system (AMTA, 2005, Standard 3.1).

Functional outcomes in music therapy for persons with ASD are integral to independent function both in the present and in the future when therapy is faded. To be functional, communication must transfer from the music therapy session to life outside of treatment. When working towards generalization of skills, a communication system that is viable with both familiar and unfamiliar people is necessary for competent communication. Related literature in speech-language pathology and communication disorders indicates that Augmentative and Alternative Communication (AAC) is a promising venue for children working to achieve competent communication (Mirenda, 2009).

Augmentative and Alternative Communication (AAC)
AAC systems facilitate communication for individuals with receptive and/or expressive communication issues. AAC systems provide an additional mode of input for reception and an alternate means for expressive communication. An AAC system may be aided, unaided, or a combination of aided and unaided AAC. Aided AAC refers to the addition of materials external of the user (Mirenda, 2003), such as pictures or speech generating devices. Unaided AAC refers to communication that does not require materials external to the user (e.g., gestures and sign language) (Mirenda, 2003). Both aided and unaided AAC augment and/or facilitate receptive and/or expressive communication; most individuals use a combination of aided and unaided AAC (Mirenda, 2009).
Utilizing AAC systems does not prevent speech from developing (Cress & Marvin, 2003); it is merely used to compensate for the individual’s current lack of functional speech (Mirenda, 2003) allowing individuals to function in a speech-focused society. Consequently, speech can remain a treatment goal when using AAC. Recent research implies that AAC may facilitate speech production by increasing interaction and helping develop the social and language skills necessary for vocal communication (Cress & Marvin, 2003; Schlosser & Wendt, 2008).

An evaluation by a speech-language pathologist indicates whether an individual requires an AAC system. Speech-language pathologists, often within the public school or early intervention setting, are licensed to conduct evaluations for AAC systems. In addition to determining the communicative competence of an individual, an AAC evaluation also serves to illuminate discrepancies between a person’s communication needs and his/her current abilities to meet them (Mirenda, 2009). Subsequently AAC systems may be needed to augment current expressive and/or receptive communication.

If an AAC system is required for a child in public school and the appropriate technology is defined in the child’s Individualized Education Plan (IEP), the school district must provide the system for the child in accordance with the Individuals with Disabilities Education Act (Turnbull, Stowe, & Huerta, 2007). If an individual is not in school, funding for an AAC system may be available through his/her private insurance company, Medicaid, or grant opportunities (United States Society for Augmentative and Alternative Communication, n. d. a).

AAC systems have been successfully implemented with persons with complex communication needs (Light & Drager, 2007); the availability of AAC systems is considered recommended practice for individuals with expressive communication impairments (Cress & Marvin, 2003). AAC systems have been implemented with success specifically with clients with ASD (Drager, Light, & Finke, 2009; Schlosser & Wendt, 2008; Wendt, 2009). The American Speech-Language-Hearing Association (ASHA) Guidelines for Speech-language Pathologists in Diagnosis, Assessment, and Treatment of Autism Spectrum Disorders across the Life Span outline the use of both unaided and aided AAC approaches to facilitate improvements in behavior, receptive and expressive language development and comprehension, speech, and social communication (ASHA, 2006). Thus, using AAC represents current recommended practice, and should be incorporated by music therapists.

### Music Therapy and AAC

When an individual has an aided AAC system, the system needs to be present and functioning in all environments in which the individual communicates (United States Society for Augmentative and Alternative Communication, n. d. b; Wendt, 2009). Yet only 14.6% of board certified music therapists consistently use aided AAC in their sessions with clients who have autism and utilize aided AAC systems (Gadberry, 2011). The consistent use of an AAC system is needed to facilitate communication; accessible AAC systems increase the likelihood of interaction as they augment input and provide an additional mode for the individual to respond. Research has demonstrated that AAC systems are best utilized in natural environments (Binger & Light, 2007) and an early intervention approach is recommended for the implementation of an AAC system (Cress & Marvin, 2003). Utilizing AAC systems within the music therapy environment is indicated for facilitation of communication via the AAC system and transfer of skills obtained during music therapy sessions to the daily life of the individual.

Music therapists may need additional training and assistance in order to embrace this recommended practice model. In a recent survey by Gadberry (2011), only 40% of board certified music therapists working with clients with ASD had additional training in aided AAC, outside of their music therapy coursework. Parents of AAC users report that a lack of knowledge of AAC among professionals is a hindrance to their child’s education and growth (McNaughton et al., 2008). Parents in the 2008 study suggested training at the pre-service and professional level in three main areas: a.) AAC technology, b.) evidence based practices for AAC, and c.) skills necessary to be an effective member of the individual’s AAC treatment team.
Speech-language pathologists are typically trained in AAC technology and use during their university coursework. They generally are working with the clients with communication issues, are accessible, and are excellent resources for music therapists for training and collaboration. Of the music therapists who reported having additional training in Gadberry’s survey (2011), the majority of the music therapists received their training on an individual basis from a speech-language pathologist. Music therapists may need to collaborate with speech-language pathologists to incorporate AAC systems appropriately and efficiently into their music therapy sessions. Two main areas are recommended: augmenting input and modeling expressive output. These are selected for discussion due to their pervasiveness in the communication literature and the denotations in the AMTA Profession Competencies 18.3 and 18.4 respectively: “Provide verbal and nonverbal directions and cues necessary for successful client participation; Provide models for appropriate social behavior in group music therapy” (2008).

Augmented input is a way to increase receptive language skills. By pairing verbal language with a picture or object, clients can process the information in various forms and may access the information after the verbalization has expired. Music therapists can implement augmented input methods to enhance the receptive communication of individuals with ASD. Modeling expressive output for the person with ASD will demonstrate appropriate social responses and is common practice among professionals working with clients who have expressive communication goals (Drager, Light, & Finke, 2009). Modeling can occur after the therapist asks a question, or seeks the client’s verbal input. The therapist verbally produces the question and then waits for an answer from the client. If no answer is forthcoming, the therapist should ask the question again and model a response by utilizing the individual’s AAC system. The question may then be asked a third time, with other prompting behaviors occurring (e.g., pointing to the AAC system, having an expectant facial expression, and/or physically prompting the individual to utilize the AAC system to respond) (Kent-Walsh, & Binger, 2009).

Regardless of whether an electronic device is required for the individual, augmented input and multiple modes of expressive communication will most likely benefit the individual with ASD who is working on communication goals since it has been determined that persons with complex communication needs require multiple communication modalities (Light & Drager, 2007). Music therapists can implement recommended practices for complex communication needs by utilizing AAC in their sessions with individuals who have receptive and expressive communication issues. Besides serving as another learning modality, AAC systems may be beneficial for persons with autism who often have strong visuoperceptual skills (Wendt, 2009). Music therapists can capitalize on the auditory and kinesthetic experiences in music therapy sessions by adding this functional visual component.

**About the Author**

Dr. Anita Gadberry is the Director of Music Therapy at Marywood University in Pennsylvania, U.S.A. For over a decade, Dr. Gadberry has specialized in music therapy with children and adolescents with ASD. She frequently presents workshops and seminars for therapists, educators, and caregivers.

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In conclusion, additional training for music therapists in AAC is recommended as is access to current communication literature. Music therapists can facilitate the individual's consistent use of an AAC system by collaborating with speech-language pathologists who are trained in AAC technology and use.

References
Words For Engagement

Ilene Berger Morris, LCAT, MT-BC
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The world of many young children with autism spectrum disorders (ASD) is colored by delays and difficulties in communication. Abnormalities in speech/language are usually the first noted area of concern for parents of children with ASD (De Giacomo & Fombonne, 1998). Although grammatical and memory aspects of language skills may be spared, the social function of communication is often hard hit (Tager-Flusberg, 1994; Wilkinson, 1998). Language development plays a large part in the ability of children to develop interactive play skills such as role playing, action narration, pretending/symbolic play, joint attention, and so forth (Paul, 2003).

Friendship Club is a weekly social skills therapy group at Alternatives For Children, co-led by the therapeutic preschool’s music therapist and social worker (Morris, 2010). Through this collaboration, music interventions are incorporated into a social skills/student counseling training format. The therapists of Friendship Club have identified six essential Words For Engagement (WFE) a limited vocabulary of core words and simple expressions that is continually reinforced, and recycled into new situations through songs and verbal interchanges. Therapists model and encourage positive use of and response to the WFE as they interact with each other and with the children.

By narrowing the range of words and phrases that the children are expected to sing/say and respond to, the children are experiencing more frequent and diverse repetitions of the same verbal cues, with more opportunities to imitate them. Imitation may be a factor in learning communication behavior including functional use of speech for children with ASD (Lim, 2010). Giving these key words a musical dimension adds a multi-modal stimulus that engages brain regions that overlap with the human Mirror Neuron System (MNS) (Wan, Demaine, Zipse, Norton, & Schlaug, 2010). The MNS is related not only to learning new skills by imitation, but also to understanding emotions in others, and its dysfunction is hypothesized to be at the root of social deficits observed in autism (Dapretto et al., 2005).

Wolfberg and Schuler (1999) described social-communication guidance strategies that “serve to extend invitations to peers to play, persist in enlisting reluctant peers to play, respond to peers’ cues and initiations in play, maintain and expand interactions with peers, and enter or join peers in an established play event” (p.46). Over time, their data revealed “advances in social play from isolation to peripheral and fleeting encounters, to coordinated and sustained interactions with peers” (p. 49). In agreement with these strategies, the words and phrases that comprise the WFE were selected to help children initiate or maintain the first level of social interaction – engagement.

**Words For Engagement (WFE)**

- Hi
- My name is _____
- Let’s ___
- Play with me
- Come on
- Here you go

“Hi” is one of the simplest greetings in the English language, with a strong musical implication. To the ears, “hi” evokes the “high” designation of register and pitch. It hints at a climax, the height of excitement. Isn’t that what seeing a friend is all about? “Hi” is used in Friendship Club songs, favored over “hello” which has a more formal sound, an association with distance (telephone response) and requires processing/producing 2 syllables (the second of which leaves us “low”). In “Hi” songs we can focus a lot of musical energy into one syllable. It can be combined with a movement cue (hand wave) that is recognized by the community at large. “Hi” may be answered by simply repeating it. When we are ready to generalize, we can pair “Hi” with a name, making unique and situationally-appropriate greeting statements in song and speech.
Often following “Hi”, “My name is ____” signals that the engagement will be extended, moving toward greater intimacy, maybe even friendship. “My name is ____” carries a certain risk; the child is disclosing personal information with the expectation that the other person will do the same. Once the communicators are identified by name, the wall of stranger-ness falls down; there is certainty and consistency in knowing that no matter who my playmates might be, I can count on always being me.

“Let’s ____” works with most any proposed activity. During Friendship Club, likely subsequent words include sing, go, play, eat, think, walk, sit, pretend, listen, and take turns. “Let’s ____” suggests a partnership; though initiated conceptually by the speaker, the act will be carried out as a team.

“Let’s ____” and “My name is ____” are both open-ended, fill-in-the blank expressions that require a certain level of generalization ability on the part of the communicators. “Let’s” serves as a starter for the dependent pursuant action. When I begin saying, “My name is”, it will end differently than when you use it. For each of us there is basically one way to conclude the phrase; David will always say, “My name is David.” The generalization here is that the ending depends on who you are. “My name is ____” and “Let’s ____” are transitions to spontaneous expressions - they’re rooted in the familiar, comfortable repertoire of the WFE, but require unique, person-specific endings.

“Play with me” is generic enough for many play situations: See-saws, dolls, and, of course, music. Because many children with ASD have confused or unusual prosody (Wilkinson, 1998), “play with me” is particularly useful as it can be expressed meaningfully as a statement (command or invitation) or a question (“do you want to -” being implied), without changing the essence of the intent.

“Come on” is probably the broadest of the inducing, inviting expressions. It suggests “join me,” and “follow me,” sometimes with the encouraging sense of “you can do it.” “Come on” often means that something is about to happen or is already transpiring and the recipient is being persuaded to be part of it.

“Here you go” is a way to put words to the act of sharing or giving, highlighting the movement and the accomplishment. “Here” can be seen as the presentation, “you,” denotes the recipient, and “go” is the completion of the exchange. In Friendship Club, we have found that focusing on using the language helps the children perform the sharing and turn-taking tasks more readily. It seems to reinforce the concept of sharing/giving, tying such acts together by virtue of the associated phrase. The song that accompanies this article, “From Me to You, Here You Go” is an example of how this expression can be the basis of an intervention that connects music, language, action, and engagement.

Music is an effective tool for helping children with ASD acquire and improve functional vocabulary speech production (Lim, 2010). The young members of Friendship Club have many and wide ranging exposures and opportunities to practice communication roles using the WFE in musical, active, and functional ways. Doing so in this social play context may be a step toward generalized engagement behaviors and improved social functioning in the natural environments they encounter in their lives.
This Friendship Club song is in a pop-rock style. A basket is prepared ahead of time with an assortment of zip bags containing small laminated picture versions of shareable objects common to preschoolers (e.g., cars, balls, blocks). Every child gets a turn to pick a bag and share what is inside with the members of the group. The words of the verse take each child in turn through the steps of sharing. Together the group sings the repetitive chorus, which could be accompanied by rhythm instruments. The words “from me to you” cue the “here you go” part, and the children may soon be sufficiently cued to produce the target words by themselves. At the end it is satisfying to look at the collections made possible by sharing together. The children in Friendship Club do well using little icons because they are less distracting than the actual items for learning purposes.

When the children are more familiar with the song and concept, real toys, instruments, books, and even snack items will provide more natural relevance.

References


About the Author

Ilene Berger Morris, LCAT, MT-BC is a music therapy clinician for close to 30 years. Lee lives and works in Suffolk County, NY. She has worked primarily in educational settings with very young children and with teenagers. She is the author of two previous articles in imagine. With two other music therapist colleagues, Lee is a member of the performing/recording group CLIMB (Children Learn In Music Best).

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Our Photo Stories 2011

Available at http://imagine.musictherapy.biz/Imagine/our_photo_stories.html

One section of the imagine website is dedicated to photo stories related to early childhood music therapy. The photo stories consist of a sequence of three pictures along with a one-sentence description of what happens in each picture during the music therapy session.

Photo stories are open for submission during the year. If you would like to contribute, please review the submission guidelines on the imagine website and contact us.

Photo Story #5
Music Therapist: Beth McLaughlin, MSE, LCAT, MT-BC
Affiliation: Wildwood School Schenectady, New York
Photographer: Stacey Jantzen

Photo Story #6
Music Therapist: Sandra Barsinevica, M.A., Psychologist
Affiliation: National Neurologic Rehabilitation Centre Vaivari/Jurmala, Latvia
Photographer: Zanda Krastina

Photo Story #7
Music Therapist: Lora Heller, MS, LCAT, MT-BC
Affiliation: Baby Fingers LLC
Photographer: Parents of Clients

Photo Story #8
Music Therapist: Petra Kern, Ph.D., MT-DMtG, MT-BC, MTA
Affiliation: Music Therapy Consulting
Photographer: John Cotter

Early Childhood Conferences 2011/2012

The Division for Early Childhood
27th Annual International Conference on Young Children with Special Needs & Their Families
November 17 - 19, 2011, National Harbor, Maryland
www.dec-sped.org

National Association for the Education of Young Children
2011 NAEYC Annual Conference & Expo
Nov. 2-5, 2011 in Orlando, Florida
www.naeyc.org

ZERO TO THREE
24th National Training Institute
www.zerotothree.org

Council for Exceptional Children
Convention & Expo
April 11-14, 2012 in Denver, Colorado
www.cec.sped.org

30th ISME World Conference on Music Education
Thessaloniki, Greece
July 15-20, 2012
www.isme.org

Early Childhood Music and Movement Association
International Convention
August 6-8, 2012 in Green Lake, Wisconsin
www.ecmma.org
This case report is a summary of intervention ideas and techniques that had a positive impact on the developmental outcomes of a 4-year-old boy with partial agenesis of the corpus callosum.

**About Partial Agenesis of Corpus Collosum**

Children with partial agenesis of the corpus collosum commonly have wide ranging deficits in communication and sensorimotor areas. Damage to the corpus callosum in utero results in decreased amounts of connective fibers communication between the two hemispheres of the brain and can have many varying effects on developmental functioning for children (NINDS Agenesis, 2011).

**Case Report**

Stephen (name changed to protect identity) had deficits in motor and communication domains. He was wearing a torso brace (TheraTog™) to aid in balance while moving, was clumsy as seen by commonly falling and running into objects while walking, was easily distracted, and had a very limited vocabulary with word approximations or vowel sounds when we first started music therapy intervention.

Stephen received intensive music therapy services occurring twice per day, 5 days a week for 2 months. After this intervention, he received continued services 3 times per week for 6 months. Music therapy interventions were delivered in a directed developmental play module. All music interactions were chosen based on the developmental skill targeting for improvements. Within each session, Stephen was able to choose the type of song he was interested in to promote the developmental play modality. The music therapists working with Stephen used therapeutic techniques to maintain attention and encourage skill advancement within each activity. The reason underlying the choice to use developmental play for the structure of the session was to increase the relevancy of the
interactions between Stephen and the music therapists.

**Clinical Outcomes**

By engaging in developmental play through music, Stephen was able to successfully transfer skills learned in the session times to his preschool and home family interactions. This shift from session planning to use cues from Stephen during the playtime resulted in meaningful and engaging interactions that were client led. For example, during a session, the music therapist and Stephen were pulling hand held mirrors out of the manipulatives bin when Stephen noticed reflections of the mirrors on the ceiling. Instead of moving on to the mirror song that focused on expressions of emotions, the music therapists instead engaged in a moon song that used gestures for words and repetitive vowel sounds for language development. One gesture for the song points up to the moon, which was facilitated wonderfully by the mirror reflection on the ceiling. By following Stephen’s interest areas within the session, the amount of time spent in meaningful interaction increased. It may appear that no structure or order existed in sessions with disjointed songs, or that they lacked focus of attention. Instead, the directed developmental play had the opposite effect due to the music therapists’ ability to correctly interpret Stephen’s disengagement cues and reinforce positive engagement in the music interventions.

Results of Stephen’s progress have been positive in every area monitored. His parents were amazed with the progress Stephen made after engaging in music therapy interventions. Anecdotally, Stephen’s preschool teacher approached his parents asking what had changed in Stephen’s medications or therapies. Stephen was attending to circle time activities for longer amounts of time, attempting to speak more, and falling less. Stephen’s parents noted that nothing had changed in medications, but his therapeutic interventions had changed with the addition of music therapy.

Stephen progressed from using the torso body brace (TheraTog™) and ankle support shoes to not wearing any braces at all. Stephen showed less frustration when trying to speak, was more expressive and alert, attempted verbal words more often in place of gestures, added new words to his vocabulary including a two syllable word, and also improved in identifying colors and shapes. In the area of motor skills, Stephen used two hands to play one handed rhythm instruments at the beginning of the intervention and by the end was able to play with one hand. Stephen’s improvement in motor skills transferred into his everyday play activities as he was able to catch a ball, and bear crawl with other children in his preschool.

The Developmental Assessment of Young Children (DAYC) communication and motor subtests were used to assess Stephen during 3 months of music therapy intervention. The DAYC evaluates children from birth to 5 years and 11 months in the areas of cognition, communication, social-emotional development, physical development, and adaptive behavior. The DAYC is used to identify children who are developing normally and those who are significantly below their peers to determine the child’s specific strengths and weaknesses, to document their progress in developmental abilities, and to measure developmental abilities in research studies. Stephen made gains in communication and in his motor skills. His DAYC communication and motor age equivalents improved beyond the number of months music therapy intervention occurred, indicating accelerated developmental improvement.

Stephen’s progress cannot be solely attributed to one intervention, as he also was receiving speech therapy, physical therapy, and occupational therapy at preschool. However, the addition of music therapy to his treatment teams appears to have had a positive impact on his development.

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**About the Authors**

**Darcy Walworth,** Ph.D., MT-BC directs the music therapy program at the University of Louisville. She actively researches the effects of music therapy in early childhood and medical settings with emphasis in autism treatment, medical procedural support, and developmental outcomes of premature infants.

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**Jessica P. Albright,** MM, MT-BC received her BME in choral music from The University of Central Florida in 2001. She was a middle school choral director in Orlando, FL for eight years where her choirs received superior ratings at the district level. Jessica graduated in the summer of 2011 with her MM from The Florida State University after completing her internship at Tallahassee Memorial Healthcare.

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**References**

Attachment-Based Music Therapy: New Opportunities and Requirements for Music Therapists Working With Young Children

Stephan Betz, Ph.D., MT-BC
Owner, Walnut Creek Music Therapy
Walnut Creek, California

Is there a natural fit between attachment and music therapy? Bruce Perry describes the development of a baby’s language from emotion-laden sound – babble to attributing meaning to words through modeling behavior. Music and sound build the platform necessary for the neural organization of language. Language develops where relationships and attachment are positive and form resilient neural networks (Perry, 2000). Music also facilitates a calm and stress-free relationship between child and caregiver. One of the main indicators of disorganized attachment is cortisol output (Morgan et al., 2001) and music was found to mitigate cortisol levels through increased melatonin (Kumar et al., 1999) and dopamine (Salimpoor, 2011).

A competent ECMH music therapist can support parents/caregivers and infants in developing a positive relationship.
using a therapeutic frame of songs, music play, games, and teaching moments. Caregivers have the opportunity to reflect on their attachment interactions and personal constraints brought forth in the relationship with the infant. As a member of a multi-disciplinary team, a music therapist educated in ECMH competencies will be able to converse with other ECMH clinicians using attachment and object relations terminology. This framework is built on our knowledge of mirroring, the process of transferring thoughts and emotions through carefully copied, then assimilated facial expressions between parent and infant. The infant experiences being experienced.

The baby experiences mom and mirrors her positive emotion with his facial expression. In return, the baby radiates positive emotion to mom, who receives the affection. The baby then mirrors receiving affection as well.

The safety sensitive child feels that others cannot be depended upon and responds with reactive restitution, where the ego attempts to restore a blissful oceanic feeling of oneness with the object, the mother.

The esteem sensitive child sees herself/himself and the other as two fused parts of the object relations: the grandiose omnipotent self-object is fused with an underlying pathologic aggressive or empty other-object.

The separation sensitive child experiences both a rewarding relationship with the other where the self is compliant and the other is beneficent, and a withdrawing relationship where the self is lost and in despair of the rejection by the other.

A competent ECMH music therapist recognizes sensitive behaviors in others and responds with adequate interventions. These may include eliciting the lullabies that bonded the mother and the in utero fetus, teaching the mother to mirror the infant through cooing, and playful music games.

The first step in therapy is recognizing the parent's sensitivities and forming a therapeutic alliance to improve the level of security in mother-child bonding. Each sensitivity requires a different intervention. Detailed and thorough assessments are key to successful treatment. Often, re-assessments are needed after one or two interventions. The therapist needs to ask, "What are the infant's and mother's strategies for attachment and how can attachment be strengthened?" For instance, the safety sensitive child may need cautious scaffolding, re-assurance, and building defenses. The music therapist may patiently observe interaction to catch a linchpin moment that allows an intervention to increase intimacy without causing a withdrawal backlash. She/he looks for the strength and the struggle in the mother child dyad while holding the therapeutic frame to provide a safe and playful environment. Signs of progress can include joy, diffuse anger and even short term abandonment depression as the suppressed real self emerges in mom and those changes affect the baby. The therapist may re-direct the new experience into a more secure relationship by mirroring it in song and play. Community based pre-school art and music programs can provide young children opportunities to explore, apply and expand their newfound socializing skills.
The Walnut Creek Civic Arts Education program provides music and art play therapy to preschoolers to address children’s special needs and enhance positive social – emotional behaviors.

Photo credit: Walnut Creek Civic Arts Education (E-News, February 2011).

Learning these interventions requires training. The California Infant Development Association has set a gold standard requiring 1,260 training hours prior to granting a specialist endorsement.

Good assessment tools for attachment-based music therapy are the Ainsworth Strange Situation Assessment, Attachment Behavior Q-set and the Diagnostic Criteria 0-3 (DC 0-3). Learning these assessments will take approximately 120 hours. Training is provided by The Circle of Security Project, Stonybrook University, Department of Psychology, the National Training Institute of the National Center for Infants, Toddlers and Families, State Departments of Education, and Children’s Hospital and Research Center Oakland.

Successful treatment interventions are the result of a carefully structured intervention goal. Its design addresses mother’s and infant’s sensitivities and capitalizes on the fact that the mother, as an adult, has more ‘degrees of freedom’ in changing patterns of attachment. While raising sensitivity issues for discussion, holding the therapeutic frame is critical. The music therapist creates a holding environment and provides a secure base from which the parent can explore changes to parenting. Parent education is included to map out the attachments. Most importantly, treatment is geared toward helping the parents develop their observational skills, especially as these apply to reading and responding to their children’s cues. Therapy can be greatly enhanced by parenting education, where music therapists can facilitate a process of reflective dialogue in the group – a skill that the parent can then use internally. This process is viewed as the central dynamic for change. A readily available tool is the Circle Of Security Parenting video, which trainers use for group discussions as a powerful tool for change. As a result, parents are able to shift their empathy from being defensive to providing a secure base for their children. Music therapy can provide the language of emotion to make that happen.

**References**


**About the Author**

Stephan Betz, Ph.D., MT-BC is the owner of Walnut Creek Music Therapy in California. He has more than 36 years of experience working with children with special needs. In 2001, Dr. Betz received the 2001 Betty Isern Howery Award and a 2010 Recognition by the Developmental Disabilities Council of Alameda and Contra Costa Counties with related recognitions by the California Assembly and Senate as well as the U.S. Congress.

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Question: How do we teach young children to read?
Answer: We don’t!
In 1965, linguist Noam Chomsky revolutionized the educational world with his theory that children are “wired” to learn the language into which they are born. All that was required was access to that language and the child would simply pick it up - “caught not taught.” That prompted psycholinguist Frank Smith (Pearson & Stevens, 1994) to make the leap that children learn to read and write in much the same way that they learn language. In his seminal book, Understanding Reading, Smith (2004) proposed:
1. One learns (is not taught) to read through the process of reading and being read to.
2. Readers make sense of what they read based on what they already know. They have a prior “context.”
3. New meaning is brought to the written word through prediction and is based on conventions defined by the culture within which one lives. Comprehension is based upon prediction made possible by convention.

This notion challenged the “skill and drill” method so popular in the educational world previously. Pearson & Stevens (1994) discovered that when children read words within a story context, they were able to read many more words than if given an unrelated word list. In other words: Comprehension and identification are much greater within a context.

Thus, the “sound-it-out” approach is not very effective in providing meaning. If prediction is at the core of reading, then we need to ask specific questions about what we will read next. (“What do you think the boy will do now?” Or “Where do you think the kitty will go?”) We also need to be sensitive to the cultural knowledge base of the child; texts lying outside the current knowledge/experience of a child will not help that child learn to read.

Thus, we start from what the child currently knows and expand from there. Likewise, a child will be unable to read a word that s/he has never heard before, so a strong language base must be in place before reading will come.

Question: How do we teach young children to sing?
Answer: We don’t!
Noted music educator Edwin Gordon (2003) argues that young children learn as much by themselves and from other children than they do from adults. He proposes that the best thing caring adults can provide for their children is informal guidance in music. This includes...
access to a rich and varied music environment from birth, putting in place a strong music base. Children need to hear, listen, move and make all kinds of music before they can eventually learn to read, write and understand it. If we take Smith’s (2004) proposal and apply it to music, it might look like this:

1. One learns to sing through the process of singing and being sung to.
2. Musicians make sense of what they hear based on what they already know (i.e., they understand the music that is part of their culture, but may struggle to attach meaning to music of other cultures).
3. Meaning is brought to music through prediction (i.e., one knows what the last word or pitch of a phrase will be based on having heard the song or others like it before).

Table 1. Adapted from Campbell & Scott-Kassner (1995), FIRST YEARS (2010), Gordon (2003), Heavner, K.S. (2008), McDonald (1979), MENC (2010), Moog (1976), and Schwartz (2008).

<table>
<thead>
<tr>
<th>Age</th>
<th>Music</th>
<th>Literacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-12 months</td>
<td>Vocalizes and moves to music; looks for the source of music; prefers higher pitched voices; as in parroting (“baby talk”) begins to recognize familiar songs.</td>
<td>Vocalizes when read to; looks at and puts pictures; responds to parroting; reading; prefers pictures of faces; “helps” turn pages; recognizes familiar objects.</td>
</tr>
<tr>
<td>12-18 months</td>
<td>Carries instruments around while playing; holds and plays instruments correctly; recognizes and asks for familiar songs; pays attention to lyrics; sings snippets of learned songs.</td>
<td>Carries books around; holds book right side up; turns pages; asks to be read to; learns that words have meaning; points to and names familiar objects.</td>
</tr>
<tr>
<td>18-24 months</td>
<td>“Sings” along; fills in words at end of song phrases; sings familiar songs; lyrics more accurate than pitch.</td>
<td>“Reads” along; fills in words; recites familiar passages; learns that print has meaning; enjoys the routine of reading.</td>
</tr>
<tr>
<td>24-36 months</td>
<td>Asks for favorite songs and instruments; sings spontaneously to self at play; knows if adult sings song incorrectly; able to sing songs with lyrics and (occasionally) pitch correctly; able to hold a pick to strum; beginning to understand song lyrics (and emotions).</td>
<td>Looks for favorite pictures; “reads” to self; upset when adult gets words wrong; repeats phrases and some stories correctly; turns paper pages; story plot emerging; coordinates text with pictures.</td>
</tr>
<tr>
<td>3-4 years</td>
<td>Enjoys singing songs repeatedly; enjoys silly songs and story songs; experiments with different voices to sing familiar songs in a funny way; uses rhythm instruments to accompany songs; sings ABCs and number songs; melodic contour is intact; makes up songs; follows color-coded chart to song lyrics.</td>
<td>Enjoys reading books repeatedly; plot more important; tracking text; willingly listens to longer books; some letter and number recognition; retells familiar stories; starting to rhyme.</td>
</tr>
<tr>
<td>4-5 years</td>
<td>Can differentiate simple rhythmic and melodic patterns; identification of simple rhythmic notation; beginning to recognize familiar melodies without lyrics; can match lead to others; enjoys imaginative songs.</td>
<td>Can differentiate and count syllables; identifies rhymes; letter and number recognition; identification and reproduction; starting to spell words they are familiar with; especially their names; enjoys making up imaginative stories.</td>
</tr>
</tbody>
</table>

The Road to Literacy: Phonological Awareness and Music Perception

Phonological awareness, or the ability to distinguish, pronounce, and manipulate the sounds in language, is best served through listening (Perigroe, 2001). And, as Goswami (2009) points out, in all languages studied, phonological awareness is fundamental to reading acquisition. A child with typical hearing will have mastered all the phonologic awareness needed for literacy by five to seven years of age.

Historically, research has reported lower levels of literacy in individuals with hearing loss, describing the typical reading plateau that high school students with hearing loss attained as the “fourth grade slump” (Geers, Strube, Tobey, Pisoni, & Moog, 2011; GRI, 2003; Robertson, 2011).

With recent hearing technologies and auditory/oral approaches, however, higher levels are possible for those children who have “learned to listen” (Fry, 1966; Robertson, 2009, 2011). The latest research concludes: A child with a hearing loss, properly aided and immersed in an oral environment, will attain the same skills necessary for literacy at a delayed, but normal progression of development (Geers, Strube, Tobey, Pisoni, & Moog, 2011).

We know, too, that music and spoken language, both relying on the auditory system, parallel each other in development (Barton, 2010). In addition, evidence supports the correlation between music skills and phonologic awareness and reading development in young children (Anvari, Trainor, Woodside, & Levy, 2002). This suggests that music perception and phonologic awareness share some of the same auditory processing structures, as well as the skills necessary for reading. The implication?

For a young child with a hearing loss, this presents a strong case for the inclusion of music as part of the listening and spoken language strategies applied in early intervention. Both “train the ear.”

Table 1 pairs literacy milestones.
alongside music milestones, representing the sequence of stages a child with typically developing hearing masters on his or her way to becoming musically competent and literate. Since children develop and grow at varying rates, the charted time frames may vary slightly, but the developmental sequence follows these established patterns. For children who are deaf/hard-of-hearing and utilizing a listening approach to language, the timelines may need to be adjusted, but the skill sequence is the same. Specifically: Children learn their native language by hearing it, then speaking it, and finally reading and writing it.

Music learning follows the same sequence. Paraphrasing Roach van Allen (1968), one of the early proponents of transcribing children’s oral stories to then use as materials to help facilitate reading and writing: If you can hear, you can listen, if you can listen, you can talk (sing); if you can talk (sing), you can read. It’s called the road to literacy!

Summary
Current research supports the notion that children with a hearing loss who are identified early, use high-quality hearing technology, and are immersed in the listening and spoken language approach, will eventually attain literacy skills equal to those of their hearing peers (Geers, Strube, Tobey, Pisoni, & Moog, 2011). It follows, then, that music, an auditory experience, may aid in the development of phonemic skills required for literacy. Indeed, early intervention music curricula have demonstrated enhanced prereading and writing skills of 4 to 5 year old children enrolled in such programs (Register, 2001; Standley & Hughes, 1997). Music and literacy may actually be a developmental duet! Future research is needed to determine the exact relationship between music learning and literacy.

References
Bilingual Early Childhood Music Therapy: Multicultural Perspectives and Family Systems

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In the two previous issues of Imagine, Matney and Stock discussed 1) the research that informs a bilingual approach to music therapy in early childhood, as well as 2) some simple ways to begin developing one’s own multicultural and bilingual skills. The two previous articles largely focused on how a bilingual approach can meet clients’ needs and better address goal areas. This article will explore cultural awareness related to family roles in therapy for clients of various cultural backgrounds.

The family plays an important part of early childhood development. Cultural perspectives can largely influence the way a family perceives its collective care-giving role (Davila, Reifsnider, & Pecina, 2009). Cultural perspectives also can largely influence the way a family perceives therapy. Cultures may feel that families play particular roles (or non-roles) in the therapeutic process. While one should not assume that any family fits a particular cultural stereotype, a therapist may be able to facilitate stronger family engagement by being aware of potential cultural tendencies within the family system. Awareness of cultural differences also allows a therapist to become better aware of his or her cultural biases, and how such may shade the therapeutic process.

The following areas describe where cultural family perspectives may inform the therapeutic process. The list below applies regardless of client age or population. Within early childhood, some considerations may be more relevant than others.

Client Autonomy vs. Family Decision-Making
Clients may defer to their parent/caregiver in all ways, including answering simple questions. The client may invariably be asked the question “Do you have a favorite song?” The individual may then turn to the caregiver, translate the question, perhaps even have an extended conversation with him or her, and then turn to answer the question. In another instance, clients may transition rapidly from openly engaging with the therapist to not making eye contact or interacting with him or her once the caregiver enters the room. Or, following a session where a patient has made a music video and been very vocal and opinionated on choices of pictures and music, the patient does not answer questions and looks to their caregiver to answer the next time the therapist attempts conversation with the caregiver present. Within Latino cultures, familismo (the strong identification with, and loyalty to, family) may be present within settings where therapy occurs. This type of family interdependence may be addressed through family systems approaches to music therapy, which would include the caregiver in the musical/therapeutic process. Also, because the family is so strong, extended family may also be available. Extended family may be more approachable than the immediate family at times. (Davila, 2009).

Trust vs. Apprehension Towards Therapists or Therapy
Especially in early childhood, a certain amount of “stranger danger” is developmentally appropriate. This is where taking the time to really get the caregivers on your team is important.

For example, recently, the first author entered a patient’s room where two parents who spoke only Spanish were present. The patient was sleeping, so the therapist did what she thought was “a good job” of explaining to the parents (in Spanish) how music therapy is utilized in the hospital setting; she said she would return when the patient was awake. In her next attempt to meet the patient, both parents were present again, as well as a younger and an older sibling. The patient took one look at the music therapists and immediately burst into tears while the parents sat by and watched, not encouraging the patient to participate. The music therapist then attempted to engage the other siblings and the parents, who were very guarded and did not engage. She explained that it is normal for the patient to have that reaction to her, and that she could try again at a later time.

There could be any number of contributing factors to this experience – what had happened in the five minutes before the music therapist entered the room, whether or not the parents viewed her as a necessary therapy, or if the siblings or the patient had had a different reaction towards her. Whatever the reasons, the music therapist left feeling like an outsider, unable to build rapport with the client. The experience reinforced the importance of parental/caregiver approval in the therapeutic process. On the flip side, when caregivers see that you invest in their child and their family, they may change their stance from very guarded to making the therapist a part of their extended “family.”

Advocacy/Disagreement vs. Deference to “Authority”
Parents of clients may approach their collaboration with you in a variety of ways, and they may do so for many reasons. Some cultures feel that it is appropriate for the parent to defer much of their knowledge and experience to the “authority,” allowing the therapist’s training and experience to supersede. Some cultures may also be less likely to participate in direct disagreement. This can be a challenge given that parents are most often intimately aware of their child’s wants, needs, and reactions.
For example, the second author had attended “Admission, Review, Dismissal” meeting (similar to IEP meetings) with parents who were interested in their child’s progress, but believed that they had nothing to offer. They personally expressed that “professionals” were much better equipped to facilitate the child’s progress than they were, even to the point of declining any opportunity for collaboration. In these cases, the music therapist had worked to identify things that they both had observed about the child’s progress, and then worked to find shared value in those observations. From that shared value, the parent and music therapist were able to create a collaborative action plan that parents were comfortable with (and hopefully also empowered by) implementing.

Cultural Perspectives on Musical/Non-musical Interaction
While music is likely a cultural universal, different cultures view music, and its roles, very differently. Some cultures are more likely to see music as intrinsic to healing. Some cultures use specific types of music for healing, but only particular people within their culture are qualified to provide that type of experience. Other types of musical interactions for therapeutic processes may be entirely foreign to the family. In each case, a knowledge of the culture’s and the family’s perception of the musical process may help inform the therapists’ decisions. One must also seek to recognize how the culture views different types of interactions, even those that are based in music. For example, music and movement with young children is seen as widely beneficial. However, particular cultural and religious practices may forbid dancing, or may forbid that people of different genders dance together. A therapist may ask parents about how they view music and dance/movement, so that any potential interactive issues may be brought to the forefront and discussed (Winkelman, 2008).

Religious Practice
Within Latino cultures (those of the Latin Americas), there exists diversity in the religions practiced. The same can be said of many regions in the Middle East, within Asia, within Africa, and other parts of the world. Music therapists can familiarize themselves with the particular cultural manifestations of religious practice in which a client and family may partake.

Perceptions of will vs. Perceptions of Pre-determined Outcomes
Different cultures may generally respond differently to life-changing events, including the birth of a child with disabilities or dealing with a child who has recently undergone trauma. In some cases, a culture/family/client may believe that a particular outcome is pre-determined and is to be tolerated. In other cases, a culture/family/client may believe that everything possible must be done to create a better situation. Therapists can use their awareness of any communicated mindset along these lines to offer, and even nurture, options in order to facilitate their client’s well-being (Winkelman, 2008).

Ritual
Cultural practices are largely defined by their rituals. Rituals are often conducted using music. Rituals may also include particular times when emotional expression, by clients and/or family members, is appropriate. A music therapist can seek to better understand the cultural rituals that a family practices, and seek to understand if and how music may play a role.

When music therapists familiarize themselves with clients’ families and cultural backgrounds, they invest themselves in part of the clients’ world views, thus meeting them where they are. This investment can be returned tenfold within the therapeutic process, allowing for rich and deep therapeutic experiences, and resulting in professional growth (Molina, 1994).

References

Resources
- CultureClues™
- EthnoMed

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Background
For families who are separated due to abuse and neglect, the resulting turmoil in the lives of all involved creates additional stress, compounding the stress that led to the separation. In Northern New Jersey, family court may refer a parent to FAMILYConnections in an effort to remediate parenting skills and provide other support to a family seeking reunification. FAMILYConnections is a nonprofit 501(c)(3) community-based counseling and family service agency with over 30 specialized programs for all ages from infants to seniors (Family Connections New Jersey). The Reunity House program is designed for families for whom reunification is the goal.

Reunity House is “a therapeutic supervised visitation model to safely reunite families separated due to abuse or neglect, teaching personal responsibility and parenting skills in a respectful, nurturing, home-like environment to reduce child abuse and neglect, decrease the time children spend in foster care, and strengthen families” (Family Connections New Jersey). Social workers assess the needs of each family and establish the treatment plan; Reunity House updates the courts and continues to monitor families throughout the reunification process and beyond.

Reunity House contracts a music therapist to provide family music therapy. A music therapy group based on Music Together® is held weekly in 10 week segments.

Program Structure
Group Supervised Visitation
Families in the Reunity House program visit weekly at a central location. The visit consists of dinner followed by a music therapy group session. After the children return home, the parents remain for class to improve parenting skills. The selection criteria for the music therapy group was initially based on pragmatics: The need for services, families who had shown little to no progress in other treatment environments, and families who had children in the desired age range (birth to five years). Parents enter the reunification process in crisis, often lacking the requisite parenting skills necessary in group social situations. Social workers are present during these supervised visits to provide in the moment coaching, modeling, and intervention if necessary.
Area of Growth for Parents

The single most important area of growth for the adults, across each of the three series of music therapy groups, is parenting skills. Reunity House implements the Nurturing Parenting Program. This program, developed by Bavolek, is a psychoeducational model of building skills in parenting that emphasizes five core values: Positive self worth; empathy; empowerment and strong will; structure and discipline; laughter, humor, and play. Pre - and post intervention assessments and weekly self-evaluations provide necessary information regarding parents’ assimilation of new information (Bavolek, 2007).

Music Therapy Group

Multicultural Considerations

Families in the Reunity House program are largely African-American and Hispanic. Pre-existing biases against the mental health and justice systems are factors in treatment (Pinderhughes, 1982). How patients exhibit investment in the therapeutic process also differs between cultures (Falicov, 1982). The music therapist must consider these factors as well as the choice of music, the language of materials the families take home, and how to communicate information about the musical development of the children during the session.

Group Design

The music therapy group experience provides a rich, musical “playground” for parents to explore their own parenting styles while engaging in a group music therapy process that addresses their own needs. This playful, developmental approach is supported by Plach’s discussion of the music making process as a way to indirectly address therapeutic issues (Plach, 1980). When followed immediately by parenting class, the aesthetic experience of music making gives parents the opportunity to examine their own attitudes, intentions, and emotional needs in relation to their roles as parents.

The music therapist’s choice to use Music Together® for this family music therapy group was largely based on the flexibility of the music included in the licensed collections. Although there is a specific set of songs in each licensed Music Together® collection, the therapist chose to use them in a variety of ways, depending on the clinical needs in each session. For example, a song can be used as a vehicle for lyric substitution as well as a lullaby to promote calmness and familial bonding.

The materials for home use supported parent and child music making outside of the family music therapy group. Parents drew on their experience of music making with their children in family music therapy during additional visits. Social workers participating side-by-side with the families in weekly family music therapy sessions could observe the benefits of family music therapy both during the session and outside of the session.

The family music therapy group followed an artistic flow. The predominantly live music experience included a greeting song, finger play, chant, small and large movement songs, creative movement, instrument playing, relaxing to music, and a closing song. The songs from the licensed Music Together® collections included examples in English as well as other languages, as well as songs in a variety of tonalities and meters that are from a variety of cultures. Each family enrolled in family music therapy received two copies of the CD with the songs for that 10-week session, one copy of the songbook, and a small selection of handheld percussion instruments and movement props to facilitate music making at home.

Challenges

This was the first time family music therapy was implemented in Reunity House. The program staff received an orientation about music therapy and its implementation. However, each staff member came to music making with a different degree of comfort. The music therapist found that it was necessary to provide ongoing coaching, modeling, and education to the staff about how to facilitate the children’s music making during the session.

For a family to participate in music therapy, they were required to state their intentions to attend at least one day prior to the scheduled group. If they did not adhere to this rule, their child was not brought to the visitation. Early in this program, parents occasionally attended without giving notice and were upset when their children were not in attendance.
Even more distressing were the times when children came and their parent failed to attend. The purpose of family music therapy was to provide feedback to the court regarding the ability of parent to resume full custody of their children. Despite the home-like atmosphere, parents were conscious of the ongoing evaluation. It bears repeating that the parents’ skills at interacting with their children were highly varied.

The children in attendance ranged in age from just a few weeks old to five years. Several children exhibited deficits in self-regulation, attention, and attachment. In the beginning, it was not uncommon to observe a child receiving attention from several adults simultaneously or receiving no attention.

As the implementation of the program entered the second and third semesters, the group structure evolved. The original group design called for approximately 8 to 10 families to be assigned to music therapy group. Many of these families had multiple children, and several adult family members attended the sessions. This led to very large groups. Subsequent sessions placed the maximum number of children at eight to ten, which decreased the number of families that were assigned to the music therapy group. Adult family members were welcomed.

Reunity House purchased CDs and songbooks for each parent and child to take home. The parents received the instruments and movement props. However, siblings in foster care are not always placed together. This was not taken into consideration in the beginning when planning for the cost of materials.

Reported Benefits
The music therapy group at Reunity House was highly valued by the participants. Families from the first group to participate in music therapy were invited to complete a pre- and post-survey that asked about the number of children’s songs they knew, their music background, and what they hoped to learn from the program. The number of children’s songs known by the group assessed (N=6) increased from an average of five to an average of 15. Each semester, parents reported they rediscovered their own musicality and felt more comfortable making music with their children. Parents also reported increased understanding of their child’s music development.

Reunity House met or exceeded their goals for reunification during this time as well: 91% of parents reported an increased use of positive non-physical parenting techniques; 84% of parents demonstrated increased understanding of stages of child development and attachment and increased ability to apply this to his or her parenting styles; 100% of families completing the program remained reunified and stable one year after completion of the program (Family Connections New Jersey). In the future, formal program evaluation should determine replicability of this service and the impact of culture on the therapeutic process among other components.

Conclusion
Family group music therapy can be meaningful in addressing the needs of families preparing for reunification. Music therapy groups provide opportunity for socialization, a safe place to practice parenting skills, and a venue to learn how to support the music development of children. Music therapy groups may benefit parents by giving them musical tools they can use in parenting and a repertoire of songs for the family. Children may benefit from the opportunity to engage in music making in a way that is developmentally appropriate in a supportive, non-performance oriented environment, surrounded by those who love them. The variety, flexibility, and qualities of the songs from the Music Together® curriculum was an appropriate choice to facilitate the therapeutic process at Reunity House. FAMILYConnections continues to choose music therapy groups for families receiving services at Reunity House. The program has grown to include two more additional locations and is increasing the number of families enrolled.

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References
When talking about development, many music therapists initially may think about development of relationships with their clients, their families, and the other professionals on the team. In early childhood music therapy, understanding the unique aspects of both typical and atypical child development is an equally important concept. In fact, knowledge of these underpinnings is essential if we are to deliver effective music therapy services to young children and their families.

Understanding typical development lets music therapists know what we reasonably can expect from our clients. For example, we can’t expect a one year old to jump forward like a bunny or a three year old to complete two to three directions. By recognizing these developmental milestones, we can plan our sessions to reflect developmentally appropriate practice (DAP) and lay the foundation for positive and successful experiences for our clients (Rainey-Perry, 2003; Schwartz, 2008).

Developmental specialists tend to look at child development across several categories:

- Cognition refers to children think and how they interpret their environment.
- Language can be divided into expressive and receptive categories. Expressive language addresses spoken language; receptive looks at how a child understands and responds to what is said.
- Gross motor skills relate to large muscle movement (e.g., trunk strength and mobility).
- Fine motor involves not only smaller muscle movements such as those of the hands and upper body, but also hand-eye coordination.
- Social skills examine how children learn to play on their own and interact with other children and adults in their environment.
- Self-help or adaptive skills address how children develop activities of daily living such as bathing, feeding themselves, and using the restroom.
- Sensory development is important for effectively interacting within one’s own environment; however, there are not specific sensory “milestones.” Most times, the sensory system develops through other skills. The sensory system is often addressed when problems are noted (Parks, 2006).

Development is fluid. A skill, which may be categorized in the cognitive area, may also be reflected in language. Social skills can be linked to motor abilities. A delay in one area may or may not impact a child’s ability to develop additional skills in another area. Music therapists need to be aware of these caveats and prepare for them within their session planning (Schwartz, 2008).

Understanding atypical development also can influence our session planning and implementation. Recognizing developmental “red flags” give us substantiation and provides talking points for leading a parent down a path toward a possible diagnosis and/or further understanding of their child (Schwartz, 2008).

Table 1 lists representative typical developmental milestones of various early childhood age ranges, focusing mainly on skill sets that could readily be utilized in designing developmentally appropriate music therapy goals and strategies to help structure more effective sessions for young clients. Examples of atypical “red flags” are provided in Table 2 (Parks, 2006; Schwartz, 2008; VORT, 1994; VORT, 1995).

References


About the Author

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Table 1. Developmental Milestones

<table>
<thead>
<tr>
<th>0–12 Months</th>
<th>12–24 Months</th>
<th>24–36 Months</th>
<th>3–4 Years</th>
<th>4–5 Years</th>
<th>5–6 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Gets excited about toys she/he likes</td>
<td>• Gives instruments back as prompted</td>
<td>• Follows simple commands</td>
<td>• Moves body with music (taps, claps, marches)</td>
<td>• Repeats words that rhyme</td>
<td>• Sings and dances to different songs</td>
</tr>
<tr>
<td>• Shows interest in sounds</td>
<td>• Matches sounds to animals</td>
<td>• Understands action words and simple opposites</td>
<td>• Sings phrases of familiar songs alone and with a group</td>
<td>• Shifts movement with tempo</td>
<td>• Names days of week</td>
</tr>
<tr>
<td>• Will repeat newly learned skills</td>
<td>• Identifies body parts</td>
<td>• Uses a vocabulary of 10-20 words</td>
<td>• Plays rhythm instruments</td>
<td>• Finds differences</td>
<td>• Matches notes and/or tones</td>
</tr>
<tr>
<td>• Coos to music</td>
<td>• Helps clean-up</td>
<td>• Imitates sounds from the environment</td>
<td>• Recites familiar rhymes</td>
<td>• Identifies rhyming words</td>
<td>• Alters movements to match music</td>
</tr>
<tr>
<td>• Babbles consonant vowel sounds (bababa)</td>
<td>• Uses a vocabulary of 50-200 words</td>
<td>• Crawls and walks alone</td>
<td>• Categorizes sounds (loud, metallic, soft, etc.)</td>
<td>• Uses time of day appropriately</td>
<td>• Finishes phrases</td>
</tr>
<tr>
<td>• Plays with an instrument for a few minutes</td>
<td>• Scribbles, uses both hands in midline</td>
<td>• Scribbles, uses both hands in midline</td>
<td>• Catches a ball, step-hops</td>
<td>• Gallops, hops on either foot</td>
<td>• Plays patterns on rhythm instruments</td>
</tr>
<tr>
<td>• Guides action on instruments</td>
<td>• Puts objects into a container</td>
<td>• Puts objects into a container</td>
<td>• Matches objects with tactile cues (sticky, rough, etc.)</td>
<td>• Obeys rules, uses words to express feelings, sits with limited fidgeting, stays on topic</td>
<td>• Describes part of an event</td>
</tr>
<tr>
<td>• Shows understanding of words</td>
<td>• Tantrums, pretend plays, displays a sense of self importance</td>
<td>• Tantrums, pretend plays, displays a sense of self importance</td>
<td>• Names friends, transitions better between activities, shares with others, sits during group activities</td>
<td>• Repeats stories</td>
<td>• Repeats stories</td>
</tr>
<tr>
<td>• Repeats sounds when others laugh</td>
<td>• Makes eye contact, cooperates in games, and engages in relational play</td>
<td>• Makes eye contact, cooperates in games, and engages in relational play</td>
<td>• Identifies sound differences</td>
<td>• Identifies sound differences</td>
<td>• Identifies sound differences</td>
</tr>
<tr>
<td>• Rolls, pushes up on hands, and sits independently</td>
<td>• Guides action on instruments</td>
<td>• Guides action on instruments</td>
<td>• Tantrums, pretend plays, displays a sense of self importance</td>
<td>• Skips, completes obstacle courses</td>
<td>• Skips, completes obstacle courses</td>
</tr>
<tr>
<td>• Grasps instruments in both hands, bangs together in midline, puts instruments in and out of containers</td>
<td>• Makes eye contact, cooperates in games, and engages in relational play</td>
<td>• Makes eye contact, cooperates in games, and engages in relational play</td>
<td>• Matches objects with tactile cues (sticky, rough, etc.)</td>
<td>• Makes more visual discriminations</td>
<td>• Makes more visual discriminations</td>
</tr>
<tr>
<td>• Makes eye contact, cooperates in games, and engages in relational play</td>
<td>• Guides action on instruments</td>
<td>• Guides action on instruments</td>
<td>• Names friends, transitions better between activities, shares with others, sits during group activities</td>
<td>• Shows more control of emotions, uses more manners, delayed gratification, and rule following skills</td>
<td>• Shows more control of emotions, uses more manners, delayed gratification, and rule following skills</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Table 2. Red Flags</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>0–12 Months</strong></td>
</tr>
<tr>
<td>- Issues with eye contact</td>
</tr>
<tr>
<td>- Hands remains open or closed most of the time</td>
</tr>
<tr>
<td>- Limited interaction with others</td>
</tr>
<tr>
<td>- Lack of social smile</td>
</tr>
<tr>
<td>- Prolonged startle reactions and other sensory issues</td>
</tr>
<tr>
<td>- Seeks or resistance to tactile input</td>
</tr>
<tr>
<td>- Difficulty moving out of midline for play</td>
</tr>
<tr>
<td>- Extreme difficulty with transitions</td>
</tr>
<tr>
<td><strong>12–24 Months</strong></td>
</tr>
<tr>
<td>- Issues with eye contact</td>
</tr>
<tr>
<td>- Limited sense of humor</td>
</tr>
<tr>
<td>- Limited or abnormal vocal sounds, echolalia</td>
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<tr>
<td>- Limited interaction with others</td>
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<tr>
<td><strong>24–36 Months</strong></td>
</tr>
<tr>
<td>- Extreme rigidity in routine, difficulty with transitions</td>
</tr>
<tr>
<td>- High incidence of toe walking</td>
</tr>
<tr>
<td>- Repetitive behaviors</td>
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<tr>
<td>- Difficulty with pretend play</td>
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<tr>
<td><strong>3–4 Years</strong></td>
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<tr>
<td>- Limited or no eye contact</td>
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<tr>
<td>- Difficulty with transitions, sharing, taking turns, sitting with the group, following simple directions</td>
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<tr>
<td>- Inappropriate laughter</td>
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<tr>
<td><strong>4–5 Years</strong></td>
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<tr>
<td>- Difficulty engaging in conversations or discussions</td>
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<tr>
<td>- Difficulty noticing the distress of others, sitting through a task, transitioning between activities, focusing on a given task</td>
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<tr>
<td>- Destructive of others’ property</td>
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<tr>
<td><strong>5–6 Years</strong></td>
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<tr>
<td>- Limited appropriate facial expressions to words</td>
</tr>
<tr>
<td>- Uses actions to make emotions known</td>
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<tr>
<td>- Impulsive, uses unsafe movements or action</td>
</tr>
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<td>- Seeks immediate gratification</td>
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<tr>
<td>- Appears unaware of consequences of breaking the rules</td>
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<tr>
<td>- Presents an extreme or neutral response to teasing</td>
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Dancing Poems:
Using Poetry to Stimulate Creative Movement

Karen R. Davidson, BS Education
Storybook Dance™
Guilford, CT

Storybook Dance™ teaching method (which integrates music, dance, children’s literature and art, in order to appeal to many different learning styles) was described in the first edition of *imagine*. In this method there is an emphasis on allowing children to move as they learn, and encourages developing their own personal movement vocabularies as a form of creative expression (Davidson, 2010a).

Eric Jensen (2001) states that dance may enhance multiple and lasting biological systems. He suggests that dance not only develops balance but also reading skills by activating the motor-cerebellar-vestibular system of the developing brain.

Dance and movement offers many forms of stimulation. Picture books with eye-catching illustrations, objects with different shapes and textures, and music from different cultures, all inspire children to move differently. Poetry written for children can be used in a variety of ways to stimulate creative movement, especially when paired with the right music.

Some poems have very specific movement cues. A humorous example by Shel Silverstein (1974, p. 23) is called *Ourchestra*. The first few lines make clear what is expected. Any class can have fun experimenting with sounds created with hands, feet and mouths and no other music experience is necessary.

So you haven’t got a drum, just beat your belly.
So I haven’t got a horn—I’ll play my nose.
So we haven’t got any cymbals—
We’ll just slap our hands together.

*Hailstones and Halibut Bones*—Adventures in Color by Mary O’Neill, illustrated by John Wallner (1989) is a wonderful collection of poems about colors. Each one has a different feeling, and thus inspires different movements. In combination with the CD *Doodle Music for Drawing and Dancing* (Davidson & Coy, 2009), children can be encouraged to discuss, listen, draw and move to the poems. The video below shows an example using the poem *What is Orange?*. Children ranging in age from 3-10 were easily drawn into the activity of creating a doodle together and dancing the color poem with streamers to become a bonfire burning. There was plenty of room for personal interpretation and experience working in a group.

**Watch “What is Orange?”**

Small Steps for a Large Dance-Movement Poems for Children (Davidson, 2010b) is a collection of poems written specifically to stimulate creative movement; it comes with a CD of original music. The poems are filled with unusual verbs to explore, interesting rhythms or suggestions of level, direction or tempo. Each has a different feeling and movement theme. Below are three examples with suggestions for implementing them.

Growing
Growing is very slow;
So slow that you don’t even know it is happening,
Until it is done.
Growing is slow and sometimes hurts,
And sometimes makes you wonder who you really are.
Growing is slow; makes you wait.
How slowly can you grow?

Moving slowly can be one of the hardest challenges for young children. It takes a great deal of control and almost as much energy as moving fast. Have the children start in the smallest shapes they can make. As you slowly count to 15 have them grow into a large shape without finishing until you say 15. Use
the music next, challenging them to move as slowly as they can. This can be done on the floor, sitting or standing.

### Sea-Blue Tumbling
Toes wiggle walk through sea shells, beach glass, soft sand
Knee deep swim tiny fish, crawl eager crabs, through seaweed
Waist deep to back float, ears under, feet up
Arms sweep back, hair spreads out, breath deep and belly shiver
Cool salt lips, seagulls cheer, sun smiling down, calm.

This summer beach poem utilizes levels and body part isolations to encourage children to relax. You can choose children to represent water with water colored ribbons or crepe paper streamers. Others can explore the movements of underwater animals or seaweed. The emphasis should be on soft energy that floats.

### Fairy Night Dance
Take my hand into the soft honeysuckle scented night;
Down the road to where the fairies dance with lanterns.
You will find them deep under heavy, leafy limbs;
Blinking through the thick marsh grasses,
Over the fence, and around the pond.
Watch them playing hide and seek between the bushes,
Then disappear, camouflaged against the starry night.

Find the words in the poem that give a sense of levels and direction. This can be fun to do with tiny flashlights in a dim room, to make the fireflies seem alive. Have the children be sure to use the words over, under, around, and through, to help direct their movements. Start with a low level and end in a very high group shape together. The study of poetry and movement together can be a joyful experience if the goal is to stimulate creative expression while enjoying language. Dancing the meaning of words will almost certainly cause a better understanding of them.

### References

### Resources

### About the Author
Karen R. Davidson, past faculty/administrator for Neighborhood Music School, New Haven, CT, for 23 years, was Head of the Early Childhood Program and the Dance Program in the Guilford Branch. She taught music and movement classes for infants and toddlers aged 6 months to 5 years, as well as Creative Dance, Modern Dance, and Storybook Dance. She currently offers teacher development workshops in her method.

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Lollipop Drum: Opportunity for Increasing Body Awareness
Beth McLaughlin, LCAT, MSE, MT-BC
Wildwood School
Schenectady, New York

Description
The purpose of Lollipop Drum activity sequence is to develop body awareness and imitation skills through simple movement and instrument play.

Goals
‣ To encourage imitation
‣ To learn body parts
‣ To encourage self-initiated response

Behavior Observation
The child will:
‣ tap drum on different body parts as modeled
‣ identify body parts
‣ sustain instrument play for duration of song

Materials
‣ Lollipop drums (small are preferred), one per child without the mallet

Directions
1. Pass out drums and have children explore different ways of playing by modeling and giving verbal directions (e.g., I’m tapping the drum; I’m tapping my knee; I’m tapping my head).
2. Introduce the song while playing the drum with an open hand.
3. Model the positional change and repeat the name of the body part tapped until all children have successfully joined in.
4. Repeat the song and include other body parts.

Adaptations
‣ Sing the song and model positional changes, but have children identify the body part being played.
‣ Let children choose the body part to be played.
‣ Pass out pictures of different body parts and have children match their picture to the body part tapped.

Lollipop Drum

About the Author
Beth McLaughlin is internship director and coordinator of music therapy services for children and young adults with autism and complex learning disabilities at Wildwood School in Schenectady, New York.

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The Very Bouncy Bear: Addressing Literacy Needs Through Music

Laurel Rosen-Weatherford, MM, MT-BC
Monroe County Intermediate School District
Monroe, Michigan

Description
The Very Bouncy Bear by Jack Tickle is an action packed pop-up book that is a favorite amongst preschool/kindergarten children and staff. The bluesy melody combined with the simple beat pattern actively engages children as they are introduced to a variety of polar animals.

Goals
‣ To learn about turn taking
‣ To practice waiting skills
‣ To develop listening skills

Behavior Observation
Child will
‣ observe peers taking turns
‣ wait for his or her turn as prompted by the leader
‣ follow both spoken instructions and those embedded within song

Materials
‣ Story Book: The Very Bouncy Bear by Jack Tickle

Directions
Have children sit in a circle.
1. Introduce a steady beat pattern with pat/clap while singing the chorus: “Lots of snowy creatures are hiding in this book. Waiting to pop out at you so come and take a look and Stop! 1 2 3. It’s a….“
2. Act very surprised when introducing the animal.
3. Have children act out the animal by imitating a simple movement to the beat.
4. Repeat the melody used for the chorus and share the next animal in the story.
5. Break children up into groups and repeat the experience by taking turns acting out the animal.

Adaptations
‣ Children may pat their knees and give each other high 10’s on the clap.
‣ Children may add instruments to represent the animals.
‣ Children may share the story book as a play with an audience.

About the Author
Laurel Rosen M.M., MT-BC is a music therapist with Monroe County Intermediate School District. She earned an undergraduate degree in music education from Miami University and an equivalency/masters degree in music therapy from Western Michigan University. Laurel specializes in community-based settings, educational collaborative for preschool and school aged students, inclusive music therapy services, and user-friendly data collection.

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The Caterpillar

Margie La Bella, MA, MT-BC
Leeway School
Long Island, New York

Description
The Caterpillar song was written to support a pre-school curricular unit, which studied the life cycle of a butterfly. The song engages children with various language issues in singing and movement activities.

Goals
- To learn about the life cycle of the butterfly
- To improve receptive language skills
- To expand curriculum-related vocabulary

Behavior Observation
The child will:
- identify the sequence, which represent the life cycle of a butterfly
- follow directions embedded in the song with appropriate body movements (i.e., crawl, eat, spin, roll, wake up, and fly).
- sing along with the song lyrics (i.e., fill in words or entire phrases)

Materials
- Pictures representing an egg; a caterpillar crawling, eating, making a chrysalis, breaking free from the chrysalis, and flying freely as a butterfly

Directions
1. Show pictures and explain the stages in a butterfly’s life cycle.
2. Introduce the song while pointing to each picture and encourage children to sing along
3. Model appropriate movements with each verse and encourage children to imitate the movements.

Adaptations
- Place the pictures out of sequence and have the children put them in the correct order.
- Have children imitate the motions with finger and hand movements while sitting in a circle.
- Use live "butterfly kits" to observe each developmental stage of the insect.

About the Author
Margie La Bella, MA, MT-BC has worked as a music therapist with preschool children for more than 20 years. She has developed over 150 music therapy activities for individuals and groups of all ages and areas of needs, which are available on her website Musictherapytunes.com.

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URL: www.musictherapytunes.com
Biddy Biddy: A Song Without Words

Carol Ann Blank, LCAT, LPC, MMT, MT-BC
Music Together LLC
Princeton, New Jersey

Description
This egg-shaker song is great for vocable play, small movement, body parts, name substitutions, dynamics, and general shaker play.

Goals
➢ To explore vocalizing in a playful way
➢ To experiment with levels of beat
➢ To promote body awareness

Behavior Observation
The child will:
➢ vocalize nonsense syllables within the context of this playful, singing experience
➢ observe and engage in exploration of macrobeat, microbeat, and beat elongation
➢ verbally or nonverbally identify parts of the body

Materials
➢ Egg shakers – two for each participant

Directions
1. While seated, establish the pulse by rocking side to side and tapping the eggs to the beat.
2. Repeat the song several times before changing the vocable to another neutral syllable (e.g., baa, doo).
3. Play while singing different consonant and vowel combinations (e.g., doobie, dee-dee, zappa-dappa, and any others you or the children can make up).

Adaptations
➢ Use a single variation for an entire repetition of the song to allow children the time to notice, process, and adapt to the changes.
➢ Try large movement activities while singing the action word: spinning, jumping, stomping, etc.
➢ Tap egg shakers to the beat on different body parts.

Note
The activity for the song "Biddy Biddy" is excerpted from the Music Together Family Favorites Songbook for Teachers. Reprinted with permission!

About the Author
Carol Ann Blank, LCAT, LPC, MMT, MT-BC is a Program Developer for Music Together LLC and is a Certification Level I Music Together® teacher. She presents at conferences around the country on the importance of music and movement for young children with special needs.

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If you are interested in contributing to the “The Color of Us” series, please contact us.

About the Color of Us Series

The Color of Us series started at the 12th World Congress of Music Therapy in Buenos Aires, Argentina. Since then, colleagues from the USA, Europe, Australia, Brazil, Korea, Colombia, New Zealand, South Africa, the Kingdom of Bahrain, Canada, Italy, Argentina, China, Singapore, Thailand, Taiwan, and Japan have shared information about current research and music therapy practice with young children and their families in the countries where they reside. All Color of Us pages are available as handouts on the imagine website under “we go international.”

At the 13th of the World Congress of Music Therapy in Seoul, Korea, Dr. Petra Kern, the editor of imagine, invited Asian colleagues to a Color of Us roundtable. The presenters’ slides give a brief overview of the content. A video excerpt can be found under the teaching episodes on the imagine website. Later this year, the Gangwon Television Broadcasting Company in Seoul, Korea will broadcast a documentary about children songs, including songs and interviews from this roundtable.
Download the roundtable slides.
Switzerland

Friederike Haslbeck
MT-DMiG
University of Witten/Herdecke, Germany

Sandra Lutz Hochreutener
Ph.D., SFMT, SPV/VOPT
Department of Clinical Music Therapy
Zurich University of the Arts, Switzerland

Demographics
Encompassing the central Alps, Switzerland is a beautiful small country in Central Western Europe, which consistently ranks high on quality of life indices. According to statistics released by the federal government in 2008, life expectancy stands at 82.1 years for populace and almost all Swiss are literate. Politically, there are 26 cantons that make up Switzerland, each canton with its own constitution, legislature, government and courts. The education system is decentralized and includes four languages. There are currently about 240 members of the Swiss Music Therapy Association (SMTA), of whom about 75 are professionally trained and accredited music therapists.

Background Information
Due to the diversity of training and clinical practice, SMTA plays an important role and functions as an overarching organization. Founded in 1981, the association aims to link the diverse training programs and promotes music therapy to be recognized as a health profession in Switzerland. Other goals are to guarantee high and consistent professional standards of Swiss music therapists through accreditation as well as to support music therapy in education, practice, and research. For more information please visit www.musictherapy.ch.

State recognition of music therapy as a health profession is still a challenge in Switzerland. However, over the past 20 years music therapy has gained more recognition and acceptance and developed into a more autonomous profession.

Since 1980, five music therapy training programs have been established in Switzerland. One of them was the “Berufsbelegende Ausbildung Musiktherapie bam,” which is now integrated in the Master of Advanced Studies in Clinical Music Therapy at the Zurich University of the Arts. The four additional training programs operate on a private basis.

Swiss music therapists work with infants, young children, adolescents and their families in various settings including neonatal intensive care units, children’s hospitals, psychiatric hospitals, rehabilitation clinics, early intervention and special education settings, schools, music schools, hospices as well as in private practice. As in Switzerland, “therapeutic pedagogy” plays an important role in the education system, many Swiss music therapists work in therapeutic pedagogy settings.

Snapshot
Area
41,285 square kilometers; situated in Central Western Europe

Population
7,639,961 million people (Spring, 2011 est.)

Official Language
German, French, Italian, and Rhaeto-Romansh

Ethnic Groups
German 65%, French 18%, Italian 10%, Romansh 1% and other 6%

Median Age
41.7 (2011 est.)

Children under 5
366,000 (2009 estimate)

Sources
http://en.wikipedia.org
www.unicef.org/info
www.emtc-eu.com
www.musictherapy.ch

Das Gras wächst nicht schneller, wenn man daran zieht.
[The grass does not grow faster if you pull on it.]
– Remo Largo
Several supplementary health insurances cover a good portion of the costs of music therapy in private practice. In outpatient settings, physicians, counselors, and (school) psychologists refer clients to music therapists, and parents can register their children for music therapy, too. This is one reason why, compared to other European countries, a large number of music therapy private practices exist and the salaries of Swiss music therapists are generally higher, although part-time positions are still most common.

**Common Approaches**

In Switzerland, active as well as receptive music therapy is provided in individual and group music therapy settings. Applied music therapy as well as the training programs work by involving several directions to link different philosophies and approaches. Music therapists in Switzerland apply instrumental and vocal improvisations, song creations, role-play, body-centered music games, and guided imagery methods. Swiss music therapy with children is based on the theoretical framework of developmental psychologists such as Daniel Stern, the Papouseks, John Bowlby, Colwyn Trevarthen, the Swiss child psychiatrist Heinz-Stefan Herzka and the Swiss pediatrician Remo Largo.

**Prominent Publications**


**About the Authors**

Friederike Haslbeck, MT-DMtG, Master of music education, Master of music therapy, and special training in NICU music therapy, has worked as music therapist with children, including infants in NICU in Germany since 2001. Currently she is a Ph.D. candidate at the University of Witten/Herdecke in Germany and lives with her family in Zürich, Switzerland.

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Dr. Sandra Lutz Hochreutener, SFMT, SPV/VOPT, Ph.D. in music therapy, Master of pedagogic, is a psychotherapist who has long-standing experiences in pediatric psychiatry. She has also worked with children (and adults) in private practice for 25 years in the greater St. Gallen area in Switzerland. Dr. Lutz Hochreutener is the founder and co-director of the Department of Clinical Music Therapy at the Zurich University of the Arts.

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Demographics
There are currently 678 registered music therapists in the United Kingdom (UK). One hundred and seventy therapists work with children of all ages, while 155 describe themselves as working specifically with pre-school children (2011).

Background Information
Until recently, there have been two national bodies representing music therapy in the UK. The British Society for Music Therapy (BSMT) was a charity founded in 1958, which existed to promote the use and development of music therapy. Membership was open to anyone with an interest in music therapy. The Association of Professional Music Therapists (APMT) was established in 1976 to support and develop the profession. Membership was open to trainees and qualified music therapists from recognized music therapy training courses. After a long period of consultation and preparation, the two organizations were recently dissolved, allowing for the creation of a new body, the British Association for Music Therapy (BAMT).

In June 1999, music therapy, along with other arts therapies, became a state registered profession. In order to practice, therapists must register with the Health Professions Council, the regulatory body established to protect the public and monitor standards in training and professional skills.

In recent years there have been a number of government initiatives which have highlighted the needs of young children and their families. Every Child Matters (ECM) was one such initiative which significantly shaped the way services for children and families were planned and delivered. This year, a government review on Early Intervention was published. The review highlighted the central objective of early intervention as being to “provide a social and emotional bedrock for the current and future generations of babies, children and young people.” Music therapists in the UK have been responsive to these shifts and developments in vision and policy, demonstrating flexibility in the ways in which they engage with children and families.

Resources
Every Child Matters https://www.education.gov.uk/publications/standard/AbouttheDepartment/Page7/DfES%200672%202003
Common Approaches

Music therapy is provided to young children in a wide variety of settings. These include children’s centers, child development services, specific music therapy centers, family homes, and health settings such as children’s hospices. Music therapists are employed by the National Health Service, Local Education Authorities, music therapy trusts or other related charitable bodies, while some music therapists work on a freelance basis. Across the range of settings, close multi-disciplinary working is considered vital.

In some contexts individual or group therapy is offered for children as part of a broader assessment process, or in order to support continuing development. Music therapy might be offered in conjunction with physiotherapy, occupation, or speech and language therapy.

Therapists also employ models which acknowledge and support the needs of parents and the wider family. For example, sessions which offer group work for children with a diagnosis of autism spectrum disorders might also include parallel support groups for parents. Programs such as Shake, Natter and Roll, a London-based group run by a cross-disciplinary team of practitioners for babies and their carers, seek to develop the parents’ own capacity to play, sing and engage with their child. Music therapy has an important role to play in supporting developing relationships in the early years and helping to build solid foundations for future growth.

Prominent Literature


About the Author

Claire Flower, BMus(Hons), Music Therapist has many years of experiences as a music therapist in clinical practice, working in a range of settings with a wide variety of client groups. She works now at the Cheyne Child Development Service based at Chelsea and Westminster Hospital, London, working primarily with pre-school children with complex needs. Claire is a past Chairperson of the British Society for Music Therapy, maintains a supervision practice and continues to both write about and present her work extensively.

Contact:
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Demographics

Music therapists have been practicing in France since the ’70’s. These “pioneer” therapists were trained in private, post-university professional programs. Over the years, the training centers, both private and public, have worked together to create the French Federation of Music Therapy (FFM). Today, five centers offering high-level training belong to the Federation. The training centers, either university-affiliated or private institutions, are located in Bordeaux, Dijon, Montpellier, Nantes, and Paris. All of the training programs are based in psychodynamic theory and emphasize the importance of personal therapy and life-long learning. Strongly committed to cooperation with other European countries, the FFM is a long-standing member of the European Music Therapy Confederation (EMTC) of which François-Xavier Vrait, director of the training Center in Nantes, was a founding member.

In the fall of 2011, a government-recognized Masters Degree program in Creative Arts Therapy will open at the University of Paris, replacing the Professional Master’s program created in 2004. Professor Edith Lecourt, internationally known for her numerous publications on music therapy, has played a key role in encouraging research in music therapy in France. Several practicing music therapists have earned a Doctoral degree in Psychology based on their research in the field of music therapy. The exact number of therapists practicing music therapy today in France is not known as there is no obligation of membership in a professional association. The FFM has 110 active members in its register. The members all adhere to the Ethical Code based on the EMTC Ethical Code.

Throughout the country, small groups of therapists have created workgroups to share their experience and maintain a high level of practice. The only specialized journal published in the French language, La Revue de Musicothérapie, was created in 1981 by the French Association of Music Therapy, one of the five member associations of the FFM. Four issues are published yearly.

Background Information

In spite of this long history of music therapy practice in France, the profession has still not achieved official recognition at the government level. A workgroup is in the process of finalizing the steps towards government recognition, which should facilitate access to jobs. Most music therapists have accredited training...
in a health care profession and in this way, are able to practice music therapy in various settings. For example, a university-trained psychologist could be hired under the official title of Psychologist with the expressed objective of practicing as a music therapist. Recently, several therapists have succeeded in achieving official professional recognition in their institutions even though the profession is not officially recognized at the national level. Increasingly, trained music therapists are making the choice to work in private practice. A few health insurance policies have even accepted to cover some of the cost of music therapy for children.

Common Approaches
The majority of music therapists in France practice in public settings as part of an integrated team. The music therapy approach applied by a multidisciplinary team is defined according to the theoretical framework of the unit; most often psychodynamic, but also cognitive. Rather than “receptive music therapy,” the therapists use “active music therapy” including improvisation when working with young children.

Music therapists can be found working in a wide range of early childhood settings. They are present in programs preparing couples for childbirth, in neonatal intensive care units, pediatric units, cancer care, child day-care centers, or in foster child placement centers. In child psychiatry units, the important role of music therapy has long been recognized in work with children with autism spectrum disorders and multiple handicaps. Family music therapy is also practiced in France. Sometimes employed in the school system, music therapists work in nursery schools and kindergartens often using a more “pedagogical” music therapy approach for young children with behavior disorders.

Prominent Publications

About the Author
Adrienne Lerner is a trained music therapist and psychotherapist with a doctorate in clinical psychology. After working for many years in public institutions – including an adult psychiatry unit, a pediatric unit, and a private placement center for abused children- she is currently self-employed as a private practitioner. Dr. Lerner is a board member of the Fédération Française de Musicothérapie (FFM) and Vice-President of the European Music Therapy Confederation (EMTC).

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Demographics
In Finland, there are currently about 500 clinically trained music therapists, and approximately half of them are working as full-time clinicians. Most therapists provide services in private practice settings as there are only about 60 official hospital and rehabilitation positions within the Finnish public healthcare system. Music therapy services are provided mostly as in- and outpatient services. Reimbursement for music therapy services comes from the governmental Social Insurance Institution of Finland (KELA), which covers the costs for specific populations with certain conditions. Funding is provided for a maximum of three years.

Music therapy education is available from introductory courses to the university level. Professional training courses can be taken at Universities of Applied Sciences or at the Eino Roiha Institute. The University of Jyväskylä offers an international Master’s program in music therapy as well as post-graduate training on a Ph.D. level. All of the music therapy training programs share similar goals with regard to their basic principles, structure, and content.

The Finnish Society for Music Therapy advocates strongly for the widespread practice of music therapy in Finland. Currently, music therapy services are provided to a wide variety of target groups across the fields of healthcare, rehabilitation, and education. Early childhood music therapy has strong traditions in Finland and there are a number of music therapists who also have a background in early childhood music education.

Background Information
There is a growing number of music therapists providing services to young children and their families in Finland. According to an informal survey on the current status of early childhood music therapy in Finland, most music therapists who serve the early childhood population work with children ages 4-5, followed by children 12-24 months. Most commonly, these clients come to therapy with social and developmental delays, though psychiatric issues and communication delays are also common.

Reimbursement for early childhood services is generally provided by KELA and occasionally by healthcare districts and communities. In rare cases, music therapy services are reimbursed by foundations, agencies, or through private pay from families.
Music therapy services are most often provided to the client in one-on-one sessions, and many therapists regularly hold separate meetings with parents. Many therapists work with dyads, including parents and others. Group sessions are rare. It is quite common that the treatment is provided over the course of one year. Short-time treatments are rather unusual. Typically, sessions take place once a week for about 45 minutes, but 30 and 60-minute sessions are also possible.

Common Approaches
Many therapists identify most strongly with psychodynamic and attachment-based theoretical frameworks, although those therapists surveyed also cited using neurological, medical, and eclectic approaches in their work. Behavioral approaches are not widely used in Finland.

Therapists apply singing, instrument play, dance and movement, listening to music, drawing and painting, dramatic play, and instrumental and vocal improvisation in their sessions with young children. The goal of improvisation is mainly to encourage social interactions. In addition, play- and nursing songs, discussions, literature, relaxation exercises and even Vibroacoustic treatment may be incorporated into a music therapy session.

The instruments used with young children include simple percussion instruments (e.g., claves, maracas), drums and melodic instruments (e.g., xylophones), piano, and guitar. Additionally, some therapists incorporate the use of a traditional Finnish string instrument, the “kantele.”

Although the actual number of music therapists providing services to young children and their families is unknown, it seems like this is a growing area in Finland, especially as more students are graduating from training programs.

Prominent Publications

Note
The information in this article is based on an informal survey conducted by the authors with Finnish music therapists during March and April 2011. The survey was distributed via email and at a national music therapy seminar. In addition, some information has been drawn from the Finnish Society of Music Therapy.

About the Authors
Kirsi Tuomi, MS is a music therapist and theraplay therapist in private practice working mainly as a supervisor for foster parents and professionals within childcare settings. She served as the Executive Manager of the Finnish Society for Music Therapy, teaching courses at the Sibelius-Academy, and is currently a Ph.D. candidate at the University of Jyväskylä in Finland.

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Esa Ala-Ruona, Ph.D., is a music therapist and psychotherapist working as a researcher at the Music Therapy Clinic for Research and Training, University of Jyväskylä. He is a trainer and supervisor and coordinates the international master’s program of music therapy. Dr. Ala-Ruona served in leading positions at several Finnish music therapy organizations and currently is the Editor-in-Chief for the Finnish Journal of Music Therapy.

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Iceland

Valgerdur Jonsdottir
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Tonstofa Valgerdar
Reykjavik, Iceland

Snapshot

Area
103,000 square kilometers, a European island country in the North Atlantic Ocean.

Population
318,452

Official Language
Icelandic (a North Germanic language)

Ethnic Groups
Icelanders are a homogeneous mixture of Norse and Gaelic descendants who settled in Iceland around 874 AD.

Median Age
35.4 years

Children under 5
23,041

Sources
http://www.pbase.com/orvaratli/icelands_seaside
http://www.statice.is/

Demographics
Music therapy was first introduced in Iceland in 1970. Since that time, between one and six music therapists have been practicing in the country in any given year.

Background Information
There is one professional music therapy organization in Iceland, Físmús, The Icelandic Music Therapy Association. It was founded in 1997 and currently holds six active members. Icelandic music therapists are educated abroad and have graduated from at least seven different academic institutions in the United States, Europe, and the Nordic countries. Music therapy in Iceland reflects the diverse backgrounds, schooling and experiences of the pioneers in this field. Practices are eclectic in nature and characterized by a variety of opinions, methods, techniques and philosophies. At least sixteen Icelanders have degrees in music therapy. Music therapy is not a recognized profession and has not been granted official government approval. Practicing music therapists are not licensed and there is no designated music therapy position within the social infrastructure. However, music therapists have been employed by the state. They have occupied teaching positions or have been hired as contractors and have had considerable freedom to shape their music therapy practices. The Icelandic music therapy association has developed a code of ethics and standards of practice and verifies the professionalism of its members with a signed document. The association’s campaign for an official approval on a governmental level continues.

Common Approaches
The institutions in Iceland serving special needs children and their families within the framework of El are: Landspítalinn - University hospital and other pediatric hospital departments and neonatal units around the country, community child healthcare services situated in various health care clinics in the capital, its suburbs and major towns around the country, the different regional offices concerning affairs of the handicapped (ROAH), day-care systems, kindergarten schools, and various associations which offer educational and counseling services to parents, such as Sjónarhóll, in Reykjavik, and The State Diagnostic and Counseling Center situated in one of the suburbs of Reykjavik.

The State Diagnostic and Counseling Center is the main evaluation and habilitation center in Iceland for children

“When I feel sad and I hear this kind of music I want to cry. When I feel good and I hear this music it is like God is sending it to me.”
– Jón Emil, a three-year-old boy
and adolescents with various types of developmental disabilities. Its main goal is to evaluate these clients, provide counseling to parents and caregivers, and offer guidance to teachers and therapists serving the family. Another important aspect of the center’s work is to organize congresses, workshops and lectures on various topics of interest to parents and professionals.

For the past few years, music groups for infants and young children have been run in Iceland by music teachers but are rarely attended by children with special needs. Within the framework of early intervention and in the rapidly growing field of infant health, varied therapeutic services are offered, but music therapy is not yet one of them. With the exception of some children with special needs who have received music therapy at Tónstofa Valgerdar and the Children’s Hospital, music therapy has not been accessible to young children with disabilities and their caretakers in Iceland. There is still much work to be done.

Prominent Publications

Three Masters’ degree research projects have been undertaken by Icelandic music therapy students graduating from Aalborg University in Denmark. The client groups in theses studies focused on patients with Alzheimer’s disease, cancer patients, and hospitalized children. Presently a Ph.D. research study is in progress at Aalborg University to be defended in 2011. The research title is: “Music-caring within the framework of early intervention. The Lived Experience of a group of mothers of young children with special needs, participating in a music therapy group.”


About the Author

Valgerdur Jónsdóttir, MA, RMT graduated as a piano teacher from the Reykjavík College of Music in 1980 and finished her bachelor’s degree in music therapy from the University of Kansas, U.S.A. She did her clinical practicum at the University of Texas Medical Branch and became a registered music therapist in 1986. Jónsdóttir graduated with a master’s degree 2004 from Sogn and Fjordane University College, Norway and is currently working towards a doctorate in music therapy from Aalborg University, Denmark. Jónsdóttir worked as a clinical music therapist at LSH Child Psychiatric Hospital, from 1987 to 2009. From 1986 to present, she has headed a special music school, Tónstofa Valgerdar, and worked there as a private music therapy practitioner and a special music teacher.

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It is difficult to state how many music therapists work in Poland because there are no official statistics. In recent decades a few hundred music therapists have graduated from various programs, but many of these graduates now work in other fields or simply have not been able to find employment as a music therapist.

Background Information

Polish music therapy has a tradition of over 40 years, with the first music therapy university program being established in 1973. Five universities now offer music therapy programs at the undergraduate, graduate, or post-graduate level. The most popular means of studying music therapy are postgraduate programs along with various trainings and workshops.

In Poland, music therapists belong to three main associations: 1) the Polish Association of Music Therapists, 2) the Polish Association for Therapy through the Arts, or 3) the Arts Therapists’ Association “Kajros.” The second of these organizations publishes the journal Therapy Through the Arts and is the administrator of the Internet portal promoting various forms of therapy through the arts (see www.arteterapia.pl).

Unfortunately, there is still no official recognition from the government or legal protection for music therapy practitioners in Poland. The term “music therapist” is not featured on the list of registered occupations. Consequently, a wide range of music education activities are described as “music therapy” even though they may be administered by individuals without a music therapy background.

At present, most music therapists work in hospitals, sanatoriums, nursing homes, occupational therapy centers for people with intellectual disabilities, psychiatric patients, or educational centers. The range of settings in which music therapy is used has grown over the years. In the early days, it was used mostly with psychiatric patients, probably because psychiatric hospitals were the institutions most interested in art as a therapy. The last decade has seen a growing interest in early childhood music therapy. More and more music therapists are working with children. As mentioned above, because of the lack of regulation there are many situations in which “music therapy” is carried out by people who have not undergone the appropriate training. Consequently, the kind of work they do often has more in common with music education than with music therapy.

“You are the music while the music lasts.”
– T. S. Eliot
Common Approaches
During the development of music therapy in Poland, two methods were created. One is the “Musical Portrait,” by E. Galinśka, intended for people with psychiatric problems. The second and most well-known is Mobile Music Recreation Model (MMR) by Maciej Kierył. This is a very simple and accessible tool for working with children. MMR sessions are comprised of several stages: Activation (i.e., warm-up), release, rhythmization, sensitivity, relaxation, and gentle activation. Each stage is flexible in time and content depending on the participants’ needs and the ideas of the therapist or leader. Various people can carry out this music prophylaxis and therapy method after undergoing several hours of training. For this reason, many preschool teachers and people working with children use this method in their practice.

In Poland there is no opportunity to study any specific music therapy method for children and their families (except the Polish methods), so music therapists tend to use an eclectic approach, bringing together elements of different methods and philosophies. They also use elements of Carl Orff’s music education system, developing movement by W. Sherborne, the Good Start Method, and the Dennison method.

The earliest form of music intervention leading to health promotion and treatment is conducted in the Infants’ Pathology Department of the Children’s Hospital in Lublin. The patients are premature babies and infants with health issues. The unit has a special integrated sound system in every room. Relaxing music is played during feeding times to enhance the infant’s sucking reflex. Some parents decide to continue playing relaxation music at home.

People in Poland are becoming more and more interested in music therapy: Elements of music therapy can be encountered in a wide range of settings, even in cultural centers. Music therapy classes take place in inclusive preschool settings and in centers for children with special needs. There are a few private centers specializing in therapeutic and development classes for children.

Movement challenges, brain damage, autism spectrum disorders, emotional disturbances, and speech/language issue are the most common reasons for participation in classes for children under 5. Music therapy sessions are usually part of a complex treatment led by a therapeutic team. Music therapy interventions are usually provided within individual sessions, and occasionally in group sessions if there are children with similar therapeutic goals. Music therapy sessions usually take 30-45 minutes. Parents often join the sessions, participating in their child’s therapy and learning how to implement specific musical activities in the home environment.

Prominent Publications

About the Author
Krzysztof Stachyra, Ph.D. is a music therapist and music educator. He works in the Art Therapy Center with a wide variety of clients and teaches at the Maria Curie Sklodowska University in Lublin, Poland. Dr. Stachyra is the Editor-in-Chief of the journal Therapy Through the Arts and serves as the President of the Polish Association for Therapy Through the Arts.

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Demographics
In Hungary, there are about ninety music therapists who graduated from Hungarian music therapy courses or received their degrees from another country.

Background Information
Due to the efforts of early pioneers in the mid 1970’s, music therapy is now a more established field in Hungary, though it still strives for broader recognition. The establishment of two post-graduate music therapy courses in the 1990’s was an important milestone in the development of music therapy in Hungary.

Due to the fact that music therapy is not a state-registered profession and courses are only offered on a post-graduate level, most professional music therapists build their music therapy practice on their original qualification such as teaching, special education, or psychology.

Most music therapists work part time or on a contract basis in hospitals, early intervention centers, child development centers, nursery schools, children shelters, or day care centers as members of multidisciplinary teams. Music therapists often integrate music therapy into their special needs practices or psychotherapy work. At present, there are no qualified music therapists who have a private practice based solely on music therapy.

Two collaborating professional bodies represent music therapists in Hungary, the Hungarian Music Therapy Association and the Hungarian Arts Therapies Society. Both currently strive towards the development of an official register.

Common Approaches
Music therapy in Hungary is based on the European traditions and has strong developmental and/or psychoanalytical foundations. Music therapists utilize active, improvisational music-making and receptive music therapy techniques as well as combinations of music with movement, artwork, and drama. As psychologists tend to master several psychotherapeutic methods, musical psychodrama and musical drama therapy groups are also offered – even for children as young as five.

Amongst the first pioneers using music with young children to encourage self-expression was Klára Kokas, whose special music and dance and movement program is now also applied by music therapists to enhance children’s self awareness, creativity and emotional expression.

With children under the age of five, music therapy is practiced in a variety of...
settings for prevention and rehabilitation in both the community and special institutions. Although music therapy techniques vary, therapists focus on the therapeutic relationship and improvisational music making, and use a balance of structure and free play depending on the therapeutic goals. Individual and group work are both common, and some music therapists also work with families. Parents are encouraged to take part in the therapy process of very young children.

The most common settings for music therapists with this age group are early intervention centers and non-governmental organizations (NGOs) for children with disabilities. In these settings, music therapy is used for multiple purposes within the multidisciplinary team: Assessment, communication and language development, motor development, improving social skills, enhancing self expression, and supporting the relationship between child and caretaker among others. The role of the music therapist, however, varies from institute to institute.

As special needs teaching and physiotherapy have strong and long traditions in Hungary, these practices greatly influence the work of some music therapists and the equipment they use besides instruments. Therapists often collaborate with other professionals and conduct multidisciplinary groups for children and their caretakers. For example, a therapist may combine sensory processing models and a focus on the parent-child relationship.

Music therapists lead groups in the community for parents and toddlers which support children’s development and foster parent-child relationships. Groups for pregnant women are provided with a focus on relevant mental health issues. Music therapists who work with children with emotional issues often conceptualize their work within the frameworks of psychodynamic, humanistic, and attachment theory, combining music therapy and play therapy.

Prominent Publications


About the Author

Eszter Forgacs, MA (psychology and music therapy) has worked as a music therapist in the United Kingdom and in Hungary. She is currently working as a music therapist, psychologist and child psychodramatist in the Gezenguz Early Intervention Center for Children with Birth Injuries, and in the Kispest Out Patient Child Mental Health Center in Budapest. She works with children of all ages and their families, conducts individual and group music and/or play therapy sessions, music therapy sessions with families and musical child-psychodrama groups. Her clinical practice also involves parent counseling.

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Music therapy is a fairly new healthcare profession in Latvia. In 1998, German music therapist Reiner Haus started a collaboration between the Liepāja Academy of Pedagogy (now Liepaja University), the University of Witten/Herdecke, Germany, and the Datteln Clinic of Children and Youth to explore the possibility of creating a specialization in music therapy. Within the past ten years, considerable progress has been made toward the establishment of a music therapy program in Latvia. Twenty-six music therapists thus far have completed Master’s programs in music therapy at Liepāja and Rīga Stradiņš Universities.

Demographics
Music therapy is a fairly new healthcare profession in Latvia. In 1998, German music therapist Reiner Haus started a collaboration between the Liepāja Academy of Pedagogy (now Liepaja University), the University of Witten/Herdecke, Germany, and the Datteln Clinic of Children and Youth to explore the possibility of creating a specialization in music therapy. Within the past ten years, considerable progress has been made toward the establishment of a music therapy program in Latvia. Twenty-six music therapists thus far have completed Master’s programs in music therapy at Liepāja and Rīga Stradiņš Universities.

Common Approaches
Societal conditions, governmental legislation, and the varying needs of clients and patients determine developmental trends in music therapy in Latvia. Today, an integrative, eclectic approach allows music therapists to be flexible in their choice of methods and techniques (Paipare, 2011). This integrative approach has been heavily influenced by prominent leaders in the music therapy field who have visited Latvia teaching classes, offering seminars and presenting current research.

Music therapists work in educational, social services and healthcare settings in Latvia. Early childhood is currently the most actively served music therapy population in Latvia. Several music therapists work in nurseries (0 – 5 years) for children with developmental delays and disorders. In child development centers, music therapists work with children who have impaired motor or cognitive development, cerebral disorders, auditory and visual disabilities (including cochlear implant rehabilitation) and other neurological conditions. In these early childhood settings, music therapists often employ creative music therapy interventions and techniques (i.e., Nordoff-Robbins Music Therapy).

Background Information
The Music Therapy Association in Latvia focuses on increasing societal understanding and acceptance of the field by promoting evidence-based research and practice and by working to strengthen formal art therapy education in the Republic of Latvia. The recognition of art therapy in the Latvian Professional Classification has resulted in better educational and career opportunities for music therapists. Graduates of certain programs now are eligible for professional certification equivalent to that awarded to other health care practitioners in the country.

Latvia

Mirdza Paipare, MA
Associate Professor of Music Therapy and Music Education
Liepaja University, Latvia

“Music expresses that which cannot be said and on which it is impossible to be silent.”
– Victor Hugo

Snapshot

Area
64,589 square kilometers; one of three countries (Estonia, Lithuania) in the Baltic region

Population
2,204,708 (July 2011 est.)

Official Language
Latvian 59.3%, Russian 27.8%, Belarusian 3.6%, Ukrainian 2.5%, Polish 2.4%, Lithuanian 1.3%, other 3.1% (2009)

Ethnic Groups
56 ethnic groups

Median Age
40.6 years

Children under 5
114,165 (2010 est.)

Source
The World Factbook

Index Mundi
http://www.indexmundi.com/latvia/demographics_profile.html
In Liepāja and Riga there are two music therapists working in psychiatric hospitals with children with autism spectrum disorders, behavioral and emotional disorders, and children who are victims of violence.

In rehabilitative settings, music therapists collaborate with other specialists (e.g., physiotherapist, speech-language pathologists, occupational therapists) to provide services to children suffering from cerebral palsy, Down Syndrome, and motor and kinesthetic disorders.

Private practitioners often work with children who have been referred to a music therapist by medical professionals. Additionally, parents independently seek out private music therapy for their own children out of concern for perceived issues of behavior, attention and/or speech and language development.

Prominent Publications

About the Author
Mirdza Paipare, MA, is a certified music therapist who currently serves as the President of the Latvian Association of Music Therapy, and as the Latvian representative at the European Music Therapy Confederation. Mirdza Paipare currently serves as the Director of the music therapy program at the Liepāja University.

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Have you taken advantage of the excellent websites available for use in music therapy with your early childhood clients? As a music therapist in private practice, I have found these websites to be an amazing resource, ever-changing and constantly being updated to reflect the needs of the 21st century. They offer opportunities to enrich my own music therapy sessions and also provide the same opportunities for parents, special educators and therapists to further reinforce and follow through at home, in the classroom and community. After personally visiting hundreds of websites, I have developed the following list of those I most highly recommend.

**Young Children**
- **KneeBouncers** offers educational games and fun experiences for babies, toddlers and preschoolers; available as a one-week free trial before requiring a monthly or annual membership subscription.
- **Boopadoo** supplies music resources for the families of young children.
- **PreKinders** “…is a website for Pre-K and Preschool teachers providing music, lessons, themes, print-ables, and hands-on activities for use with the early childhood population.”
- **Earlychildhood games** has an extensive library of websites presenting free early childhood music games; these resources incorporate a wide variety of media, including piano, drums, guitar, and other musical instruments; note flashcards, music puzzles, rhythms, ear training and music composition.
- **Uptoten** is a bilingual website-English and French-and offers 1,000 free games and activities; “online learning for kids aged from 0-10 years old.”

**Reinforcing Communication**
- **do2Learn** provides ready to use communication tools such as songs, sing-a-long sounds, and games, using excellent downloadable pictures (i.e., facial expressions and feelings).
- **starfall** opened in September 2002 to teach children to read using a systematic phonics approach and in May, 2009 released a Starfall Kindergarten Reading and Language arts curriculum as well; very user-friendly and a wonderful site for children to use.
- **jppss** is operated by the Jefferson Parish Public School system, in Louisiana and has a mission “to design engaging, challenging and satisfying work for each student, addressing survival skills necessary for every day.”
- **Special Education Technology** is a searchable database, originating in Vancouver, BC, which makes available a collection of downloadable visuals (Picture SET) for expressive and receptive communication, as well as Accessible Books, curriculum SET resources and technology based content (e.g., templates for familiar children’s songs), Zoo animal sounds, musical instruments and seasonal and holiday selections. It is not necessary to purchase the program discs to use and print their materials as most of them are PDFs.

**Children Songs**
- **Sing Along Songs** incorporates lists of sing-a-long songs (i.e., “theme songs”) using familiar melodies to teach and learn the alphabet, vowel sounds and spell words.
- **Song For Teachers** is another website that uses music to promote learning, and offers thousands of children’s songs, sound clips, lyrics and teacher suggestions.
- **KIDiddles** is a collection of children’s songs with free lyrics and downloadable music located in Tucson, AZ. It offers web-based easy learning books with visually highlighted moving text simultaneously presented with clear narration and sound effects. Each unit includes lesson plans, interactive quizzes and progress charts for automatic data collection. There are more than 40 themed books for the entire school year. KIDiddles also include interactive reading and comprehension lesson plans for special needs and for English as a Second Language (ESL).
students. Free downloadable “lyrics to 2,000 most popular children’s songs,” printable music and activity sheets are also available.

For Children

- Creating Music is a “children’s online creative music environment for children of all ages,” including opportunities to play along with musical performances, compose music and enjoy musical puzzles and games.
- Melody Street is another website featuring interactive musical games and videos for children.
- Arts Alive is an “educational website produced by Canada’s National Arts Centre. Arts Alive is divided into three main sections: Music, theatre and dance; they supply free lesson plans for teaching with technology, and the music section includes an “Instrument Laboratory” as well as music activities and games.
- PBS Kids to Go helps children understand music and musical compositions by teaching basic musical concepts and performance skills in the study of popular song styles from around the world.
- PBS Teachers explains that most PBS children’s programs offer one year extended taping rights for teachers.
- Children’s Music Web is the Kids Public Radio site (KPB), a “nonprofit resource for kids, families and children’s performers worldwide.” It supplies thousands of free monthly concerts in over 22 US hospitals, as well as free community web-based channels, links, podcasts and audio.
- Many symphony orchestras offer websites for children such as the SFS Kids Fun with Music and New York Philharmonic KidZone. These provide great introductions to music that can then be enjoyed in person at a future live concert performance. Please make sure you check out information available on the web from your local and regional symphony orchestras, too!

Downloadable Music

- easybyte provides free easy to play piano sheet music, and song notes, for holidays, weddings and other occasions.
- Easy Sheet Music allows up to 3 free downloads daily. Presently all pieces are for easy level piano but they hope to include pieces for other instruments in the future as well as Music For Teachers and KIDiddles, which were previously mentioned.

Curriculum and General Information

- BBC Learning Schools offers good connections to curriculum with interactive materials.
- Enabling Devices is “a company dedicated to developing affordable learning and assistive devices to help people of all ages with disabling conditions.” For over 35 years, they have created innovative enabling switches, communicators and toys for those with physical challenges, and
- Sites for Teachers incorporates links to hundreds of sites that contain educational and resource materials, i.e., lesson plans, worksheets, printables, activities and clip art for all ages, rated by popularity by fellow educators and therapists.

When selecting material from websites for your clients, I strongly encourage you to view song lyrics and check sound clips (when available) as musical tastes/styles vary and song titles may not accurately reflect your specific needs/setting. Also, double-check the dozens of related links to more specific sites that are frequently included on individual websites. The websites presented in this article barely “scratch the surface” of what is currently available. This is an ever growing list, so stay tuned!

About the Author

Ruthlee Figlure Adler currently practices as a private music therapist/consultant in Bethesda, Maryland.

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Building Your Own Business in Early Childhood Music Therapy

Rachel Rambach, MM, MT-BC
Music Therapy Connections
Springfield, Illinois

Not once during my time as a music therapy graduate student did I think to myself, “I’d better take some business courses, just in case I own a business someday.” Fast forward a few years later, and here I am leaving my job as music therapist at a school to take my private practice full-time.

While I haven’t taken any business courses, there are many resources that I use on a regular basis to keep my business running smoothly so that I can focus on the most important part: Providing quality services to my young clients.

Here are a few of the resources that I consider to be invaluable to my business:

- **Music Teacher’s Helper**: Although the name of this service implies that it is meant for music teachers only, that is certainly not the case. I use this online software to keep track of my calendar, income, expenses, and even invoice my clients. The monthly subscription fee for Music Teacher’s Helper depends on the number of clients (or students, as they’re called by the program) you have.

- **Dropbox**: This free application allows me to sync documents, audio, pictures, and other files across multiple computers, my iPhone, and other mobile devices. I can work on documentation, bookkeeping, and other administrative tasks from any location, since I always have access to those files. Additionally, Dropbox allows me to share files such as progress reports and recordings with my clients and their families.

- **PayPal**: More and more of my clients’ families are willing to make online payments. This makes bookkeeping much easier for me, since I can integrate PayPal invoices and payments with the aforementioned Music Teacher’s Helper program. I also use PayPal to accept payment for other services and products I offer, such as children’s music, consulting, and a subscription resource website.

- **Wordpress**: I use this blogging software to run not only my early childhood music resources blog, but also my private practice website. Parents and caregivers often turn to Google when it comes to finding a music therapist, so having a presence on the web is a great way to build your clientele. Wordpress is free, user-friendly, and will help boost your search engine ranking.

- **Voice Memos App**: This is an application that comes standard on the iPhone and iPad. I use mine for songwriting, making audio notes to myself while I’m driving or running errands, and even recording my students. You can email voice memo recordings or download them to iTunes as mp3 files.

- **iCal App**: If you’re a Mac user like me, then you’ve no doubt utilized this standard app on your computer, iPhone, or iPad. The two best features of iCal are 1) its ability to sync across devices, and 2) integration of several calendars. I have separate calendars for work (with which my Music Teacher’s Helper calendar syncs beautifully) and home. You can also integrate your Google calendars with iCal.

These resources all play an important role in the expansion and streamlining of my business. Of course, they’re not quite as fun as the apps I use in my early childhood music therapy sessions (e.g. Garageband, iMovie, PocketGuitar, Virtuoso, and too many others to name) but they have helped my business become what it is today: a place for young children of all abilities to learn and grow through music.

**About the Author**

Rachel Rambach, MM, MT-BC is a music therapist providing individual and group services to children of all ages and levels of development. Her blog contains intervention ideas, music downloads, and links not only to the websites of other music therapists, but also of music educators, entrepreneurs, and anyone else who might offer innovative ideas and products to use in working with young children.

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Cool Music Apps for Little Ones

Petra Kern, Ph.D., MT-DMtG, MT-BC, MTA
Music Therapy Consulting
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Over the past year, numerous apps have been developed that allow turning mobile devices such as iPhones, iPods, and iPads into musical instruments for young children. Many of the apps are accessible for children with and without disabilities alike. Meaning, the intentional use of the latest apps may motivate all children to learn while having fun.

Music therapists, early childhood educators, and parents may think about how to use music apps during children’s daily life. For instance, a child with cerebral palsy may participate in music-making during circle time by touching a screen to produce tones and chords. Music apps may also be used to teach basic music skills such as rhythms, melodies, and age-appropriate songs, or simply to keep children entertained during a car ride back home.

Here is a short review of selected music apps, which are appropriate for young children.

Touch Xylophone: This is a virtual xylophone with colored keys. Children may play single notes when touching one bar as well as chords when touching several bars at once.

iMaracas: A pair of colorful maracas appears on the screen. Shaking the mobile devise activates the sound.

Kazoo: By tapping on letters next to a picture of a kazoo, children can make kazoo-like sounds and play melodies.

Baby Drums: This app offers a variety of drums and percussive instruments, which are easy to activate for infants and toddlers.

Baby Scratch: This virtual DJ Turntable allows children to scratch music from the “Baby Scratch Library” or the recording of children’s voices and subsequent scratching by moving the finger over the LP displayed on the screen.

Beatwave: Children can create beats and unique tunes by setting dots on a squared screen. Colorful stripes moving over the dots active the sounds and create musical waves.

Moozart: This app allows children to compose and save their own songs by dragging sound-making farm animal icons onto music stave. Children can also follow along with preloaded songs and manipulate the tune by interspersing animal sounds.

Talking Tom: Tom is a comic cat that repeats and records what children sing or say with a very funny voice. Giggles are guaranteed! Video recordings can be uploaded on YouTube, Facebook, or sent by email.

Preschool Music: This app allows children to explore four music activities based on rhythm (by tapping animated sea animals in an aquarium), melody (by tapping animated sheeps singing tones), harmony (by tapping animated birds singing melodies), and music notation (by creating notes on a virtual piano repeated by a animated parrot).

Tappy Tunes™: By tapping the screen in time and rhythm, children can activate selected tunes (notes and chords are preloaded in sequence) accompanied by colorful animated graphics.

Free ABC Songs: This is a sing-along of five traditional children songs with big letter lyric display.

Stay tuned and informed about the rapidly growing number of music apps for young children by using the google search engine or iTunes Store search feature. And, it is always a good idea to appraise new apps and try them out before letting little ones use them.

About the Author

Petra Kern, Ph.D., MT-DMtG, MT-BC, MTA, owner of Music Therapy Consulting, has a clinical and research focus on young children, especially those with Autism Spectrum Disorders in inclusive settings. She is the editor of imagine, author of numerous publications, a dynamic international speaker, and serves as the Past President of the World Federation of Music Therapy and other music therapy committees and boards.

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Amy Robertson, MM, MT-BC
Florida Hospital Orlando
Orlando, Florida

Rounding With Medical Staff to Increase Music Therapy Awareness in the Neonatal Intensive Care Unit

At the Walt Disney Pavilion at Florida Hospital for Children, the music therapy team has started rounding with NICU physicians and other staff which has improved communication as well as orders for music therapy services. In this podcast, the current protocol for receiving music therapy orders is discussed as well as tips for improving awareness of music therapy services in the Neonatal Intensive Care Unit.

Matt Logan, MT-BC
Owner, Matt Logan Music
Iowa City, IA

Practicing Music Therapy in the NICU: An Interview with Kim Hawkins

In this podcast, Matt Logan interviews Kim Hawkins, an experienced NICU Music Therapist who provides services in a highly-rated Neonatal Intensive Care Unit in the United States. In the interview, the speakers address current approaches to treatment, including a NICU layout, common goals and objectives as well as music therapy interventions.

Christine A. Barton, MM, MT-BC
Central Canal Creative Arts Therapies
Indianapolis, Indiana

Constructing Meaning in Music and Text: Implications for Literacy Development in Young Children with Hearing Loss

How does constructing meaning affect a child’s path to literacy? This podcast attempts to meld music schemas with the constructivist theories surrounding literacy development and examine where meaning in text and music lies and how children with hearing loss might benefit from such ideas.

Elizabeth K. Schwartz, LCAT, MT-BC
Alternatives for Children Suffolk County Long Island, New York

Lessons Learned in Least Restrictive Environments: The Role of Music Therapy in Preparing Young Children to Succeed in Inclusive Schools

This podcast presents lessons learned by the author during a two year music therapy project in a K-12 school and discusses the role of music therapy in preparing young children to succeed throughout their entire educational career in the least restrictive environment of inclusive, public schools.
Cathy Knoll, MA, MT-BC  
Private Practice  
Stephenville, Texas  
Moving Beyond “Moo, Cow, Moo:” Targeted Song-Based Language Experiences for Young Children

Many traditional children’s songs focus on farmers, animal sounds, and imaginary topics, e.g. an “old woman who swallows a cow.” This podcast moves beyond sing-alongs in early childhood, providing examples of reality-based, customized songs created by music therapists to address specific goals and to assist individual preschoolers learn and practice new language skills.

Dorothy Simonis Denton, BM, MT-BC  
Music Moves Studio  
Mansfield, Ohio  
Seed Pod: Collaboration to Help Children Grow Through Music and Movement

This podcast is an invitation to join the growing number of early childhood music & movement professionals encouraged by collaborative efforts to produce a broad knowledge base in the field. The author introduces music therapy to the Early Childhood Music & Movement Association and makes a case for engagement, informal and formal, between early childhood music educators and music therapists working specifically with children under age 5.

Kalani Das, MT-BC  
Kalani Music  
Granada Hills, California  
Laughter in Music Therapy and With Young Children

Humor and laughter both have a role in music therapy from helping clients feel more at ease to creating interpersonal connections and serving as a catalyst for emotional release. This podcast identifies the primary types and uses of humor and laughter and explains the roles they play in music therapy practice with young children.

Dorothy Simonis Denton, BM, MT-BC  
Music Moves Studio  
Mansfield, Ohio  
Seed Pod: Collaboration to Help Children Grow Through Music and Movement

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Kat Fulton, MM, MT-BC  
RhythmForGood  
Del Mar, California  
Music Therapists Talk About Self-Care: A Video Interview

In this video podcast, Kat Fulton weaves together the self-care experiences of eight music therapists working with a wide variety of clients, including children. The interviewees delve into the topic of self-care, revealing their definition, problem indicators, personal tools, and special considerations.

about our podcasts

Our imagine podcasts bring you the perspectives, knowledge, and vision of clinicians, researchers, educators, administrators, parents and children connected to early childhood music therapy. You can access and subscribe to the podcasts at http://imagine.musictherapy.biz/Imagine/our_podcast/our_podcast.html
New Publications 2010-2011
Complied by Petra Kern, Ph.D., MT-DMtG, MT-BC, MTA

The following articles and podcasts reflect a selection of publications published during 2010-2011 that relate to early childhood music therapy.


We invite colleagues from around the world to send their references for future inclusion in this annual list.