

CONVERSATIONS WITH MUSIC THERAPISTS

Scott Snow, MT-BC
Editor

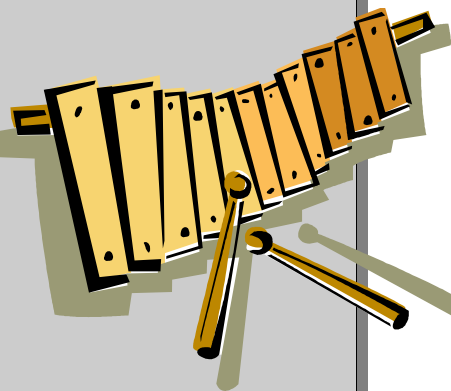
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NINA GALERSTEIN, M.M.Ed., MT-BC **Music Therapist, Stockley Center** **Georgetown, Delaware**

Ms. Galerstein received her B.A. in Music/Liberal Arts from the University of Michigan and Master's degree in Music Education/Music Therapy from the University of Kansas. She is a MAR member of the Affiliate Relations Committee of AMTA. She published a book titled, "Age Appropriate Activities for Adults with Profound Mental Retardation: A Collaboration Between Music Therapy, Occupational Therapy, and Speech Pathology" (MMB Music, 1998). In 2001, Ms. Galerstein started a summer practicum program for students who wanted a more intensive practicum experience (full-time for 3-5 weeks). An article describing this program will be published in Music Therapy Perspectives this fall. Ms. Galerstein is a music therapist at the Stockley Center, where she has been working since 1979. (continued on page 2)

KATHLEEN M. MURPHY, MMT, MT-BC, **FAMI** **Music Therapist, Private Practice** **Philadelphia, PA**

Kathleen M. Murphy, MMT, MT-BC, FAMI, has been a practicing music therapist for over 20 years. She has worked primarily with children and adolescents in a variety of medical, psychiatric and educational settings. Currently, Kathleen maintains a private music therapy practice in the Philadelphia region and is a Ph. D student in the music therapy doctoral program at Temple University, Philadelphia, PA. Kathleen has given several workshops, lectures and continuing education courses to music therapists and other related disciplines on reimbursement, advocacy, clinical practice, and experiential learning. Additionally, she is the President of the Mid-Atlantic Region of the American Music Therapy Association. (continued on page 4)

ROIA RAFIEYAN, MA, MT-BC **Music Therapist** **Hunterdon Developmental Center** **Clinton, New Jersey**

Roia Rafieyan received her undergraduate degree in music therapy, with a concentration in classical guitar, from Temple University in Philadelphia, PA in 1987. While in college she worked as a direct support staff in a group home with three men who had moved out of the infamous Pennhurst state institution. Since that time she has been providing music therapy services to adults with various developmental disabilities, mostly autism, at Hunterdon Developmental Center, another state institution in Clinton, NJ. After avoiding it for as long as she could, she finally got her master's degree from the Drexel University Hahnemann Creative Arts in Therapy program in 2002. (continued on page 7)

NINA GALERSTEIN CONTINUED

The Stockley Center is a state residential facility for adults with developmental disabilities, most of whom function in the severe and profound range of MR. Many of the residents also have orthopedic and sensory challenges, and medical issues. In addition, Ms. Galerstein has a private practice and has worked with children with Autism, people in a nursing home, and people at an Alzheimer's Day Center.

SS: What is important to the people you serve?

NG: I'm going to have to venture a guess because this isn't something most of my clients can verbally describe to me. I would say what's important is for someone to pay attention to them and engage them. It is important to them to have somebody show they care about them and assist them in experiencing new things in life.

SS: How do you effectively involve direct care staff in your sessions?

NG: I have spent most of my time here supervising interns and doing work myself so I really have not gotten involved in what the direct care staff was doing. I work in a state institution and we are currently down-sizing. In years past, we've had between 300-500 clients. I've had to focus on the interns and what they were doing with the clients. Since my position has changed and I don't have interns anymore, I am trying to get direct care staff involved more. I find that very few staff members are motivated to participate in music activities. If people are asked to provide music activities for clients and they are not musical to begin with, they often claim they can't sing or play an instrument. We had one staff person who played guitar, loved music, and was good at it. He was really interested in playing music with clients. I'm now supervising the recreation dept. and starting to teach them to do some music activities as they are much more motivated. There is one way, though, that I can formally involve direct care staff in music activities. We call this "role releasing," which means that a therapist can release the primary role of treatment to a direct care staff member. So, if I feel I no longer need to do direct therapy but still want a part of the "treatment" to continue so skills are not lost, this is what I do. Usually a role-released activity involves recorded music and some sort of gross and/or fine motor activity with small instruments. Sometimes it even involves adapted equipment and switches. This is a formal plan in that it requires some sort of data, but not the same thing I would do as a therapist. Because it requires data, the staff are required to do the activity, and so it gets done. Again, some people are more motivated to do these activities than others, but often I can show them how much both staff and clients enjoy these activities, and then there is more motivation to do the activities and do them well.

SS: It sounds like you're saying a music therapist can provide an in-service to show techniques for direct care staff people to use when they are on their own.

NG: Yes, but again, not therapy techniques. Many of the things that are role-released are similar to activities they already do. With the recreation staff, I've been showing them video tapes of past interns to give them examples of simple things the interns did. A lot of activity-based things are great to pass along. There are a lot of good things that people can do with recorded music if they are intimidated by the idea of singing or playing an instrument.

SS: I've gotten the impression from the music therapy field that unless you're doing a movement activity, using recorded music in therapy is kind of a waste.

NG: There's a lot of controversy about recorded music versus live music. I've had some interns that have come in and said their professors told them never to use recorded music. I think it's wrong to make a blanket statement like that. It depends on the population and I feel there is a place for both recorded and live music. I don't think a music therapist should use recorded music unless there is a reason. I've told my interns that recorded music is important for a number of reasons. One is that it frees your hands. If you have to have both hands on the client (which we do) you can't be holding a guitar. You could record yourself and sing with your own accompaniment, which could be a good choice. Personally, when I'm in a nursing home down the pike, I don't want to be listening to a music therapist singing Beatles songs. I want to listen to the Beatles because that's what moves me. It is their harmonies and sound. I would hope that the music therapist working with me will look for music that is meaningful to me and will somehow apply it to whatever we are doing together. We forget that many of us have become music therapists because of music we've heard. We loved Mozart concertos, for example, and we need to hear Mozart as Mozart. I don't want to hear someone singing the melody of a concerto. I want to hear the orchestra playing it. Recorded music is important and meaningful. However, it is important for the music therapist to select the appropriate music based on needs and preferences of clients.

SS: There is a lot of thought that occurs with that choosing.

NG: Yes, of course. Sometimes the music therapist finds out about client preferences just from personal observation over time. And sometimes this valuable information comes from the direct care staff who observe their clients daily in a different setting. From this information we can design activities and treatments that are meaningful to our clients. In some situations using recorded music becomes a good starting point for providing therapy for our population, and for assessing client needs. I have often told students that if you are in a session with people who are very challenged and use wheelchairs, put on music and do movement activities and observe what happens. Almost everyone who uses a wheelchair can benefit from opportunities for movement, and music is a natural means by which to encourage movement. It will help their body tone. I would also suggest encouraging

KATHLEEN MURPHY CONTINUED

SS: Would you describe your position and responsibilities?

KM: I am a Board Certified Music Therapist and Fellow of the Association of Music and Imagery. I have a private music therapy practice in which I currently work with children and adolescents having a variety of developmental, emotional, and medical disorders. I have been working as a music therapist for over twenty years and have worked in both private practice and institutions (public schools, private schools, rehabilitation hospitals, rehabilitative hospitals, hospice, out-patient, partial hospital programs, inpatient psychiatric units). I'm currently working on my PhD in music therapy at Temple University.

SS: Is Temple University the only university that offers a PhD program for music therapy?

KM: It is the only school having a bonafide PhD in music therapy. There are other schools who offer PhD's in music education with a concentration in music therapy, holistic studies, or inter-disciplinary studies.

SS: Let's focus on music therapy for adolescents if we may. What is important to the people you serve?

KM: I provide clients with musical experiences that are going to help them achieve maximum health in the broadest sense of the term. I believe health encompasses physical, emotional, and spiritual health. It is my job to figure out how to best use music therapy to address whatever needs the clients are presenting with whether it is a physical need (gait training), fine motor development (independent finger movement), or more esoteric things like dealing with the existential crises in life.

SS: I never considered how some adolescents might find themselves having to confront existential factors so early in their lives but given their extreme conditions and experiences they would need to do so.

KM: Right. For example, let's say you are working with an adolescent who has a diagnosis of PTSD. There are huge issues around trust, relationships, sexuality, and dating for that adolescent. For adults, these issues may not be so daunting but when you are sixteen and your whole world has been shattered by some traumatic event, it becomes an existential issue. On the flip side, imagine you have an adolescent with a terminal illness who is faced with dying at a very young age. A music therapist needs to help people make that transition.

SS: What is the most challenging part of your job?

KM: It is getting the medical community to understand music therapy. It is important to effectively communicate how music therapists are different than performing artists or harp therapists. There have been huge pushes towards including more of the integrative and complementary-type therapies and this is where music therapy lies. I prefer to use the term complementary, as opposed to, alternative because I don't think we are an alternative to anything. I'm looking forward to the day when we are mainstream medicine like Occupational Therapy, Physical Therapy, Speech Therapy, and Psychiatry. That day is coming slowly. I've seen advances in music therapy's job market. Around where I live, there aren't enough music therapists to fill all the positions. This is a good problem to have.

SS: I wish that were the case here in Massachusetts.

KM: I started my career in Massachusetts and I would think there would be more growth there given all the schools and educational centers. The biggest challenge is helping people understand why they should value music therapy and why it should be included in programs and not just be an after-thought or the icing on the cake.

SS: What are common goals that your clients are working towards and what are some activities and techniques you utilize to facilitate them?

KM: I don't use the term activities. I create experiences. I want you to look those two words up in the dictionary and then you'll understand why (laughing). Actually, I make my class do this assignment. An activity is something you do and an experience is something that someone works through. An experience is transformative and I believe music therapy is a transformative experience.

SS: Do you mean something changes about the person?

KN: Yes. Something changes in who you are, how you experience music, how you experience yourself, and how you experience other people. There is some element of transformation.

SS: Is it fair to say that a music therapist is not doing his/her job if a transformation doesn't take place in the client?

KM: I don't think it is possible to make music and not be changed in some way. When I get my horn out and play, I change in some way. Sometimes I become more relaxed and sometimes I become more frustrated. There is some element of change. I really try to be with my clients and hear, sense, and intuit what they need from the music on any given day. Right now, I work with children who have Autism and I'm working with some developmental pre-school groups. My goals in these settings are to foster normal development for children having delays. In my work with autistic children I am designing music experiences that will develop interpersonal relationships, listening skills, and social interaction skills. In addition, we work on more practical things like helping to develop fine motor skills through playing instruments, improving speech and language skills, increasing vocabulary, and helping people find ways of expressing themselves either verbally or non-verbally. When I worked with adolescents, we worked on goals more related to developing an identity, developing a respect for themselves and others, learning how to work together, and learning how to identify and express feelings. We worked a lot on understanding how they presented themselves to the world and why they were getting the reactions they were getting. I used improvisation a lot for that. I asked them to listen to themselves in the music. I'd ask them to recall other times when they were like they were in the music.

I'd ask clients how others responded to them and explore whether they understood why people responded that way musically. I'd help them to connect that understanding to how they are outside of music. In addition, I worked a lot with adolescents who were in chronic pain. In that instance, the music therapy goals helped them to use music as a way to manage their chronic pain, as a way to identify and express all the emotional issues related to being someone who is sixteen or seventeen years old, a straight A student, on the track team, school president, but having this debilitating pain condition where they just can't move. The one thing that characterizes all my work regardless of population is really helping people find a way to use music in their lives for healthy purposes.

SS: How do you approach working with the family members of adolescent clients?

KM: My first responsibility is always to my client. I believe parents have rights to know what is going on with their children and they need to be involved but my responsibility is first and foremost to my client. I share my goals with parents and inform them of the progress or lack of progress being made. If there are issues between my clients and their parents, music therapy is a really good way to role play and work through some of those issues. I don't reveal a lot of content especially when I am working with adolescents unless I suspect the client may try to harm oneself or others. Children who are emotionally disturbed need a place that is safe where they can do what they need to do and say what they need to say without fear that it is going to get back to Mom and Dad. It is a very delicate balance because parents have rights to know what is going on with their children.

SS: How do you choose the music for your work with adolescents?

KM: It really depends on the rules of the facility. It is important to follow the facility's rules to avoid staff splitting. In individual work, I typically let kids bring in whatever song they want but we really talk about what that song is saying and what it means. I often ask: Why do you need to listen to this particular song? What message are you getting from this song? What are you relating to? Can we rewrite this song in a way that isn't so violent? I don't censor a whole lot. What truly guides everything I do is asking myself what this person needs from music in the moment. I focus on what I can learn from this person based on how they are in music, what they do in music, and what they bring to music. This helps me choose which experiences I will use.

SS: What are some experiences you have found effective for relaxation groups with adolescents?

KM: The first thing you need to do is help adolescents get in touch with their bodies because it has been my experience that they don't know when they are relaxed or when they are tense. I have clients hold a fist as tight as they can for one minute. When clients relax their hands early, I encourage them to keep up the tension until the minute is up. This exaggerates tension so when you do release you really feel the difference. Many adolescents having emotional or behavioral disorders are tense and on-guard all the time. They can present as being jumpy – especially if they are from the inner city. They've dealt with gangs. Their body stance has to be tense. They are hyper-vigilant. Many of my clients appear to feel that it is a terrible world out there and they have to pay attention. They can't let their guard down.

SS: Would this be a survival skill they developed?

KM: Yes. You have to be very careful when you present relaxation with adolescents for that very reason. If you facilitate relaxation and it's causing them to let their guard down but they don't have the skills to cope, you have to be very careful. I always had clients engage in the relaxation/tension exercises while in a seated position and never while lying down to help put some boundaries on it. I worked in a short-term facility and I may only get to work with some clients once or twice. Drawing and writing to music are very relaxing. I try to present concrete things. Instead of classical music, I used New-Age music that was not as emotionally charged. Yanni and Enya are good examples. I taught people breathing techniques. I took a lot of time teaching people how to breathe. Sometimes we would blow bubbles and sometimes not depending on the group.

SS: Did you have them blow bubbles because it required them to breathe in a relaxed way?

KM: Blowing bubbles is childish and sometimes adolescents like to regress. Blowing bubbles requires good diaphragmatic breathing as well. I've taught some adolescents how to play recorder as a way to work on breathing and becoming more relaxed.

SS: How long does it take for typical adolescent group to buy into the experience? I would think they would moan and groan saying the experiences are silly.

KM: Sometimes I would have the adolescents take their pulse. Taking your pulse is not the most effective way to evaluate your level of relaxation but it is very simple to do. I'd have the clients take their pulse before and after the music was played. They started to see changes in their pulse rates and the adolescents seemed to think this was pretty cool. I would have everyone bring in a favorite song and I'd bring one in too. We'd listen to the song then compare how we felt before the song, as compared to, how we felt after the song. I may ask: What kind of mood were you in? What kind of a mood are you in now? Were you more tense? More relaxed? When I worked in a hospital, they had skin thermometers that weren't too expensive so we had a lot of them. We looked at physiological things and put real numbers to it. Adolescents seem to be intrigued by those things. Rapport and trust are extremely important. As ridiculous as it was for me to rap, I did it. The clients would make fun of me and I would make fun of myself. If you are willing to take a risk and go out on a limb, they will give back to you. They are going to test limits. Improvisation is also a great way for relaxation because you

can start it really high energy and then bring it down. Many of my clients like to play drums and like making noise. These are many ways you can work on relaxation without putting them in a deep, altered state.

SS: I recall being surprised that none of the adolescents I worked with owned any relaxing CD's.

KM: It's not a very relaxed world out there for them.

SS: What trends do you see presently and what do you see in the future for music therapy?

KM: The field will continue to develop as more music therapists stay in the field longer. The average professional lifespan for a music therapist right now is five years. There are only 10-15% of music therapists that have been working for over twenty years. Maybe 20% over ten years. More work towards advocacy and research will bode well for us. I see more and more facilities looking to hire music therapists. I haven't seen the growth as much with adolescents as in developmental disabilities, mental health, and hospice populations. However, some of the mental health facilities do have adolescents. The field will continue to grow but only to the degree that those working with adolescents are doing research and trying to push the field forward.

SS: What is your secret to longevity in the music therapy field?

KM: I believe in the power of music. I have story after story. I started out as a music therapist at Fernald State School in Massachusetts. There were close to twenty music therapist there at the time. I worked on the unit with the most severely disabled adults. I worked with clients who had an I.Q.'s of 2. I worked very closely with OT and PT. I decided to pursue my Master's in OT but after a while I felt something was missing. I've always been very interested in medicine and the mind-body connection. Neurology, Neuroanatomy, Neuropsychology, and Neurophysiology are all interests of mine. I went to pre-med school at Harvard. I was working through the Community Music Center of Boston and I worked with a boy who had Muscular Dystrophy. I was working very hard to pass Algebra II because math was not my strength. This boy was dying and we wrote a song together. The words were "I can't play basketball and I can't do things that my friends can do but I can still sing and the music is what keeps me strong." Up until the moment he died, there was always something as a music therapist that I could do for this child. Whether it was writing a song, music-assisted relaxation, or music and imagery, there was always something I could do. There was nothing more medicine could do for him because he was going to die. I found my way to Temple University to get my Master's degree and it was the best thing I ever did. To that point, it was the hardest thing I ever did. Temple is very experiential in their training and I experienced music as a client would experience music. It was amazing because I learned more about myself in the year and a half of classes than I had learned in the twenty previous years. I saw what music could do. Next, I got my training in guided imagery and music and it further convinced me there was really something to this and people need music. This is truly what is missing and why people who don't respond to other therapies respond to music therapy. They really need the music. Music touches people and helps them work through things in ways that other therapies do not and that is why I am still here. I'm getting my PhD because I want to teach and do research.

SS: Do you have any advice for a young music therapist?

KM: Keep very good documentation. In addition, every client you will work with probably sees some sort of a medical professional on a regular basis. You need to make it a habit of sending them progress reports. Of course, you need to get HIPPA releases. Keep showing progress. The more that people hear and see the successes of music therapy the better. You don't want to have only anecdotal evidence but actual data and this will help us all move forward. 🎵



ROIA RAFIEYAN CONTINUED

She has co-authored a chapter in Inside Music Therapy: Client Experiences (J. Hibben, Ed.) and contributed a case study to Psychodynamic Music Therapy: Case Studies (S. Hadley, Ed.). Roia is a periodically performing singer-songwriter, and she released a CD of her music, Songs from Behind Locked Doors, in 1999. She is currently at work on a second CD which is taking even longer than the first. She is active in the New Jersey Association for Music Therapy, and is currently serving as the editor of the NJAMT News.

SS: Is there a definable difference between the terms Developmental Disability and Mental Retardation?

RR: Yes, mental retardation is a diagnosis under the general heading of developmental disabilities. Developmental disabilities encompass a range of diagnoses, including mental retardation, autism, cerebral palsy, Down Syndrome, and a whole host of other syndromes. So, when I say I work with folks who have developmental disabilities, I mean that I work with people with a range of diagnoses, all of which fall under the general heading of developmental disability.

SS: How are the private practice opportunities in New Jersey?

RR: We actually have a lot of opportunities for private practice in this state. There are, in fact, quite a few music therapists in private practice in New Jersey and many more who see private clients in addition to having full-time employment as music therapists. When I was accepting clients for private practice I received a lot of referrals from a doctor who works at the facility where I work, as well as, providing services in the community. He was quite willing to refer people for music therapy. He works in developmental medicine. If you are trying to find referrals in your state you might want to look into learning about the Developmental Disabilities Council (you can find them on the web) or check out University Affiliated Programs (UAP). They disseminate a lot of information and could possibly connect you with either families or provider agencies who are in need of services.

SS: Is it correct that you work at a state facility?

RR: Yes, I work at the Hunterdon Developmental Center.

SS: How many clients do you usually see in a week?

RR: It varies as it depends on who is in the mood and who is not (laughs). Generally, my case load is between fifty and sixty people. My case load was cut in half because when I finished grad school, I convinced my supervisor that one hundred and twenty clients per week was too much.

SS: So, you are able to continue to do a lot of work directly with the clients.

RR: Ninety-nine percent of my job is doing therapy. I work with two other music therapists, and we have a music therapy unit. We work as a part of the Recreation Department. Once in a while, I take part in the recreation activities and shows but mostly my responsibilities are to do music therapy. I don't have insane amounts of paper work. Our unit is responsible for helping with the faith care services. Once a month, we have an interfaith service for the residents at our facility. We have a variety of chaplains who serve the folks who live there on a weekly basis. We provide the music for the services, as well as, doing most of the organizing. We also coordinate memorial services when residents (and sometimes for staff members) die.

SS: What instruments do you use in your sessions?

RR: I travel from building to building, so I try to travel light. I mostly use guitar and a variety of rhythm instruments (mostly tambourines, maracas, various sorts of drums, and cabasas). I also use the piano when I'm in the music room. I've made good use of a Native American flute in my sessions as well.

SS: What are some goals and techniques you focus on in your sessions?

RR: Mostly I help clients to develop relationships. The vast majority of the clients I see have been institutionalized since they were young. Many of the people I work with have a lot of trauma. Abandonment is an issue we frequently address. It is very common for folks who live in institutions to develop relationships with people who then leave them. There is sometimes no conversation around the fact that someone is leaving (the assumption being that "here's a person with a significant disability, and s/he won't be affected by the loss"), and there's often not a lot of effort to continue the relationship. Other issues I find myself paying attention to are learned helplessness and a large degree of dependence.

As for techniques, for the first six years I worked in the institution, I found it very anxiety-provoking because I couldn't get the folks I was working with to do anything. Many of the folks didn't want to touch instruments. They would throw them down or ignore them. They wouldn't grasp them. If I wanted them to engage, I would have to "force" them (via hand-over-hand interventions), and I didn't feel right about that either. It was maddening. The thing that saved my life was getting a clinical supervisor. She asked me what I was trying to do with my clients. I said I wanted them to pay attention and take part. She suggested I started by singing about what they were doing. I practiced improvising and my poor clients lived through me fumbling through it. I started singing about what they were doing and they started paying attention, because (finally) I was paying attention to *them*.

Many times, we expect people with disabilities to do what we want them to do and don't pay a lot of attention to getting to know them. I need to find out who my client really is and how can I learn about the client in the music. I don't do activities at all any more. I work in a very process-oriented way and use a psycho-dynamic approach. A lot of it is reflecting, interpreting, and paying a lot of attention. Reflecting is letting people know that you are paying attention to them. Interpreting means that I am trying to attach a meaning to the things I'm noticing in order to build a relationship. The focus is mainly on the relationship. I use the music to develop and express the therapeutic relationship I have with the client. It's really fascinating how people express themselves in the music. I have a group of four men, and I realized that each person had one instrument they were willing to play. When I tried to give any of the guys a different instrument, they were very resistant. To me, this unwillingness to try a different instrument, a different perspective, so to speak, implied a sense of stuckness that my clients were experiencing. It is almost as if they were using this way of using the instruments and the music to say, 'This is how I choose to see myself: 'in this little box' or 'This is how people see me and this is how I choose to be. It is scary to grow.' I have a music therapy student working with me right now doing her practicum. We were talking about her wanting to have clients feel "comfortable." But really, therapy is *not* comfortable. If you've ever been to therapy, it is horrible! You're asking someone to change. You and I usually choose to go to therapy but many of our clients do not. Their team has decided that music therapy would benefit them. I think that's something to be conscious of as we provide services to folks who have severe disabilities.

SS: So, these clients are used to being done to.

RR: Yes. I think it's important to let your clients know that you are paying attention to them and that you want them to take an active role in the therapy process. That's not an easy thing to do when your experience in life is one of being told what to do.

SS: Do you think a person who is severely disabled understands the cognitive aspect of what is happening when a therapist is listening and reflecting?

RR: People always ask me this, and I always explain to them that you never know what an individual understands. Even though we (you and I) are having a conversation, I will never know what you do or don't know or what you understand about what I'm saying to you. There are a lot of people who make like they know an awful lot but they really do not. The best policy is to treat all people like they understand what you are saying and respect that everyone has an innate intelligence. If they don't understand then that's fine too – the world is not going to end, in my opinion anyway, because we choose to treat someone with the respect of presumed intelligence.

SS: I've observed some great occupational therapists who explained everything they were doing in the session and I've seen other staff who will ask me why I explain things to the individuals because they "don't get it anyway."

RR: I'm a very strong advocate for reading books and articles written by individuals whom have autism (since that's the group with whom I mainly work). They have experienced learning differences firsthand, and there is an awful lot of literature these days (especially on the Internet) describing what it's like to be autistic. It has been very helpful to me, because it has helped me to make better guesses as to what is going on with my clients.

SS: How do you utilize adapted equipment?

RR: When I worked with folks who used wheel chairs, I used more of the adaptive equipment. I don't use a lot of "equipment" to be honest. We have some folks who are willing to use instruments and some who are not. For the folks who prefer not using instruments, I'll sometimes ask their direct support staff whether the person is able to hold on to a spoon or fork and feed him/herself. It may be a motoric issue, or it may be a sensory issue. I'm not about to force someone to play an instrument if they can't stand to feel something in their hands. If you're working with somebody who has cerebral palsy, and they struggle to grasp things, Velcro is very helpful. A few of our clients use a letter board to communicate. I have asked the occupational therapists at our facility for help with designing and making built-up grips for mallets in the past. I think lately there have been more catalogues with these sorts of gadgets.

SS: So, your focus is more on creating sounds and making eye contact?

RR: I don't force people to make eye contact. I find that when I started paying attention to my clients and when they have something to communicate is when they would pay attention (in the sense of making an effort to let me know they're paying attention) and naturally make eye contact. I might say, "Please look at me or towards me if you want to say yes." I have a lot of clients who prefer using their peripheral vision, as opposed to, looking directly at me. Some folks will make a sound to say yes. This is how you develop a relationship with the person. You start by reflecting and trying to find out how this person usually interacts with people. To a certain degree, you are helping to shape a way to communicate "yes" and "no." You are helping the person communicate that they are interested in what you have to say or to let you know you're on the wrong track. You are trying to make a connection between what the person does and what s/he is meaning to communicate.

Let's say you observe a client pacing around. Well, what does that mean? Is the client telling me that he is anxious? Is he mad about something? Is he excited? I'm trying out different things and giving my client time to respond. If I ask the person, "Are you anxious?" and the person looks at me then it could mean "yes." Next, I may ask, "If you mean 'yes' then look at me again." It takes a long time to gradually build up a relationship.

For the first six years I worked at the developmental center, I thought I had relationships with my clients but it wasn't until I shifted my approach that I realized that I did not have true relationships with them. I had very superficial relationships with my clients. It astounded me that as I changed my approach my clients began to seek me out to let me know they wanted to go to music therapy. This didn't happen as much before.

SS: Do you involve sensory integration into your sessions?

RR: I don't do a lot of occupational therapy in my sessions (at least not consciously). I work with one man who has very severe sensory integration problems. Sometimes I will work with the massage therapist but it is very rare. I don't do a lot of sensory integration because it isn't something I feel particularly well-versed in. I am very conscious of sensory-integration problems but I wouldn't be the best person to tell you an appropriate intervention for it.

SS: How do you involve the direct care staff?

RR: Way back when I first started, I wanted to please the staff, but that got to be futile, because I was not a performer, and I felt like I wasn't hired to help them. For years we fought back and forth because I had the attitude that the support staff wasn't being very helpful. I used to have eight clients and one or two direct care staff. Nowadays, I don't usually have any direct care staff with me. Over the years, I've learned that many of the direct care staff truly needs support, and I realized I wasn't helping anyone by having a negative attitude- including the clients. It has been my goal to find ways of supporting the staff instead of assuming that I know better than them. A lot of staff members, including music therapists, feel they need to be constantly 'doing something.' Many music therapists come out of school with a mentality that if they are not doing something every second they are not doing their jobs. In an institution, that mentality comes from the top down. It's very hard for people to understand that *being with someone*, even quietly, *is* doing something. Having a rah-rah party is not music therapy and it is not necessarily useful to the individual. For some people it may be helpful but others may not learn best from that approach.

SS: Even ten seconds of silence or inactivity can seem like an eternity. For example, if you provide a choice of two instruments and the client sits inactive it can be unnerving.

RR: If a person has a disability, you might need to give him thirty to forty-five seconds to respond. Maybe he'll need a full minute. To wait expectantly is really doing that person a favor versus doing it for them.

SS: How do you help clients work towards communication goals if they are non-verbal?

RR: I mentioned earlier (in answer to another question) some of the ways we work toward developing communication- by reflecting and interpreting (or attaching meaning to the ways that the person already uses to communicate). In terms of groups, though, I co-lead a group with an intern and the group members are all non-verbal and they do watch one another. Sometimes people think that individuals with developmental disabilities can't function as a group and initially they can't. One of my teachers described the usual activity-based approach as being diagrammatically like a wagon wheel. Think of a circle with points around the outside and the therapist being in the center of the circle. Lines would be connected to the center like spokes of a tire. There is no interaction between the group members as they only interact with the therapist. What I've found useful is reflecting what individuals are doing in the group (and attaching meaning to it) as well as reflecting what's going on for the group as a whole (and, again, helping the group to attach a meaning to the actions and behaviors they're using to interact). Irvin Yalom's book, [The Theory and Practice of Group Psychotherapy](#), is really helpful in understanding groups. It's not a lot different with folks who have developmental disabilities. You have to work harder because you have to pay so much attention when you have people who do not use speech. You need to look at the roles group members play within the group.

People express things differently for the group. When one person is making all the noise in a group, I ask what that person is saying to the group. This is a very gradual process. Gradually, people do behave more as a group. I've had some group members that really started working wonderfully as a group then suddenly stopped. Sometimes there is an investment in not moving forward and not growing.

SS: That's very interesting. I haven't considered applying the Yalom concepts to a group of individuals with developmental disabilities.

RR: A lot of people don't. This is a subtle group of people. You might not see it as overtly as you would with people who use speech. Our job as therapists is to point things out. We need to notice things and confer with other staff and ask if they are noticing these things as well. When you make an observation or an interpretation about what's going on in a session (to your clients) there is such a shift in the session. There is a palpable shift and you physically feel it.

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