

An Analysis of Music Therapy Student Practicum Behaviors and Their Relationship to Clinical Effectiveness: An Exploratory Investigation

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The purpose of the present study was to investigate specific clinical behaviors exhibited by music therapy students in their 1st through 4th semesters of practicum. A secondary purpose of the study was to determine if a relationship exists between therapy students' behaviors and their assessed clinical success. Participants were instructed to submit 20-minutes of videotape from one practicum session, chosen at random from the current practicum semester. Two trained observers then viewed the videotapes and simultaneously recorded the occurrence and duration of practicum student behaviors using SCRIBE, a data collection computer program. The SCRIBE program was configured to include 5 broad categories of therapist behaviors: musical behaviors (singing, playing, listening), physical behaviors (such as hand-over-hand assistance, cueing, or clapping), verbal behaviors (therapy-related verbal interactions or other), a combination of two of the above, and other nonspecified behaviors. The percentage of time practicum students exhibited behaviors within in each category was calculated for all session segments. These same videotapes were also evaluated by 2 professional board certified music therapists who were unfamiliar with the practicum students. Students were assigned an overall rating for clinical effectiveness. Evaluators were also asked to provide comments related to their ratings. A descriptive analysis of clinical behaviors indicate that students spend nearly 40% of their practicum time engaged in musical behaviors and over 50% of their time engaged in verbal behaviors. No significant differ-

ences were found in the behaviors exhibited by students in the various practicum levels; however, behavioral differences were found for individual student therapists. Additionally, no relationship was found between students' behaviors and their clinical effectiveness. An analysis of comments by the evaluators indicates that the quantity of musical behaviors does not affect clinical effectiveness as much as the quality of the musical behaviors. Evaluator comments also indicate that students identified as personable or as having rapport with their clients were also more effective in the practicum setting.

The use of music is the identifying feature that distinguishes music therapy from other types of therapeutic interventions. Student music therapists typically spend a great deal of time developing their musical skills. The musical behaviors they exhibit define their clinical work. They do, however, often engage in other clinical behaviors during a typical music therapy session such as verbal or physical behaviors that also assist in achieving therapeutic objectives. These nonmusical behaviors are often utilized in conjunction with musical behaviors though they are sometimes used independently of musical behaviors. Nonmusical behaviors are commonly used to prompt, cue, or reinforce a client. The majority of research regarding music therapist behaviors has focused on the importance of various musical and nonmusical competencies. Educators and clinicians have identified the various therapeutic skills and behaviors necessary to achieve clinical proficiency; however, researchers have not yet determined whether or not a relationship exists between the time spent engaging in specific behaviors and clinical effectiveness.

Over the last 5 years, a number of researchers in the field of music education, have systematically observed the behaviors of teachers (Blocher, Greenwood, & Shellahamer, 1997; Brendell, 1996; Goolsby, 1996, 1997, 1999; Hendel, 1995). In instrumental music education, Goolsby (1996) compared the behaviors of experienced, novice, and student teachers. Variables included preparation time, initial teacher talk and time in warm-up, playing of instruments, breaks, and dismissal. Experienced teachers spent significantly more time in performance and used more nonverbal modeling than did novice or student teachers. Student teachers spent more time talking and less time having students play their instruments. In a follow-up study, Goolsby (1997) examined verbal behaviors in in-

strumental rehearsals by comparing expert, novice and preservice teachers. In identifying the content of verbal behaviors, results indicate all three groups of teachers' verbal behaviors were concerned with rhythm/tempo issues more than any other performance variable. In a recent study, Goolsby (1999) found that novice teachers are more likely to stop a rehearsal and begin a passage again without providing instruction and expert teachers direct students to perform more frequent repetitions than novice teachers.

In choral music education, Brendell (1996) examined the use of rehearsal behaviors of high school teachers. Choral conductors were observed during various rehearsal activities and time allotted to specific behaviors was recorded. The teacher behaviors observed and their percentages of rehearsal time were: sight-reading (22.23%), vocal warm-up (9.63%), getting ready (6.75%), physical warm-up (3.37%), literature instruction (1.84%), and other behaviors (1.46%). Student off-task measurements were also taken during the various activities and results indicated that the highest percentages of off-task behavior occurred during activities that required less singing.

In summary, research in music education has found that experienced teachers spend more time directing students in performance (Goolsby, 1996, 1999) than verbalizing (Brendell, 1996; Goolsby, 1996, 1997, 1999). The research also indicates that their proportional use of time contributes to more effective instruction and improved performance quality. It may be that more experienced music therapists who engage in a similar use of clinical time also evidence similar findings regarding their effectiveness.

Several studies were reviewed that parallel those found in the music education literature—studies that examine music therapists' use of time during therapeutic sessions. Only three studies could be found that were closely related to the purposes of the present investigation. These studies were concerned with music therapists' musical and/or verbal behaviors during clinical practice.

Wolfe, O'Connell, and Epps (1998) analyzed undergraduate and graduate student music therapists' verbal behaviors during six 50-minute group music therapy sessions. Verbalizations of the student therapists were organized into six categories: (a) continuing responses (comments made by the music therapists to encourage clients to continue talking); (b) leading responses (comments made by the music therapist to influence or reinforce, to give advice, or to ask questions or give directives); (c) instructions; (d) ex-

planations; (e) self-disclosures; and (f) other (greetings, salutations, closure comments). Analysis of the verbalizations in Wolfe et al.'s study indicated that the greatest percentage of comments occurred in the category of questions. Over a fourth of the comments made by the therapist across all sessions took the form of questions to elicit responses from the group member. Understandably, the next greatest percentage of verbalizations made by the therapists included influencing or reinforcing remarks, followed by "Mm Mm" responses (often accompanied by head nodding). Verbalizations in these last two categories were ones that the therapist used to actively support ideas presented by group members. Over half of the student therapists' verbalizations were either questions or supporting comments made in response to a group member's answer to a question. The authors also noted that the categories of music and therapists' verbalizations shared nearly equal durations of time; therefore, raising the question should a greater percentage of time be devoted to music than to therapist talk? Which is the more active therapeutic agent—music or the therapist's verbalizations?

In his qualitative study of musical and verbal interventions in music therapy, Amir (1999) discusses the role of music versus words. In doing so, he identifies three traditional models of music therapy and their sources:

1. Models that are based on the perception of "music as therapy." All interventions are musical and there is little talking during the session. If there is talking, it is not considered a psychotherapeutic intervention (Ansdell, 1995; Lee, 1992; Nordoff & Robbins, 1977, 1992; Robbins & Robbins in Bruscia, 1991).
2. Models that are based on the belief that music is the primary force of change but that verbal interventions are used in order to communicate ideas, share insights, make interpretations, and so on (Alvin, 1976, 1977, 1981, 1982; Bonny, 1978a, 1978b, 1980; Priestly, 1975, 1978, 1987, 1988, 1994).
3. Models that are based on the perception of "music in therapy" and give equal importance to musical and verbal interventions in music therapy (Katsh & Merle-Fishman in Bruscia, 1987; Platch, 1980, Rioedan-Bruscia in Bruscia, 1987; Sokolov in Bruscia, 1987; Stephans in Bruscia, 1987, p. 145).

In order to examine various aspects of musical and verbal inter-

ventions, Amir (1999) interviewed six experienced music therapists in Israel and the United States in order to understand how they "experience, apprehend, perceive, feel, and think about musical and verbal interventions" (p. 173). His findings were organized into eight core-categories: (a) definitions of musical and verbal interventions; (b) general functions of musical and verbal interventions; (c) factors that influence the therapist in making decisions concerning interventions; (d) transitions from one mode to the other; (e) musical and verbal interventions: types and techniques; (f) meaning of instruments in musical interventions; (g) decision making process; and (h) therapist's role. In summary, Amir states (in part) that "We need to carefully explore why and when we are doing what."

One study by Alley (1980) reported the length of time music therapy practicum students spent in music. The purpose of her study was to examine the effect of self-analysis of videotapes on selected competencies of music therapy majors. In addition to time spent in music, Alley also examined the length of time practicum students addressed the session objective. Obviously, these two categories were not mutually exclusive, since much of the time spent in music was also time spent addressing the session objective. Alley found that students greatly increased the time spent in music from the 4th week of the practicum to the 11th week, and also increased their use of directives and approval, and their attention to the session objective. She concluded that as the length of the practicum experience increased, so did students' overall clinical skills and their use of music.

The purpose of the present study was to investigate specific clinical behaviors exhibited by music therapy students in their first through fourth semesters of practicum. The researchers were particularly interested in students' use of musical, as well as verbal, or physical behaviors, combinations of these behaviors, and any other behaviors they might exhibit. A secondary purpose of the study was to determine if a relationship exists between the student therapists' behaviors and their clinical success as assessed by independent evaluators.

Method

Participants

Twelve music therapy practicum students volunteered to partici-

TABLE 1
Behavioral Dimensions with Examples

Behavioral Dimensions	Examples
Music behaviors	behaviors such as singing, playing or listening to client sing and play
Physical behaviors	behaviors such as hand-over-hand assistance, cueing or clapping
Verbal behaviors	behaviors such as giving directives, feedback, explanations, or asking questions
Music & verbal	multiple behaviors that are a combination of music and verbal behaviors
Physical & verbal	multiple behaviors that are a combination of physical and verbal behaviors
Music & physical	multiple behaviors that are a combination of music and physical behaviors
Other behaviors	behaviors that are unrelated to music therapy such as closing door, talking to person at the door

pate in the study (mean age = 23.1 years). All subjects were enrolled in upper level music therapy courses at a Midwestern university, and were completing one of the four levels of supervised music therapy practice at the time the data were collected. All 12 subjects were female and are representative of the population of music therapy students at the university. Six subjects were pursuing a bachelor's degree, and six were pursuing a music therapy graduate equivalency and master's degree.

Procedures

Participants were instructed to submit all practicum tapes from the current practicum semester. The only criterion was that each tape had to have at least 20-minutes of actual clinical work. Each student submitted three to four tapes. Some tapes had more than one recorded session. The tapes for each student were numbered, and researchers randomly selected one tape for each student. Therefore, tapes were selected without regard to date or any other identifying information other than the students' names. If there was more than one session recorded on the tape, the first session was recorded onto the master tape used in the study. The resulting videotaped segments were divided into two groups: session segments from the first practicum levels (Ia and Ib) and segments from the last two practicum levels (II and III). All segments were

TABLE 2

Example of Scribe Data for Subject 1

Test Time: 0:20:04	Frequency	Time (min:sec)	Time (%)	Mean (min:sec)	Standard deviation	Rate (#/min)
IDLE	1	0:02	0.2	0:02.0	0.000	0.0
Musical behavior	28	6:37	33.0	0:14.2	9.396	1.4
Physical behavior	5	0:30	2.5	0:06.0	4.604	0.2
Verbal behavior	42	6:35	32.8	0:09.4	8.269	2.1
M & V	5	0:30	2.5	0:06.0	7.642	0.2
P & V	12	3:37	18.0	0:18.1	13.169	0.6
M & P	14	2:13	11.0	0:09.5	6.555	0.7

dubbed in random order on two VHS master videotapes for further analysis. The clinical populations represented on the master tape were: children with autism, preschool children, adolescents and adults with developmental delays, nursing home residents, older adults, and children with behavior disorders. Sessions were almost evenly divided between small groups and individuals. Session objectives varied depending on the population.

Two trained observers then viewed the master videotapes and simultaneously recorded the occurrence of practicum student behaviors using SCRIBE (Simple Computer Recording Interface for Behavioral Evaluation) (Duke & Farra, 1997), a computerized observation program designed to record frequencies and durations of selected events or behaviors. SCRIBE presents data in three forms: (a) a graphic timeline, which is a visual representation of the sequence and durations of recorded events; (b) a summary table, which displays the frequencies, durations, rates per minute, total durations, mean episode durations (and few corresponding standard deviations) of recorded events; and (c) a chronology of recorded events. For this study, the SCRIBE program was configured to include five broad categories of therapist behaviors: musical behaviors, physical behaviors, verbal behaviors, a combination of two of the above, and other nontherapy related behaviors. Table 1 includes examples of the behavioral dimensions. The percentage of time practicum students exhibited behaviors representative of these dimensions was calculated for each session segment. Table 2 shows an example SCRIBE data collection.

Student practicum videotapes were also evaluated by two professional board certified music therapists who were unfamiliar with

TABLE 3
Means and Standard Deviations for Percentage of Total Time Student Therapists Exhibited Behaviors

Behavioral dimensions	<i>M</i>	<i>SD</i>
Verbal behaviors	27.87	12.36
Music behaviors	25.63	13.59
Physical & verbal	23.08	8.82
Physical behaviors	10.08	7.68
Music & physical	10.04	10.81
Music & verbal	2.90	3.06
Other behaviors	0.25	0.42

the practicum students. Students were assigned an overall rating on a Likert scale from 1 to 5 (5 being the highest) for their overall clinical effectiveness. Evaluators were also asked to provide comments related to their ratings.

Data Analysis

As stated previously, the percentage of time practicum students exhibited behaviors representative of these dimensions was calculated for each session segment. A correlational analysis was conducted between the percentage of time subjects spent in the various behavioral dimensions and the overall clinical effectiveness score they received. Additionally, comparisons were also made between the subjects' practicum level and their clinical effectiveness scores, and between the subjects' practicum level and the percentage of time they exhibited behaviors representative of the various behavioral dimensions.

Results

Music therapy students' behavioral data were converted to summative percentages for each of the seven categories. Data from each observer were compared to each other to establish interobserver reliability. Observer reliability was computed by dividing agreements by agreements plus disagreements. Reliability was determined to be .94. Because the reliability of the behavioral observers was so high, a mean percentage for each behavior was calculated for each subject. Means and standard deviations for each behavior are presented in Table 3. The greatest percentage of time was spent utilizing verbal behaviors, followed closely by musical behaviors, and then ver-

TABLE 4

Pearson Product Moment Correlation Results for Subject Behaviors, Practicum Level, and Overall Clinical Effectiveness

	Music beh.	Physical beh.	Verbal beh.	Music verbal	Physical verbal	Music physical	Other beh.
Music behaviors	1.00						
Physical behaviors	-0.61*	1.00					
Verbal behaviors	-0.52	0.06	1.00				
Music & verbal	0.37	-0.60*	-0.10	1.00			
Physical & verbal	0.00	0.04	-0.36	-0.03	1.00		
Music & physical	-0.35	0.15	-0.22	-0.21	-0.42	1.00	
Other behaviors	0.19	-0.50	0.00	0.56	0.00	-0.09	1.00
Evaluation	-0.16	0.10	0.16	0.44	-0.35	0.10	0.32

* Correlation is significant at the .05 level.

bal/physical behaviors. Differences in behavioral patterns between practicum levels and between graduate and undergraduate students were sought using *t*-test procedures, but no test on any behavior yielded a significant difference. Therefore, all participant data remained in the same pool for subsequent analysis.

Evaluation data of the music therapy practicum students' overall effectiveness were also collected from two separate and independent adjudicators. These data were compared, but found to be identical; therefore, no reliability calculations were necessary. The overall mean rating for the therapy students' clinical effectiveness was a 3.58 on a 5-point Likert type scale ($SD = 0.79$). Pearson Product Moment Correlation procedures were used to compare interrelationships of behaviors, as well as the evaluations of the student therapists to their observed behaviors (see Table 4). When considering the interrelationship of behaviors, only two pairs of behaviors correlated significantly. Physical Behaviors correlated negatively with both Music Behaviors ($r = -.61$) and Music and Verbal Behaviors ($r = -.60$).

When comparing behaviors to evaluations only two pairings had even a moderate correlation. The first was Music and Verbal Behaviors, which correlated positively ($r = .44$), but only occurred an average of 5% of the total time. The other behavior that correlated with the evaluations was Physical and Verbal Behaviors. Those behaviors occurred much more frequently, 24% of the total time, but correlated negatively ($r = -.35$).

TABLE 5

Means for Percentage of Total Time Individual Student Therapists Exhibited Behaviors

Therapists	Music beh.	Physical beh.	Verbal beh.	Music verbal	Physical verbal	Music physical	Other beh.
1	33.40	1.70	32.15	3.95	17.70	9.50	1.35
2	27.70	6.90	31.05	10.15	17.60	5.95	0.50
3	24.90	5.10	52.45	2.15	10.30	4.95	0.00
4	54.80	2.05	12.40	2.80	27.15	0.50	0.00
5	13.55	2.00	27.25	5.05	34.60	17.00	0.55
6	37.85	8.95	16.36	5.95	29.45	0.65	0.60
7	23.75	13.75	10.65	1.25	11.05	39.65	0.00
8	19.65	21.35	21.05	0.00	37.70	0.00	0.00
9	4.95	19.60	45.30	0.35	20.60	9.00	0.00
10	15.40	22.45	30.70	0.00	17.20	14.20	0.00
11	14.65	12.05	30.80	0.00	29.65	12.60	0.00
12	37.00	5.05	24.25	3.20	23.95	6.45	0.00

Discussion

The purpose of the present study was to investigate specific clinical behaviors exhibited by music therapy students in their first through fourth semesters of practicum. Like similar studies in music education and music therapy (Goolsby, 1996; Wolfe et al., 1998), findings indicate that students spent more time engaged in verbal behaviors than in musical behaviors, though only by a few percentage points. When the times students spent engaged in musical, musical/verbal, or musical/physical behaviors were tallied, the total time spent engaged in musical behaviors was nearly 40%. A lower ratio of music to verbalizations is not necessarily indicative of poor therapeutic intervention; it is important to remember, however, that music is the music therapist's *raison d'être*, and that logically a substantial amount of session time should be spent engaged in musical behaviors.

In reviewing the multiple behavior categories, students in the present study spent over twice as much time engaged in verbal/physical behaviors than in the combination of music/verbal or music/physical. The low percentage time spent in music/verbal (2.90%) is understandable since one obviously cannot sing and verbalize at the same time—and singing is often the student's behavior of choice for musical intervention. The combination of music/verbal behaviors must then be playing music and talking or listening to music and talking. Though one can listen and talk at

the same time, there may also have been some difficulty on the part of the observers to determine whether a student was listening and talking or just talking. Generally, engaging in multiple behaviors is more difficult than single behaviors; although, once again there were no difference found in the time spent in single or multiple behaviors based upon students' practicum level. The ability to engage in multiple behaviors is probably more indicative of the student's musical abilities—their comfort with playing and talking, or with singing and giving physical cues—than in their stage of clinical practice development.

A common characteristic of first semester practicum students is a tendency to over verbalize—to repeat themselves, or to give extended explanations or directives; although again, data in the present study indicate that lower level practicum students were no different than upper level students in the amount of time they spent engaged in verbal behaviors.

Students in their initial practicum are often exploring various uses of music to meet client objectives. Although the data in the present study did not indicate any difference in the amount of time spent engaged in music based on practicum level, there may have been differences in the appropriateness or effectiveness of music behaviors based on practicum level. The study was not designed, however, to assess the appropriateness or effectiveness of musical behaviors. An analysis of the evaluators' comments does indicate though that the quality of musical behaviors is related to clinical effectiveness. With very few exceptions, students given a 5 rating had comments regarding their musical abilities.

A secondary purpose of the present study was to determine if a relationship exists between the student therapists' behaviors and their clinical success. No significant differences were found in the behaviors exhibited by students in the various practicum levels, or in the behaviors of undergraduate and graduate students. Both undergraduate and graduate students in this university program take a clinical techniques class before they are enrolled in practicum work. In this class, a great deal of emphasis is placed on utilizing musical skills and on appropriate verbalizations. Since all students go through the same curriculum with the same teachers, their orientation to therapeutic interventions is similar, and apparently set by the first semester of practicum work.

The ratio of verbal to music behaviors and use of physical behav-

iors may also be dependent upon the music therapy clientele, the specific music application, or the skills of therapists and how comfortable they are with their functional music skills. Some student's principal instrument is, for example the trumpet or oboe, and not the piano or guitar which are commonly used in music therapy sessions. These students may be more comfortable with a higher ratio of verbal to music behaviors.

Comments by the evaluators indicate that good musicianship skills are key to practicum students' effectiveness. Evaluator comments emphasizing musical skills provide implications for university faculty or clinical training directors in music therapy. Good music skills are important. Objective and narrative data in the present study imply that the quantity of musical behaviors do not affect clinical effectiveness as much as the quality of the musical behaviors. Analysis of evaluator comments also indicates that students identified as personable or as having rapport with their clients were also viewed as more effective in the practicum setting. Future research may seek to determine specific verbal or affective behaviors that are viewed as indicators of rapport or personality.

Related to these observations might be the decreased evaluations paired with increased levels of physical and verbal behaviors ($r = -0.35$). This negative correlation is curious, but when considered, at least two possible explanations seem likely. First, the more a student therapist is engaged in physical and verbal behaviors, the more music is not (by definition) happening. It seems axiomatic that a music therapist cannot be considered extremely effective without music present and this may well have influenced the overall evaluations. The second apparent reason (not mutually exclusive from the first) is that a higher level of disorganization would likely accompany higher levels of physical and verbal activity. In fact, it might be hypothesized that disorganization and unpreparedness would necessitate additional verbal and physical behavior, once again, requiring a less effective evaluation. Though evaluators frequently commented on student therapists' cueing or prompting behaviors and saw these physical behaviors as effective supplements to verbal behaviors, this was clearly not the case when those behaviors took too much of the session time.

Evaluators also commented on student's lack of or use of specificity when providing verbal reinforcers. Higher evaluations were given to student therapists who were explicit when giving direc-

tions and feedback to clients. The only other comments that were consistently associated with higher evaluations were comments regarding the creativity of the student therapists. Students who used creative props or visuals, or who used music in creative ways were consistently given a higher rating.

Future research may reveal differences in the behaviors of students from other university programs with different philosophical orientations, or differences in the interpretation of student behaviors. Though the present study found no relationship between student behaviors and their clinical effectiveness, further analysis of specific musical behaviors (singing, playing, or listening) or of specific verbal behaviors (directive, feedback, explanation, question) may reveal a relationship to clinical effectiveness.

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