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교육학박사 학위논문

**An Exploratory Inquiry into
Music Therapy Assessment for Children with
Special Needs**

특수아동들을 위한 음악치료 진단평가에 대한
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Abstract

An Exploratory Inquiry into Music Therapy Assessment for Children with Special Needs

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Purpose: This study was conducted to investigate what music therapists who work with children with special needs experience in the course of assessment in the field. **Methods:** Through the pilot study, a form of semi-structured interviews with open-ended questions was developed. Interviews were completed with twelve professional music therapists and they were asked about 1) an intake process, 2) a full-scale assessment, and 3) the experience of using music as an assessment criteria. Telephone interviews were conducted for every participant and each interview was transcribed. Data collected from the

interview were analyzed through Consensual Qualitative Research (CQR) methods. **Results:** Overall, the information of recognition, procedure, instrument, and issue of each initial (intake process) and full-scale assessment were discussed. In addition, music assessment issues were also discussed. First, the intake process was considered as the process of collecting basic information while establishing rapport at first sight and during parental counseling. For the procedure, the participants were provided the intake information obtained by other health-care professionals of the institutions. Hence, all participants did a meet-up with parents/guidance after the initial intake interview was done for the upcoming music therapy service. There was no specific music therapy intake form used in the field. Nevertheless, what participants usually did was to add extra information as needed on the intake information collected by other professionals. In the pattern of intake, self-made intake forms were utilized, and professional forms from other disciplines such as special education and psychology were adapted to the forms. For assessment items, there were two major categories to gather the information needed: non-musical and musical. Within intake interview issues, two sub-domains were assigned under the main theme for more concrete classification: difficulties and needs. Second, assessment was considered as establishing therapeutic goals

and objectives during this term and identifying the current level of the client. For the implementation of the assessment, it is reported that assessment was categorized into two major areas (musical and non-musical) and that the assessment took approximately a month based on one session per a week. For the assessment tool per se, a variety of resources were utilized. The descriptive approach was the most preferable method for documenting the information observed. There were two major categories to collect information during assessment: musical and non-musical. In the issues of assessment, two sub-domains were also assigned under the main theme for more concrete classification: difficulties and needs. Lastly, there existed some uncertainty in how to deal with music in the context of assessment criteria. In addition, some characteristics of music and subjective experience and response to those elements were reported for the music assessment issue. **Discussion:** Then, it is discussed based on what the results could offer music therapists in terms of suggestions toward the course of assessment.

Key words: Children with special needs, Music therapy, Intake process, Assessment, Qualitative inquiry, CQR

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Chapter 1: Introduction

1. Purpose of the Study

If there is consideration for professionally assisting a child with a disability who needs specific help, first and foremost, sufficient information is required of the subject in a variety of areas in order to provide appropriate and qualitatively therapeutic service. In particular, it is vital to collect concrete and systematic information of the specific areas that need professional intervention in addition to basic information such as age, gender, pathological condition, etc. Such areas of information must be deeply investigated and documented prior to implementing any intervention for the subject. Hence, when there is a specific issue for a child with special needs, it must begin with a professional investigation in order to find out the current condition in the areas of physical, mental, and emotional well-being. In an assessment, these investigations are performed to discover the areas of need.

The overall assessment process is composed of two stages: initial assessment (the intake process) and a full-scale assessment. It begins with an intake interview where the therapist first encounters the child

and collects basic information. Then, it proceeds to a full-scale assessment, which identifies substantial areas of need and seeks to establish therapeutic goals and objectives. Information on quantity, type and method collected in the intake process is analyzed, which is significant because it subsequently directly impacts a full-scale assessment and the entire process of therapeutic intervention (Meyer and Melchert, 2011). Even if the basic information collecting process prior to substantial intervention were a primary goal of the intake interview, establishing rapport with the child and their parents would remain critical since it also affects any establishment of a developmental therapeutic relationship. After the intake interview, a full-scale assessment is implemented. This is the continuous process that a therapist focuses on to better understand the client/child (Corey, 2012). Since a thorough and professional understanding of the child helps the therapist identify areas of substantial need, and this understanding is directly connected to the establishment of therapeutic goals, this assessment process is essential to the therapeutic service as a whole.

Assessment is the collection of both subjective and objective data. The subjective data includes what the child or family states as issues, and objective ones include what the health care practitioner finds with

the techniques of inspection, palpation, percussion and auscultation (Fergusson, 2008). Assessment is performed on an individual basis in accordance with the needs of each client in relation to music therapy. For example, formal methods like standardized tests can be administered or informal ways of clinical observation based descriptive methods can be utilized. In addition, the combination of both formal and informal tends to be used on a case by case basis. A professional assessment performed prior to therapeutic intervention is critical to providing efficient and successful intervention. Such processes must be objective and scientific in order to maximize their effectiveness as vital evidence-based practices in providing professional help to clientele including juvenile populations. Houser and Oman (2011) illustrated that “evidence-based practice is a systematic process of reviewing the best available research evidence and then incorporating clinical experience and patient preferences into the mix (p. 5).

In the same context, music therapy assessment for children with special needs also needs to be done systematically and methodically. Music therapy has become increasingly popular and is increasing in popularity not only in Korea, but also worldwide. It is being developed as a professional system that provides therapeutic intervention while also observing how music affects people who need help, including

children with special needs. Due to its secondary standing in relation to other health care professions, music therapy is still going through a process of trial and error to become an established health care profession. The therapeutic use of music on behalf of the children appears to have gained more attention and become more accepted as time goes on, although there have been critical challenges in the context of evidence-based empirical practice because of the complexity of music itself, the individualized response to music, and the combination of musical and extra-musical components in therapy. To provide therapeutically appropriate intervention for children who need specific help, assessment must be done rigorously and accurately prior to establish therapeutic goals and objectives. A thorough analysis is the key of success in the course of assessment while the assessment issue specifically, is centered on the struggle of music therapists who are working with children with special needs just as they are with other clientele populations in the course of this development.

The importance of assessment must be emphasized throughout the entire therapeutic process. Music therapy assessment is the process of observing children strategically and making clinical

recommendations in terms of services and/or treatment planning based on a sole assessment session or sessions (Goodman, 2007). Music therapy assessment should also be an evidence-based practice so that it can provide an objective and accurate range of information on the current level of function, as well as fostering the understanding required to enhance the quality of life that children with special needs experience.

Currently, a number of music therapists practice actively either in full-time or part-time positions with the children. These therapists are already working on putting interdisciplinary teamwork into practice. Not many music therapists have their own clinic, and most work independently under contract with institutions such as schools, community centers, hospitals, etc. That is, most music therapists work in an institutional setting and use various modes of assessment based on where they work. Goodman (2007) stated, "assessment varies widely depending on one's clinical orientation, the population and the demands of the workplace" (p.42). Therefore, music therapists usually prefer implementing informal methods of assessment with subjective, but creative, and qualitative approaches in accordance with the requirements found in each workplace. Moreover, there is demand to maximize the effectiveness of music and its elements while also using

scientific classification and applying that information to assessment criteria in the field. In music therapy, music is used as an effective intervention tool. Work using music and its elements are required to prove the effectiveness and efficacy of psychological and medical treatments in modern societies and current health care systems (Hillecke, Nickel, Bolay, 2005). In order to function as a recognized and independent health care profession, particularly functioning in this setting, this area of assessment needs to be explicitly explored and established with a solid framework.

Why then does music present such difficulty when it needs to be analyzed and assessed on behalf of children with special needs? Music is composed of a number of elements and music itself has the unique characteristic of a diversity that exists in an open-ended universe. Lee (2003) stated that music is an enigma as its power to influence human existence is concrete yet transient. Also, music itself reflects a multiplicity of human events that are difficult to analyze (Hillecke, Nickel, and Bolay, 2005). The unique character of music can cause difficulty in measuring quantitative factors in therapy situations; furthermore, the perception and reception of each individual to music involves a complex range of responses as each individual has unique and varied experiences in their life. Each child with special needs may

or may not respond differently to musical components. Subsequently, it appears that this attribute of music and the individualized response that follows creates difficulty in standardizing music therapy assessment. Every music therapy approach possesses assessment components either during the initial stages of therapy, or as part of sustained treatment (Wigram, Saperston, & West, 2009). However, many assessments found in music therapy literature were produced in order to measure domains of functioning distinctive to the population on behalf of a specific population (Layman, Hussey, & Laing, 2002). That is to say, music therapy research on assessment for children with special needs has been primarily dealing with individualized test tool development of a certain area of disability with therapeutic intervention by the individual, institution, organization, etc.

In general, music therapists in practice with the children review and make an application of those tools on an individual basis to meet a need or specific circumstance where they work. However, this is simply limited to a personal use of self-made tools. Furthermore, there has not been research on what kind of tools other music therapists use and how they perform in assessment of their practice as a whole. There is a need for an inquiry that can represent informative data of what other music therapists do in the course of assessment and how

they apply it in the process to work with the children. This research information would enable music therapists to review and identify a current level of assessment competency, including recognition and related skills, for themselves. Additionally, this study intends to investigate what music therapists recognize and actually do in the music therapy assessment process including initial assessment (aka intake process) and full-scale assessment for the population of school-aged children with special needs that is actively practiced amongst diverse music therapy client populations. In addition, the varied experiences of using music as an assessment criteria will also be investigated. To investigate this phenomenon in music therapy, qualitative inquiry was deemed suitable to conduct research. Personal experience and engagement are frequently used to generate new theories of ideas in qualitative music therapy research (Wheeler, 2005).

Consensual Qualitative Research (CQR) was used to analyze the data collected since it allows participants to construct their own truths and utilize internal experiences, while researchers used a consensus process to analyze the data (Hill et al. 2005). This study will explore practical information in relation to music therapy assessment in search of the development of an assessment framework and its useful application to real practice. In addition this study will explore how that

basic information can be useful for developing probable standardized music therapy assessment tools in the future.

2. Research Questions

Bruscia (2005) illustrated the use of open-ended research questions, which are unanswerable by a yes/no or true/false determination by qualitative researchers. Based on the purpose of the study, a sole research question emerged. The research question was as follows:

- What assessment procedures have been developed in music therapy for children with special needs?

Through this research question, the investigation was implemented in order to find how music therapists performed assessments from the stage of initial assessment to that of a full-scale assessment. There were a total of twelve music therapists, who held master degrees in music therapy and who currently work with children with special needs in diverse settings, recruited as research participants. In qualitative research, there are two major interview techniques: structured with close-ended questions and unstructured with open-ended question interviews (Denzin & Lincoln, 2005):

The former aims at capturing precise data of a codable nature so as to explain behavior within pre-established categories, whereas the latter attempts to understand the complex behavior of members of society without imposing any a priori categorization that may limit the field of inquiry (p. 706).

In this study, the participants were given open-ended questions and data was collected through an in-depth interview process prior to the analysis using the CQR method (Hill, 2012). That is, the purpose of this study was to look for information on the experiences of a dozen music therapists in relation to intake interviews, assessment, and using music as assessment criteria through semi-structured interviews with open-ended questions since there was a need for establishing a balance between structured and unstructured methods in order to benefit from each unique form in accordance with how CQR is oriented: using a quantitative analytic method. Barriball & While (1994) stressed that there are two primary considerations that a researcher decides using a semi-structured interview:

First, they are well suited for the exploration of the perceptions and opinions of respondents regarding complex and sometimes sensitive issues and enable probing for more information and clarification of answers. Second, the varied professional, educational and personal histories of the sample

group precluded the use of a standardized interview schedule (p. 330).

Moreover, it was also explored how they constructed and organized the meaning of those experiences with regard to the themes of the research question. Given the diversity of the participants, it was appropriate to use a qualitative research method in order to analyze data yielded from the interviews. CQR was used to analyze the data since it allows participants to communicate their own opinions and internal experiences, while researchers used a consensus process to analyze the data (Hill et al. 2005). CQR is increasingly being used within a range of diverse fields such as psychology, counseling, and education. It allows for the probing of participants in a safe environment without predetermining their responses (Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996; Rhodes et al., 1994). Amongst diverse qualitative inquires, CQR is a differentiated method that enables researchers to work on analysis in a quantitative way in order to enhance objectivity as well as validity with quantitative components (Hill, Thompson, & Williams, 1997).

Throughout this method, the aim was to deduct a specific theory/framework of the assessment process out of the data. Table 1 exhibits the questions that were given in order to conduct this study.

Research Question	Interview Question
What assessment procedures have been developed in music therapy for children with special needs?	1. What is the practice of the intake process?
	2. How is the full-scale assessment performed?
	3. What is the experience of therapists using music as assessment criteria?

Table 1. The research question & main interview questions

3. Definition of Terminology

1) Children with special needs

In the Individuals with Disabilities Education Act (IDEA), children with special needs are defined as young children who have been diagnosed as having developmental delays. Any child who has been evaluated as having one of a limited list of disabilities specified in IDEA

are considered as having special needs in that they require special education and related services (20 U.S.C 1401 and 34 C.F.R §300.8).

2) Music therapy

The World Federation of Music Therapy (WFMT) defines music therapy as the professional use of music and its elements as an intervention in medical, educational, and everyday environments with individuals, groups, families, or communities who seek to optimize their quality of life and improve their physical, social, communicative, emotional, intellectual, and spiritual well-being. Research, practice, education, and clinical training in music therapy are based on professional standards according to cultural, social, and political contexts (WFMT, 2011).

3) Intake interview

This is an initial stage of therapy that the therapist and client/client guardian encounters first. Through this stage, the therapist needs to not only collect basic information about the client, but also to establish a level of rapport with them. Establishing rapport with a client is of primary importance as it directly impacts the therapeutic relationship in the course of the therapy process. In addition, the therapist gathers

and charts essential information in order to set suitable therapeutic goals and objectives in the subsequent assessment period.

4) Assessment

Assessment is the process of identifying the area of need for the client by collecting both clinical and non-clinical information. Assessment is also subsequently utilized in decision-making and service plan development on behalf of the client's well-being. Through this stage, the therapeutic goals and objectives are established in order to provide therapeutic intervention.

5) Musicology

Beard & Gloag (2005) illustrated musicology as a process of music study, inquiry and reflection. It is also said that musicology is the scholarly study of music. However, the boundary of musicology appears to be ambiguous because of the diversity between subjects and methods. According to the Harvard dictionary of music (2003), there are two major distinguishable categories when musicology is discussed: disciplines and subjects of study (ethnomusicology that is concerned with music in its human context) and historical musicology (deriving from the nature of the tradition of Western art and music).

Also, Webster's dictionary stresses that musicology has two central, practically oriented sub-disciplines with no parent discipline: performance practice and research, and the theory, analysis and composition of music. At times, music theory, including forms and style of music, are considered as equivalent to musicology.

Chapter 2: Literature Review

1. Music Education and Music Therapy

In general, the significant role of music is discussed and stressed in accordance with development either through public or private music education. Campbell & Scott-Kassner (2010) stressed the characteristics of music associated with musical training as it can provide significant components for children's holistic development, including their intellectual, emotional, physical, and spiritual selves (p. 6). Hence, it may be expected to see that positive development is a product emerging naturally through music education. Nevertheless, it appears to be difficult to monitor specifically which element of music itself affects children through merely general music education, particularly for children with special needs. In order to specifically monitor what's happening in music therapy, there needs to be more systematic and professional ways of approach to the client (child)'s needs and it appears music therapy has the answer. Essentially, the essence of music which enables people to connect interpersonally suggests that music is a valid tool for use in music therapy (Aigen,

2011). Music influences children with special needs in a variety of ways, not only affecting mood and psyche, but also eliciting changes in behavior while interacting with others including the therapist. Music therapy can fulfill the needs of systematic procedure through the unique services (therapeutic interventions) provided. Bruscia (1996) stressed, "In treatment, the therapist uses music as a means of intervention to induce specific changes in the client, condition, or state of health" (p.10).

There are many similarities between music education and music therapy. It is apparent in both that music is utilized for a specific goal, whether education, or therapy oriented, and the use of music is the core for both. However, there is also a significant difference between music therapy and music education. While music education focuses more on academic/educational growth and fostering professional musicians, music therapy focuses more on non-academic elements. This includes aspects such as the children's dispositional changes in relation to specific needs and providing therapeutic interventions accordingly by professionally trained music therapists. That is to say, music is used for *different goals and intents*, differentiating from general musical experiences, including the music education seen in everyday life. *The different goals and intents* here are linked so that

the approach is implemented specifically for achieving certain goals in the course of trial and error. In this context, the term, *clinical* can replace those words (*the different goals and intents*). Hence, the differentiated goals are established in order to develop communicative potential, attention, motive and develop functional hand use, social behavior and facilitate emotional expression through music therapy assessment and treatment (Wigram and Lawrence, 2005). The fact that music is used clinically represents how music is utilized differently for therapeutic goals beyond its more general use for leisure, recreation, or even music education. Such differentiated goals are easily distinguishable, particularly when music therapists work with children with multiple severe disabilities. Meadowes (1997) suggested the potential goals for the population described above as follows:

No.	Goals	Details
1	Fulfilling the child's basic needs	Creating a trustworthy and responsive environment
2	Developing the child's sense of self	Child builds relationship with musical instruments, music, and the therapist.

3	Establishing or re-establishing interpersonal relationships	—
4	Developing specific skills	Eye contact, reaching, or using a switch within musical activities
5	Dispelling pathological behavior	—
6	Developing an awareness and sensitivity to the beauty of music	—

Table 2. Six music therapy goals suggested for children with severe and profound multiple disabilities.

Therefore, music therapy can be defined as a professional study and practice that demonstrates how music affects the children and those who need help can be provided appropriate service (intervention) for the established therapeutic goals via music therapy logistics.

2. Children with Special Needs and Music Therapy

For the juvenile population, particularly children with special needs, music therapy can provide not only a general musical experience, but also specific and therapeutic intervention. Children with special needs

have a right to get involved with musical activities during their education and such a right has been supported by law (PL 94-142). One of the key concepts represented by the Individuals with Disabilities Education Act (IDEA, 2004) and preceded by the Education for All Handicapped Children Act (EHA, 1975) which is another amendment to Public Law (94-142) is that a total, free and appropriate public education should be available for all handicapped children. In addition, PL 94-142 stresses that a variety of services including music and art should be provided to the handicapped children by states and institutions. Furthermore, PL 94-142 states that such services should be provided in accordance with special educational needs. That idea has been incorporated into special education and developed actively in special education settings for the benefit of children with special needs since music therapy has the unique characteristic of potentially not only being therapeutic, but also fun. One of the most prominent features of music therapy is the use of music as an effective non-verbal communication method, particularly with children with special needs. Music is often called the “universal language,” and can often function as non-verbal communication. Aiello (1994) illustrated the merit of music and its characteristics, compared to a function of language as:

Language is based on understanding the interaction of its phonetic, syntactic, and semantic levels. And while music conveys meanings, its semantic level is not as uniformly defined as that of language...Music is the art form that expresses feelings and meanings through the qualities of sounds and the relationships between sounds. In language, the specificity of the semantic component provides information. Indeed, verbal communication cannot take place if the listener does not understand the semantic meaning. But in music this is not necessarily the case. Although the meaning of music is enhanced by our knowledge of musical styles and practices, musical meaning remains both pluralistic and personal. (p. 55).

Such music is frequently used for the purpose of enhancing communication with children in music therapy. No matter what kind of therapeutic service is provided, verbal/non-verbal communication is the key for a successful intervention as many children referred to music therapy exhibit interaction disorders, which can pose a secondary threat to development (Sarimski 1993; Wosch et al. 2007).

Wigram & Gold (2006) introduces music therapy as an effective communication intervention:

Music therapy has been recommended as an effective treatment in facilitating communication, as music is a medium that involves a complex range of expressive qualities, dynamic form and dialogue, and offers a means by which some form of alternative communication can be

established to help achieve engagement, interaction and relationship (Trevarthen 1999; Wigram 2002a; Wigram & Gold 2006, p.535).

In addition, the American Music Therapy Association (AMTA) suggests that music therapy intervention can also be designed to facilitate a wide range of other areas beyond communication. It can be used to: promote wellness, manage stress, alleviate pain, express feelings, enhance memory, improve communication, and to promote physical rehabilitation. For example, individual music therapy sessions can be provided for children with special needs in all grade levels and the potential therapeutic goals would be as follows in table 3:

Music therapy program goals for elementary, middle, and high school group sessions:
(1) Create structured, safe musical experiences for students to achieve success and increase self-esteem.
(2) Establish group cohesion and cooperation using a check-in method incorporating drumming and chanting.
(3) Provide organized and planned sessions focused on achieving a group goal, based on individual IEPs, group needs, and treatment team recommendations.

(4) Encourage on-task and appropriate behavior using immediate positive reinforcement, second chances, and music as a contingency for appropriate behavior.
(5) Provide musical experiences to encourage self-expression, communication skills, and socialization.
(6) Facilitate group movement in music activities enhancing motor coordination, fine and gross motor skills, overall physical fitness, and self-awareness.
(7) Provide musical experiences to reinforce cognitive skills and aid in the development of speech and language.
(8) Allow for students to explore personal musical interests and develop skills in becoming a musician.

Table 3. The potential music therapy goals with children with special needs in all grade levels

From Individual Music Therapy Sessions Goals with Students in All Grade Levels: A model for Music Therapy with Students with Emotional and Behavioral Disorder, *The Arts in Psychotherapy*(2006), 33, 1-10

3. Children with Special Needs and Music Therapy Assessment

Walvoord (2010) defines assessment via an educational perspective as the systematic collection of information to decision-making that affects student learning. In order to provide proper and effective intervention to children with special needs, it requires an objective identification of the area of potential and current need. That

is, there must be an efficient assessment process. In music therapy, the essence of the children's strengths and weaknesses are identified in both musical and non-musical areas through the assessment process. Hanser (1999) suggested that music therapy assessment is divided into three categories including the areas of initial assessment, comprehensive assessment, and on-going assessment. The relationship between special education and music therapy was briefly discussed in the previous section. In special education, assessment is viewed as a complex procedure including multiple methods of collecting student (potential client for music therapy) information, and it is conventionally stressed that the assessment should provide useful and beneficial information of the student's strengths and weaknesses, the characteristics of their specific disability, the disability's influence on academic performance, and realistic and appropriate instructional goals and objectives (Pierangelo & Giuliani 2009). In the assessment conducted within a special education setting, the music therapist should seek for what he/she wants to find out about the child with special needs and ultimately the assessment tool should be able to provide appropriate information about musical activities associated with the goals and objectives of the Individual Education Program (IEP)

while providing appropriate suggestion and recommendation for the therapeutic intervention (Barksdale, 2003).

Similarly, music therapy assessment is a systematic information collecting process implementing appropriate intervention through establishing therapeutic goals relevant to the needs of the children in a clinical setting. Music therapists use any or all of the musical experiences to understand the client/child in the areas of condition, therapeutic needs, musical capabilities and preferences (Bruscia, 1996). Assessment is the initial starting process although the referral stage including probing background information of client/the child is also previously done. Assessment is required to inform the decision making in regards to what intervention is most comprehensively needed. Also, the function of assessment can include screening whether the client/child referred is suitable for the service of music therapy (Lathom-Radocy, 2002). In the support of this decision-making function, the American Music Therapy Association (AMTA) clinical standards state that "assessment is the process of determining the client's present level of functioning and screening may be incorporated into this process."

As stressed by IDEA, there is significant responsibility placed on the teachers, parents, schools, as well as interdisciplinary healthcare

professionals to cooperate with each other in order to meet the individualized needs of children with special needs (Kim et. al, 2010). In this case, educational assessment issues could be much more important for music therapists since it would necessitate the provision of services including those related to providing consultations to music educators or non-music education faculty (VanWeelden and Whipple, 2005).

In providing intervention services to identify the specific disability of a child with special needs, therapeutic approaches, particularly music therapy approaches, focusing on non-academic development can be more beneficial than traditional educational approaches. Therefore, music and its elements could be utilized as an effective assessment criteria and therapeutic medium in the course of therapy. The relationship between musical elements and children with special needs should be observed and tested clinically, however it appears that there is a significant difficulty in the area of establishing criteria when music is used by music therapists. That is, the children's response to music seems difficult to objectively classify in the use of music and its elements as an assessment criteria. It may stem from the fact previously mentioned, that music possesses an inherent uniqueness that is somehow difficult to quantify, particularly when considering the

individualized response of each child. Music as one of arts components, and its development are complicated and follow multiple processes of growth. Moreover, the development of artistic competence is a difficult consideration upon to make a generalization (Gardner, 2006).

4. Music Therapy Assessment Literature

Bruscia (2005) presented three major categorizations in the administration of music therapy research: Discipline research, profession research, and foundational research. Assessment belongs to discipline research, and he illustrated that a researcher's aim is obtaining insights about clinical conditions and problems, musical characters, personal resources and experiences, and therapeutic needs (Wheeler, 2005).

Music therapy has been given an impetus to meet general standards oriented to evidence-based practice (like other professions such as psychology, education, medical science, etc.). In order to meet the qualification of evidence-based practice and monitor whether diverse therapeutic interventions are used appropriately, the intervention should be providing information based on three

components: patient-reported, clinician-observed, and research-based methods (Baker and Wigram, 2008). However, music therapy is basically composed of a variety of elements from various fields and it is dealing not only with music, but also therapy. Music and therapy have a plethora of sub-categories that makes full comprehension difficult. Ruud (2010) presents the components of diversity as follows:

Music therapy, both as a discipline, a profession, and a practice, is a complex field of knowledge encompassing a whole range of areas of practices, a multitude of professional roles as well as an interdisciplinary theoretical field rooted in different research traditions, philosophies of science, and systems of values.

Nevertheless, many diverse studies have been conducted so far and there is a volume of clinical resources available about music therapy components as it grows. However, it seems that research has not been for the most part intensively conducted in assessment areas and it has become biased. Wigram et al. (2002) addressed the reason for the lack of assessment: "because music therapy has developed theory out of empirical practice, attention to the importance of assessment has been limited" (p. 246). Due to the unique

characteristic of music, it appears that music therapy is being practiced somewhat outside of empirical practice.

Although assessment has increasingly become a significant theme of research in the area of theoretical and methodological perspectives, still little literature is available compared to other areas. Keeping this in mind, the following are examples of areas that music therapy literature can be found in (Sabbatella, 2004):

- Assessment and evaluation of clients
- Evaluation of treatment effectiveness
- Assessment tools (including tests and observation)
- Analysis of improvisation
- Assessment analysis
- Assessment report

There has been a focus in research with regard to music therapy assessment tools. Brooke (2006) introduces several representative model forms of music therapy assessment tools in association with the form of assessment techniques in her book:

- Improvisational model
- Psychoanalytic model
- Educational model,
- Biomedical model.

She also characterizes these models with the explanation that each system provides a unique view into the music therapy process. More specifically, Goodman (2007) provides multiple examples of music therapy assessment for children with special needs cited from research previously conducted (Wilson & Smith, 2000):

1) Nordoff-Robbins Scales (Nordoff and Robbins, 1977, 2007)

- The scales are both quantitative and qualitative and, in their original form, rely upon videotaped analysis of the music therapy session to invite a measure of both objectivity and subjectivity.

2) MTA-ED or Music Therapy Assessment for Emotionally Disturbed Children (Goodman, 1989)

- It's open-ended and outlines basic musical elements that the child may express. The interpretation of how, why, and when the child musically communicates may be viewed in context of the child's

pathology.

3) The Musical-Perception Assessment of Cognitive Development
(M-PACS)

- Written for a general population (Rider, 1981), the M-PACS outlines 15 musical tasks which conform to Piagetian tasks for school-aged children. Although it was written for a normal population, it was later field-tested by Jones (1986) as an adapted tool for mentally retarded children.

4) Cleveland Music School Assessment of Infants and Toddlers
(Libertore and Layman, 1999)

- Written for developmentally delayed infants and toddlers, this assessment is based on developmental age norms in five developmental areas and requires a yes/no response. Scoring creates a quantitative tool.

5) Auditory-Motor Perception Test (Heimlich, 1975)

- Created by a para-verbal therapist, this little known perception test consists of rhythmic imitation tasks which are then scored to predict neurologic impairment.

6) Improvisation Assessment Profiles (Bruscia, 1987)

- Written for a wide variety of ages and diagnoses, the IAPs are based on musical analysis and interpretation of client behavior during improvisation. Six profiles, each containing subscales of musical descriptors, relate to the following areas of behavior: integration, variability, tension, congruence, salience and autonomy. Interpretation of musical behavior is related, in effect, to aspects of personality.

7) Music Therapy Assessment for the Diagnosis of Autism and Communication Disorders in Children (Wigram, 2000)

- Wigram devised this assessment to include aspects of the Bruscia IAPs (Bruscia, 1987) he considers most relevant to the diagnosis of autism and communication disorders. Musical behaviors from the improvisation are scored for further analysis.

8) Special Education Music Therapy Assessment Process, commonly referred to as the SEMTAP (Coleman and Brunk, 1999)

- Created for the specific purpose of establishing music therapy eligibility on the Individual Education Plan, or IEP, the SEMTAP outlines the systematic collection of information from related

therapists and teachers as well as the observation and interviewing necessary to form a picture of the child who will be assessed for music therapy. Given this information as well as the goals and objectives of the IEP, the music therapist prepares a music therapy session to prove or disprove the efficacy of music therapy in furthering the goals of the IEP through music therapy.

9) Psychiatric Music Therapy Questionnaire, commonly referred to as the PMTQ (Cassity and Cassity, 1998)

- This is essentially a verbal interview intended to collect information related to symptoms for the disturbed child. The information will presumably be used to form a music therapy intervention program. There is no music used in the assessment.

10) Music Psychotherapy Assessment (Loewy, 2000)

- Loewy created a music psychotherapy assessment tool. Initially it was used with both children and adults in a medical setting. Her assessment is exploratory in nature and qualitative as a report. It relates to the following areas of inquiry: awareness of self, others and of the moment, thematic expression, listening, performing, collaboration, relationships, concentration, range of effect,

investment/motivation, use of structure, integration, self-esteem, risk-taking and independence.

11) Music Therapy Assessment Profile for Severely/Profoundly Handicapped (Michel and Rohrbacher, 1982)

- Now out of print, the MTAP serves as a developmental checklist model. Milestones of development up to 36 months of age are listed within their various domains (social-emotional, fine motor, gross motor, cognitive, and communication).

In addition, there is a concretely established manual of music therapy assessment profiles already published. The Individualized Music Therapy Assessment Profile (IMTAP) was created for use in pediatric and adolescent settings which includes children with special needs (Baxter, Berghofer, MacEwan, Nelson, Peters, & Roberts, 2007). It is available for music therapy and special education, or for collaboration work. The main feature of IMTAP is stated as "a multi-level process of assessment, beginning with intake and ending with a computer-based graphing of a report system that provides a clear profile of each client over time"(p. 13).

In the ongoing development of the music therapy profession itself,

assessment tools meeting the standard of validity and reliability are critically necessary although there have been few standardized assessment tests published. It appears that IMTAP is the most recent and innovative assessment tool providing a number of resources that can be applied to the implementation of assessment processes in music therapy. IMTAP introduces eight specific components:

- 1) Intake process for referring and pinpointing assessment domains and planning assessment sessions.
- 2) Cover sheet summarizing the intake data and indicating the domains to be assessed.
- 3) Session outline form used for planning assessment sessions.
- 4) Domain scoring forms with ten domains of functioning:
 - gross motor
 - fine motor
 - oral motor
 - sensory
 - receptive communication/auditory perception
 - expressive communication
 - cognitive
 - social

- emotional
- musicality

*each domain contains various sub-domains.

- 5) Summary sheet providing assessment data including discussion with stakeholders, such as the parents.
- 6) Goals and objectives.
- 7) Quantification module providing a quantified replicable score on a single skill for research and documentation purposes.
- 8) Computer software allowing scoring electronically, creating reports/graphs, and tracking (Baxter et. al, 2007).

5. Music Therapy Assessment Issues

It is assumed that focusing on what's happening in music with children with special needs makes it difficult for music therapists to generalize and replicate the unique experience elicited during a music therapy intervention. Mostly interventions in music therapy involve musical activities and it is often observed that every individual has their own reaction to music that contains diverse styles, forms, contexts, and options. During music therapy, most of the music created between

the therapist and client is produced in an improvisational way. Snow & Damico (2009) emphasized that it became problematic for replication when music was improvised. That is, musical improvisation potentially has a problem in regard to reliability for empirically-based assessment. Snow & Damico (2009) also stated the difficulty in standardizing the assessment through improvisational music making and in having the improvisation capable of replication by any other music therapist, creating a difficulty of generalization.

Wigram, Pedersen, & Bonde, (2002) suggested five categories for data gathering during assessment and evaluation in music therapy:

- Musical data
- Musical behavioral data
- Behavioral data
- Interpretative data
- Comparative data.

It is stressed that musical data includes examples of musical events or characteristics while musical behavioral data indicates the examples of children's behavior without musical description.

Behavioral data is the characteristics of general behavior in music therapy while interpretative data indicates the interpretation of the children's musical and general behavior supported or not supported by musical or behavioral data. Lastly, comparative data is the comparison of children's behavior in music therapy with information from other situations (Wigram et al., 2002).

Such data categorized above could become raw materials to be assessed both in quantitative, or qualitative ways in music therapy. However, it seems so far that there have been more informal attempts and methods generated for the qualitative way in the course of making music therapy assessments. Music and its related experiences during music therapy seem to make it difficult to create well-established music-centered therapy assessments. As explained above, although there have been many trials in producing music therapy assessment tools in accordance with the many needs encountered in music therapy, criteria of assessment is mostly related to extra-musical components. As Bruscia (1998) stated, music therapy has a transdisciplinary framework and is composed not only of musical, but also of many extra-musical components. Hillecke et al. (2005) stated the necessity of pluralism in music therapy as “music therapy is a multidisciplinary field in which the researchers can learn from others.

The field overlaps with a wide spectrum of scientific areas, including mathematics, natural sciences, behavioral and social sciences, as well as the arts. Figure 1 displays the position of music therapy (research) in multidisciplinary field:



Figure 1. Music therapy (research): a multidisciplinary field.
From *Scientific Perspectives on Music Therapy*, New York Academy of Sciences (2005), 1060, 271-282.

Nonetheless, the influence that music has on people needs to be significantly assessed in a music-centered way based on musicology. It will be continuously challenging during the development of music

therapy as a well-recognized health care profession unless the study of music therapy assessments via music itself based on musicology is actively conducted.

Music is the key element in music therapy and it needs more attention and research to produce an assessment tool based on musicology that is unique to music therapy. Snow & Damico (2009) pointed out the current issues of assessment that the music therapy profession encounters as follows:

- 1) Many music therapists administer assessments that are developed by other disciplines, and that are not musically-based.
- 2) Assessment tools are not widely published in music therapy research literature, unlike many other disciplines, thus, a major reason that assessment tools are not used in more than one setting is because music therapists are simply not aware of their existence.
- 3) When assessments are published, they rarely contain all of the information necessary for other music therapists to replicate the assessment. What is often left out is information on the music that is used in the assessment. At other times, instructions on how to score the information gathered using the scales is lacking (p.52).

The existing music therapy assessment tests developed by borrowing other discipline's methods have been valuable and significant for the development of music therapy. They have helped

music therapy to become more developed as a recognized health care profession. Nevertheless, perhaps it is time to consider seriously making a balance, to have at least an equivalent amount of music-based/centered music therapy assessment tests as those of the extra-music based tests. In addition, the role of music in music therapy needs to be represented via musicology as Lee (2003) stresses, "if we are to evaluate the role of music in music therapy then we must be prepared to use analytic theories of music, even if these are deemed as 'traditional musicology'." Also, he stressed that the danger of putting aside examining musical elements as a primary concern and that avoiding the core of our own work to focus on other areas creates a new "tradition." Therefore, there is a need to develop music-centered music therapy assessment tests that are reliable for music therapy. The power of music in helping people should not be taken for granted as music therapy continues to grow as a health care profession. Lee (2003) states that it would be critically challenging as well as problematic if a physician were not well aware of the biological structure of a human body and the usage of surgical tools when operation is needed. Similarly, music therapists must utilize knowledge of both music-centered and extra-music based tests in order to be truly effective. This could be taken as a hyperbolic or biased statement.

However, it is not an exaggeration to say that the full application of music is necessary to utilize music as a therapeutic tool. As stated, there needs to be a change in direction from the current era that is focused on too many extra-musical components to a new phase of emphasizing musical elements themselves, based on musicology, in developing music therapy assessment tests.

Due to these difficulties, there have been few standardized assessment tools in music therapy. Wigram, Pedersen, & Bonde (2002) explain the possible reason as follows:

One explanation is that the administration of the standardized tool in the natural science professions is usually quite strict and there is little room for flexibility or creativity. What you get is what you test, and no more...But not all assessment protocols are based on tests, and there are emerging models where the quality of what is happening is also evaluated through a freer and more flexible assessment (p.246).

Consequently, a key issue in music therapy has been concerned with producing an objective empirical-based assessment although there are still certain ways of assessment that music therapists are using in practice. Several major reasons for this issue

were discussed above. There is still an ongoing need and demand for the emergence of a standardized tool due to the lack of generalizing universality among current methods. Even though there are a number of informal music therapy assessment tools currently in use, it appears that most of them were created individually in limited circumstances and thus with limited usages. Music therapists ultimately are still searching for criteria which could become a standardized assessment tool. Yet the therapists are already attempting to utilize an individualized tool created by adapting and applying existing methods. The desire for an accurate, convenient, and universal assessment tool should be continued.

As discussed throughout this section, the individualized production and use of music as criteria or assessment are main issues of concern. In addition, the musical data produced by music therapists and children with special needs during musical activities creates a challenging dilemma when it comes to empirical investigation and analysis, particularly in the course of assessment. Hence, there must be an innovative approach to step forward in order to produce decent and more formal assessment tools. It would be valuable to investigate how other music therapists recognize, perform the assessment process, and deal with the musical data as a whole. This study will

provide the therapists seeking milestones of assessment an opportunity for reflecting on their individualized work in relation to the research findings. Such an attempt has not been implemented through either thematic or methodological ways.

Chapter 3: Method

1. Participants

There are two groups of participants for the study: participant group/interviewees and a research team.

Interviewees

A total of 12 music therapists currently working with children with special needs agreed to participate in the study as interviewees. Table 3 shows the socio-demographic information of each participant. The sample included 12 women, aged late 20 to mid 30, who graduated from two major universities providing graduate level education in music therapy in Korea. All participants were women since they were educated and had master degrees of music therapy from all-female universities. The participant group was predominantly composed of women in their thirties, with only one in her late twenties. Two held non-music bachelor degrees (BS & BA) while the remainder all held music bachelor degrees. For clinical experience, only one had four years of experience, three had five years, another three had six years, the other three had seven years, and the remaining two each had eight

years of clinical experience as a music therapist. The entirety of the information is displayed in table 4.

Participant	Gender	Age Group	Undergraduate Education	Highest Education	Clinical experience (year)
1	Female	30	BMus	MMT	5
2	Female	30	BMus	MMT	5
3	Female	30	BS	MMT	6
4	Female	30	BA	MMT	7
5	Female	30	BMus	MMT	8
6	Female	20	BMus	MMT	4
7	Female	30	BMus	MMT	8
8	Female	30	BMus	MMT	7
9	Female	30	BMus	MMT	6
10	Female	30	BMus	MMT	5
11	Female	30	BMus	MMT	6
12	Female	30	BMus	MMT	7

BA=Bachelor of Arts; BS=Bachelor of Science; BMus=Bachelor of Music; MMT=Master of Music Therapy

Table 4. The socio-demographic information of the research participants

Research team.

The research team was composed of a total of five individuals including the author. The author has more than 10 years experience of music therapy clinical work and that of CQR as a rater as well as an auditor. Ahonen-Eerikainen (2007) addressed the role of the researcher in doing qualitative research as “the researcher’s self is the primary instrument of data collection, analysis, and interpretation in any qualitative research (p. 278).”

The team was also divided by two subgroups: the analysis team (three individuals) and the audit team (two individuals). The analysis team members specifically focused on analyzing data (coding to cross analysis), and the audit team focused on an overall view of analyzing data and audit work. Amongst the analysis team members, two are currently doctoral students in a special education program (Korea) while the other is currently a doctoral student in a music therapy program (England). For the audit team, one already held a PhD degree and the other one was an established professional music therapist with approximately 10 years of clinical experience. In addition, every team member of those two groups already had experiences in qualitative research on a variety of academic levels. These experiences included taking doctoral courses and conducting actual

qualitative research. The audit team members had conducted a variety of qualitative research including Consensual Qualitative Research (CQR). Every member of each group was required to read the 1997 and 2005 CQR articles (a guide to conducting CQR) in the beginning of this study. In addition they were required to study the 2011 book of Consensual Qualitative Research. This book, a practical resource for investigating social science phenomena, was used as a manual to process this study. As recommended by the guidelines of the book, the research team discussed their own thoughts and biases on the topic before the interview began.

2. Interview protocol

Initially, the author designed five possible interview questions consisting of themes including demographic information, career background, conception of music therapy assessment, the assessment experience, difficulty and need. The author subsequently conducted a pilot study with 3 music therapists currently working with children with special needs in the field in order to clarify the meaning and effectiveness of the questions and interview protocol as a whole for the upcoming main study. As a result, three questions were

developed and finalized for the main study based on feedback from the pilot test.

3. Procedure

Recruitment

The author looked for individuals who held a master degree with a minimum of four years of clinical experience with children with special needs in the field of music therapy. A specific method of recruiting participants was used: the snowball technique. Snowball sampling is the recruiting technique particularly used in qualitative research based on the assumption that a *bond* or *link* exists between the initial sample and others in the same target population. Such a method allows researchers to gather a series of referrals from within a circle of acquaintances (Berg, 1988).

According the recent CQR book, it is recommended to have the range of the sample size between twelve and fifteen people (Hill, 2012). A total of fifteen candidates were nominated and contacted by the primary investigator via phone. Every candidate of the initial fifteen was informed about the purpose of the study procedures for interviewing including audio taping, transcribing, and the ensuring of

confidentiality issues. A final total of twelve individuals were interviewed by the author in the course of data collection due to issues that emerged with three candidates, which included: a lack of assessment experience, an unwillingness to open clinical experience, and departure from participation. In this study, overall research procedure was implemented as suggested by the CQR method. The following table (table 5) exhibits the entire procedure:

Data collection	Recruitment of participant	<ul style="list-style-type: none"> Recruited by snowball sampling method Professional music therapists possessing clinical experience with special needs children targeted 	
	Development of interview form	<ul style="list-style-type: none"> Verification of appropriate interview questions through pilot study Production of a form of a semi-structured interview with open-ended questions 	
	Implementation of interview	<ul style="list-style-type: none"> Conducted interview for 12 research participants via phone Recorded interview (approximately 1 hour) and subsequently transcribed. 	
Data analysis	Organization of research (analysis) team		
		Rater team (3)	Auditor (2)
		* 2 PhD students in special education * 1 PhD student in music therapy	* 1 PhD in Education with experience in with CQR * 1 Professional music therapist with 10 years of clinical experience and experience in conducting qualitative research
	Coding of domain	<ul style="list-style-type: none"> Constructed conceptual interpretation framework and produced similar themes and clusters of related information Every member of the research team had read all the cases and extracted relevant domains Shared and compared the framework that each member produced Prior to determining final domains, the team discussed the content. 	

	Coding or core idea	<ul style="list-style-type: none"> • Simplified the content of each domain • Minimized the meaning of information/data (no inference given) • Every team member shared and reviewed the individualized work • Exchanged opinions and drew a consensus
	Auditing of domain and core idea	<ul style="list-style-type: none"> • One auditor reviewed and identified the appropriateness of domains and core ideas deducted based on raw data
	Cross-analysis	<ul style="list-style-type: none"> • Identification of the level of similarities amongst cases • Produced categories by gathering similar core ideas amongst cases • Every team member worked individually and discussed prior to drawing consensus
	Auditing of cross-analysis	<ul style="list-style-type: none"> • The other auditor reviewed every category including sub-categories • Identified if core ideas were classified and represented appropriately
	Stability check	<ul style="list-style-type: none"> • Finally the first author reviewed if every domain, core idea, and category is identifiable, compared to raw data

Table 5. Research procedure

Interviews

It took over a month to complete the entire interview process (August to September, 2013). The participants were interviewed over the phone by the main investigator and the informed consent paperwork, including research questions, was sent to each participant prior to the phone interview. Originally, a one hour interview was assigned for each participant although most interviews were done in forty-five minutes. The interview was comprised of a semi-structured form and each interview was audio-taped by a smart phone application called, "Recording Lite." In addition, the audio-taped data was

transcribed verbatim by three different groups: the main investigator, a music therapist, and a non-music therapist. After all interviews were transcribed verbatim, the main investigator (the author) collected and double-checked all transcriptions to ensure accuracy.

4. Data analysis

This study specifically intended to investigate the inner as well as outer experience of music therapists with regard to music therapy assessment in the field. Aldridge (2005) addressed the function of qualitative research in his book, "one of the tasks of the researcher in a qualitative approach is to make tacit knowledge, as a therapist, available as a propositional knowledge. The purpose of some research is intended to find out what we know (p. 35). To gather and analyze the information of personal experiences related to the topic was more suitable for a qualitative rather than a quantitative method. CQR involves inductive reasoning that concludes that the result of the study is an inference drawn from data collected by the interviews. The open-ended questions are provided and the interview is designed for a semi-structured format in order to avoid affecting the participant's thoughts with the interviewer's bias during the course of the interview process.

The CQR method provides a specific value during the initial stages of research regarding the iterative process combining vital, rich, and vivid data along with an analytic and systematic procedure. In addition, there are several researchers and auditors participating in the analytic process by working together. Amongst the researchers and auditors, the iterative consent work is a vital necessity to this CQR methodology. Such a method enables researchers to produce a richer conceptualization of the phenomenon and reduce the potential bias inherent in the use of a single judge (Hill, et al., 2012).

Analytic strategy

The CQR analytic strategies was recently updated and edited by Hill et al. in 2012. Such a method was used to process the course of analysis from coding through core ideas to cross analysis in order to interpret the interview data. Hence, there were six steps for the analysis of data including auditing and stability checks to complete the entire analysis process.

Step 1. Coding of domains

In this stage, the conceptual frame of data collected is constructed and the domain which is the information cluster of related and similar themes is supposed to be determined. The coding of domains was performed by the research team including the author. Initially, there were fifteen domains elicited although later nine domains were modified and finalized after a course of discussion and consensus in dealing with redundancy, duplication, and merging domains.

Step 2. Coding of core ideas and categorization

Throughout this stage, the content of domain yield should be simplified and the meaning of data is minimized, but inferred. The coding of core ideas was performed by each member of the research team. Each researcher read individually all the data categorized under each domain while working on searching for more concise ideas and related descriptions. Also, sub-categories were yielded and some were linked when similarities were found amongst those sub-categories. In the course of reviewing and searching, the research team discussed, argued and came to a consensus with a list of final core ideas for each domain.

Step 3. Auditing of analysis for each case

After developing domains and extracting core ideas, auditing was carried out for those steps. Two members of the team trained with qualitative inquiry worked on this audit. During this process, it was investigated if raw data was placed into the appropriate domains and categories, including sub-categories, if all the significant data in domain were summarized properly, and if the summary of core ideas was concise but appropriately reflected the raw data (Hill et al., 2005).

Step 4. Cross analysis

In this stage, the first step identified what level of similarity appeared to the extracted core ideas for each case throughout a variety of cases. Then, it was also investigated if core ideas categorized under each case were applied appropriately among the cases. During the work, modification and supplementation were done if necessary. The research team searched for similarities in core ideas for each domain across cases, based on the core ideas in each domain for all twelve cases. Then, the team categorized similar core ideas across all cases. After confirming final domains and categories, the team reviewed all data extracted from the interviews in order to clarify whether all the core ideas were correctly represented.

Step 5. Auditing of cross analysis

This auditing was performed by one of the team members who didn't participate in the previous auditing. During this process all the categories, including sub-categories identified in the cross analysis, were reviewed. Then, they were focused to clarify whether core ideas were classified and represented appropriately. In addition, it was checked whether the raw data was placed into the correct domain, core ideas reflected the raw data correctly, and significant content was extracted from each domain.

Step 6. Stability check

Lastly, the main researcher completed a stability check in order to confirm if all domains, core ideas, and categories were identifiable with the raw data. The author monitored the entire methodological process based not only on methodological theories from relevant literature, but also personal experience of conducting previous qualitative research studies and assessment work in music therapy. The experience of the researcher with the phenomenon takes precedence over the methodology in order to keep adapting the focus and procedures of data collection during the process (Wheeler, 1995).

Chapter 4: Results

Through the data analysis conducted, nine domains and related topic areas were elicited from the data. In CQR, the data was organized into categories within each domain and each category needed to be labeled for specific classification: general, typical, and variant (Hill et al., 2012). As the data was collected from the twelve interview participants, the general section included only the mutual information found from all the participants statements (12 of 12), the typical section included six to eleven participants (6 to 11), and lastly the variant section included under six participants (under 6). Hence, seventeen (17) categories were labeled as *general* findings, thirty-seven (37) categories were labeled as *typical* findings, and thirty-five (35) categories were labeled as *variant* findings. The following discussion of the results is classified into the 9 domains yielded from the data. The domains that emerged were as follows:

- Domain 1: Recognition of intake interview
- Domain 2: Intake interview procedure
- Domain 3: Intake interview instrument
- Domain 4: Intake interview issues

- Domain 5: Recognition of assessment
- Domain 6: Assessment procedure
- Domain 7: Assessment instrument
- Domain 8: Assessment issues
- Domain 9: Music assessment component issues

Table 6 displays the entirety of the information that emerged from the analysis including the categories and related codes (general, typical, variant).

Domains/Categories	Frequency
Domain 1: Recognition of intake interview Basic information collection process Parent counsel Establishing rapport at initial meet-up Identification of therapeutic goals → Set up for therapeutic direction Contract of therapeutic procedure	Typical(10) Typical(9) Typical(9) Typical(6) Typical(2) Variant(3)
Domain 2: Intake interview procedure Intake interview conducted by other professional(non-music therapist) of institution → Sharing intake data and other chart information Subsequent meet-up with parent/guidance	General(12) Typical(11) General(12)
Domain 3: Intake interview instrument <i>Intake framework</i> Absence of music therapy intake form <i>Intake pattern</i> Adding additional information on initial intake information obtained by other professional → Using self-made intake form → Using audio/video excerpt → Adaptation to other professional form (special education/psychology) <i>Intake form components</i> Non-musical (socio-demographic, pathology, development, family, social skills, etc.) Musical (preferred type of music, their response, musical activities, etc.)	Typical(10) General(12) Variant(4) Variant(3) Variant(4) General(12) General(12)

<p>Domain 4: Intake interview issues</p> <p><i>Difficulties</i></p> <ul style="list-style-type: none"> Lack of information → Uncooperativeness of parents/guidance → No framework of intake interview set <p>Conducting intake interviews twice due to institutional policy Necessity of sustainable education for music therapy recognition Avoidance of sharing client information by the institution</p> <p><i>Needs</i></p> <ul style="list-style-type: none"> Standardization → Standardized intake form(paper) including rich information → Being objective → Checklist type → Easy access 	<p>Typical(10) Variant(3) Variant(3) Typical(9) Typical(7) Variant(4)</p> <p>Typical(9) General(12) Typical(7) Variant(5) Variant(3)</p>
<p>Domain 5: Recognition of Assessment</p> <ul style="list-style-type: none"> Assessing in music and its activities Setting up term for establishment of therapeutic goals and objectives Identification of current level of client function and need Decision-making on therapeutic direction 	<p>General(12) Typical(11) Typical(8) Variant(5)</p>
<p>Domain 6: Assessment procedure</p> <ul style="list-style-type: none"> Assessing in two major categories: musical and non-musical A month long assessment term Utilization of video-taping 	<p>General(12) Typical(7) Variant(5)</p>
<p>Domain 7: Assessment instrument</p> <p><i>Assessment framework</i></p> <ul style="list-style-type: none"> Producing applied assessment form through diverse resources → Music therapy literature → Special education → Psychology → Domestic and international articles <p><i>Assessment pattern</i></p> <ul style="list-style-type: none"> Adjustment for therapist preference → Descriptive → Checklist → Mixed → Audio/video-taping <p><i>Assessment component</i></p> <ul style="list-style-type: none"> Non-musical(communication, social skills, mood, language development, kinetic skills, cognition, pathology, etc.) Musical(melody, rhythm, harmony, composition, performance, appreciation, improvisation,emotional and physical response to music and its activities) 	<p>General(12) Typical(6) Variant(3) Variant(2) Variant(2)</p> <p>General(12) General(12) Variant(2) Variant(2) Variant(3)</p> <p>General(12) General(12)</p>
<p>Domain 8: Assessment issues</p> <p><i>Difficulties</i></p> <ul style="list-style-type: none"> Absence of professional music therapy assessment tool → Objective measurement → Dependence on subjective observation <p>Descriptive assessment</p> <ul style="list-style-type: none"> → A wide range of assessing area categories → Credibility issue of descriptive assessment → Time consuming descriptive assessments 	<p>General(12) Typical(11) Typical(9) Typical(12) Typical(9) Typical(11) Typical(8)</p>

<ul style="list-style-type: none"> → Establishment of assessment framework on criteria → Worrying about subjective assessment through observation Sharing objective result when interdisciplinary work requires → Explanation of assessment criteria → Absence of numerical measurement → Absence of checklist Absence of a tool fitting each disability area → Musical assessment on diverse disabilities and characteristics Diverse format of assessment needed in each institution/culture → Fitting in specific format of institution in limited time → Individual assessment in group therapy work in limited time <p><i>Need</i></p> <p>Standardized assessment tool</p> <ul style="list-style-type: none"> → A comprehensively detailed tool made up of the tools currently in use by music therapists → Assessment tool designed like manual → → Assessment tool with concrete and easy explanation → Objective and scientific approach → Individualized tool meeting standards of validity and credibility → Practical and applicable test that is usable in the field → Simplified test with the format of scales → Assessment tool for group → Assessment tool representing clear categories → Assessment tool providing standardized music sample → Assessment tool displaying explicit service direction <p>Systematic support and cooperation from institution</p>	<p>Variant(5) Typical(8) Typical(11) Typical(9) Typical(10) Typical(10) Typical(8) Variant(5) Typical(10) Typical(8) Variant(4)</p> <p>General(12) Typical(8)</p> <p>Typical(9) Variant(4) Typical(7) Variant(5) Variant(5) Variant(4) Variant(3) Variant(5) Variant(4) Variant(5) Typical(10)</p>
<p>Domain 9: Music assessment component issues</p> <p>No idea what assessment criteria should be used in music</p> <ul style="list-style-type: none"> → Ambiguity → Diversity → Uniqueness <p>Subjective experience and response to music</p> <ul style="list-style-type: none"> → Personal preference of music differs with each individual → Each individual experiences music subjectively even if the same music is provided → Therapist and client receive music differently and subjectively → Reliability issue → Characteristics of music draw individualized responses → Difficult to generalize response as each individual experiences music differently 	<p>General(12) Typical(9) Typical(9) Variant(3) Typical(9) Typical(9) Typical(7) Variant(5) Variant(5) Variant(3) Variant(3)</p>

Table 6. Domains, categories, and frequencies

There was a sole research question initially established and three specific interview questions were provided to collect data in order to conduct this study. Each domain/category was sorted out and classified by relevance: the actual condition of initial

assessment/intake process (domain 1 – 4), a full-scale/on-going assessment (domain 5 – 8), and the experience of using music as an assessment criterion (domain 9). In the domain of 3 and 7, particularly three sub-domains emerged for each. Categories were placed into the sub-domains accordingly for the purpose of more specific classification of the instrument: intake framework, intake pattern, intake form components in domain 3 with assessment framework, assessment pattern, and assessment components in domain 7. In addition, two sub-domains were also used for the same purpose in the domain of 4 and 8: difficulty and need.

1. The practice of initial intake interview

Domain 1: Recognition of intake interview	
Basic information collection process	Typical(10)
Parent counsel	Typical(9)
Establishing rapport at initial meet-up	Typical(9)
Identification of therapeutic goals	Typical(6)
→ Set up for therapeutic direction	Typical(2)
Contract of therapeutic procedure	Variant(3)

Most participants considered the intake interview as the process of collecting basic information (10) while establishing rapport at first sight (9) and it appeared that parental counseling (9) was also commonly done. Half of the participants stated that the therapeutic goals would be initially identified during this process (6). In addition,

establishing therapeutic direction (2) and contract were considered as components of the intake interview (3).

“I think that it’s a basic procedure essentially needed to explain the basic information of children, reason to referral, and suitability to music therapy service and because therapy direction and philosophy are affected by how the intake interview is done. It also impacts the goals of therapy. During this process, it is determined what to proceed with regard to the relationship between child and parents, an understanding of the child’s development, and what kind of philosophy I should keep in therapy. Through parental counsel, it’s time for deeply understanding and assessing the child. It is also very important because assessment subsequently implementing will be affected based on intake interview providing significant information orally passing beside the written information on the form. Trust from parents is important and it will be affect therapeutic procedure if the rapport is not established during the intake interview (Case 10).”

“I consider the intake interview as a primary interview done before carrying out assessment. It becomes like parental counsel because parents are usually with children/adolescents with special needs. Client’s development, personal and social background, and medical history are identified throughout the intake interview. It would be also said that the process of collecting information on the areas of diverse skills in daily life (Case 11).”

<p>Domain 2: Intake interview procedure Intake interview conducted by other professional (non-music therapist) of institution → Sharing intake data and other chart information Subsequent meet-up with parents/guidance (counseling)</p>	<p>General(12) Typical(11) General(12)</p>
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All twelve participants worked for institutions providing music therapy service. However, there were no official music therapy intake interviews done at those institutions; instead the participants were provided the intake information obtained (11) by other health-care professionals of the institutions (12). Hence, all participants did a meet-up with parents/guidance after the initial intake interview was done for the upcoming music therapy service (12).

“First a social worker does the general interview and then I get the information subsequently. The information of diagnosis title and outbreak timing would be obtained through a medical chart and other information is provided from the intake interview carried out by social worker (Case 2).”

“After an intake interview carried out by a director of counseling center or doctor, referral comes to music therapist when it is determined that music therapy service is needed through an interdisciplinary team meeting. The basic information like circumstance of fostering children, or medical history is acquired and also that of music preference as well as response is identified and handed over. For example, if it is

identified like the child likes to listen to music, or becomes relaxed through music, music therapy intervention is suggested unconditionally. Parental counseling is the most important part in intake interview as the quality of information is determined on the parents' active participation (Case 7)."

<p>Domain 3: Intake interview instrument</p> <p><i>Intake framework</i> Absence of music therapy intake form</p> <p><i>Intake pattern</i> Adding additional information on initial intake information obtained by other professional → Using self-made intake form → Using audio/video excerpt → Adaptation to other professional form(special education/psychology)</p> <p><i>Intake form components</i> Non-musical(socio-demographic, pathology, development, family, social skills, etc.) Musical(preferred type of music, their response, musical activities, etc.)</p>	<p>Typical(10)</p> <p>General(12) Variant(4) Variant(3) Variant(4)</p> <p>General(12) General(12)</p>
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The majority of participants stated that there was no specific music therapy intake form used in the field (10). Nevertheless, what participants usually did was to add extra information as needed on the intake information collected by other professionals (12). In the pattern of the intake, some participants independently utilized self-made intake forms of their own (4), and some adapted to professional forms from other disciplines such as special education and psychology (4). There were also some participants who recorded the process using technology such as cameras, phones, and mp3 recorders (3). All of the participants that did their own intake process used two major

categories to gather the information needed: non-musical and musical. All the participants essentially collected the information in the areas of socio-demographical, pathological, developmental, parental (family), and social skills for the non-musical section (12). As for the musical section, information was gathered in the areas of music type preference, their responses, and musical activities (12).

“There is no music therapy intake form. The content of intake should include the child’s music preference, level of singing capability, family background, communication method, or what parents want from music therapy and these are documented on the form. Also, it is a form to get the information of musical taste and competence (including vocalizing), readability, recognition of numbering, attachment with mother, availability of eye contact, emotional, social, and getting basic information like family members relationship (Case 2).”

“There is no specific music therapy intake form. I directly use assessment form instead. I am usually handed over the intake interview form filled out by a team called, “social counseling.” Then, I add more information in the area where I feel insufficient. Those contents involve basic information, phone number, name of disability, clinical history, treatment history, and family background... and... such items are mainly placed. In addition, mother’s prenatal situation, family circumstance/environment, child’s characteristics are additionally asked and documented. In musical part, music educational

background, musical preference, musical instrument lesson history, or preference on the size of instruments (Case 3).”

<p>Domain 4: Intake interview issues</p> <p><i>Difficulties</i></p> <ul style="list-style-type: none"> Lack of information <ul style="list-style-type: none"> → Uncooperativeness of parents/guidance → No framework of intake interview set Conducting intake interviews twice due to institutional policy Sustainable education for music therapy recognition Avoidance of sharing client information by the institution <p><i>Needs</i></p> <ul style="list-style-type: none"> Standardization <ul style="list-style-type: none"> → Standardized intake form (paper) including rich information → Being objective → Checklist type → Easy access 	<p>Typical(10) Variant(3) Variant(3) Typical(9) Typical(7) Variant(4)</p> <p>Typical(9) General(12) Typical(7) Variant(5) Variant(3)</p>
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In the domain of intake interview issues, two sub-domains were assigned under the main theme for more concrete classification: difficulties and needs.

Difficulties

The majority of participants cited the lack of information needed in the process as a main concern (10). Negligence/uncooperativeness of parents/guidance (3) and the fact that no intake interview framework existed were also closely linked with difficulties during the process (3). Due to institutional policy that initially a non-music therapist did the intake interview, it appears that most participants felt concern over

completing a music therapy intake interview prior to beginning the assessment (9). More than half of the participants also stated that educating parents about music therapy repeatedly was hard work due to the low recognition in mainstream culture (7). In addition, some participants voiced concerns about the avoidance of sharing client information by the institution (4).

“I experience difficulty when there is no concrete information of child from parents. It seems that parents are reluctant to provide specific information of family relationship, particularly sibling relationship in many cases. So, getting into an assessment session with insufficient information makes it difficult to process. Since only basic information is acquired during the intake interview, it is naturally required to get more information orally and additionally. In addition, I experienced difficulty when I was a novice therapist due to lack of counseling skills. I would feel some problems related to identity when I am trying to get the in-depth information as the intake form usually provided very limited information only (Case 3).”

“The lacking recognition of parents about music therapy, and discussing as well as convincing about the necessity of therapy does cause some difficulties. Moreover, when the information is limited it makes therapy difficult (Case 7).”

Needs

The foremost need discussed by participants was the wish for greater standardization of the process as a whole (9). Furthermore, every participant insisted on the need for a standardized intake form with a variety of items so that the music therapist would get enough rich information through this process (12). More than half of participants stated that there needs to be an objective format for intake (7). In addition, there was a stated preference for a checklist type intake form (5) due to its easy access (3) and subsequent usefulness in the field.

“Some kind of checklist type form is needed that can identify things which I must know before getting into an intake interview. In addition, it would be beneficial for me if there was some kind of comprehensive manual providing information before the interview, or I get information during the interview. Also, it would be very helpful if the implemental information of what kind of test is needed for each disability, clarity of related protocol, and all the questions needed to ask are included in the desired manual. Moreover, it would be good to have clear standard that I can explain about the needs for the interview to institution/other professionals. It would be great to have a standardized music therapy intake form. In this case, if non-musical elements could be also tested in the tool, it would be very nice (Case 8).”

“It would be helpful if there was a professional intake form easily identifying things at a time and get to know the necessity, rather than getting information through many procedures. If there is an itemized form that has clear boundaries and does not duplicate items between the intake and assessment form. I think that it’s the best when the test can be processed explicitly and quickly (Case 7).”

2. Music therapy assessment process

<p>Domain 5: Recognition of Assessment Assessing in music and its activities Setting up term for establishment of therapeutic goals and objectives Identification of current level of client function and need Decision-making on therapeutic direction</p>	<p>General(12) Typical(11) Typical(8) Variant(5)</p>
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All participants considered assessment as assessing in music and its related activities (12) and the majority of participants recognized that music therapists established therapeutic goals and objectives during this term (11). Eight participants shared the task they most associated with assessment: identifying the current level of client function and their needs (8). In addition, some of the participants stated that another task was important; decision-making done during the assessment term was necessary in order to set up therapeutic direction (5).

“I think that assessment is a series of processes that establish therapeutic goals and objectives needed for the child in identifying the level of current functioning through musical experience through diverse musical activities (case 1).”

“Assessment is the procedure of looking for the need of the child with diagnosing current condition and also this starting point can be a standard for when the child’s therapy ends. In addition, it is considered the procedure looking for the needs of child through current merits and demerits, developmental competence, emotional state, or musical ability (Case 4).”

<p>Domain 6: Assessment procedure Assessing in two major categories : musical and non-musical A month long assessment term Utilization of video-taping</p>	<p>General(12) Typical(7) Variant(5)</p>
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In the implementation of the assessment, all participants had a common framework of categorizing two major areas in their clinical work: musical and non-musical (12). More than half of the participants stated that they spent approximately a month on the assessment procedure (7). That is, the assessment period usually was done after four sessions were completed. In addition, some participants used a video-taping method in order to facilitate explicit assessment (5).

“Social counseling team does the intake interview first when the client visits the institution. During this process, referral is given when it is determined that there is a use for music therapy. After that, I collect more information through parental counseling to add to the original information obtained (usually not enough info) from the team prior to commencing the assessment session. In doing the assessment, I use mainly two major categories to assess things: musical and non-musical. Video-taping is used during the assessment (Case 3).”

“I check out and identify many areas and look for parts of the needs through roughly a month of time. Then, I begin sessions while providing therapeutic intervention in order to attain goals. After a month, I establish specific goals and objectives. During this period, musical areas like singing and playing instruments, and non-musical areas like expression and mobility are both identified and subsequently therapeutic intervention begins (Case 8).”

Domain 7: Assessment instrument	
<i>Assessment framework</i>	
Producing applied assessment form through diverse resources	General(12)
→ Music therapy literature	Typical(6)
→ Special education	Variant(3)
→ Psychology	Variant(2)
→ Domestic and international articles	Variant(2)
<i>Assessment pattern</i>	
Adjustment for therapist preference	General(12)
→ Descriptive	General(12)
→ Checklist	Variant(2)
→ Mixed	Variant(2)
→ Audio/video-taping	Variant(3)
<i>Assessment component</i>	
Non-musical(communication, social skills, mood, language development, kinetic skills, cognition, pathology, etc.)	General(12)
Musical(melody, rhythm, harmony, composition, performance, appreciation, improvisation, emotional and physical response to music and its activities)	General(12)

Three sub-domains were assigned to the main theme of the assessment instrument in order to facilitate the classification of analyzed data.

Assessment frame work

All the participants already used some kind of assessment framework independently even though there was no official standardized music therapy assessment tool. The participants created their own applied framework by using a variety of resources (12). Half of participants used music therapy literature including textbooks as resources to create their own assessment framework (6). Some of the participants borrowed specific frameworks from the special education field (3). In addition, some used applied items of assessment from psychology (2) and domestic and international music therapy research articles (2) that represented an assessment tool.

“I don’t have a specific assessment form, but produce forms case by case along with child’s condition based on the information obtained from the intake interview as needed. I pick some items from school text book I learned, literature, or research articles and apply those to the self-made form on behalf of my work (Case 4).”

Assessment pattern

Every participant had an individualized method to assess based on their preference (12). In the context of the “free style” method, the descriptive approach (12) was the most preferable since all the participants shared the commonality. In addition, the checklist (2) and the mixed method (description & checklist) made independently (2) were used by some participants. There was also the use of technology such as audio/video taping (3) in order to ensure clarity in doing the assessment.

“I don’t use a formal assessment form. Informal use of descriptive method is being used to assess. I assess while checking out mainly musical preference, and preference on musical instrument playing and accompaniment, or preferable songs and singing dependent on speech ability. Child’s emotion or characteristics is identified through lyric that the child likes. In addition, what volume of sound and emotional/physical distance between therapist and child is welcomed and comfortable are identified during the period. The level of rapport and specific parts that child feel scary and cautious about are also identified (Case 6).”

Assessment component

All the participants shared the same components and there were two major categories divided to collect information during assessment: musical and non-musical. All the participants collected information in the areas of communication skills, mood, language development, kinetic skills, cognition, and pathology for the non-musical section (12). Information was gathered for the musical section in the areas of melody, rhythm, harmony, composition, performance, appreciation, improvisation, and emotional and physical response to music and its activities (12).

“The frame I use is divided by two major categories. First is non-musical including social skills, emotion, communication, cognition and the other is musical including listening, movement, singing, playing, response to music. These are written descriptively accordingly (Case 8).”

Domain 8: Assessment issue	
<i>Difficulties</i>	
Absence of professional music therapy assessment tool	General(12)
→ Objective measurement	Typical(11)
→ Dependence on subjective observation	Typical(9)
Descriptive assessment	Typical(12)
→ A wide range of assessing areal categories	Typical(9)
→ Credibility issue of descriptive assessment	Typical(11)
→ Time consuming descriptive assessment	Typical(8)
→ Establishment of assessment framework on criteria	Variant(5)
→ Worrying about subjective assessment through observation	Typical(8)
Sharing objective result when interdisciplinary work needs	Typical(11)
→ Explanation of assessment criteria	Typical(9)
→ Absence of numerical measurement	Typical(10)
→ Absence of checklist	Typical(10)

Absence of a tool fitting each disability area	Typical(8)
→Musical assessment on diverse disabilities and characters	Variant(5)
Diverse format of assessment needed in each institution/culture	Typical(10)
→Fitting in specific format of institution in limited time	Typical(8)
→Individual assessment in group therapy work in limited time	Variant(4)
<i>Needs</i>	
Standardized assessment tool	General(12)
→ A comprehensively detailed tool made up of the tools currently in use by musical therapists	Typical(8)
→ Assessment tool designed like manual	Typical(9)
→ → Assessment tool with concrete and easy explanation	Variant(4)
→ Objective and scientific approach	Typical(7)
→ Individualized tool meeting standards of validity and credibility	Variant(5)
→ Practically applicable test usable in the field	Variant(5)
→ Simplified test with the format of scales	Variant(4)
→ Assessment tool for group	Variant(3)
→ Assessment tool representing clear categories	Variant(5)
→ Assessment tool providing standardized music sample	Variant(4)
→ Assessment tool displaying explicit service direction	Variant(5)
Systematic support and cooperation from institution	Typical(10)

In the domain of intake interview issues, two sub-domains were assigned under the main theme for more accurate classification: difficulties and needs.

Difficulties

All the participants stated concerns over the absence of a professional music therapy assessment tool (12). The majority of participants reported that it would be difficult to measure phenomena objectively during assessment without a professional tool (11). This difficulty stems from the fact that the participants had to depend on their own subjective observation (9). Descriptive assessment appeared to be a difficulty for all the participants (12). With regard to this

difficulty, most participants discussed the challenge of having a wide range of categories to assess (9) and the credibility issue in general of descriptive assessment (11). This yielded concerns about subjective assessment as a whole (8). Most participants also reported the issue of the time-consuming aspects of descriptive assessment (8). In addition, establishment of assessment framework on criteria was difficult (5) for some participants as there was no standardization. Basically, most music therapists worked in institutional settings involving interdisciplinary work with other professionals (11). The majority of participants reported that sharing objective results from music therapy assessment continues to prove controversial when interdisciplinary work is needed (9). It seemed that the absence of numerical measurement (10) and a checklist type tool was difficult issue for most participants (10). Without numeral data or a checklist sharing the results of assessment in relation to an explanation of assessment criteria has proved to be difficult. In doing clinical work, music therapists need to deal with a variety of disabilities, creating a possible need for a specific assessment tool for each type of disability. More than half of the participants reported that an absence of such a tool fitting each disability area created difficulties while doing assessments (8). Musical assessment on diverse disabilities and

characteristics were also another cause of difficulty in conducting assessments (5). Hence, most participants needed to deal with a variety of assessment formats/tools (5) as there was no generalized tool to use universally. Specifically speaking, it would be difficult for most participants to adjust to the specific format of each institution (10) in the limited time (8) whenever they visited different institutions. In addition, it was stated that individual assessment in group therapy under time limits (4) was one of the factors that some participants felt made it difficult to work in the field.

“The biggest problem is that there is no standardized tool. Every institution has its own form and furthermore, some institutions didn’t even have forms. I feel often that music therapy assessment is done very subjectively, particularly when working with other professionals in interdisciplinary settings. Since there is little information that I can provide numerically, it becomes problematic (Case 2).”

“The reason I prefer a checklist type of form is because the descriptive way of writing on clinical things often becomes subjective even though I try hard to observe objectively. For example, when the result of a test is provided numerically and can be seen with visual changes on the form whether it is improved, or not in the course of assessment, parents seem to have a better understanding of therapy (case 9).”

“In the present, assessment tool doesn’t apply to diverse disability areas, it is difficult to have general/objective frame of tool. Since there is no standardized tool specifically fitting into each disability area, it takes more time and I feel often burden to screen sustainably what item is needed and what is not. Such work is done differently depending upon the child. Because disability and characteristic of each child are diverse, it is difficult to assess the musical part accordingly (Case 3).”

Needs

Every participant stated that there is a need for a music therapy standardized assessment tool (12). The majority of participants hoped to have some kind of assessment tool designed like a manual (9) in relation to assessment tools with specific and easy explanations (4) in the same context. Some desired an assessment tool presenting clear categories (5) and including standardized music samples (4). Also, most participants reported that it would be beneficial if there was a specific tool made out of diverse assessment tests reflecting a variety of music therapist’s work (8). Also, more than half of participants wanted a more objective and scientific approach (7) in dealing with the assessment process. The need for an individualized assessment tool with well-known validity and credibility (5) was reported in addition to the demand for a practical applicable test tool (5). Some participants

reported a preference for a simplified test with the format of scales (4). Since most music therapy clinical work commonly involves group work, some participants reported that there is a need for a specific assessment tool for group settings (3). Some reported the need for an assessment tool displaying explicit service directions (5). Lastly, most of the participants stated the need for systematic support and cooperation (10) from the institution where they worked in order to provide a better quality of music therapy service for clients.

“In music therapy as an established field, it would be great if there was a formal music therapy assessment tool with reliability so that it can be introduced professionally to any institution. In this case, it would be also beneficial if a musical sample is included in the tool. Since every district and institution have their own frame and culture, there always needs extra and supplementary work to change or edit the form. Also, I have been often asked the grounded theory of assessment tool that I use, particularly when I work with other professionals in an interdisciplinary setting. If someone makes some kind of comprehensive assessment reflecting diverse tools music therapists use independently through the work of collecting and editing existing tools, it will be very helpful for music therapists to use it officially (Case 10).”

“I think that it is urgent to make a standardized tool. Also, there needs to be more objective and scientific tools with reliability and validity due to subjective work issue related to personal variables like therapist’s philosophy, theoretical background, etc. Even though there still needs the development of standardized music therapy assessment tool to test diverse disabilities, on the other hand, it is also required to have specific criteria and content fitting into specific characteristic of each disability area. So, I hope to see the emergence of a differentiated assessment tool from the comprehensive style assessment tool as well. That is to say, it can be produced like a more professional tool if there is a differentiated way of presenting test tool including both comprehensive and divided sections. And I am sure this kind of tool will be very helpful when music therapists are working with other professionals as it will display our own professionalism in the context (Case 11).”

“Personally, I encourage the child to sing and play an instrument during the assessment. It would be beneficial if there was an assessment tool like manual providing a specific framework. That is, it would be nice to have a checklist type form along with a manual. For example, speech therapy use its own letter/picture card to assess and some tools using photos are used in art therapy and those are professionally well recognized in the field. Music therapy should have officially standardized assessment tools. Actually, there is huge demand and urgent need for standardized assessment tools in practice. I know that lots of research is conducted in accordance with the need. However, most cases are limited to only research and it’s hard to apply in real situations. Due to time and speed of work process,

we need a simple and easy one-page form although it unrealistic for practical use. Research related tools could be used in the hospital setting, but there is something different needed in the setting where music therapy services are usually provided frequently. It is critically needed to have a comprehensive and official tool recognized in practice. In addition, it would be good if there was a pre-assessment form that can be easily used for children with music psychological approach (Case 1).”

“In doing assessment, it would be good if the scope or category would be more clearly set. For example, phonemes or words expected to use are already set for each age in linguistic test. Like this, it would be beneficial for music therapy if there are melodies, or songs and categories already set for assessment implementation. That is, it would be very helpful in doing assessment if there are standardized music samples that are formal, or well-recognized by most people. Samples mean specific melody lines, or songs. We need formal and standardized assessment tool that enable us to identify vocalization skills, range, sense of rhythm, etc. It would be good to have some tools that can test things using CD or something like that. I do use a self-made assessment tool, but it is just from voluntary work. I feel that I need a specific tool with a manual form (Case 7).”

3. The experience of the use of music as test criteria

<p>Domain 9: Music assessment component issues</p> <p>No idea what assessment criteria should be used on music</p> <ul style="list-style-type: none"> → Ambiguity → Diversity → Uniqueness <p>Subjective experience and response to music</p> <ul style="list-style-type: none"> → Personal preference of music differs with each individual 	<p>General(12)</p> <p>Typical(9)</p> <p>Typical(9)</p> <p>Variant(3)</p> <p>Typical(9)</p> <p>Typical(9)</p>
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<ul style="list-style-type: none"> → Each individual experiences music subjectively even if the same music is provided → Therapist and client receive music differently and subjectively → Reliability issue → Character of music draws individualized responses → Difficult to generalize response as each individual experiences music differently 	<p>Typical(7) Variant(5) Variant(5) Variant(3) Variant(3)</p>
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All participants commonly reported that they experienced uncertainty in how to deal with music in the context of assessment criteria (12). In the experience of using music in therapy, participants talked about some characteristics that music possessed. Most participants shared that some characteristics of music such as ambiguity (9) and diversity (9) made assessment a predicament since it produced unclear criteria issues with music used in the course of assessment. Some participants attributed the same problems to music's characteristic uniqueness (3). In addition, it appeared that the subjectivity of music became a primary challenge in the issue of assessment criteria since most participants shared that subjective experiences and responses (9) to music made them difficult to quantify. Specifically, more than half of participants shared that each individual experiences music subjectively even if the same music is provided (7). The majority of participants reported that personal preference of music differed with each individual (9). In accordance with this statement, almost half of the participants stated that the therapist and client

experienced the music differently and subjectively (5). Some participants discussed the reliability issues (5) with such inconsistency between therapist and client (7). Some other participants explicitly stated that the unique characteristics of music drew individualized responses (3). Additionally, it was also reported that there was difficulty in generalizing responses (3) and drawing valid assessments due to each individual experiencing the music differently.

“No matter what, there are different responses to musical experience, but there seems to be no specific standard to grasp. Since I don’t know how much I have to assess, I feel difficulty to gauge things and this is the most difficult part for me. Also, there is no standardized music or frame set, I encounter difficulty in the course of assessment. I have been frequently troubled by the question of what to provide, what kind of music should be provided, and how the child might react as there is no clear step and frame. Other things like arts should be expressed by writing and painting, but it is undeserved to use and understand in the process. For example, improvisational music in therapy is unpredictable and on the other hand, it is too huge to set frame in order to check out responses when pre-composed music pieces are used (Case 8).”

“Even the existing tools mostly take descriptive means to assess. It is ambiguous to establish some criteria scientifically and make items with regard to music. Most cases, things are presented in descriptive way, it is natural to feel the ambiguity in a full-scale assessment. That is,

comparing to the standardized assessment tools from speech therapy, psychotherapy, physiotherapy, or occupational therapy, music therapy assessment has reliability/credibility issues and these are connected to a lack of professionalism. Also, difficulty and ambiguity become issues in the expression/presentation of therapist due to the same reason (Case 3)."

Chapter 5: Discussion

1. General discussion

The purpose of this study was to deeply investigate experiential and practical information through the analysis of in-depth interview data obtained from professional music therapists who had experience in the music therapy assessment process for children with special needs. This investigation was originally designed and conducted first, to conceptualize specific and accurate criteria for music therapy assessment from not only the internal but also external experiences of twelve music therapists for educational purposes. Moreover, the information generated was expected to contribute to the development of a potential standardized and formalized music therapy assessment tool in the future.

In the following sections, discussion on the results elicited from each domain is sorted out and highlighted for each domain. In addition, the implications of the music therapy assessment process are discussed as there are several from the major themes that emerged

from the data analyzed. The characteristics of these research findings are, simply speaking, associated with specific answers to five areas:

- How music therapists define assessment
- What music therapists perform in the assessment process
- What kind of instrument is used in the process
- What are the assessment issues music therapists experience
- What is the experience of therapists using music as assessment criteria

The research participants revealed separate information on individualized experiences for each step of the overall assessment process divided by two sections: an initial assessment and a full-scale assessment. Therefore, discussion of analysis will be discussed separately.

1) Initial assessment/intake process

The core of initial assessment is an intake interview and music therapists recognize this process as obtaining the basic information of children with special needs. That is, there is a primary interview carried

out in order to gather the necessary information before a full-scale assessment commences between music therapist and the child. However, most of the children experience difficulty in independently providing the necessary information verbally or in written form. Parents or guidance counselor's assistance is required in dealing with the task; therefore the intake interview is also considered parental counsel. This process includes the establishment of rapport since it is the first meeting between the therapists and children. Hence, it could be considered a vital step that the therapist focuses on establishing mutual rapport not only with the child, but also parents/guidance. Moreover, therapists can gauge possible therapeutic goals and direction in the course of getting basic information from children with special needs.

Most cases that utilize music therapy services for children with special needs are processed at an institution or school rather than at a personal practice. In fact, every research participant was working with their clients at an institution on either a full-time, or part-time basis. Consequently, the feasibility of contracts and eligibility for music therapy for children with special needs are identified through intake interviews in institutional settings. Nevertheless, it was discovered that music therapists are not involved in the initial intake interview. Other

professionals like social workers perform the interview and the music therapist is not directly involved in the decision-making. Consequently, the intake interview is first done with another professional and then the music therapist takes the role of primary care giver using that information for music therapy service. This is the typical protocol of music therapy referral in associations with intake interviews. As reported from every participant through the interviews, the real music therapy intake interview exists although it is formatted and performed as a secondary procedure before the full-scale assessment commences.

As described above, the music therapist gets the information after the primary interview and it was discovered that there is no professional music therapy intake form/tool. Essentially, the music therapist adds information onto the form written from the primary interview if necessary during the secondary interview. In addition, self-made intake forms are commonly used, or audio/video taping is used in order to collect the vivid resources. Analysis through multi-media resources provides more detailed information. Some adaptive methods were utilized by making an application out of forms belonging to other professions such as counseling, psychology, and special education. Under the circumstances commonly found in working for institutions, it

is understandable protocol to use a non-music therapy form. However, there should be consideration for a specific intake form that music therapists could use universally in diverse settings and circumstances. Regarding the content of intake form components (items), every participant reported that they collect information through two major categories: musical and non-musical. Preferred music, responses to the music, and musical activities were mainly identified in the music category while socio-demographic, pathological, developmental, family, and social characteristics of children with special needs were investigated in the non-music category.

The recognition, procedure, and form of intake interviews were reviewed in the previous section. Now, the internal experience of the intake process will be discussed via two points: difficulties and needs.

First, the most common opinion regarding the greatest difficulty every participant experienced was having a lack of information. Since the intake interview is primarily carried out by the institution, the related form does not necessarily contain information that the music therapist needs, including detailed musical items. The form used in the primary interview is usually produced with no regard to music therapy; therefore information of importance to music therapy is often missing. Another common concern was that the information collected from the

primary interview should be at least delivered appropriately and professionally. Music therapists often experience resistance from their institution when attempting to get necessary information. This resistance creates a difficult process as the music therapist attempts to collect necessary information in order to provide a qualitative service within a professional framework.

In order to supplement this lack of information, music therapists perform secondary interviews and collect information that is vital to starting a full-scale assessment. The complexity and confusion caused by implementing intake interviews twice causes difficulties not only for the music therapist, but also eventually for the parents/guardians as well. It causes the parents/guardians to become uncooperative or negligent, wastes time, and creates frustration. This condition of repeating interviews twice creates a difficulty for music therapists, as they have to experience an informal and unofficial framework with no set of time and place between service sessions. Additionally, another related concern is that the music therapist repeatedly is forced to introduce and educate relevant individuals as to what music therapy is. Music therapy is spreading and becoming more broadly practiced in Korean society although it is still lacking the social recognition of an established professional health care profession. This problem implies

that there is a need for a sustainable and universal educational program regarding the meaning and effect of music therapy for family and guidance counselors of children with special needs. In addition, it would be very beneficial for music therapists if they were able to conduct an educational session at least monthly in order to present music therapy work for not only parents/guidance, but also for the personnel/staff of the institution where they do clinical work. In the following section, this need will be discussed.

Music therapists in the field frequently state that standardization is necessary. Particularly, it was reported that there is a need for the emergence of a unique music therapy intake form by all participants and discovered through the research findings. Such need corresponds with the need for a unique intake form that objectively checks, classifies, and records conveniently but accurately in the stage of the intake interview during music therapy service.

2) A full-scale assessment

In the full-scale assessment implemented after the initial assessment (designated as primary and secondary), every participant considered assessment itself as investigating music and its related

activities with children with special needs in the question of how the music therapist recognizes assessment. As represented in the two categorizations of musical and non-musical intake form components, it was thought by participants that assessment focused on the experience of music and its related activities in regards to children with special needs. Music therapists can identify the type of help required as well as a current level of functioning for the children in a diverse range of areas. Therefore, it was also discovered that assessment is considered to be the duration of time spent establishing therapeutic goals and objectives and in the decision-making of therapeutic direction.

With this conception of assessment in mind, the actual procedure of assessment takes approximately a month to gauge a variety of different areas under the conditions of one session per week. However, it was reported that the duration could be shorter depending on the support and system of the institution. Like the intake process, assessment is also carried out focusing on two major categories divided between musical and non-musical. However, in this stage, diverse music and activities are attempted in greater depth, and also assessment is performed with more clinical observation systemically geared to the responses from the children. During this stage, video-

taping is at times done for the purpose of accurate clinical analysis. This method enables music therapists to seek the establishment of therapeutic goals and objectives appropriately and precisely.

In the use of assessment tools, a specific assessment form is used within each framework. Nevertheless, it appeared in every case that the therapists individually produced (self-made) the assessment tool by collecting information and making an application out of diverse resources. It may cause music therapists in practice to feel somewhat disoriented regarding how to make an objective assessment tool by themselves. In many cases, assessment forms introduced in music therapy literature (text books) is applied for use, but other sources from other fields like psychology, counseling, or special education are also used. In addition, domestic/international music therapy articles are utilized as resources in adaptive application. This will be reviewed and discussed in detail in the following section concerning assessment issues. There still exists a need to discover how music therapists make an application of the form and what pattern they use to adapt to the circumstances they are working on in detail.

Music therapists use individualized methods to produce the form and this is associated with a specific preferred method and pattern. Amongst the various methods, descriptive methods on collected data

in the process were utilized by all the participants in addition to a self-made checklist, or a combination of the two. In addition, some of the therapists used methods involving having a pattern applied to audio/video taping.

It was discovered that the assessment form is traditionally composed of various test items under two major categories: musical and non-musical.

The musical category consists of tests of melody, rhythm, harmony, song writing (composition), music listening (appreciation), improvisation, and the children's emotional and physical response to music and its related activities. The non-musical category assesses the children's communication, social skills, mood, language development, kinetic skills, cognition, and pathological issues with music.

The issue of assessment was also discussed in regards to the management of procedure and assessment forms in use as well as the recognition of assessment. It was stated, first and foremost, that the most difficult factor mutually shared among all of the participants was the absence of a professional music therapy assessment tool. This is directly connected to the absence of a professional tool based on objective measurement. Furthermore, it represents the problems

arising due to dependence on subjective observation when assessment is needed for children with special needs.

Such an assessment form is documented mostly in a descriptive way. However this method, without a certain framework or specific standard, depends on subjective observation which creates a large workload for therapists. Group therapy sessions that require an individualized assessment for each child in a limited time create huge challenges for music therapists. The main difficulty that arose with descriptive analysis was the issue of reliability. Since it is description based merely on subjective observation from an external view, there is concern over whether it is trustworthy or not as collected information. Moreover, in the same context, it appears that most music therapists experience a high level of stress when dealing with the wide scope of assessment due to the absence of categories classified by a specific framework or trustworthy standard. Since it is time consuming to document the assessment contents focusing on skills it is an inefficient method that eventually overwhelms therapists. In addition, the therapists experience a feeling of helplessness in the production of an assessment framework in regards to the criteria. This variety of distressing factors is directly linked to the worries stemming from subjective assessment performed through observation as a whole.

It becomes problematic when music therapists are requested to provide objective assessment results for children with special needs in an interdisciplinary setting. In other health care professions, care providers can share the results of assessment using standardized, or at least official, tools and perform team-plays in interdisciplinary settings. However, there is no specific tool in music therapy that can display numerical values through measurement as well as a checklist with reliability. After all, music therapists experience difficulty in creating results based on accurate numerical assessment criteria. Furthermore, it appeared that the absence of tools individualized and differentiated for each disability area creates even greater difficulty for music therapists in practice. This challenge also stems from the fact that there are no standardized musical assessment criteria for diverse disabilities utilizing the characteristics of music therapy.

Moreover, since each institution has its own assessment form, there is another difficulty that emerges in association with limitations placed on music therapists administratively. They are forced by the standards of their institution to adhere to a less than optimal assessment form. This subsequently creates the difficulty in the attempt at assessing many things using a fixed form in a limited time.

Such time-based assessment issues also stress group session resources creating an even greater burden for music therapists.

Possible improvements and specific needs in relation to the difficulties of music therapy assessment were also discussed. What is most needed is the development of a standardized music therapy assessment tool. There is an especially strong need for a specific tool created with a specific framework through the analysis of the assessment tools developed and applied individually by many music therapists currently. It was discovered that the music therapists in practice want some kind of standard manual-based assessment tool with simple explanations which focus on reliability, clarity, ease of approach, and presentation of which direction to assess. The issues and needs of therapists in the field reflect that music therapy assessment tools are in need of a transformation with an objective and scientific approach similar to assessment tools used in other professional fields. Thus, there is a great demand for an assessment tool that can feasibly be applied to real circumstances rather than assessment tools that merely exist for theoretical research. During the course of research, music therapists outlined the characteristics of several ideal tools:

- Simplified tools in the form of a checklist
- Specialized tools designed for group assessment
- Tools indicating explicitly each category that needs to be assessed
- Tools providing standardized music samples
- Tools that can give clear direction of therapeutic service

Do all of the many difficulties discussed mean it is impossible to create a standardized music therapy assessment tool? Korean psychiatrist, Kim (2010) suggested that people listen to music in order to change mood selectively and it is possible since music has the role and functioning of an emotional guide in general. Also, it has recently become possible to study how music affects people's brain physiology due to the development of neuro-imaging technique in the 1990's (Sacks, 2007). Such scientific evidence may imply that there is universality to people's musical response that can be extracted and used as feasible musical criteria when it comes to assessment in music therapy. Moreover, I believe that such perspectives and attempts could help us develop a potential music therapy standardized assessment tool. However, there must be in-depth considerations and pilot studies on these tools prior to possibly developing a viable music

therapy specific tool. Also, well-established assessment tools need to be studied and applied in order to provide a good model. The Wechsler Intelligence Scale for Children (WISC) is a good example as well as a viable model since it is a world famous intelligence test most frequently used for children. Furthermore, the WISC is practically utilized in not only schools, but also clinical settings as an established assessment tool. The WISC is administered to children at the ages of 6 and up and it takes approximately 2 to 3 hours. The WISC is a norm-referenced test and the WISC-IV is currently most recent although WISC-V will be published in fall of 2014. The WISC-IV provides a Full Scale IQ (FSIQ) that exhibits overall cognitive competency. The FSIQ represents a sum of 4 index scores like below (Wechsler, 2004):

- Verbal Comprehension index (VCI)
- Perceptual Reasoning Index (PRI)
- Processing Speed Index (PSI)
- Working Memory Index (WMI)

Here are a few examples that could support my suggestion to use musical elements, or music itself, in application to produce a possible standardized music therapy assessment tool. Schellenberg (2005) did

controlled experiments with two groups of children. One was a group of children with musical experiences through activities (lessons), and the other one was the group of children with no musical experiences. The results below displays the approximate mean difference of their scores on the Wechsler Intelligence Scale for Children-III (WISC III) and the outcome measures for groups of children receiving keyboard lessons, vocal lessons, drama lessons, or no lessons (Schellenberg, 2004). This is a good example (Figure 2) that involving musical activities through learning yields positive effects for children as the music groups exhibited larger increases than the controlled drama-lessons, or no-lessons groups.

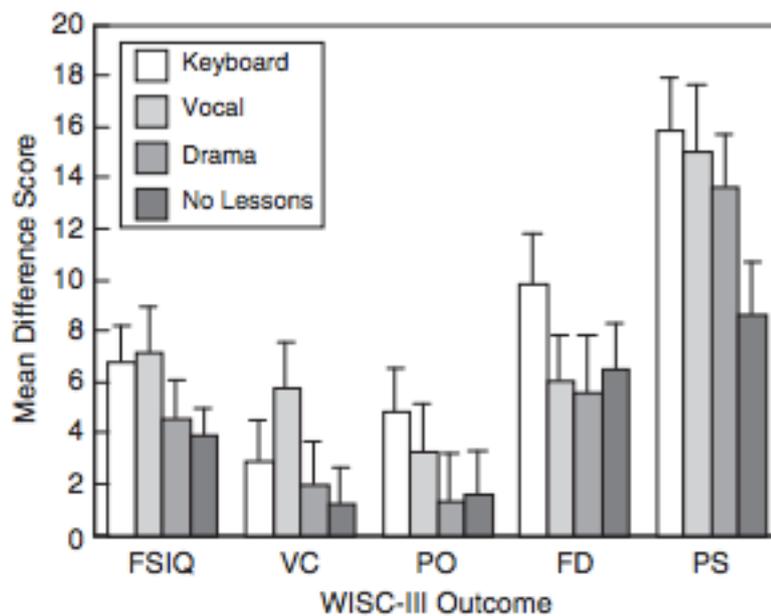


Figure 2. Mean difference scores on the Wechsler Intelligence Scale for Children-III (WISC-III) outcome measures for groups of children receiving keyboard lessons, vocal lessons, drama lessons, or no lessons (Schellenberg, 2004). FSIQ: Full-Scale IQ, VC: Verbal Comprehension Index, PO: Perceptual Organization Index, FD: Freedom from Distractibility Index, PS: Processing Speed Index.

E. Glenn Schellenberg (2005). Music and cognitive abilities. *Current directions in psychological science*. (14), 6

According to Bergman, Nutley, & Klingberg (2014), musical activities including instrumental practice also promote working memory development, particularly the development of working memory during childhood and adolescence. Lastly, there was also the experiment of listening to music called the “Mozart effect” to probe enhancing performance on spatial tasks using Stanford-Binet IQ battery spatial subtests. Hetland (2000) illustrates that “the logic leaped from a laboratory result showing a transient boost in spatial scores after listening to Mozart leading to the conclusion that listening to Mozart could raise children’s IQ (p. 105).

In WISC-IV, the examination is composed of 16 subtests. Those are as follows:

- Block Design
- Similarities
- Digit Span

- Picture Concepts
- Coding
- Vocabulary
- Letter-Number Sequencing
- Matrix Reasoning
- Comprehension
- Symbol Search
- Picture Completion
- Cancellation
- Information
- Arithmetic
- Word Reasoning
- Perceptual Reasoning

One of the special features of this test is there is no requirement for writing/reading competency for children (Wechsler, 2004). This point should be considered highly significant to the development of a potential music therapy tool as no specific academic skills are needed. In music therapy, the musical ability of children is not necessarily needed to intervene therapeutically. Through the WISC test, an IQ score is produced as a result and it is used to identify the current level

of children's functioning in a variety of areas. The WISC provides significant information on children's development as well as their psychological well-being. This test is administered by a trained psychologist in a one-on-one individual setting (Pierangelo & Giuliani, 2006). That is, the relevant professional must be knowledgeable about the test protocol as well as its components. It also implies that music therapists will also be required to train specifically for test tools and components in the future to create a standardized music therapy tool. Music therapy is composed not only of musical but non-musical elements, and thus requires study and training in a wide variety of areas. Nevertheless, the value of a deeper level of assessment/evaluation including test tools should not be minimized or avoided.

As previously discussed, there are 16 subtests within the test. The following are some suggestions that could be applied in developing a possible assessment tool based on the subtests using music. Music is composed of various elements, the three major components of music being performance, appreciation, and composition. In music therapy, every therapeutic intervention falls under these three categorizations. Children with special needs engage when playing with various instruments. This indicates that the therapeutic intervention would

happen during performance and additionally would vocalization. Listening to music and feelings in reaction to it would also be used in therapeutic intervention with music appreciation. In this case, the intervention would be dealing with more psychodynamic issues. Music making including song-writing can be used the therapeutic intervention with compositional perspectives. In music therapy, any type of musical activity can be used, whether via a pre-composed song or in creating a new song.

Music production has the potential to provide several different methods relevant to the production of a standardized tool. Music is also structured in a logical way and it requires some skills to compose it. To understand how harmony is produced, you need knowledge of the numerical combinations of each note. The music doesn't need to be complex when dealing with juvenile clients, but the basic concept of how music is structured is essential. Such an idea can be applied to the 'digit span.' Also, singing a song containing lyrics can be used to gauge language competency. For example, key vocabulary in the lyrics can be used for vocabulary acquisition, word reasoning, comprehension and coding (presenting the meaning of words verbally, or through writing if possible). Counting a bar can display arithmetic competency. There are a lot of instruments in the world, and each

unique feature can be used as icons and applied to both ‘picturing concepts’ and ‘symbol searches’. Ear training could be adapted to ‘similarities.’ The ‘letter-number sequencing’ can be utilized using lyrics in accordance with identifying the rhymes in it. Using features of famous instruments such as the piano and drum can be applied to the ‘block design’ and ‘picture completion’ tasks. Also, ‘cancellation’ could be tested using both lyrics and melodies in music. Talking about music in life could be adapted to the ‘information’ stage. Though it appears that the matrix and perceptual reasoning could require a deeper level of thought and ideas to provide some adaptation due to its complexity although music notation, lyrics, and simple music theory could be used for each. Table 7 further exhibits the potential components of music that could be used in developing the possible assessment tool.

WISC-IV	Potential music therapy assessment tool component
Block Design	Using blocks of instrument’s feature
Similarities	Ear training
Digit Span	Based on structuring harmony
Picture Concepts	Instrument’s feature
Coding	Lyrics of songs
Vocabulary	Lyrics of songs
Letter-Number Sequencing	Lyrics (using rhymes)
Matrix Reasoning	Notation
Comprehension	Lyrics
Symbol Search	Instrument icon
Picture Completion	Using block of instrument’s feature
Cancellation	Lyrics and melody
Information	Story of music in life

Arithmetic	Counting bars
Word Reasoning	Lyrics
Perceptual Reasoning	Lyrics and simple music theory

Table 7. Potential music therapy assessment tool component

In regards to music assessment, I would like to suggest some ideas for creating possible musical-based criteria using three major musical components called melody, rhythm, and harmony. As discussed previously with neuro-imaging, there might be an underlying universality that most people might feel the same receptive way when music is provided. This is a valuable starting point to begin from in designing musical criteria. First, melody is composed of musical notes and some of the format of melody lines in notation can be used as criteria in the arrangement of notes. For example, each note has its own length and musical value. Such a diverse range of musical notes can be categorized by representative musical notes and its sound value, such as whole note, half note, crochet, quaver, semi-quaver, etc. Then, very popular well-known melody lines from various resources could be applied to meet these possible melodic criteria in music therapy. Second, rhythm is the one of the most basic ways of communication for human-beings. Usually children, including those with special needs, sensitively respond to rhythmic patterns and change. For example, dividing and adding beats/meters could be utilized. Certain rhythmic patterns from diverse world famous music

could be utilized for rhythmic criteria. Lastly, harmony could be used as musical criteria as well. My suggestion in this area is that it would be good to have two major categories within harmony: consonance and dissonance. Also, gaps between notes and intervals can provide some criteria such as minor 2 & 3, perfect 4, perfect 5, etc. In addition, I suggest that four musical characteristics should also be utilized as criteria: height, length, dynamic, and timbre. Table 8 displays potential musical assessment criteria suggested.

Musical Criteria	Content
Melody	Melody lines consisting of certain arrangement of notes such as whole note, half note, crochet, quaver, semi-quaver, etc.
Rhythm	Rhythmic patterns consisting of dividing and adding beats/meters such as simple and complex beats
Harmony	Interval consisting of Consonance and dissonance such as minor 2,3, perfect 4, perfect 5, etc.

Table 8. Potential music assessment criteria and contents

Nevertheless, it appears that there must be an in-depth study carried out beforehand in order to meet with the standards of reasonable reliability and validity for all the suggested solutions. The strength of the WISC is its strong reliability and validity (Pierangelo & Giuliani, 2006). The WISC-IV was give normative value using a sample of 2200 children from eleven age groups with an equal gender rate in each group. Each age group represents a one year

range(Wechsler, 2004). How to mimic this reliability and validity in developing music therapy assessment brings is one of the most relevant questions need of in-depth study. This issue should be investigated thoroughly in both the psychometric and musicological fields.

As an author of this study, personally I believe that it is possible to create a music therapy standardized assessment tool. The protocol must begin first with designing a test frame by collecting and investigating information on various individualized informal tools currently used and subsequently should be dealing with normative samples based on as wide a range of children as possible. Through the research findings, the extent of the current state of music therapy assessment practices has been discovered. I believe that the next step is in producing a music therapy standardized assessment tool utilizing the information generated in this study.

Notwithstanding that most of the stated needs are involved with the development of a practical assessment tool itself, what cannot be overlooked as an issue of prime importance is the need for positive systematic support and cooperation from the institutions in which music therapists work.

3) Music Assessment Issues

Lastly, about the issues which music therapists experience in the field, there was universal agreement amongst the participants as to which characteristics posed the greatest challenges in using music as an assessment tool. The characteristics, mentioned in detail in the sub-domains, are ambiguity, uniqueness, and the subjective use of music. Regarding the subjective character of music, it was stated that musical preference for music genres differs for each individual in sub-domains. Thus despite the fact that the same music was provided, the responses were different and subjective. This corresponds to the idea that music is even received differently and subjectively by both the therapists and children with special needs in a therapy setting. Such a discrepancy of receptiveness creates an issue of reliability in the context of evidence-based practices. It also reinforces the idea that music engenders an individualized response from each person. Consequently, the application of music as assessment criteria is impaired due to such varied and unique responses. Hence, a music therapist experiences uncertainty in setting up what and how musical components should be used as assessment criteria. Such an issue leads to a predominant use of non-musical components, which can be

set up more clearly and easily as assessment criteria. Excessive use of non-musical components as criteria is apt to decrease the use of music and its elements and it can possibly lead a music therapist to use less music clinically overall. Furthermore, sharing and communication on the results of assessment among diverse professionals frequently becomes an issue when objectivity and validity are discussed, particularly in an interdisciplinary setting. This forces music therapists in practice to often deal with a hostile atmosphere. Also, such complexity frequently makes music therapists experience a feeling of helplessness and creates a burden in the process of assessment; in the end they might even become skeptical about music therapy itself as a professional field.

Nevertheless, it appears that there is universality existing as to how children receive music in a general sense as discussed in the previous section. For example, most children respond to upbeat fast-tempo music by rocking, singing, or swaying. It is not common to observe a child crying because they become emotionally depressed while listening to those types of music. Conversely, children may become emotional or sentimental in response to sad and melancholic types of music. Just like before there is a general universal response. It is not common to observe a positive physical response, like someone

dancing, to this kind of music. Lee (2011) illustrates such universality that can be generated among individualized musical experiences as follows:

Music appears to have some objective properties that tend to yield similar subjective experiences in listeners, whether it is the urge to dance to intoxicating swing rhythms or to find our deepest longing expressed in a lyrical ballad...It would be naïve, however, to assume that everyone's experience of a particular style is the same or that specific musical components can be associated with specific responses from listeners. (p. 3).

Therefore, there is an inherent intuitive nature that be exploited in order to produce valid musical criteria in music therapy regardless of all the difficulties discussed earlier. I believe that it is possible to develop a standardized music therapy assessment tool based on the essence of the universality that music affects.

2. Limitations

There are several issues on the methodological limitations that must be addressed in this study. First and foremost, this was a qualitative inquiry that narrowly focused on one specific phenomena

related to the assessment process throughout a homogeneous sample of twelve individuals. Due to the methodology utilized for the analysis, there was a clear limitation of the extent to which the results from such a small sample generalize to an unspecified number of the music therapists in general. As with all qualitative research, CQR potentially has the same limitation although it has a more rigorous and differentiated methodology for analysis, compared to other inquiries of qualitative research.

Second, it should be admitted that there is still a possibility of representing a unique cultural method that emerged during the consensus coding process while interpreting the data even though there was a concerted strategic attempt to increase the objectivity of findings such as repeated review of CQR methodology, extensive time spent on coding, and rigorous steps taken in regards to gathering the consensus.

Third, the homogenous sample was predominantly composed of female music therapists. In Korea, the ratio of male to female music therapists is highly disproportionate as female therapists, including prospective ones, represent the majority.

Fourth, there were a lot of themes discovered and addressed regarding music therapy assessment procedure in relation to the sole

research question. It might have been helpful for the reader to be pre-informed on a wide variety of relevant fields. Nevertheless, there was a certain limitation providing information on each theme's in-depth levels due to the wide scope of the question.

Lastly, a larger utilized sample and more raters who were in charge and participated in the analysis process as a research team would have enhanced the external validity of the study. In the same context, replication and extension of the investigation with other research teams would be helpful in order to increase the external validity of the inquiry.

3. Implications

As discussed in the section above, the explicit information of how music therapy assessment is being performed in the field has been discovered. The research findings of this investigation have several different implications. First and foremost, it was discovered that the most desired item in the process of music therapy assessment is a standardized or at least formal assessment tool. Throughout the research findings, it appeared that there was a huge need for the emergence of a standardized test tool that can be utilized both in

intake and in full-scale assessment processes. There was a strong desire for a test tool with validity and reliability so that music therapists could come to depend upon the results of assessment in accordance with evidence-based practice. Every country and field must have their own practice style and culture. Nevertheless, it would be of great benefit if there was additional/further research to develop an assessment tool which comprehensively sorted out and combined the tools that a variety of music therapists' use in the field currently; the research findings already revealed most music therapists produced individualized or adaptive tools in the course of assessment. Such trial and development will eventually create what most music therapists want and would benefit to have when it comes to assessment in the field.

Second, it appeared that music therapists in the field need something concrete, clear, reliable, objective, and scientific when music therapy assessment is discussed. Among those needed characteristics, there is one common implied need: a guide. As reported in the results, music therapists want to have a diagnostic test with a manual (clearly explaining each step) and individualized sections/categories for each of the major disabilities. This suggests the need for research to develop a manual-based test tool with a clear

explanation of test protocol that is divided into sections by each disability.

Third, this study provides clear information on music therapy assessment protocol that is currently being practiced in the field. When and how music therapists begin involving music therapy assessment is now known. Some music therapists, including prospective ones, might be interested in knowing how other music therapists perform assessments in the field, particularly in the setting of working with other disciplinary professionals. It was also reported that there were at times a lack of client information from institutions. That is, it appears that there is not always smooth communication and cooperation in institutional settings. Other researchers might consider researching this phenomenon. It would also be worth researching how the therapist feels about the lack of information about their clients when they work in institutional settings and how that affects their work.

Fourth, even though the research findings display the recognition of initial assessment (intake process) and a full-scale assessment distinctly through analysis, it would appear that there is the need for a more clear distinction between those two processes. Most research participants recognized the difference during the interview process; however it has been reported that there is a need for more training in

assessment in the educational therapy field. For instance, some participants stated that they knew little about the intake process until they got out into real working conditions. Every educational institution has its own curriculum for music therapy and in how much detail music therapy assessment is being taught at each school is not clearly known yet. Furthermore, practicing music therapy in interdisciplinary settings is critical as music therapy has been becoming increasingly more important and is undertaking more responsibility as an established health care profession in our society. Before the prospective step into the real healthcare world, music therapists should be able to at least recognize the steps of assessment including the intake process. If other researchers conduct studies about music therapy education focusing on assessment/evaluation in school curriculums, it would be a good indicator of the current level of music therapy education with regard to those involved in the test.

Lastly, the role and characteristics of music used in music therapy throughout a diverse range of literature has already been discussed. As discussed at length in this study, music has subjective, ambiguous, and unique characteristics. The information of possible musical universality was discussed earlier. There must be some kind of universality that most people naturally feel and agree with in music and

its elements. Mitterschiffthaler et al. (2007) discovered an emotional processing network in response to different types of music, such as happy, sad, and neutral music, activates different areas of brain. The blood oxygenation level dependent (BOLD) signal contrast was measured in response to the mood state induced by each musical stimulus in their functional magnetic resonance imaging (fMRI) study.

With collaboration with the neuroscience field, it would be innovative as well as a step forward to the next level of assessment development if other researchers began the search for music-based universality using neuro-images. Development of an assessment tool using neuro-images and other methods designed for finding scientific musical criteria for music therapy assessment would elevate music therapy to a more evidence-based practice as a whole.

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APPENDIX

Domain 1

“아동의 기본적인 정보 및 그리고 위탁사유, 음악치료의 적합성을 설명해줄 수 있는 반드시 필요한 기본과정이라고 생각하며, 초기면접을 어떻게 하느냐에 따라 치료방향 및 치료철학도 영향을 받기 때문에 목적에 또한 영향을 주는 것 같다. 아동과 부모의 관계, 아동의 발달에 대한 이해, 그리고 어떤 치료철학을 가지고 가야할지를 이시간에 정하게 된다. 부모상담을 통하면서 아동을 깊게 이해하고 평가할 수 있는 시간이라고 생각한다. 이미 작성되어 전달 받은 자료들외에 구두로 직접 얻는 귀중한 정보라 이것은 후에 이어지는 진단평가에도 영향을 주게되어 매우 중요하다고 본다. 부모와의 신뢰가 중요한데 초기면접때 라포가 형성이 안되면 치료진행에도 영향을 주게된다(Case 10).”

“음악치료 진단평가를 하기 전에 치료사와 아동간의 일차적인 면담이라 생각한다. 대개 장애아동이나 청소년의 경우에 보호자가 동반이 되어서 보호자 상담으로 이루어지게 된다. 초기면접을 통해서 치료 대상자의 발달, 개인적, 사회적인 배경, 병력 등의 개인적인 정보를 파악하고 일상생활을 하는데 있어서 다양한 기술영역에 대한 정보를 수집하는 과정이라고 말할 수 있다(Case 11).”

Domain 2

“사회복지사가 일반적인 면접을 실시하고, 후속적으로 정보를 확인하고 공유하는 과정을 갖고 있다. 진단명이나 발병시기 같은 정보들은 의사들이 작성한 차트를 보고 정보를 얻고, 그 다음의 사항들은 사회복지사들이 실시한 면접을 통해서 얻고 있다(Case 2).”

“초기면접은 상담센터 원장이나 의사가 진행한 후에, 음악치료가 필요하다고 판단될 때, 회의를 통하 의뢰를 받게 된다. 이 때, 양육환경이나 병력같은 아동의 기본적인 사항들에 대한 정보를 얻는 것과 동시에, 아동의 음악선호도 및 반응에 관한 기본적인 음악관련 사항들도 파악을 해서 전달해 준다. 예를 들어, 음악듣기를 좋아한다거나 음악을 통한 안정등이 확인되면, 무조건 음악치료개입을 주선한다. 초기면접에서 부모상담은

매우 중요한 부분이고, 부모의 적극성에 따라 필요한 정보의 질이 결정되는 것 같다(Case 7).”

Domain 3

“음악치료 초기면접지는 따로 없다. 음악에 대한 아이의 선호도, 노래부르기 가능한 정도, 가족환경, 의사소통방법, 혹은 부모가 음악치료를 통해서 어떤 것을 원하는지에 대한 그 목표에 대한 정보를 기록하는 서면양식으로, 음악적 취향 및 능력(노래부르기 포함), 글을 읽을 수 있는지, 숫자 인지 가능한지, 엄마와의 애착관계, 눈맞춤여부, 정서적, 사회적, 그리고 가족간의 관계 같은 기본적인 정보를 얻는 양식이라고 할 수 있다(case 2).”

“음악치료 초기면접지는 따로 없다. 바로 진단평가지를 사용하고 있다. 다른 사회상담팀이라는 곳에서 작성한 초기면접지를 가지고 와서 그것을 보고 부족한 부분을 더 채우게 된다. 그 내용들은 기본적인 정보. 전화번호, 이름, 또 장애명, 임상에 대한 히스토리, 치료에 대한 히스토리, 그리고 가족환경...기본적으로 이런 항목들이 대부분이며, 추가적으로 서술형으로 보호자의 임신상황, 가족환경, 아동의 특성같은 것들에 대해 추가적으로 질문을 하게 된다. 음악적인 부분에 있어서는 음악교육배경, 음악선호도, 악기교육여부, 혹은 악기 사이즈에 대한 선호도를 조사한다(case 3).”

Domain 4

Difficulty

“아동에 대한 보호자들의 구체적인 설명이 없을 때 어려움을 느끼며, 가족관계, 특히 형제관계에 대한 질문들을 할 때 설명을 꺼려하는 경우가 많다. 이럴 때는 부족한 정보를 가지고 진단평가에 들어가게 되는 점이 어려운점이다. 초기면접에서는 기본적인 항목만 다루다 보니까 구두로 추가적으로 물어보는 것이 생기게 된다. 그밖에 초보 치료사일 때 상담기술의 부족으로 어려움을 겪었다. 전달 받는 초기면접지의 내용들이 아주 기초적인 것이라 더 깊은 정보들을 알려고 시도할 때 정체성에 대한 문제를 느낄 수 있다(case3).”

“음악치료에 대한 부모들의 부족한 인식과 치료의 필요성을 논하는 것과 동시에 설득하는 것에 애로사항이 있으며, 때로는 부모들로 진정성 있는 정보를 얻는 것에 대한 제한을 느낄 때 어려움을 느낀다(case 7).”

Need

“미리 체계적으로 초기면접 때 알아야 할 것들을 체크하는 체크리스트 같은 것이 절실히 필요한 것 같다. 더불어, 면접전에 필요한 정보를 미리 받고 하는 것인지, 아니면 면접에서 정보를 받으면서 해야하는 것인지, 그리고 아동 증상에 따른 어떤 검사들이 필요한지에 대한 시행정보 및 프로토콜에 대한 명확함과 면접 시 이루어지는 각종 질문에 대한 샘플이 매뉴얼화가 돼 있으면 좋을 것 같다. 그리고 면접에 필요한 것들에 대해서 기관에 잘 설명할 수 있는 기준이 있었으면 좋겠다. 음악치료만의 표준화된 검사도구가 있었으면 좋겠다. 그런데 이는 비음악적인 것들을 검사할 수 있는 항목들과 함께 하나의 검사도로 제시가 되면 좋을 것 같다(case 8).”

“많은 절차들을 통한 정보를 얻는 것 보다 쉽게 한번에 확인하고 그 필요를 알 수 있는 전문적인 초기면접지가 있으면 좋겠다. 진단평가와 초기면접의 항목들이 겹치지 않는 세분화된 검사지가 있으면 좋겠다. 정확하고 빠르게 처리하는게 가장 좋은 것 같다(case 7).”

Domain 5

“진단평가는 음악적인 경험, 즉 여러 가지 음악활동을 통해서 그 아이가 가지고 있는 전반적인 어떤 기능 수준을 치료사가 파악하여서 이 아이한테 어떤 목적 및 목표가 필요하겠는지를 세우는 일련의 과정이라고 생각한다(case 1).”

“진단평가는 그 아동의 현재 상태를 진단을 해서 그 아동의 필요를 찾는 과정이면서 또한 이아이가 치료가 종결될 때 그 기준이 될 수 있는 시작점이라고 생각한다. 대상 아동이 현재가진 장점단점 발달에 따른 능력이라던지 정서 상태나 음악능력 그런 것들을 통해서 아동이 필요한 것을 찾는 과정이라고 생각한다(case 4).”

Domain 6

“사회상담팀이 처음에 내담자가 기관을 방문 했을 때에 초기면접을보고, 이 과정에서 음악치료에 대한 욕구가 있다고 결정이 되면 의뢰를 받고, 초기면접시에 부족했던 부분을 보호자나 내담자를 통해서 충당하고 진단평가를 시작하게 된다. 진단평가에 있어서 틀은 크게 음악적 그리고 비음악적이 부분으로 나누어 평가를 실시하고 있다. 동영상녹화자료를 통해서 진단평가에 이용한다(case 3).”

“한 달 정도의 기간 동안에 여러 영역들에 대해서 확인을 하고 아동들의 필요한 부분을 찾은 다음에, 실제 목표를 달성하기 위한 어떤 치료 중재를 시작하게 된다. 한 달 이후에 목적이나 목표를 성립하게 된다. 이 기간동안 노래, 연주와 같은 음악적 영역들, 그리고 표현, 운동같은 비음악적 영역들에 대한 파악을 하고 치료개입을 하게 된다(case 8).”

Domain 7

“특정한 진단평가지를 갖고 있는것이 아니라, 아동의 상태에 따라 초기면접에서 얻은 정보를 바탕으로 그때 그때 필요한 것을 만든다. 학교에서 배웠었던 교재나 참고문헌, 연구자료들 참고를 해서 거기서 항목을 뽑아서 쓴다(case 4).”

“형식화 된 진단지를 사용하지는 않는다. 서술하는 비형식적인 방법을 사용하고 있다. 음악의 선호도에 대하여 알아보고, 우선 언어사용 여부에 따라, 악기에 대한 선호 및 연주 그리고 반에 관하여, 혹은 선호하는 노래 및 부르기를 중심으로 진단을 한다. 선호하는 노래가사를 파악하여 아동의 정서나 성격등을 알아보기도 한다. 그 밖에, 어느 정도의 음량을 제공했을 때, 부담감없이 잘 활용이 될 수있는지와 치료사와 정서적 및 물리적으로 어떤 거리를 두어야 아동이 좋아하는지를 전반적으로 확인하게 된다. 음악활동을 통하여 치료사와의 라포정도와 정서적으로 두렵거나 경계하는 부분들도 파악하게 된다(case 6).”

“사용하는 틀은 우선 비음악적인 항목에 있어 사회기술, 정서, 의사소통, 인지 이렇게 포함되어 있고, 음악적인 부분에 있어서는 듣기, 동작,

노래부르기, 연주하기, 음악에 대한 반응 같은 영역으로 세분화하여 서술형으로 기술하고 있다(case 9).”

Domain 8

Difficulty

“일단 가장 큰 문제는 표준화 된 도구가 없다는 것이다. 기관마다 양식이 너무 다를 뿐만 아니라, 아예 양식이 없는 경우도 있었다. 다른 분야 치료사들과 간학문적으로 일을 할 때, 음악치료의 진단평가가 너무 주관적으로 이루어지는 것 같은 느낌이 많이 들었다. 그 이유는 수치로 나타낼 수 있는 것들이 별로 없기 때문에 애로사항이 있다(case 2).”

“제가 체크리스트대로 하는 것은 아무래도 서술형으로 기재를 하다보니까 제가 객관화된 눈으로 기재를 한다고 해도 서술형이 그런것들이 자꾸 주관적으로 느껴질 수도 있을 것 같다는 생각이 들더라구요. 언어평가지도 보면은 확실히 점수로 표기화 됐을 때 부모님들에게도 조금 더 지나서 다시 평가를 했을 때 향상된 모습들이 그렇게 가시적인 효과를 볼 수가 있는데(case 9).”

“현재 평가도구가 다양한 장애군에 적용되지 않기 때문에 일반적/객관적으로 평가할 수 있는 틀을 갖기가 어렵다. 장애군에 맞게 공식적으로 만들어진 표준화된 틀이 없기 때문에 내담자에 따라서 항목들이 필요한지 지속적으로 선별작업을하며 침착하는 작업 때문에 시간이 더 소요되며 어려움을 느낄 때가 많다. 내담자가 갖고 있는 장애와 특성이 다 다르기 때문에 음악적인 부분을 평가하는데 어려움이 있다(case 3).”

Need

“음악치료라는 큰 학문 아래에서 누구든 어떤 음악치료사든지 어느 기관에 가서도 진단도구 하나를 가지고 타당하게 말할수 있는 음악치료진단도구만 있는게 아니라 그 도구 안에 뭔가 음악도 같이 포함되어 있었으면 좋을 것 같다. 지역마다 그리고 기관마다 다 다른 문화와 틀을 가지고 있기 때문에 항상 수정 및 보완작업이 필요했고, 다른

전문인들과 함께 일을 할 때 사용하는 진단도구에 대한 평가의 논거에 대해서 질문을 받곤했다. 현재 음악치료사들이 사용하는 다양한 틀을 모으고 정리해서 한국에서 공통적으로 쓸 수 있는 도구를 만들면 좋을 것 같다(case 10).”

“표준화된 도구 개발이 시급하다고 생각한다. 또 특수한 아동 진단에 있어서 치료사의 철학이나 이론적인 배경 등 그런 개인적인 변인에 의해서 좀 주관적인 요소가 많이 개입이 될 수가 있기 때문에 더 신뢰성과 타당도의 바탕을 둔 객관적이고 과학적인 접근의 표준화된 도구가 필요하다고 본다. 진단평가를 할 때 모든 대상군에게 공통적으로 평가되어지는 영역과 관련된 내용을 바탕으로 표준화된 음악치료 진단평가 양식을 만드는 작업이 물론 필요하지만, 한편으로는 그런 특정, 특정한 장애군의 특성에 따라서 또 평가되어야 될 그런 기준과 내용들이 있을 것 같다. 그래서 그런 부분들을 보충을해서 전반적인 진단평가 양식과 차별화되어 진단평가가 이루어졌으면 하는 바람이다. 다시 말해서, 공통적으로 체크 될 수 있고 평가 될 수 있는 부분들과 그 다음에 그 장애군에 따라서 특성을 갖고 있는, 그런 섹션을 갖고 있는 것과 공통적으로 사용하는 것이 합쳐져서 어떤 차별화되고, 세분화되며, 그리고 좀 더 객관적으로 개별화된 어떤 검사도구를 만들면 다른 치료사나 전문가들과 교류할 때 많은 도움이 되는 물론 음악치료 전반적으로 전문성을 보여줄 수 있다고 생각한다(case 11).”

“중재에 있어서 개인적으로 악기연주를 하게 하고, 노래를 부르게 하고 하는데, 어떤 틀을 제공할 수 있는 활동 메뉴얼이 있었으면 좋겠다. 다시 말해서, 활동 메뉴얼에 의한 체크리스트가 있으면 더 유익할 것 같다. 그 이유는 언어치료의 경우 언어치료 카드나, 그림카드를 이용해서 진단하고 있고, 미술치료 경우에는 그림을 이용한 도구를 이용하는 검증된 평가도구가 있다. 음악치료에서도 누구나봐도 인정할 수 있는 표준화된 도구가 있으면 좋겠다. 현장의 음악치료사들이 표준화된 진단평가도구에 대한 갈망이 크다. 그리고 관련된 연구도 많이 진행되고 있지만, 연구로만 그치기 때문에 실제 적용이 어렵다. 현장에서는 시간 및 정황상 빠르게 진행되기에 한장짜리가 필요한데, 이것은 또 사용하기에 너무 벅찬것이 사실이다. 병원에서는 그런 연구용 도구를 사용할 수 있을수도 있지만,

학교나 실제적으로 많이 임상이 이루어지는 곳에서는 무언가가 필요하다. 병원, 학교 포함하는 모든 곳에서 쓸 수 있는 검증된 간소화된 도구가 절실히 필요하다. 아동한테 친숙할 수 있는 음악심리적인 접근이 가능한 사전검사지 같은 것이 있으면 좋을 것 같다(case 1).”

“진단에 있어서 범위나 범주를 조금 더 정확하게 정하면 좋을 것 같다. 언어검사 같은 경우는 연령대별 말할 수 있는 단어나 음소 같은 것들이 다 정해져 있는 것처럼, 음악치료도 멜로디나 동요 같은 것을 정해놓는다든지 좀 더 범주를 정확히 정해서 진단평가마다 쓸 수 있는 것을 정하면 좋을 것 같다. 다시 말해서, 공식화 된 것이나, 누구나 들었을 때 알만한 것들, 인식할만한 것들, 그런 표준화된 음악샘플이 있으면 좋을 것 같다. 샘플이라는 것은 곡이나 특정 멜로디같은거라고 얘기할 수 있다. 발성기술이나 노래부를 수 있는 음역범위라든지 리듬감 같은 것들을 확인할 수 있는 공식적이고 표준화된 검사도구가 필요하다. CD 라든지 관련성 있는 것들을 샘플로 검사할 수 있는 도구가 있으면 좋겠다. 자체제작하여서 쓰기는하나 임의로 만들어 사용하다보니 정해진 틀에 의한 매뉴얼화된 것을 필요로 한다(case 7).”

Domain 9

“아무래도 음악을 해서 반응하는 거에 대해서 반응이 워낙 다양하게 나오는데 그런 것들에 대해서 파악할 만한 기준이 없는것 같다. 반응에 따라 얼마만큼 평가가 되어야 하는지 기준을 모르기 때문에 겪는 어려움이 제일 컸었고, 기준이 되는 음악이나 틀이 설정되어 있지 않기 때문에 또한 어려움을 겪는다. 무엇을 사용하여 어떤 음악을 제공했을 때, 아동이 어떻게 반응했다라는 명확한 단계와 틀이 없어 고민한 적이 많다. 미술이나 다른 것들은 그림이나 글로써 표현이 되는데 음악 같은 것은 파악하기에 애매한 부분이 많은 것 같다. 예를 들어, 즉흥적으로 사용되는 음악같은 경우, 그때 상황마다 나오는 표현들이 예측불가하며, 기존의 음악을 사용했을 때의 반응을 보는 것에서는 사용할 음악이 워낙 방대하기 때문에 틀에 대한 고민이 큰 어려움이다(case 8).”

“기준에 많이 쓰는 평가틀도 주관적으로 서술해서 쓰는 것들이 많은데, 이는 음악에 대하여 과학적으로 어떤 기준을 세우고 문항들을 만들어야

하는데 이 부분이 애매모호한 것 같다. 이러한 부분들을 서술형으로 대개 표현하기 때문에 전반적인 평가에 있어서 애매모호함을 느낄 수 밖에 없다. 이는 언어치료, 심리치료, 물리치료, 혹은 작업치료처럼 표준화 된 평가틀이 있는 것과는 비교가 되기 때문에 신뢰성 부분에 있어서 이슈가 있게 되고 이는 전문성의 부족과도 연결되는 것 같다. 치료사의 표현에서도 같은 이유로 어려움과 애매모호함을 동시에 갖고 있는것 같다(case 3).”

국문 요약

본 연구는 우리나라 음악치료 현장에서 특수아동을 대상으로 임상을 하고있는 음악치료사들이 진단평가과정에서 무엇을 경험하는지를 탐구하기 위하여 최근 심리학 및 상담 분야에서 자주 사용되고 있는 질적 연구 방법인 합의적 질적 연구 (Consensual Qualitative Research: CQR) 를 통하여 연구를 실시하였다. 임상 현장에서 특수아동들과 함께 일을 하는 음악치료사들이 전반적인 진단평가과정에서 내적 및 외적으로 무엇을 경험하는지에 대하여 심층적으로 파악하기 위하여, 12 명의 치료사들에게 초기면접의 실태 (an initial assessment/intake interview), 종합진단평가과정(a full-scale/ongoing assessment), 그리고 평가 기준으로서의 음악사용경험(the experience of using music as assessment criteria)에 대하여 질문하였다. 예비조사를 통하여 반구조화된 개방형 질문지를 개발하여 연구참여자 전원에게 전화인터뷰를 심층적으로 실시하여 자료를 수집하였다. 관련 자료는 명확하게 전사되었으며, 이는 세명의 연구자들이 합의적 질적 연구 방법(CQR)으로 분석하였고, 두명의 감수자가 결과를 감수하였다. 자료 분석 결과로서, 초기면접 및 진단평가 각각에 대한 인식, 절차, 도구, 그리고 쟁점에 대한 주제를 바탕으로 한 분석결과를 알 수 있었으며, 마지막으로 음악적 사정에 대해서도 파악할 수 있었다.

첫째로, 초기면접에 대한 인식으로는 기본정보를 모으는 과정으로서 라포형성 및 부모상담을 포함하는것이라고 보고되었다. 절차로서는 기관에서 근무하는 경우 다른 전문인들에의해 1 차적으로 초기면접이 실시되고 있으며, 2 차적으로 음악치료를 위한 초기면접이 다시 실시되는 것으로 나타났다. 도구로서는 대부분이 음악치료용 접수면접지가 없다고

대답했으며, 다른 전문인들이 수집한 정보가 기입된 면접지에 내용을 추가하는 방법을 사용하는 것으로 나타났다. 초기면접지 항목구성으로는 크게 음악적 및 비음악적 영역으로 나누어 정보를 수집하였다. 접수면접에 대한 쟁점으로서 어려운점은 충분한 정보습득의 어려움, 기관의 정책으로인해 초기면접을 두번 실시할 수 밖에 없는 부분, 그리고 지속적인 음악치료 교육에 대한 어려움등이 보고되었다. 필요한점으로는 표준화된 객관적인 접수면접지로 나타났다.

둘째로, 진단평가에 대한 인식으로서는 음악 및 음악활동안에서의 진단을 통하여 치료적 목표 및 목적들을 세우고, 아동들의 현 수준의 기능과 필요한 부분들을 판별하는 과정으로 인식하고 있었다. 진단절차로서는 초기면접의 경우와 같이 크게 음악 및 비음악 영역에서 필요한 정보들을 얻는 것으로 나타났으며 한달정도의 시간에 걸쳐 진행되는 것으로 나타났다. 진단검사도구에 있어서는 다양한 자원을 사용하여 개별적으로 응용해서 만든 도구들을 사용하는 것으로 나타났으며, 실시 형태로서는 평가내용을 서술하여 기술하는 방식으로서 치료사 개인 선호도에 맞추는 것으로 나타났다. 평가 구성요소로서는 초기면접과 같이 크게 음악적 및 비음악적으로 나누어서 해당내용들을 수집하는 것으로 나타났다. 쟁점부분에서 어려움으로서는 전문적인 음악치료 진단평가도구가 없다는 것이 가장 크게 나타났으며, 서술형으로 기술하는 것, 간학문적 팀 구성원으로 함께 일할 시 객관적인 결과를 공유하는 부분, 장애 각 영역에 맞는 검사도구가 없는 부분, 그리고 각 기관마다 요구되는 형식과 문화가 다른 점들에서오는 불편 및 혼란이 조사되었다. 필요한 부분으로서는 표준화된 진단도구 제작이 강조되었으며, 각 기관의 체계적이고 협력적인 지원이 필요한 부분으로 나타났다.

마지막으로, 음악에 대한 진단평가 실시할 경우 경험하게되는 쟁점으로서는 음악을 어떤 진단준거로 사용해야하는가와 음악에 대한 주관적인 경험 및 반응이 보고되었다. 이후 이러한 결과가 임상현장의 음악치료사와 진단평가에대하여 시사하는 점을 중심으로 논의하였다. 본 연구는 다양한 환경에서 특수아동들을 대상으로 임상을하는 12 명의 음악치료사들이 초기면접부터 종합적 진단평가까지 무엇을 경험하고 있는가에 대한 면접자료를 CQR 이라는 분석틀을 통하여 개념화함으로써, 독자들로 하여금 현장에서의 음악치료 진단평가가 가지는 의미를 간접경험할 수 있는 기회를 제공하였다. 그리고 현재 현장에서 특수아동들과 임상을하고 있는 음악치료사들에게는 개념화된 이론적 정보를 통하여 자신들의 진단평가 역량에 대해서 비교, 분석, 그리고 반영의 계기를 제공하고 있다는 것에 의의를 갖는다.