IDEOLOGY AND SOCIAL CONSTRUCTION

OF REALITY --- A CASE STUDY

ON MUSIC THERAPY

By

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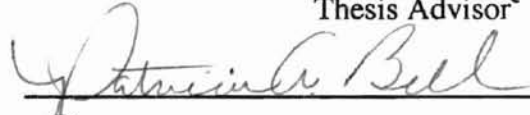Danjiangkou City, Hubei, PR China

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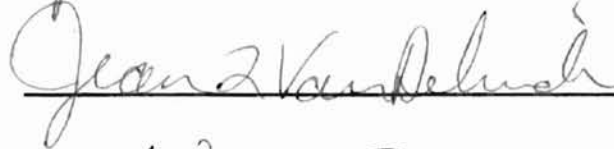the requirements for
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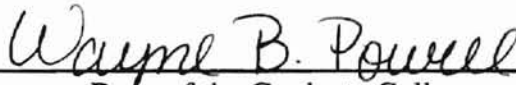
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TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

I wish to acknowledge the following works that have been intensively used in this thesis:

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"I am part of my dreams, and all my dreams are me myself".

----- An Old Chinese Saying

"...Thinking begins only when we have come to know that reason, glorified for centuries, is the most stiff-necked adversary of thought."

----- Martin Heidegger

The bourgeoisie ... has pitilessly torn asunder the motley feudal ties that bound man to man to his 'natural superiors' and has left remaining no other nexus between man and man than naked self-interest, than callous 'cash payment'.

Marx and Engels, *The Communist Manifesto*

The single most important development in modern music is making a business out of it.

Frank Zappa (*Telos* 91, 125)

"Patients? Oh no, we don't call them patients anymore...client, we call them clients"

Interview with a music therapist, March 1999

Ideology and Social Construction of Reality

— A Case Study on Music Therapy

CHAPTER I

INTRODUCTION

Social Construction of Reality and Ideology

The central theme of this thesis is that modern scientific knowledge is seen as empirically constructed through the ideological elements. Scientific knowledge is viewed as an enterprise driven by the features that could be interpreted as ideological. It argues that modern scientific ideology has become part of the constructed social realities and plays a great impact on the process of constructing scientific knowledge.

The notion of the "social construction of reality" has been prevalent among the social sciences for at least three decades since its first inception in 1967 by Peter Berger and Thomas Luckmann. Drawn from various scholarship, Berger and Luckmann maintained that the "sociology of knowledge is concerned with the analysis of the social construction of reality" (Berger & Luckmann, 1967; p. 3). They contended that "sociological interest in question of 'reality' and 'knowledge' is initially justified by the fact of their social relativity" (p. 3) and this interest has its roots in German philosophies. The German epistemology in the late 19th and early 20th century has led scholars to be concerned with the relationship between thought and its historical situation. Max Scheler, a German philosopher who coined the term "sociology of knowledge" (*Wissenssoziologie*) during the 1920s, claimed that the sociology of knowledge is concerned with the relationship between human thought ("ideal factor") and the social context ("real factor") within which it arises. He proposed that "real factors" determine the presence (*Dasein*) but not

1

the nature (*Sosein*) of idea factors. This similar relationship was also reflected in Marx's works but for Marx the relationship is viewed as reciprocal in which he proposed a dialectic schema – "substructure/superstructure". What concerned Marx from this schema is that human thought is found in human activity (substructure) and in the social relations brought about this activity (superstructure), and social relations actively shape and influence the human activity and human thought. Furthermore, Marx's historical materialism places historical concrete reality in a central stage in the development of human thought and ideas. This sense of historicism in human knowledge was further developed by the historicists especially by the works of Wilhelm Dilthey (1958). The dominant theme in the historicist perspective is "an overwhelming sense of the relativity of all perspectives on human events, that is, the inevitable historicity of human thought" (Berger & Luckmann, 1967; p. 7).

These historical scholarships had provided theoretical frameworks for Berger and Luckmann's analysis of social construction of reality. They further extended the previous studies and had proposed three elements in the process of social construction of reality: externalization, objectivation and internalization. Their analysis was to examine how these elements are being constructed. In other words, in what way is the taken-for-granted "reality" or "knowledge" being initiated, sustained, transmitted and legitimized within societies?

In this thesis I asked the similar question: in what role that the tangible and intangible factors play in the process of constructing social reality? I identified the tangible factors ranging from individual agents, group cohort to institution units, societal and historical contexts. Intangible factors were observable only in their effects such as individual

2

leadership, organizational strategy and power relationships. I am primarily concerned with the dialectical interaction among individual agents, institutional units and immediate societal contexts. Berger and Luckmann argued that the process of social construction of reality is intimately tied to a particular place and time (social context). They called this context "the existential determination of thought" and emphasized "the extent to which thought reflects or is independent of the proposed determinative factors" (ibid; p. 5). In this thesis I apply their theories to a much smaller social setting and examine the specific dynamics of the existential determinative factors on the development of human thought.

Another issue I am concerned with is related to the conceptual schema in Berger and Luckmann's analysis, namely, the dichotomy between thought and its "determinative factors". This schema was necessary for it provided a conceptual framework to analyze the process of constructing social realities. In other words, thought and idea were viewed by Berger and Luckmann as separated from the social realities. I propose, however, that this dualistic schema represents one of the theoretical limitations in Berger and Luckmann's analysis. It is viewed here as an example of "dualistic reductionism"--the one-handed reliance on the dichotomous conceptual machinery. I also argue that, conceptually and practically, this schema tends to overlook the integral dynamics of ideological thought into the "determinative factors"--the social realities.

It is here that this thesis is set to overcome this "dualistic reductionism" by introducing the concept of ideology as a bridge between the two dualistic ends (object and subject). I argue that ideology or ideologies play an important role integrating object and subject into the whole social reality.

3

Given its numerous conceptions, ideology has remained a popular and controversial topic in social sciences. From a commonsensical view, ideology is often understood as a system of ideas that serve the interests for the idea beholders. It bears the features like repressing, distortion or conviction. This understanding was probably from the concept of ideology developed by Marx and Engels. Ideology for them "was condemned to reflect an inverted view of the distorted socio-economic arrangements of a decaying capitalism" (Freeden, 1998; p. 5). Clearly Marxian concept of ideology confined itself in the specific critique on capitalism. Karl Mannheim, however, extended the concept to a more general term—ideology was viewed as "to express change-resistant interests and antiquated ethical norms within the existing social order". Ideology for him seemed to obtain the ability to stray beyond its political origin. Ideology was seen as a system of mechanism revolving around the attainment of the broader social goals: "Its domain is the competition over the "correct" meaning of the concepts and ideas embedded in social goals. In a social universe which characterized by multiple, perhaps infinite, potential goals and values, *ideologies* constitute choosing and deciding mechanisms which legitimate certain meanings of the ideas and concepts available to a specific society and delegitimate others" (Freeden, 1998; p. 8, italics added).

This shift from focusing on ideology to focusing on ideologies invokes that "no longer the term [ideology] to denote a singular process (of distortion, misrepresentation, exploitation, or rhetorical obfuscation)" (p. 8). It has now become an object, a cluster of thought practices, or a set of attitudes and behaviors. Ideologies have played an important role in the process of constructing social realities and attaining various social goals. The domains and functions of the concept make it impossible separating ideologies from the

4

social realities. I have argued throughout this thesis that ideologies have transformed themselves into the *part* of an empirically detectable social reality they were previously thought to mask. Ideologies become particular kind of ideal and behavioral clusters, which occupy a specific range within the broader spectrum of social realities.

Some specific ideologies may serve better the purpose of analyzing construction of social realities than the general ideologies, for the former may reveal more nuance, dilemma and empirical complexity that may be more useful for the central theme of my analysis. For this reason I will examine two particular kinds of ideologies within the range of social realities – namely, the scientific ideology and the medical ideology.

<center>Scientific Ideology and Medical Ideology</center>

Berger and Luckmann had theorized the construction of social reality implicitly on the basis of ideology. I extend this idea by arguing that scientific (reason) knowledge is empirically constructed through certain ideological features and elements. Thomas Kuhn (1967) has similar idea and he synthesized the empirical and ideological elements into the concept of "paradigm". He successfully identified several special features of medical thinking as the intellectual roots and stimulation of his analysis of scientific paradigm. He attributed his theory of scientific knowledge to the medical way of thinking. Kuhn (1979) had claimed that Ludwig Fleck's work, *Genesis and Development of a Scientific Fact*, has had an important impact on his analysis of the constructivist perspective on scientific knowledge.

Besides Fleck and Kuhn, Osborne (1998) also tried to integrate ideology (i.e. medical ideology) into concrete realities (i.e. medical knowledge). He differed from Kuhn for he placed ideology in a central role in the construction of scientific knowledge. He

<center>5</center>

summarized two features of the concept of scientific ideology: "that such an ideology is always more than merely the 'institution' of science, and that a feature of such an ideology will be its capacity to stray beyond its own norms of scienticity" (Osborne, 1998; p. 259). Osborne had claimed that these two features of scientific ideology might be exemplified best in the modern medical thinking. In other words, modern medical discipline might be a good example of a scientific ideology; hence an example of "medical ideology" (pp. 41-50). The very idea of this phenomenon poses the question of whether, in fact, medicine can ever be a science, or in Osborne's view, whether modern medicine is inherently driven by ideology. He had suggested that "modern medicine necessarily bears the double stamp of ideology... medicine may be made up of regional rationalisms that have a scientific status, but medicine itself is not a science; in its epistemological spirit, it is rather a kind of ideology" (p. 260). Modern medical rationality is viewed as an enterprise driven by impulses that might be interpreted as ideological.

The relationship between modern medical ideology and the process of constructing scientific knowledge is explored in this thesis. In particular, the notion of medical ideology in the development of the music therapy knowledge, discipline and profession will be examined as it is related to the medical community. The concern is primarily with the process of how music therapy profession borrows the notion of science to pursue medical recognition and to gain legitimization from the medical community, and ultimately how it establishes a medical ideology that may be able to be integrated into the construction of medical knowledge.

At an empirical level, this thesis also pursues the process of professionalization of music therapy into the medical paradigm. The process of becoming a profession for music therapy was constructed by ideological impulses involving organizational action and strategy, organizational linguistics and rhetoric, and individual belief system. The thesis starts an analysis on the organizational strategies for developing the music therapy profession and a music therapy body of knowledge through research credibility. Research articles published in professional music therapy journals are then used to analyze the process of constructing a scientific basis for a newly established profession. Finally, a case study using both quantitative and qualitative methodologies is used to compare the different perspectives between music therapy researchers and practitioners regarding the scientific bases for the music therapy profession. For the quantitative part, a panel study on music therapy for people with developmental disabilities was conducted. 168 people living in public facilities receiving music therapy in 1997 and 1998 were chosen from a data set of 3,360 individuals living in Oklahoma who received services from the Department of Human Services. Four dependent variables (initiation, integration, adaptation and cognition) were chosen according to the suggestions from the music therapists in the facility. $\underline{T}$-tests are used to examine if the changes on the four dependent variables were significant between 1997 and 1998. These results were discussed with the music therapists and served as the basis for the analysis on the music therapy ideologies used to legitimize the music therapy knowledge.

CHAPTER II
THEORETICAL FRAMEWORK

Theory of the Social Construction of Reality

The starting point of this thesis's theoretical framework is concerned with a theme similar to what Berger and Luckmann (1967) had proposed – namely, the process of social construction of reality and the process of ideologizing influences on human thought and human knowledge. Specifically, my central argument is that the process of constructing scientific realities is viewed as an enterprise driven by the impulses that could be interpreted as ideological.

The first aspect of the starting theoretical point came from the work by Peter Berger and Thomas Luckmann (1967)–*The Social Construction of Reality*. Berger and Luckmann had explicitly contended that "the sociology of knowledge is concerned with the analysis of the social construction of reality" (p. 3). Their analysis was initially justified by the "vertigo of relativity"— the vast accumulation of historical scholarship, especially that of German philosophy in the nineteenth century (p. 5). A variety of epistemological dimensions of human thought such as from Kant, Hegel, Niezsche, Marx and Dilthey led scholars to "the concern to investigate as painstakingly as possible the concrete relationships between thought and its historical situation" (p. 3). The sociology of knowledge thus took up this concern and attempted to examine the relationship between human thought and the social context within which it arises.

Berger and Luckmann's analysis on the relationship between thought and its social context was developed from two intellectual traditions in nineteenth-century German thought – the Marxian and the historicist perspectives.

8

Marx's scheme of substructure/superstructure provided a dialectic framework for the relationship between concrete human activity (substructure) and the world produced by that activity (superstructure). The relationship is reciprocal and dialectic in which the substructure determines and precedes the superstructure; and at the same time, the superstructure actively influences and shapes the substructure. For the historicist tradition, the dominant theme was a sense of relativity of all perspectives on human events; that is, the inevitable historicity of human thought. This historicist heritage predisposed sociology of knowledge toward an emphasis on the use of historicist methods to examine any development of human thought and ideas.

The second aspect of the starting theoretical point originated from two other traditions in the sociology of knowledge. One of them is concerned with the analysis of the relationship between "ideal factors" (*Idealfaktoren*) and "real factors" (*Realfaktoren*) developed by Max Scheler. Scheler's analysis was "regulative" and modest, for Scheler argued that the "real factors" regulate the conditions under which certain "ideal factors" can appear in history, but cannot affect the content of the latter. "In other words, society determine the presence (*Dasein*) but not the nature (*Sosein*) of ideas" (Berger & Luckmann, 1967; p. 8). Karl Marx differed from Scheler for his analysis was reciprocal and dialectical and Scheler's was only one directional.

The other tradition came from Karl Mannheim's sociology of knowledge. Mannheim also differed from Scheler since he viewed society as determining not only the appearance but also the *content* of human ideation. Moreover, Mannheim expanded Marx's conception of ideology. Marx emphasized the material factors over ideology and he limited and underestimated the role of ideology in the construction of concrete reality.

9

His emphasis was on the influence of historical material conditions over ideological structures, not vice versa. Mannheim, on the other hand, separated ideology from the empirical concrete reality. He "distinguished between the particular, the total, and the general concepts of ideology – ideology as constituting only a segment of an opponent's thought; ideology as constituting the whole of an opponent's thought and ... ideology as characteristic not only of an opponent's but of one's *own thought* as well" (cited in Berger & Luckmann, 1967; p. 9). Ideology, from Mannheim's view, has the ability to stray away from its concrete reality and to formulate its own "thought structure". This feature of ideology may explain how social relativity of human thought are cast a drift from a particular context, shaping and influencing other forms of ideas. Given Mannheim's concept of general ideology, one of the theoretical goals in this thesis is reached – "the understanding of no human thought... is immune to the ideologizing influences of its social context" (p. 9).

The third aspect of the starting theoretical point is more directly related to how society has been simultaneously characterized by the three moments proposed by Berger and Luckmann-- externalization, objectivication and legitimization. First, Berger and Luckmann (1967) had argued that externalization starts from man's necessity for social order which stems from man's biological equipment. "The instability of human organism makes it imperative that man himself provide a stable environment for his conduct" (Berger & Luckmann, 1967; p. 52). They argued that social order is a human product produced in the process of ongoing externalization. Second, through the process of externalization and institutionalization, human knowledge and the institutional world are "experienced as possessing a reality of their own, a reality that confronts the individual as

10

an external and coercive fact" (p. 58). This process by which the externalized products of human activity attain the character of objectivity is characterized as "objectivation". Externalization and objectivation are the moments in a continuing dialectical process ("the product acts back upon the producer"). The third moment of this process is internalization "by which the objectivated social world is retrojected into consciousness in the course of socialization" (p. 58). Put differently, Berger and Luckmann had indicated that each of these three moments in social reality corresponds to an essential characterization of social world -- "society is human product, society is an objective reality, and man is a social product" (p. 59).

The fourth aspect of the starting theoretical point is concerned with the *legitimation* of scientific knowledge. Berger and Luckmann (1967) had stressed that "knowledge .... is at the heart of the fundamental dialectic of society" (p. 66). Following remarks revealed this emphasis in detail:

> "It [knowledge] 'program' the channels in which externalization produces an objective world. It objectifies this world through language and the cognitive apparatus based on language, that is, it orders it into objects to be apprehended as reality. It is internalized again *as* objectively valid truth in the course of socialization. Knowledge about society is thus a *realization* in the double sense of the world, in the sense of apprehending the objectivated social reality, and in the sense of ongoingly producing this reality" (p. 66, italics added)

Legitimation, therefore, plays a crucial role in the process of "ongoingly producing reality". Legitimation is defined by Berger and Luckmann as a "second order" objectivation of the knowledge meaning. The function of legitimation is to make objectively available and subjectively plausible the "first -order" objectivations that have been institutionalized. Legitimation has two elements: 1) it explains the institutional order by ascribing cognitive validity to its objectivated meaning, and 2) it justifies the

11

institutional order by giving a normative dignity to its practical imperatives. Most of hed

writers have argued that one of the key features of ideology is legimation (Gerring, 1997).

Ideology is not just a matter of "values", it always implies "knowledge" as well. I have

also argued in this thesis that ideology, as a *means* of legitimating scientific knowledge,

has reached its *end*. It has become part of the legitimized scientific knowledge. The

ideological characteristics of legitimized knowledge are presented in the latter part of this

thesis from the formation of certain aspects of social reality — the formation of the music

therapy profession and knowledge.

Medical Roots of the Constructivist Perspective

The second main theoretical framework came from the analysis on the relations of

constructivist perspective with medical knowledge. In this thesis I am concerned with the

conceptual construction of one specific aspect of medical knowledge--therapeutic

knowledge. According to Berger and Luckmann (1967), one of the applications of the

"universe-maintaining conceptual machinery" used to transfer society into objective

reality was therapy. The authors argued that "therapy entails the application of

conceptual machinery to ensure that actual or potential deviants stay within the

institutionalized definitions of reality" (p. 113). Therapy is the means by which scientific

ideology put into practice. It is a field applying the legitimating apparatus to individual

"cases" and what interests the authors is the *conceptual* aspect of therapy. "Since therapy

must concerns itself with deviants from the 'official' definitions of reality, it must

develop a conceptual machinery to account for such deviants and to maintain the reality

thus challenged" (p. 113). This necessitates the construction of a body of knowledge that

includes a theory of deviance, a diagnostic apparatus, and a conceptual system for the

"cure of souls". Similarly, this thesis proposed that music therapy as a newly established therapeutic profession, it also require a system of knowledge that can be accountable and justifiable for the existence of a unscientific method (music) used as a form of therapy. If we think music as a form of art, therapy then becomes a form of science.

The constructivist characteristics of therapeutic knowledge mentioned above is reflected and embedded in general medical knowledge. The prioritization of everyday experiences in constructing medical practice requires a body of knowledge that can be recognized and legitimized as "scientific" knowledge in order to justify the existence of the medical profession. Several scholars (Kuhn, 1979; Lowy, 1989; Osborne, 1998) have recognized this phenomenon, and they considered these features of medical knowledge stimulated and contributed to the analysis of social construction of reality. This consideration was specifically presented in Kuhn's work (1979) regarding the roots of his analysis on scientific knowledge. In the preface of the second edition of his book *The Structure of Scientific Revolutions*, Kuhn (1979) had mentioned five historians and philosophers of science who have influenced his thinking: Emile Meyerson, Annelise Maier, Alexandre Koyre, Helene Metzger and Ludwig Fleck. Concerning the last, Kuhn explained that he discovered Fleck's major work, *Genesis and Development of a Scientific Fact* (first published in 1935) in the 1950s

> "I was reassured by the existence of his book, a non-trivial contribution because in 1950 and for some years later I know no one else who saw in the history of science what I was myself finding there. Very probably also, acquainted with Fleck's text helped me to realize that the problem which concerned me had a fundamental sociological dimension" (Kuhn, 1979; P. VIII).

Lowy (1989) also explored the intellectual roots related to the theories of Thomas Kuhn and Berger and Luckmann — the study of the sociology of scientific knowledge.

13

Ludwig Fleck, Lowy contended, "was indeed among the first to advocate the investigation of the historical, sociological and cultural roots of scientific knowledge" (p. 39). But interestingly enough, Fleck was "neither a philosopher nor a sociologist, and had no institutional ties with the sociological or with the philosophical milieu" (p. 40). He was a *physician* and started his epistemological reflections with the article, *Some Specific Features of the Medical Way to thinking* (1927). Fleck argued that the goal of medical knowledge is "the so-called diagnosis – the filling of a result into a system of distinct disease entities, and this assumes that such entities actually exist, and that they are accessible to analytic method" (cited in Lowy, 1989; p. 40). But in fact, diseases are "ideal fictitious pictures, known as morbid units, around which the individual and the variable morbid phenomena are grouped, without, however, ever corresponding completely to them" (p. 40). The pathological phenomena are so complex that they do not allow the formation of a unified vision of a given "disease". Thus, different views of the same "disease" each dependent on different points of view on pathological phenomena, co-exist at the same time. Fleck developed several ideas that were considered later as the genesis of the constructivist perspective. These ideas included 1) the dependence of every observer's "thought collective", 2) the collective genesis of "scientific facts", 3) the interdependence of the scientific and the lay "thought styles", and 4) the vision of science as a complex socio-cultural phenomenon that should be investigated by historical, sociological and psychological methods. Most importantly, "Fleck's first epistemological articles, drawing on his experience as physician and bacteriologist and inspired by his vision of medicine, contained, however, the full breadth of his *theories of science*" (pp. 41-42; italics added).

14

Reflections on the epistemological aspect of medical knowledge partially stimulated the development of a constructivist perspective on the study of scientific knowledge, at least at the empirical levels. Following this stimulation, theorization of social construction of reality continuously draws the intellectual elements from the epistemological studies of medicine and other disciplines as well. But the importance of the ideological aspects of the constructivist perspective has been greatly underestimated and overlooked by previous scholarships. In recent year, analysis of the relationship between medicine and ideology (or "medical ideology"; see Osborene, 1998) has contribute a great deal to the analysis on the ideological dynamics of the constructivist perspective.

<center>Integrating Ideologies into the Constructivist Perspective</center>

This thesis seeks to integrate ideological and contextual elements into the constructivist perspective. To me there appear to be at least three major theoretical limitations Berger and Luckmann's constructivist theory of social construction of reality. First is the lack of attention on the role of ideology in the process of constructing realities. Second can be characterized as the "decontextualizaton of theorization" in the constructivist perspective. The third one is related to the notion of *"dualistic reductionism"*--- the one-handed reliance on a dichotomous conceptual schema. I will address the first two in detail and briefly discuss the latter one in the conclusion part of this thesis.

<u>The concepts of ideology</u>

It is impossible and also unnecessary within the scope of this thesis to provide a comprehensive definition for ideology, given its "perplexing and polysemic" nature. As

<center>15</center>

Freden (1998) points out, "any attempt to carve out a single meaning would be a harmful, and artificial, exercise in controlling language. But that doesn't mean that we should not try to make sense out of a confusion which threatens to undermine the usefulness of the term 'ideology' as well as to obfuscate the phenomenon (or perhaps phenomena) which the term signifies" (p. 5). The debate over the concept of ideology has remained in political science but the concept can be extended to other social sciences and to general human knowledge.

After a quick perusal of the definitions of ideology, Gerring (1997) indicated that conceptually, ideology remains a highly flexible and contradictory tool:

> "One is struck not only by the cumulative number of different attributes that writers find essential, but by their more than occasional contradictions. To some, ideology is dogmatic, while to others it carries connotations of political sophistication; to some it refers to dominant modes of thought, and to others it refers primarily to those most alienated by the status quo (e.g., revolutionary movements and parties). To some it is based in the concrete interests of a social class, while to others it is characterized by an absence of economic self-interest." (p. 957)

Among the definitions that Gerring demonstrated, I have chosen the following concepts of ideology which are closely related to the constructions of social knowledge:

> "Systems of belief that are elaborate, integrated, and coherent, that justify the exercise of power, explain and judge historical events, identify political right and wrong, set forth interconnections (causal and moral) between politics and other spheres of activity" (McClosky, 1964; p. 362).

> "Maps of problematic social reality and matrices for the creation of collective conscience" (Geertz, 1964/1973; p. 220).

> "A system of collectively held normative and reputedly factual ideas and beliefs and attitudes advocating a particular pattern of social relationships and arrangements; and aimed at justifying a particular pattern of conduct, which its proponents seek to promote, realize, pursue or maintain" (Hamilton, 1987; p. 39)

Given this "semantic confusion", Gerring (1997) had proposed a "comprehensive framework containing all attributes regularly associated with "ideology" in contemporary

16

social science discourse" (p. 964). I have chosen several the attributes from his comprehensive framework that are closely related to the analysis of social construction of knowledge. This deliberate act may also be viewed as "ideological" and served for the purpose of the analysis. As Karl Mannheim astutely commented, "the very way in which a concept is defined and the nuance in which it is employed already embody to a certain degree a prejudgment concerning the outcome of the chain of ideas built upon it" (Mannheim, 1936; p. 197). The chosen attributes from Gerring's comprehensive framework of ideology are listed in Figure I and will be elaborated later.

Figure I

An excerpt from Gerring's comprehensive definitional framework for ideology

1. Location	4. Function	6. Cognitive / affective structure
(a) Thought	(a) Repressing	(a) Simplicity
(b) Behavior	(b) Integrating	(b) Distortion
(c) Language	(c) Legitimating	(c) Conviction
2. Subject matter		(d) Dogmatism
(a) Power		
3. Subject	5. Motivation	
(a) Any group	(a) Interest-based	
(b) Any group or individual		

Source: Gerring (1997)

1. Location.

This attribute is concerned with "where is ideology located – in the mind, in behavior, or in language?" (a) Thought. Gerring (1997) contended that "the traditional common sense approach is to look at ideology (which meant originally a 'science of ideas') as a set of beliefs, values, principles, attitudes, and/or ideals" (p. 964); but (b) "Behavior

17

Ideologies, unlike political philosophies, are not isolated from real-world political d in dilemmas. Rather, ideologies direct, or at least influence, political behavior". In this sense, it is impossible to study ideological phenomena as purely ideational. It has taken more concerns with the set of practices that ideologies propose to act upon; (c) the third y attribute is more related to the current analysis: Language. Gerring (1997) had argued pl that "the rules, regularities, and principles of any ideology, according to this one of the p contemporary line of argument, derive not so much from the intentions of the ideologists (their values and beliefs), but rather from the linguistic norms in which they are embedded. It is impossible, therefore, to evaluate values, beliefs, attitudes, and principles independently of the speech, or speech-acts, in which they are manifested" (p. 965)

2. Subject matter.

(a). Power. This attribute enables ideology a "peripatetic term fining its territory difficult to demarcate". Campbell et al. (1960) noted that "by origin and usage its connotations are primarily political, [but] the scope of the structure is such that we expect an ideology to encompass content outside the political order as narrowly defined- social and economic relationships, and even matters of religion, education, and the like" (p. 967). Ideology has the ability to stray away from its origin and form its own thought structure in other territory. "Consequently, ideology is often defined as pertaining more broadly to relationships based on power, coercion, or domination. "Ideologies," writes Birnbaum (1960), "appear wherever systematic factual assertions about society contain . . . evaluations of the distribution of power, including aesthetic and moral statements about the human situation" (p. 91). One currently popular definition of ideology is the "discourse plus power" – or more generally, "the ways in which meaning (or

18

signification) serve to sustain relations of domination" (Thompson, 1984; p. 4; cited in

Gerring, 1997; p. 967).

3. Subject.

(a) Any group. The ability of stepping outside of its political domain entails ideology

applying to any group. Ideologies "are group beliefs that individuals borrow; most people

acquire an ideology by identifying (or disidentifying) with a social group" (Lane, 1965; p.

15); and (b) Any group or individual: many scholars have applied the word ideology as a

property possessed by a single individual or a group of individuals.

4. Function.

(a) Repressing. Ideology, when utilized in non-political sphere, also tends to self-

consciously manipulate languages or strategies to achieve a given goal. Thompson

(1984) acknowledges that "ideology allows only certain things to be communicated and

discussed... It not only 'expresses' but also 'represses'" (p. 86).

(b) Integrated. Gerring (1997) had acknowledged that "perhaps the foremost exponent

of ideologies as mechanisms of social integration was Talcott Parsons. In The Social

System (1951: 349-50), Parsons wrote of ideology as 'a system of beliefs, held in

common by the members of a collectivity . . . which is oriented to the evaluative

integration of the collectivity, by interpretation of the empirical nature of the collectivity

and of the situation in which it is placed, the processes by which it has developed to its

given state, the goals to which its members are collectively oriented, and their relation to

the future course of events.' Here, ideology functions to bind individuals to a community

by establishing an authoritative set of norms and values. Ideologies 'provide the

19

individual with a sense of identity and belonging' serving to achieve 'social solidarity and cohesion'" (cited in Gerring, 1997; pp. 968-969).

(c). Legitimating. Gerring (1997) noted with irony that "the legitimation function of ideology is understood to be illegitimate" (p. 969). According to this understanding, "ideology 'legitimates' – i.e., make legitimate-action, whether or not those actions are in support of or in revolt against the established order" (p. 969).

5. Motivation.

(a) Interested-based. The concept of "interest" has been changed from its original Marxian meaning – material interest – to a broader concept which may refer "to group interests and even to self-interest, and to a set of tangible and intangible interests which include position, status, power, and perquisite" (Gerring, 1997; p. 968). "An ideology," Elster (1982) writes, "is a set of beliefs of values that can be explained through the (non-cognitive) interest or position of some social group" (p. 123). Whether the ideology actually serves the interests of the group in question, or is dysfunctional in this respect, the origin of the system of values is thought to be traceable to the social position of the group in question (for this point, also see Geertz 1964/1973).

6. Cognitive/Affective structure.

(a) Simplicity. One of the features of ideological rhetoric is its simplicity. Sutton et al. (1956) claim that "Ideology tends to be simple and clear-cut, even where its simplicity and clarity do less than justice" (pp. 4-5; quoted in Geertz 1964/1973; p. 209).

(b) Distortion. Another common feature of ideology is distortion. "Each new class which puts itself in the place of one ruling before it," wrote Marx and Engels (1970; p. 6566), "is compelled, merely in order to carry through its aim, to represent its interest as

20

the common interest of all the members of society, that is, expressed in ideal form: it has to give its ideas the form of universality, and represent them as the only rational, universally valid ones." Gerring noted that in Marx's writings and particularly in the German Ideology, a "realm of real history" is counterposed to a "realm of ideology". He further pointed out that "this sense of distortion is likewise the gist of Mannheim's 'particular' definition of ideology, which denotes a 'more or less conscious disguise . . . of the real nature of a situation the true recognition of which would not be in accord with [the ideologists] interests'" (quoted in Naess et al. 1956; p. 166).

(c) Conviction. Ideologies are related to a system of beliefs that are strongly held. There is an element of conviction to any ideology. Gerring (1997) noted that "ideology is often equated with a deep, passionate, or emotional sort of commitment" (p. 972).

(d) Dogmatism. Marx and Engels (1970) referred repeatedly to society's ideologists as "dogmatic". As Gerring (1997) pointed out that to many writers of the postwar generation, ideologies were 'secular religions', characterized by their obstinacy in face of facts, counterarguments, and opposition of any sort. A good summation of this view is provided by Loewenstein (1969; p. 335), who writes: 'It is characteristic of the religious that it does not admit degrees of acceptance. Being absolute by nature it must either be accepted or rejected; there are only believers and heretics'" (cited in Gerring, 1997; p. 973).

These attributes of general ideology will serve a framework for later analysis on the specific medical ideology and scientific ideology. There will be overlapping parts between the general ideology and the specific ideologies, and some features of specific ideologies may not be reflected in the attributes of the general ideology discussed above.

21

<u>Scientific Ideology and Medical Ideology</u>

In most recent years, analysis on the relationship between medicine and ideology, or science and ideology, has brought a renewed interest in the understanding of the general conception of ideology and the ideological aspects of the constructivist perspective of human knowledge.

For example, in his most recent work, *Medicine and Ideology*, Thomas Osborne (1998) discussed in detail the concept of scientific ideology as developed by Canguilhem (1988). Canguilhem contended that scientific ideology is "less a false programme of science so much as one that was useful, even decisive, with regard to the advent of something like a genuine science" (Canguilhem, 1988, p.33; also see Osborne, 1998, p. 259). Osborne (1998) summarized two features of Canguilhem's concept of scientific ideology: "that such an ideology is always more than merely the 'institution' of science, and that a feature of such an ideology will be its capacity to stray beyond its own norms of scienticity" (p. 259). These two features of scientific ideology might be exemplified best in modern medical thinking. That is, the modern medical discipline might be a good example of a scientific ideology; hence an example of "medical ideology". The very idea of such phenomena poses the question whether in fact medicine can ever be a science, or in Osborne's view, whether modern medicine is inherently driven by ideology. In fact, he suggested that "modern medicine necessarily bears the double stamp of ideology... medicine may be made up of regional rationalisms that have a scientific status, but medicine itself is not a science; in its epistemological spirit, it is rather a kind of ideology" (p. 260). Modern medical rationality is thus viewed as an enterprise driven by impulses that might be ideological. In other words, the process of constructing scientific

22

medical knowledge may have inherently ideological origins and features. Modern

medical ideology may be "more than merely the institution of science" and has the

tendency to stray beyond the limits of its own epistemological norms.

In the latter part of this thesis, the relationship between modern medical ideology and

scientific knowledge will be explored. In particular, the notion of medical ideology in the

development of the music therapy profession will be discussed in detail as how it relates

to the broader atmosphere of medical community. My primary concerns are on the

process of how a newly established profession, i.e. music therapy, borrows the ideological

strategies and the legitimacy of the scientific model to pursue its medical recognition and

gains legitimation from the medical community. And to what extent music therapy

established a type of medical ideology that bears the attributes of the general and specific

ideologies. I suggested in the end how to integrate the ideological analysis of medical

knowledge into the analysis of the constructivist perspectives on human knowledge.

CHAPTER III

THE DEVELOPMENT OF MUSIC THERAPY KNOWLEDGE

In this Chapter I will discuss how music therapy knowledge has been constructed as a "scientific" medical profession. Music therapy has adopted ideological strategies to develop a scientific basis for the profession. Before turning to the field of music therapy profession, it is helpful to present a brief history of how modern medicine emerged and became a profession or a therapeutic practice. The music therapy profession was developed within the context of the broader medical sphere and was largely influenced by the general medical practice.

A Brief History of the Development of the Medical Profession

Most ancient and oriental societies (China, India and Japan) considered disease to be an outcome of the supernatural characteristics of human body. Early Christianity viewed sickness as punishment for sin and it was not surprising that the Church dogma dominated theories and practice of medicine and that priests were physicians. Renewed interest in ancient Greek medical knowledge in the Renaissance in Europe marked the beginning of a drift toward natural medicine and the emergence of medicine as an occupation separate from the Church (Cartwright, 1977).

During the first half of the 19th century the organization of the medical profession began to emerge in America, and sought to establish "regular" system of medical practice, despite its "lack of any substantial body of usable scientific knowledge" (Rothstein, 1972; p. 27). As Conrad and Kern (1990) pointed out, about 1800, "regular", or educated physicians convinced state legislatures to pass laws limiting the practice of medicine to practitioners of a certain training and class (prior to this nearly anyone could claim the

24

title "doctor" and practice medicine) (p. 142). Furthermore, the "regular" practitioners

who practiced "heroic" therapy such as bloodletting, vomiting, blistering, and purging,

were concerned about the public resistance and opposition to their highly interventionist

form of medicine. A number of competitive and less dangerous forms of medical sects

("irregular" practitioners) emerged in this context, such as homeopathic and botanical

physicians. No doubt the regular physicians were concerned about the competition and a

group of them founded the American Medical Association (AMA) in 1847 "to promote

the science and art of medicine and the betterment of public health" (cited in Conrad &

Kern, 1990; p.142). The AMA was set to enforce standards and ethics of "regular"

medical practice and to strive for exclusive professional and economic rights to the

medical turf. The drives may essentially be "interested-based".

The AMA was the turning point of the regular doctors' attempt to "professionalize"

medicine. As Magali Sarfatti Larson (1977) pointed out, professions organize to create

and control markets. Organizational professions attempt to regulate and limit the

competition, usually by controlling professional education and by limiting licensing. The

development of the music therapy profession appears no exception. It follows the similar

path of developing the medical profession through a process of borrowing "scientific"

knowledge from medical community.

Constructing a "Scientific" Basis for the Music Therapy Profession

The use of music in medicine originated from mythology, biblical stories and the uses

of music in tribal medicine and other cultures. There is a large literature on the historical

use of music in medical and industrial settings (Soibelman, 1948). It was often pointed

out that music is the oldest art form associated with helping the ill. Benenzon noted that

25

the use of music to influence the human body was first mentioned in writings in Egyptian medical papyri dating back to 1500 BC (Bunt, 1994). In the field of psychiatry Goodman (1981) traced the history of including music in psychiatric practice back to early Arabic-Hebraic traditions (pp. 564-83).

But music therapy as a modern medical profession was developed gradually after WWII. Identification of a physiological basis for music therapy played a large part in the emergence of music therapy in the USA. The advent of psychoanalysis and the work of Freud and Jung and their successors provided a major scientific legitimating point for the emerging profession. For example, Engel (1977) proposed a biopsychosocial model of illness that emphasized the integral relationship and interconnectedness between the mind and the body and the influence that each has upon the other. He contended that psychosocial phenomena can contribute to biomedical illness and, conversely, biomedical illness is associated with changes in psychosocial phenomena. Many music therapists at this time believed that the use of organized sounds and music within an evolving relationship between client and therapist can be supportive and helpful for physical, mental, emotional and social well-being.

One aspect of the well being relies on the mutual interaction for people with various physical or mental deficiencies. Music therapists at this period of time also believed that music could be helpful in the communication processes of the human brain such as reminiscence and memory restoring. This belief is largely based on the theory of the relationship between music and communication. For example, Franco (1993) proposed that if we take into account the two means of expression -- melody and rhythm -- in the process of communication, voice and movement, we can associate them in music: (p. 85)

26

$$\frac{\text{VOICE}}{\text{MOVEMENT}} = \frac{\text{MELODY}}{\text{RHYTHM}}$$

Thus music can be used as a more or less structured language to establish better relation through communication or with the aim of increasing the ability to communicate with an individual who does not suffer from a definite pathology. At the same time, music may be used in specific situations where there is an evident pathology in which the communication process is damaged and where one is trying to repair such a fault within a more global therapeutic project to which the individual is entrusted.

It appears that in the beginning of promoting a new profession, music therapy adopted the psychoanalysis, psychosomatic and communicative models of pathology as the key theoretical components to develop a scientific image in order to gain recognition from other medical professions.

During the 1950s to 1980s music therapists have turned their theoretical interests from the psychoanalytical approach to the behavioral therapy approach, which was the emerging form of the psychological medical knowledge at that time. The behavioral model emphasized direct observation and documentation of externally observable behaviors to justify a medical intervention. It quickly became the supporting arm for the music therapy profession and the basis for research in combination with the psychoanalytical model.

There are many examples of the use of a behavioral model of research in contemporary music therapy research. For example, Bunt (1987) investigated the relationship between childhood development and processes in music therapy on children with handicaps. He used questionnaires to assess the role of music therapy and video

27

analysis to examine external behavioral changes in children as a consequence of music therapy. The same type of research was also conducted by Pavlicevic and Trevartten (1989) who looked at the effects of music therapy in enhancing the rehabilitation of chronic schizophrenics. Their study compared a matched group of 21 patients who attended irregular music therapy sessions with 20 patients who participated in regular weekly sessions. When they examined the impact of the programming of music therapy practice on external behavioral changes, the researcher concluded that the results showed significant improvement in their musical interaction rating scores and in formal psychiatric measures for the group that participated in regular individual sessions.

Similarly, Standley (1986, 1992) conducted two meta-analyses of experimental research in music and medicine. The results of her analyses revealed that the subjects who receive music as part of the medical treatment generally scored about one standard deviation above the mean on dependent variables compared to the control subjects. These dependent variables included anxiety, perceived mood, attitudes, perceived contentment, responses to hospitalization, distraction from medical procedure, sleep satisfaction, choice of anesthesia, helplessness and pleasure.

Furthermore, several studies have focused on examining the effect of musical materials in improvisational music therapy. Dunachie (1992) studied the comparative improvisations of mentally handicapped adults and pre-school children. Lee's study (1992) was concerned with both the analysis of the structure of music and the critical moments in improvisation, such as moments of high emotion, moments of depression and silence. Studies have also been geared toward investigating the physiological effects of sound and music on certain physical and psychological conditions. Vibroacoustic therapy

28

has emerged as an adjunct form of music therapy involving the passive treatment of clients with a combination of relaxing music and a pulsed low frequency tone. There were also several studies that examined the effects of this treatment on clients with cerebral palsy, anxiety, and self-injurious behavior. (Skille, Wigram & Weeks, 1989; Wigram, 1993).

In their research comparing music therapy and inflammatory bowel disease, Aldridge and Brandt (1991) identified the value of music therapy as stimulating emotions, enhancing coping responses and enabling recovery. Several complementary medical applications indicated that one of the values of music therapy is at the pre-disease stage where people who build up stress-related disorders can benefit before the disorder becomes an acute or chronic disease or illness (Aldridge, 1990; Aldridge and Pietroni, 1987; Aldridge and Brandt, 1991).

There were also several studies involving the use of videotapes to evaluate the external behavioral effect of the music therapy programs. Oldfield (1990) compared the differences between music therapy and play activity in clients with severe learning difficulties, analyzing videotapes to see what behavioral changes occurred. Also, Odell-Miller (1993) compared the effects of music therapy with reminiscence therapy in a group of elderly people with mental illness. The results showed that music therapy was most beneficial when held on a regular weekly basis. Observational methods such as video and observational analysis were used to evaluate significant events in the patient's behaviors. Lawes and Woodcock (1993) also used video analysis to study the observable effect of music therapy sessions with clients who have self-injurious behavior.

29

But at the same time researchers had felt the inadequacy or inappropriateness of using quantitative methods in music therapy research. They have been pursuing alternative approaches other than the use of traditional controlled methods of research that have been the predominant direction of American music therapy research and psychotherapeutically based work. For example, in Europe researchers in the third music therapy conference in Paris in 1987 began to explore various alternative methods such as video sampling and self-evaluation in order to satisfy the characteristics of music therapy (Reason and Brown, 1981; Hoskins ,1987; Payne, 1993). In Germany the medical faculty of the University of Witten/Herdecke has also explored such alternative methods as ethnology or clinical anthropology. The principles of ethnology of clinical anthropology can be summarized as follows: (1) the process of research is built up from the early observations that are made up of what is happening in the therapy; (2) questions which are raised from the observations stimulate the next stage of research; and (3) a single case design as a result of individual music therapy sessions is usually the predominant modality of work after research questions have been raised (Aldridge, 1990).

During recent decades a third school of alternative method (humanistic psychology) began to emerge in music therapy research under the growing influence of naturalistic inquiry on the medical field. In the UK, for example, Ritchie (1993) conducted case studies to observe the effect of music therapy intervention on people with learning difficulties who display challenging behavior. She wrote "I have tried to show the benefits of a *humanistic* and *pschodynamic approach* to music therapy for people with severe learning difficulties who display challenging behavior. By valuing the client's actions and non-verbal communications through *interpreting* them, musically or verbally,

30

I believe that this client group can be given the chance to change their institutionalized way of living and become more spontaneous and free thinking people." (p. 101; italics added).

But the alternative approaches to music therapy research have not been widely accepted within the profession. This is partly due to the fact that gaining acceptance of the clinical value of music therapy by mainstream medicine still depends on *hard evidence* from the controlled studies. The strategy has to turn into developing "transferable" scientific evidences within medical community even though the outcomes of this strategy is not very satisfactory. The intention is to get music therapy recognized as a legitimate profession. It is an intention appearing "legitimating" and "distortion" in the sense that music therapy selectively chose certain theoretical bases for the purposes of promotion and legitimization, not for the purpose of developing "scientific" knowledge. Thompson (1984) acknowledged that "ideology allows only certain things to be communicated and discussed. . . . It not only 'expresses' but also 'represses'" (p. 86). Ideologies always involve choosing and deciding mechanisms which legitimate certain meanings of the ideas and concepts available to a specific society and delegitimate others.

One example of relying on the hard evidence to gain acceptance of the values of music therapy, presented at the 1996 annual meeting of the National Association for Music Therapy (NAMT), came from Mcintosh and Thaut. They reported on the effects of rhythmic auditory stimulation in improving the mobility of patients with stroke or Parkinson's disease. The rhythmic stimulation, or cueing, is delivered by metronome pulses embedded in the music, which is recorded on audiotapes and listened to over headphones. Patients choose the music they like. Results do not seem to be related to the

31

kind of music chosen according the researcher. The Colorado group first studied

rhythmic cueing in normal people to obtain baseline data. Even normal individuals have

wide variations in their walking patterns, McIntosh noted, but when those in the

experiment were given the rhythmic cueing, stride variability was reduced. In the stroke

study, 10 patients, half with left hemiplegia and half with right hemiplegia, were given

rhythmic auditory stimulation 30 minutes a day for 3 weeks. At the end of this time, the

patients had improved their cadence, stride, and foot placement compared with patients

who had not been given auditory stimulation. In addition to ensuring patients' walking

patterns, the Colorado group takes surface electromyographic readings of the muscles

used in walking—including the gastrocnemius, tibialis anterior, and vastus lateralis--

before and after auditory stimulation to document the timing and magnitude of changes in

the patients' gait. The therapists have also studied rhythmic auditory stimulation in

patients with Parkinson's disease and similar "improvement" in walking patterns

compared with controls were reportedly obtained. The primary clinical importance of

music is not its emotional or motivational value, Thaut noted, but the neurological effects

that improve motor control. When muscle activity is synchronized to auditory rhythm it

becomes more regular and efficient. "The brain is organized in a complete pattern.

Stride length, step cadence, symmetry, posture, everything, is centrally, not segmentally,

related. So when one improves on one of these parameters, everything else comes into

place. *This fits in very well with modern theory about motor control,*" he explained

(Marwick, 1996; p. 270, italics added)

Music therapy researchers attempt to collect hard "scientific" evidence in order to

"fit" music therapy knowledge well into the modern scientific and medical theories (i.e.

32

neurological effects of music on motor control in Thaunt's study). It is difficult to due to

discern the actual research process in these studies since only the findings in favor of

music therapy have been reported in the meeting. But some of the research rhetoric may

reveal the "shaky" ground of these "scientific findings". These findings appear vague in

content, arrogant in nature, and ideological in essence. Consider following accounts

about one study on the effects of music therapy on stroke patients:

> "A study reported by Scotland's Purdie was also designed to show the effects of music therapy on stroke patients. It involved 40 long-term institutionalized stroke patients randomly assigned to music therapy or standard care... Purdie reported that, after 12 weeks of music therapy involving sessions of about 40 minutes per day, treated patients showed *some signs* of being less in depressed, less anxious, more emotionally stable, more interactive, and more motivated to cooperate and communicate than did a control group... Purdie noted that *although the small numbers of patients* in her study do *not* permit drawing firm conclusions, the findings suggest that music therapy *may* have contributed to improvements in behavior, communication, and psychological state." (Marwick, 1996; p. 270, italics added).

This research rhetoric may be interpreted from another point of view that "some

signs" and "small numbers of patients" are the essential hindrances to draw the final

conclusions. There is no surprise that the word "may" appears in the conclusion

sentence. The organization of research jargons appeared to be vague and convictional.

This is the feature of "repressing" in music therapy ideology in which the researches not

only "express" the favorable findings but also "repress" the non-favorable ones. In

reviewing these research, one need to pay close attention not merely to the procedures and

findings of the research which has been self consciously projected, but also to that which

remains submerged.

It is quite understandable that in the beginning of developing a new profession, music

therapy has to assemble hard evidences to achieve recognition from the peer professions.

But this task has remained extremely difficult for music therapy researchers partly due to the nature of the medium. Even after 50 years of its establishment, the National Association for Music Therapy (NAMT)'s 1996 annual meeting still addressed the need to assemble evidenced. As Michael H. Thaut said that collecting hard evidence "will allow us to break into the mainstream of acceptance" (Marwick, 1996; p. 269).

Previous summary of the process of developing music therapy knowledge reflected some aspects of how the dominant "scientific" knowledge and ideologies have influenced the construction of the music therapy knowledge. The central modalities of music therapy research have revolved around psychoanalytic, behavioral and neurological theories with a recent excursion to the fields of clinical anthropology and humanistic psychology. The predominant mode of inquiry is positivistic in nature and methods being used vary from baseline-comparison, meta-analysis to standardized statistical design and case study. Studies also centered around evaluating the effect of music therapy on physiological, psychological and behavioral aspects of human being, using questionnaire and videotapes to collect hard evidence and to justify the findings. But as the analysis has shown that traditional controlled methods have been more adopted by the music therapy researchers than other alternative approaches in order to assemble hard evidences to justify the existence of the profession, despite the suspicion and controversies among music therapy researchers. The ultimate "conviction" for music therapy is to break into the mainstream of acceptance. This developed strong bias toward traditional quantitative methodology over other approaches. In this sense, the process of developing music therapy profession is not a process of developing reasonable scientific knowledge, rather,

it is a process of socially constructing a professional image through the selected research activities to justify the existence. The strategy and mindset appear ideological in essence.

As Peter Conrad and Joseph Schneider (1990) suggested, "the status of the medical profession is a product of medical politicking as well as therapeutic expertise" (p. 141). The development of music therapy may be no exception in this aspect. It is a process of establishing music "therapeutic expertise" through the marriage with the dominant "scientific" knowledge (psychoanalysis, behavior therapy, etc.) permeating the medical community. Promoting the medical profession in general and music therapy in particular, therefore, appears a pragmatic process of developing a scientific ideology rather than developing "scientific" knowledge.

The process of developing the music therapy profession always involves the recognition and legitimization of a collective image in constructing theoretical and "scientific" bases in the peer professional community. In this sense, music therapy organizations also played an important role in the ideological aspects of promoting the profession.

CHAPTER IV

ORGANIZATIONAL STRATEGIES FOR DEVELOPING

THE MUSIC THERAPY PROFESSION

There were two major organizations for the music therapy profession: the National

Association for Music Therapy (NAMT) and the American Association for Music

Therapy (AAMT). The common goal of these two organizations is to promote music

therapy profession through the establishment of research credibility in the medical

community, but the strategies they adopted were quite different due to the differences in

their perspectives about the role of music in medicine.

Strategy from the National Association for Music Therapy

A perusal of articles published during the formation period of the National

Association for Music Therapy (NAMT) revealed that research using quantitative

methodology such as descriptive and experimental methods were important

organizational issues in promoting the profession. The original constitution of NAMT,

formulated at the founding meeting on June 2, 1950, included the promotion of

progressive uses of music in medicine, the establishment of educational standards, and

the encouragement of research (Gilliland, 1953). To encourage and report research

articles was the first one of six objectives promoted by the new professional organization

(Gilliland, 1952; p. v).

The National Association for Music Therapy (NAMT) leaders played an important

role in shaping the music therapy research and in developing its professional basis. For

example, the Research Committee was the only standing committee originally provided

for in the formation of the Association (Boxberger, 1963). The committee included two

music scholars and two physicians who were interested in the therapeutic applications of music. More directly, the president of National Association for Music Therapy (NAMT), Esther Gilliland, expressed the need for research articles in a paper entitled "*The Development of Music Therapy as a Profession*":

> "While many of the effects of music on the human organism have been measured scientifically, it has been pointed out that *more research is necessary*. It is expected that those trained in therapeutic procedures will be able to spend a portion of their time in research... The National Association for Music Therapy is pledged to promote *experimental* studies and to publicize significant findings... Fellowships need to be established for research projects throughout the country so that *scientific* methods may be established" (p. xii; italic added)

In 1955, results of a NAMT-supported survey on the uses of music in institutions included the recommendation that "scientific" methods were needed to determine how music therapy functions in the clinical setting (Boxberger, 1963). Books of Proceedings from NAMT during the formation period from 1952 to 1962 included a section labeled "Research" which contained not only abstracts but also the issues addressed by music therapists, psychologists, and physicians of the pressing need for adopting scientific methods to justify music therapy.

It is clear that the early leaders of NAMT espoused the experimental and positivistic mode of inquiry. Being a young association, NAMT had to establish credibility and recognition among the medical community (Aigen, 1991). As Gaston stated:

> "The music therapist finds himself in a world highly concerned with scientific endeavor, yet he has chosen the most subjective of the arts as a functional medium... finding himself in juxtaposition to medical science, and being young professionally, he feels he must achieve status, respect and confidence. One of the best means for the accomplishment of this will be research" (Gaston, 1957, p. 227; cited in Gfeller, 1997, p. 38)

In her 1958 presidential address, Dorothy Brin Crocker expressed the similar sentiment:

37

"We have always recognized the importance of research... Research is, and will always be, one of the most significant and certainly one of the most challenging goals in the advancement of Music Therapy. It is difficult because of the many variables... It requires being objective about the subjective... Objective research will give scientific validity to many techniques we have found to be effective, confirm or deny some of our suppositions, and eventually open the door to greater understanding concerning the influence of music on behavior" (Crocker, 1959, p. 16).

The fact that the early Research and Executive Committee of NAMT consisted mainly of physicians, psychologists, and psychiatrists also played a predominant or even a "distortional" role in adopting the positivistic mode of inquiry for music therapy research. The music therapy professionals vigorously advocated scientific, experimental studies but some of them expressed concerns over the adequacy and appropriateness of using experimental design in music therapy research. Jules Masserman, MD, a psychotherapist and one of the first members of the NAMT Research Committee, advised greater stability in the preparation of music therapists before seeking recognition from the American Psychiatric Association (APA) and the American Medical Association (AMA) (Boxberger, 1963). Abe Pepinksy, Chief of Psychological Services at Norristown State Hospital, stated:

"We have come to an important crossroad on our path toward a search for truth in Music therapy. We are leaving behind those who are still given to ruminating on the virus of David's treatment of Saul's depression with his playing of a few well chosen selection on his harp. The psychiatrist is amply justified in his scathing criticism of repeated emphasis of uncontrolled observation and wishful thinking. He will, however, give due credit to more scientific studies and controlled experimentation... The psychiatrist resents unproven statements such as "It has been found that music lessens the fury of the most violent cases."... Masserman warned that we have no verification of foci of influence of music in the cerebral process. In fact, we still gave to answer the baffling question as to how music really affects the mind... Where do we go from here? To the left, we will be urged to do more and better basic research. To the right, we will be tempted to evolve better theoretical considerations of stimulus-response... It is important that we make frequent excursions in both theses directions (Pepinsky, 1955, pp. 235-236).

38

It is evident that both patrons of music therapy and NAMT leaders "advocated a particular type of research based upon the medical model" (Gfeller, 1997; p. 39), research that could be fitted into the traditional, psychological model – "research that could explain music's influence through physiological and psychological processes"(pp. 40-41). The concern over the "appropriate" model of music therapy research was developed among NAMT leaders such as A. Flagler Fultz, E. Thayer Gaston, and Donald Michel to the extent that they "admonished members that unsubstantiated claims about music's healing power were unacceptable" (Aigen, 1991; cited in Gfeller, 1997, p. 41). The quest for recognition of music therapy among therapeutic professions led the early leaders to establish a strong "distortional" bias toward experimental research, particularly toward the research examining the physiological and psychological response to music. The principle modes of early studies, in turn, were largely drawn from the frameworks of behavioral, positivistic and psychoanalytical theory. This was reflected both in the mindset of early NAMT leaders described above and in the trends of articles published in NAMT from 1964-1985.

It is clear that the early leaders hoping "to establish credibility within the medical community through scientific research, would establish a strong bias toward experimental research, particularly that examining physiological and psychological response to music" (Gfeller, 1997, p. 40). But the extent to which this young organization used experimental research to produce an appropriate scientific base within its early years is quite another issue. Boxberger (1963) wrote, "it was apparent that the deficiency of *scientific* research in music therapy was almost as great as it had been ten years previously" (p. 189; italic added). Scientific research here equates with the traditional, experimental mode of

39

inquiry in music therapy research, not including philosophical and historical research which did appear in the early volumes of the *Journal of Music Therapy*. This "conviction" only to experimental research using psychoanalytic and behavioral theories among early leadership in NAMT was developed and shaped by the internal characteristics of members in Research and Executive Committee of NAMT and the dominance of scientific methods among therapeutic profession external to the NAMT. These influences will be discussed in the next section of this chapter.

This sketch of the NAMT history provided partial information on how organizational ideologies have an influence (through leadership, strategy) on developing the scientific basis for the music therapy profession. It revealed the difficulties as well as the struggles in promoting music therapy as a medical profession due to the uncertain role of music in medicine. For the past 20 years, the American Association for Music Therapy (AAMT) has also contributed to the promotion of music therapy profession and research.

Strategy from the American Association for Music Therapy

According to Gfeller (1997), a second professional group, the American Association for Music Therapy (AAMT), initially known as The Urban Federation for Music Therapists, was organized in 1971. Gfeller (1997) summarized four purposes of the organization related to research issues based upon the personal communication with Dena Condron:

1. To stimulate, guide, and direct research of music therapists nationally.

2. To publish the results of such research in scientific papers and in professional journals and to authorize publication of the results of such research by other educational institutions without compensation payable to the corporation.....

40

6. To furnish grants in aid to investigators who propose to undertake study and
   research in the field of music therapy.

7. To promote the exchange of information among the various individual and
   institutions engaged in the practice and research of music therapy nationally.

These stated purposes were similarly included in the NAMT's early leadership efforts

to promote the music therapy profession through credible and sophisticated research

activities. However, as Gfeller (1997) noted, "the early professional initiatives within

AAMT suggest that research activity may initially have had a lower priority for this

organization" (p. 42). He went on to demonstrate that "for example, research abstracts

and bibliographic sources were disseminated in official NAMT documents from the First

Book of Proceedings of 1951. In contrast, no publication for disseminating research was

forthcoming for the first decade of AAMT history" (p. 42). While both NAMT and

AAMT were facing scarce financial resources in their early period, the publication of

scientific papers was clearly not an organizational priority in AAMT's agenda.

It was not until 1981, ten years after its establishment, that AAMT sponsored an

annual journal called *Music Therapy*. As one can see from Table II, *Music Therapy*

differed from the *Journal Music Therapy* in the type of articles accepted in its

publication. From 1981-1993, of the research articles were published in the *Journal*

Music Therapy 94% are descriptive or experimental research articles, whereas only 38%

of the articles of same type were published in *Music Therapy*. At the same time span

53% of the articles published in *Music Therapy* were of the case study mode of inquiry,

which was considerably more than the percentage of the same type of articles in the

Journal Music Therapy (2%). According to the *Publications Manual of the American*

41

Due to the potential differences between the NAMT and AAMT, Hunter had contended that a development that will ultimately facilitate the expansion of music therapy in clinical practice is a reorganization of the two professional groups of music therapists. As Hunter noted in the 1996 Annual meeting, "we will never realize our full potential as long as there are two associations whose missions cause them to compete with each other and confuse the public, third-party payers, government agencies, and our clients." In January 1998 the National Association for Music Therapy (NAMT) and the American Association for Music Therapy (AAMT) merged into one organization as the American Music Therapy Association (AMTA). This step enabled advocates of music therapy to speak with one voice for the music therapy profession in order to delegitimate other approaches that are potentially "harmful" for the acceptance of music therapy profession.

Besides the influence from the professional organizations, research articles published in music therapy journals also has demonstrated the impact of changes in scientific method on shaping and promoting the music therapy profession.

Current Research Trends in Music Therapy

There were several content analyses studying the research trends among articles published in professional music therapy journals. For example, Jellison (1973) had analyzed the major publications of the National Association for Music Therapy (NAMT) including books of proceedings (published from 1952 to 1962) and the *Journal of Music Therapy*. She obtained a total of 153 articles, and the content of those articles by mode of inquiry is listed in her analysis as shown in Table I. Her analysis showed that from 1964 to 1972 there was a considerable increase in the percentage of experimental studies. The

43

Association for Music Therapy (AAMT, 1983), many types of articles were to be included, with experimental research or case studies listed among the types of articles acceptable for publication (e.g. theoretical papers; critical reviews of literature, research, or treatment; articles illustrating treatment, education, or training approaches) (Gfeller, 1997; p.42). Furthermore, the large portion of case study research and discipline-related topics in *Music Therapy* maintain the focus on clinical practice.

The organizational goals and aspirations expressed in the formative years of both NAMT and AAMT included the promotion of research activity (Gfeller, 1997; p. 43) in order to establish professional identity and credibility. Although NAMT and AAMT may appear having different view on the type of music therapy research but gaining legitimation and recognition for music therapy have remained the same for both associations. There are indications that music therapy is gaining greater acceptance due to the efforts of both associations. One was noted by Bryan C. Hunter, the president of the National Association for Music Therapy (NAMT) from 1993 to 1995, who said in the 1996 Annual Meeting for the NAMT that the Health Care Finance Administration now includes music therapy as a reimbursable service under certain conditions in Medicare's partial hospitalization policies. Obtaining universal third-party reimbursement for their members' services has been one of both associations' goals for at least 3 years. "If you take a poll of physicians at random, they may not have even heard of music therapy," Hunter said in an interview. "If they have, they probably think of it as a sort of fringe thing. But among physicians who have had some experience, who have received the services of a good, competent music therapist in treating patients, I think you would find strong support for music therapy."

42

percentages of philosophical articles declined dramatically, and there was barely any historical research done at that time. While she reported a large proportion of descriptive articles, it is important to know that her definition for descriptive research included not only surveys, case studies, and correlational studies but also articles describing programs and activities. Only 16.6% of the descriptive articles were data based (see Gfeller, 1997).

In 1979, Gilbert updated Jellison's analysis of the content of the *Journal of Music Therapy*, categorizing articles published from 1973 to 1978 by mode of inquiry. One hundred and fifteen articles were examined and similar trends were identified: (1) philosophical research declined further still, (2) experimental research increased as the proportion of total output, (3) descriptive research maintained a position of prominence, and (4) only a few historical articles were published (see Table I). In 1987, Codding looked at 158 articles published in the *Journal of Music Therapy* between 1977 and 1985. She found that the research mode of inquiry was predominantly experimental, and statistical designs were more prevalent than were behavioral designs in experimental research. Descriptive research appeared in less than one-third of the total articles, and there was barely any philosophical and historical research presented over this period (see Table I).

Table I

Trends in Research from 1964 to 1985 in the *Journal of Music Therapy* as Reported by Jellison (1973), Gilbert (1979) and Decuir (1987): Percentage of Articles by Mode of Inquiry

Mode of Inquiry	Years							
	1964-66	1967-69	1970-72	1973-75	1976-78	1977-79	1980-82	1983-85
Philosophical	41%	39%	13%	28%	7%	0%	2.0%	2.0%
Descriptive	44%	41%	54%	36%	48%	25.9%	22.5%	30.6%
Experimental	13%	20%	33%	33%	45%	46%	61.2%	53.1%
Historical	2%	0%	0%	3%	0%	0%	4.1%	4.1%

Source: Gfeller (1997)

There was another study done by Decuir (1987) in which he examined articles published in the *Journal of Music Therapy* from 1964-1986. Different from Jellison (1973), Gilbert (1979) and Codding (1987), Decuir only made an attempt to include research articles in which quantitative data were presented. According to Decuir, the *Journal of Music Therapy* contained a total of 346 articles from 1964 to 1986, 206 of which met his definition of a research article. The research articles can be classified as follows: (a) 51% of the articles were on discipline topics, (b) 19% were on profession topics, (c) 20% were on foundational topics, and (d) 10% were on related topics.

Besides NAMT, AAMT sponsored *Music Therapy (MT)* as a major journal since its inception in 1981 until 1992. Interesting differences existed between the *Journal of Music Therapy* and the *Music Therapy*. Gfeller (1997) noted that the overwhelming proportion (89%) of research articles in the *Journal of Music Therapy* have been experimental or descriptive studies, while the *Music Therapy* contains 47% data-based

45

articles. He also pointed out that there was also considerable difference in the type of research conducted: almost half of the research published by AAMT used the case study as the mode of inquiry. In contrast, NAMT had published almost exclusively descriptive quantitative and experimental research. The fact that NAMT has also supported another more clinically oriented journal, *Music Therapy Perspectives (MTP)*, while AAMT has only one journal to disseminate all writings, may in part explain the difference. But even before the establishment of the *Music Therapy Perspectives*, according to Codding (1987), the great majorities (75.9% from 1977 to 1979, 87.8% from 1980 to 1982) of articles in the Journal of Music Therapy were descriptive and experimental research rather than clinical articles (see table II).

Table II

Trends of Research in MT and JMT from 1981-1993:
Percentage by Mode of Inquiry and Topic as reported by
Gfeller (1997)

Mode of Inquiry	Music Therapy	Journal of Music Therapy
Descriptive or experimental	38.0%	94.0%
Case study	53.0%	2.0%
Philosophical	8.0%	0.0%
Historical	3.0%	3.0%
Topic		
Discipline	88.0%	65.0%
Professional	13.0%	16.0%
Foundation	3.0%	15.0%
Related	0.0%	5.0%

Source: Gfeller (1997)

In summary, the leadership of the National Association for Music Therapy (NAMT)

and the American Association for Music Therapy (AAMT) adopted a similar strategy

promoting the music therapy profession through the establishment of scientific research

credibility and recognition in medical community, as also reflected in recent research

trends. The extent to which of this strategy was successful is largely debated among

music therapy researchers and practitioners. As Charles Marwick (1996) stated,

"however, those practicing music therapy and treating patients have almost entirely

limited their publications to single case studies, occasional reports of small groups of

patients, and anecdotal accounts. The result has been that any beneficial effects have not

made much of an impression on clinical medicine" (p. 277). In the 1996 annual meeting

of the National Association for Music Therapy (NAMT), several speakers noticed that

47

music therapists have been reluctant to subject their work to scientific study. Heather Purdie, a music therapist at Woodend Hospital in Aberdeen, Scotland suggested that this reluctance might stem from the expressive, creative nature of the medium. But like her colleagues, Purdie also recognized the need to provide evidences of the efficacy to secure professional credibility and validity. "It is increasingly urgent for music therapists to be able to demonstrate that the intervention they offer is both effective and efficient in a competitive market."

Some researchers thus began to question the appropriateness and suitability of the experimental mode of inquiry in early stage of music therapy studies. For example, Aigen (1991) argued those research methods traditionally useful in other fields, such as psychology and the biological sciences, have been essentially imposed on music therapy research due to professional self-consciousness in efforts to gain acceptance within the health care field at large. He asserted that methodology borrowed from psychology is poorly suited for answering questions about the creative process, especially music therapy processes such as improvisation (p.55). For example, the concept of generalizability in traditional positivistic inquiry has been defined as the ability of research findings to be applicable to all contexts within the same population. Aigen has questioned this concept of generalizability based upon following beliefs: "(a) music therapy in a generalized sense (even limiting it to particular techniques) can never be evaluated as such because clinical practice varies greatly among practitioners---it has no generic structure; (b) sharing a disability does not make a group of individuals into a meaningful class in determining how they may respond to music therapy; (c) because a positive therapeutic relationship is a salient component of music therapy treatment, one can never make generalized

48

statements about the efficacy of a treatment method that does not take into account these unique relationship dynamics" (Aigen, 1995; p. 303). Other researchers have expressed the same concern and tried to reevaluate the organizational ideology of the marriage between positivistic mode of inquiry and music therapy research (Brusica, 1995). The split view over the use of traditional scientific methodology becomes gradually apparent within the music therapy community. Following chapters are set to address this concern and reevaluate the organizational strategies and ideologies in a particular setting.

METHODOLOGY: A CASE STUDY OF MUSIC THERAPY PRACTICE

This chapter examines the process of how music therapy organizational ideologies have been adopted among music therapy practitioners in the efforts to promote a scientific profession. The differences between music therapists' perceptions and the findings obtained from a quasi-experimental panel study will be compared in order to gain insight on the split view between music therapy research and the perceptions from music therapy practitioners.

The procedures of a panel study for people with developmental disabilities will be presented in the first part of this chapter, including subjects, measurement, and statistical design. Presentations of the findings from the study are analyzed in a subsequent chapter, and these results are used to compare to the qualitative data gathered from the music therapists regarding their evaluation on the effect of music therapy included in the quantitative study. This comparison finally will be examined for the role of the ideology as a means used to legitimize the music therapy knowledge.

Subjects

A panel study of the subjects who participated in music therapy in Oklahoma in 1997 and 1998 was conducted. The subjects were a sub-sample of individuals in the data set of all family/caregivers and individuals with developmental disabilities living in Oklahoma and receiving services from the Department of Human Services Developmental Disabilities Services Division (3,359 in 1997; 3,230 in 1998). Subjects in this study were individuals with developmental disabilities living in two public facilities in Oklahoma who received music therapy in 1997 (N=168, the Therapy Group). The control group

included those who did not receive music therapy but lived in the same public facilities in 1997 (N=351, the Non-Therapy Group). The majority were diagnosed primarily with mental retardation (73.2%, n=123) with less than six percent of them having hearing impairments (5.4%, n=9). Less than half of the subjects in both years used gesture as their principle mode of communication (41.1%, n=69), and a few of them were capable of using verbal language (29.2%, n=49). Almost all the subjects did not use sign language or alerting devices to communicate. With regard to the types of disabilities of subjects, approximately half of them had physical disabilities (43.5%, n=73); one third of the subjects had visual impairment and multiple disorders; and a few of them had hearing impairment, autism and seizure epilepsy (see Table 3).

Table III

Characteristics of the sample in 1997 and 1998

Characteristics	1997		1998	
	N=168	(%)	N=187	(%)
Gender				
Male	103	(61.3)	105	(56.1)
Female	65	(38.7)	82	(43.9)
Diagnosed Level of Retardation				
Mild	12	(7.1)	10	(5.3)
Moderate	10	(6.6)	10	(5.3)
Severe	21	(12.5)	23	(12.3)
Profound	123	(73.2)	143	(76.5)
Unknown	1	(0.6)	1	(0.5)
Principle Mode of Communications				
Verbal	49	(29.2)	36	(19.3)
Sign language		--	2	(1.1)
Communication device	3	(1.8)	4	(2.1)
Alerting device		--	2	(1.1)
Gesture	69	(41.1)	62	(33.2)
Other Disabilities				
Visual impaired	52	(31.0)	75	(40.1)
Hearing impaired	9	(5.4)	8	(4.3)
Physical disabilities	73	(43.5)	103	(55.1)
Autistic	8	(4.3)	10	(5.3)
Multiple disorder	41	(24.4)	49	(26.2)
Seizure, epilepsy	7	(4.2)	9	(4.8)
Cerebral palsy		--	69	(36.9)

Measurement

The independent and dependent variables were chosen from the Developmental Disabilities Quality Assurance Project (DDQAP) questionnaire which was used to collect quantitative data through the interview regarding the well being of people with developmental disabilities. The independent variable involved the quantity of music therapy experienced. Caregivers in the two facilities were asked by the interviewers to indicate the number of hours the consumers participated in the music therapy per month. Dependent variables were asked of both caregivers and individuals in the facilities by the interviewers. Four groups of dependent variables were chosen after the researcher visited the facility and later were revised according to the recommendations from the music therapists. The four groups included initiation, integration, adaptation and cognition. Initiation refers to behaviors that are self-motivated. Integration includes behaviors and skills involved in the group interaction inside and outside the facilities. Adaptation involves behaviors and skills related to retention, motor performance and endurance, and ability to use sign and verbal language. Cognition is defined as the skills related to attention to activity and understanding of numbers. The response categories for the four variables were not the same for each item. These four dependent variables are listed as follows:

Initiation. Fourteen questions (items) were asked about the initiation of social activities. These questions were: (1) Does s/he initiate most of own activities, initiate some of own activities, will engage in activities only if assigned or directed, or will not engage in assigned activities? (2) Does s/he initiate group activities at least some of the time (leader and/or organizer), participate in group activities spontaneously and eagerly

(active participant) and does not participate in group activities (unless physically guided)? (3) Does s/he choose their activities or does someone else choose their activities? (4) Does s/he choose their friends or does someone else choose their friends? (5) Does s/he choose what food to eat at home or does someone else choose what food they eat? (6) Does s/he choose what food to order in a restaurant or does someone else choose for them? (7) Does s/he choose how to spend money or does someone else choose for them? (8) Do you choose the clothes you will buy or does someone choose for you? (9) Do you choose the clothes you will wear or does someone choose for you? (10) At home, do you choose the food you will eat or does someone choose for you? (11) In a restaurant, do you choose the food you will eat or does someone choose for you? (12) Do you choose how you spend your money or does someone choose for you? (13) Do you choose your own friends or partners or does someone choose for you? and (14) Do you choose what you will do or does someone choose for you? Questions from (1) to (7) were asked of caregivers and the response categories range from yes or maybe assisted (3) through sometimes (2), to no/paid staff makes these decisions or family/friends makes these decisions (1). Questions from (8) to (14) were asked of consumers and the response categories ranged from yes, nice, like, good, always or frequently (3) through sometimes or occasionally (2) to no, mean, bad, never or don't like (1).

Integration. Nine questions that were related to the frequencies of group interaction within and outside the facilities were included in this category. These questions were: (1) How often did s/he go out to visit with friends, relatives, or neighbors? (2) How often did s/he go out to visit a supermarket or food store? (3) How often did s/he go out to a restaurant? (4) How often did s/he go out to a shopping center, mall, or other retail store

54

to shop? (5) How often did s/he go out to recreational activities (movies, arcades, etc.)? (6) How often did s/he go out to the bank? (7) How often do you visit your family? (8) How often do you visit your friends? and (9) How often do you visit with your advocates? Questions from (1) to (6) were asked of caregivers and the response categories range from more than twice a week (5), twice a week (4) and once a week to 2-3 times a month (3), once a month (2) less than once a month (1), and never (0). Questions from (7) to (9) were asked of consumers, and the response categories ranged from yes, nice, like, good, always or frequently (3) through sometimes or occasionally (2) to no, mean, bad, never or don't like (1).

Adaptation. This category refers to adaptive behavior skills related to motor performance and endurance, retention and ability to use sign and verbal language. There were six questions. The first question was Does s/he use knife and fork correctly and neatly (7), use table knife for cutting and spreading (6), feed self with spoon and fork - neatly (5), feed self with spoon and fork - considerable spilling (4), feed self with spoon - neatly (3), feed self with spoon - considerable spilling (2), feed self with fingers or must be fed (1)? The second was How is his/her sense of direction? Does s/he go several blocks from grounds, or from home, without getting lost (4), go around grounds or a couple of blocks from home without getting lost (3), go around cottage, ward, or home without getting lost (2), and demonstrate no sense of direction (1)? The third was Does s/he sometimes use complex language containing "because", "but", etc. (4), ask questions using words such as "why," "how", "what," etc. (3), communicate in few words, short phrases or simple sentences that make sense (2), does not communicate verbally, with sign language or communication device (1)? The fourth question was Does s/he say a

few words (7), sign a few words (6), nod head or smile to express happiness (5), indicate hunger (4), indicate wants by pointing or vocal noises (3), express pleasure or anger by vocal noises (2), chuckle or laugh when happy (1)? The fifth was Does s/he understand instructions containing prepositions, e.g., "on," "in," "behind" (4), understand instructions referring to the order in which things must be done, e.g., "first do this, and afterward, do that" (3), understand instructions requiring a decision, e.g., "put on your shorts, but if they are dirty, put on your jeans" (2) and none of the above (1)? Lastly was Does s/he recognize significant others (5), recognize others (4), have information about others (3), know the names of people close to him/her (2), and know the names of the people not regularly encountered (1)?

Cognition. This category included two questions. The first was Does s/he pay attention to purposeful activities for more than 30 minutes (5), about 15 minutes (4), about 10 minutes (3), about 5 minutes (2) and will not pay attention to purposeful activities for as long as 5 minutes (1). The second was Does s/he do simple addition and/or subtraction (6), count 10 or more objects (5), mechanically count from one to ten (4), count two objects by saying "one" and "two" (3), discriminate between "one" and "two" (2), and has no understanding of numbers (1)?

<div align="center">The Statistical Design</div>

In 1997, there were 168 individuals participating in music therapy (the Therapy Group) in two mid-western state resource centers. Music therapy has been provided for people with developmental disabilities over nine years. Only baseline averages on all dependent variables in 1997 were calculated in this study. Averages on the same dependent variables were also calculated for the same 168 individuals in 1998. T-tests

<div align="center">56</div>

then were used to examine if the changes on the dependent variables were significant between these two years. In the mean time, a control group (the Non-therapy Group) was formed and consisted of the individuals living in the same type of facilities who did not have music therapy in 1997 and 1998. The same t-tests as performed in the Therapy Group were repeated to examine the changes on the same dependent variables between the two years. It was expected that in the Therapy Group, there would be significant differences on the dependent variables scores between 1997 and 1998 with the scores being higher in 1998 than that in 1997 ($p= .05$, 1-tailed) due to the persistent exposure of music therapy. While in the Non-therapy Group it was assumed that there would be no significant differences on mean scores of each dependent variable between 1997 and 1998. Finally the sample of 168 individuals in therapy was broke down into two sub-samples: the Non-Profound Therapy Group and the Profound Therapy Group. The same t-tests used in the Therapy Group were performed on each dependent variable in order to determine whether the level of mental retardation has impact on the mean scores between 1997 and 1998. It was hypothesized that there were more significantly different items in the Profound Therapy Group between 1997 and 1998 than that in the Non-Profound Therapy Group.

Reliability

The test-retest reliability of the dependent variables in the DDQAP questionnaire has been examined in Dodder, Foster, Bolin's (1999) research. Caregivers and consumers were revisited within six months of the original interview. These researchers concluded that there was high reliability for integration and adaptation skill scores ($r= .93$).

Cognitive behaviors and initiative activity questions, however, displayed lower reliability

correlations between .59 and .76.

Validity

The validity of this study first relies on the trustworthiness of information gathered by

interviewers over the last ten years. The instrument was originally developed by the

experts in the Pennusrt study (Conroy & Bradley, 1985) and later modified to fit the state

situation. Interviewers in Developmental Disabilities Quality Assurance Project

(DDQAP) received total 30 hours of formal training, and were supervised in the field.

Although there were probably social desirability biases among caregivers responses since

the research had been court ordered as part of the quality assessment, caregivers had

developed personal trust to ensure the trustworthiness of the data. For the consumer

interview, visual techniques (picture book, sign language) have also been developed to

enhance the communication between interviewers and consumers. Finally, one of the

means in Table 4 and 5 (initiate own activities) was hand calculated from the raw scores

in order to verify the correctness of the computer output. It was found that the results

from hand calculations were the same as the output generated by statistical commands.

Generalizability

Perhaps this design would be generalizable to the field of music therapy for people

with developmental disabilities living in public facilities. Since the therapy program is

conducted in a highly individual manner, the findings of the effect of one certain program

probably won't be applicable in general. In fact, researchers in the music therapy field

have rejected the notion of generalizability based upon following beliefs: "(a) music

therapy in a generalized sense (even limiting it to particular techniques) can never be

58

evaluated as such because clinical practice varies greatly among practitioners---it has no

generic structure; (b) sharing a disability does not make a group of individuals into a

meaningful class in determining how they may respond to music therapy; (c) because a

positive therapeutic relationship is a salient component of music therapy treatment, one

can never make generalized statements about the efficacy of a treatment method that does

not take into account these unique relationship dynamics" (Aigen, 1995; p. 303). This

study rejects the emphasis on producing generalized statements oriented toward providing

the music therapist with the powers of prediction and control. It instead focuses on the

description of music therapy practices in one public facility in Oklahoma and on the goal

of achieving insight and understanding for music therapy research.

Limitations

There are several limitations inherent in this statistical design due to variety of

reasons. The first is the sample size. Less than six percent of the total individuals

participated in music therapy (5% in 1997, 5.8% in 1998). This was partly due to the fact

that music therapy has not been fully recognized in DRG (Diagnostic Related Groups)

and practiced in the mid-western state. In 1997 and 1998 the number of participants in

music therapy was much less than that participating in other therapies such as physical

therapy and occupational therapy. Statistically, a small sample size requires greater

differences to be significant. Second limitation is the lack of prolonged involvement and

persistent observation in music therapy sessions practiced in the field. Lastly,

longitudinal data are not fully available for quantitative and qualitative analysis. Music

therapy has been practiced in the state since 1991 but the questionnaire used only

collected information on music therapy for 1997 and 1998.

In sum, this quasi-experimental design assessing music therapy has been carefully carried out based upon the practical situation such that it meets the requirements of a standardized design to secure reliability and validity of the findings. Efforts have been devoted to eliminate the impact from other factors and to concentrate on the effects of music therapy on the people with developmental disabilities. Researchers have visited the facility twice in order to ensure the credibility of the design and also to obtain field data.

FINDINGS OF STATISTICAL DESIGN

Finding in the Therapy Group

Table 4 shows the means, correlated t-values and probabilities of the four dependent variables in 1997 and 1998, respectively. Overall there were 12 items with scores higher in 1998 than in 1997 as expected. However, 16 out of 31 mean scores were lower in 1998 than the same scores in 1997. Correlated t-tests showed that ten items (more than chance) were significantly different between the two years, but only four of them were higher in 1998 as hypothesized by the researcher. The other six items received lower scores in 1998 than that in 1997. Thus the main hypothesis of this statistical analysis was not supported.

In the Initiation variable, the mean scores in 1997 and 1998 demonstrated opposite patterns between caregiver and consumer responses. Specifically, according to caregiver responses, six out of seven items were higher in 1997. The exception was the item "Choose food at home" which had equal scores in both years. However, according to consumer responses, it was the reverse situation in which six out of seven items were higher in 1998 and only the item "Choose what to do" was higher in 1997. Also among caregiver responses, the items "Choose activities" and "Choose own friends" were significantly different across two years with higher scores in 1997 ($p= .05$, 1-tailed).

For the Integration variable, five of six items were higher in 1997 than in 1998 according to caregiver responses with only one item "Go out to bank" being significantly higher in 1998 than in 1997 ($p= .05$, 1-tailed), suggesting that those with therapy were having more chances of going out to a bank in 1998 than they were in 1997.

Furthermore, the item "Visit friends" for consumer responses was significantly different between 1997 and 1998 with the score in 1998 higher than that in 1997 (p=.05, 1-tailed).

In the Adaptation variable there were only two out of six items scoring higher in 1997 than in 1998 and the remaining four were higher in 1998 than that in 1997. Among these latter four items, the means of two items "Have sense of direction" and "Understanding instructions" were significantly different in 1997 and 1998. Both of them favored 1998, suggesting that music therapy had an impact on the development of adaptive skills related to finding directions and understanding instructions.

In the Cognition variable, the item "Attention to purposeful activities" received a higher score in 1997 than in 1998; and the item "Understanding of numbers" was higher in 1998 than in 1997. T-tests showed that neither difference was significant between the two years (p= .05, 1-tailed).

Table IV

Means and T-tests for the Therapy Group in 1997 and 1998

Dependent variables	1997	1998	t	P (1-tailed)
Initiation				
Caregiver responses(N=120)				
Initiate own activities	1.20	1.16	0.42	0.68
Initiate group activities	0.73	0.63	1.16	0.15
Choose activities	1.98	1.80	2.38	0.02*
Choose own friends	2.94	2.24	4.47	<.01*
Choose food at home	1.77	1.78	-0.14	0.89
Choose food in restaurant	2.50	2.24	1.39	0.17
Choose how to spend money	1.65	1.52	1.59	0.11
Consumer responses (N=14)				
Choose clothes to buy	1.64	1.79	-0.38	0.71
Choose clothes to wear	1.85	2.38	-1.17	0.27
Choose food at home	1.36	2.14	-1.56	0.14
Choose food in restaurant	2.33	2.56	-0.48	0.65
Choose own friends	2.10	2.62	-1.17	0.27
Choose how to spend money	1.86	2.00	-0.37	0.72
Choose what to do	1.85	1.38	1.15	0.27
Integration				
Caregiver responses (N=120)				
Visit with friends/relatives	1.12	1.01	0.97	0.34
Visit supermarket/food store	1.10	0.91	2.14	0.03*
Go out to a restaurant	3.07	3.03	0.32	0.75
Go out to shopping	3.08	2.84	2.04	0.04*
Go out to recreational activities	3.78	3.51	2.37	0.02*
Go out to the bank	0.01	0.07	-2.72	<.01*
Consumer responses (N=13)				
Visit family	2.44	2.44	0.00	1.00
Visit friends	1.62	2.38	-2.13	0.05*
Visit advocates	2.44	1.22	2.23	0.06
Adaptation (N=120)				
Use silverware	2.17	1.93	2.10	0.04*
Have sense of direction	1.08	1.36	-2.20	0.03*
Use complex language	0.42	0.38	0.67	0.51
Recognize words	0.19	0.41	-1.86	0.07
Understand instructions	0.62	1.14	-3.09	<.01*
Recognize others	2.31	2.55	-1.42	0.16
Cognition (N=120)				
Attention to activities	1.19	1.14	0.43	0.67
Understanding of numbers	0.47	0.73	-1.54	0.13

* Statistical significant (p= .05, 1-tailed); The italic scores were higher in 1997 and the blackened ones were higher in 1998.

63

Findings in the Non-Therapy Group

Table 5 shows the means, correlated t-values and probabilities of the four dependent variables in 1997 and 1998 in the Non-therapy Group. Overall, there was only one item, "Understanding instructions", out of 31 items which was significantly different across the two years (p=.05, 1-tailed). This result could have occurred by change when making 31 comparisons. This was considerably fewer significant differences than the results (12) in the Therapy Group. Comparing the direction of differences in the mean scores in 1997 and 1998, 15 of 31 items were higher in 1997 and only 13 of 31 were higher in 1998.

Furthermore, most of the mean scores in the Therapy Group generally scored lower than that in the Non-therapy group in the same year. Specifically, in 1997 there were 27 items scoring lower in the Therapy Group and only seven of 31 variables scored higher in the Therapy Group than in Non-therapy Group. And in 1998 20 variables had lower means in the Therapy Group while 11 variables were higher in the Therapy Group. This feature suggested that the Therapy Group and the Non-therapy Group were not equivalent since these two groups differed from each other in 1997 on the dependent variables selected. The differences may indicate that music therapy was probably provided for individuals who initially had lower abilities on Initiation, Integration, Adaptation and Cognition skills.

Table V
Means and t-tests for Non-Therapy Group in 1997 and 1998

Dependent variables	1997	1998	t	P (1-tailed)
Initiation				
Caregiver responses (N=19)				
Initiate own activities	1.79	1.95	-0.72	0.48
Initiate group activities	1.37	0.95	2.04	0.06
Choose activities	2.26	2.10	1.00	0.33
Choose own friends	3.00	2.68	1.68	0.11
Choose food at home	2.42	2.42	0.00	1.00
Choose food in restaurant	3.73	3.26	0.65	0.52
Choose how to spend money	2.00	1.74	1.32	0.21
Consumer responses (N=5)				
Choose clothes to buy	2.40	1.80	1.50	0.21
Choose clothes to wear	1.80	2.60	-1.40	0.24
Choose food at home	1.40	1.60	-0.25	0.82
Choose food in restaurant	2.25	0.75	3.00	0.06
Choose own friends	2.40	1.80	1.00	0.37
Choose how to spend money	1.40	2.80	-2.33	0.80
Choose what to do	2.00	2.20	-1.00	0.37
Integration				
Caregiver responses (N=19)				
Visit with friends/relatives	1.58	1.42	0.62	0.55
Visit supermarket/food store	0.47	0.84	-1.44	0.17
Go out to a restaurant	2.63	2.63	0.00	1.00
Go out to shopping	2.68	2.11	1.93	0.07
Go out to recreational activities	3.68	3.16	2.14	0.05*
Go out to the bank	0.00	0.05	-1.00	0.33
Consumer responses (N=5)				
Visit family	2.50	2.25	1.00	0.40
Visit friends	1.80	2.60	-1.37	0.24
Visit advocates	2.50	2.00	0.52	0.64
Adaptation (N=19)				
Use silverware	2.11	1.74	1.51	0.15
Have sense of direction	0.84	1.74	-1.33	0.20
Use complex language	0.79	0.79	0.00	1.00
Recognize words	0.50	0.39	0.70	0.50
Understand instructions	1.53	2.26	-1.17	0.26*
Recognize others	3.21	3.32	-0.27	0.80
Cognition (N=19)				
Attention to purposeful activities	2.32	2.79	-1.06	0.31
Understanding of numbers	1.11	1.26	-0.29	0.77

* Statistical significant (p= .05, 1-tailed); The italic scores were higher in 1997 and the blackened ones were higher in 1998.

Table 6 shows the findings from the correlated t-tests performed for those in the Non-Profound Therapy Group. Overall, only one item out of 31 was significantly different between 1997 and 1998 with the higher score being in 1997. One of 31 will likely occur by chance; however, this item concerned going out to recreational activities and had higher scores the first year. This suggests that music therapy was not influential on people with no or mild diagnosed mental retardation.

For the Initiation items, a similar pattern to that reported for the Therapy Group was shown where five out of seven items received higher scores in 1997 than in 1998 according to caregiver responses. The exceptions were the item "Choose own friend", which had the same score in both years and the item "Choose food in restaurant" which had a higher score in 1998. But according to consumer responses, six out seven items were higher in 1998 with one exception "Choose what to do".

For the Integration items, the same trend was also shown according to caregiver responses. Five out of six items were higher in 1997 with one exception "Go out to the bank". The pattern for consumer responses on integration items was one tie, one higher score in 1997, and one higher in 1998.

For the Adaptation variable, five out of six items were higher in 1998 with one exception "Use complex language". Finally, on the Cognition variable, "Attention to activities" was higher in 1997 and "Understanding of numbers" received a lower score in 1997. None of these differences was significant.

Table VI

Means and T-tests for Non-Profound Therapy Group in 1997 and 1998

Dependent variables	1997	1998	t	P (1-tailed)
Initiation				
Caregiver responses (N=19)				
Initiate own activities	2.11	1.89	1.17	0.26
Initiate group activities	1.00	0.84	0.72	0.48
Choose activities	2.68	2.52	1.14	0.27
Choose own friends	3.00	3.00	0.00	1.00
Choose food at home	2.26	2.11	1.00	0.33
Choose food in restaurant	2.95	3.37	-0.98	0.34
Choose how to spend money	2.32	2.11	1.29	0.22
Consumer responses (N=9)				
Choose clothes to buy	1.44	1.77	-1.41	0.20
Choose clothes to wear	1.89	2.67	-1.79	0.11
Choose food at home	1.11	2.11	-1.73	0.12
Choose food in restaurant	2.17	2.83	-1.20	0.29
Choose own friends	2.00	2.44	-0.74	0.48
Choose how to spend money	1.78	2.22	-0.94	0.38
Choose what to do	1.89	1.33	1.35	0.21
Integration (N=19)				
Caregiver responses				
Visit with friends/relatives	1.63	1.26	1.44	0.17
Visit supermarket/food store	3.11	2.84	0.84	0.41
Go out to a restaurant	4.53	3.89	1.94	0.07
Go out to shopping	4.74	4.26	1.63	0.12
Go out to recreational activities	5.21	4.21	5.34	0.00*
Go out to the bank	0.00	0.05	-1.00	0.33
Consumer responses (N=9)				
Visit family	2.17	2.17	0.00	1.00
Visit friends	1.55	2.33	-1.79	0.11
Visit advocates	2.33	1.17	1.56	0.18
Adaptation (N=19)				
Use silverware	3.79	3.89	-0.27	0.79
Have sense of direction	1.73	1.94	-1.71	0.10
Use complex language	1.21	1.16	0.27	0.79
Recognize words	1.07	2.71	-2.14	0.05*
Understand instructions	1.58	1.79	-1.17	0.26
Recognize others	3.68	3.84	-0.64	0.53
Cognition (N=19)				
Attention to activities	2.63	2.47	0.43	0.67
Understanding of numbers	1.88	2.29	-0.79	0.44

* Statistical significant (p= .05, 1-tailed); The italic scores were higher in 1997 and the blackened ones were higher in 1998.

Findings in the Profound Therapy Group

Table 7 shows the findings from Profound Therapy Group. Compared to the results in the Non-Profound Therapy Group, there were more significantly different items between 1997 and 1998 in this group. This supports the previous hypothesis which suggests that music therapy is more influential for people with profound diagnosed mental retardation than people with no or mild diagnosed mental retardation. Overall there were six significantly different items between the two years. There were only six of 31 items which were higher in 1997 when only considering the people with profound diagnosed mental retardation compared to ten of the 31 for the whole Therapy Group. Three of the six were higher in 1997 and the percentage of higher scores in 1997 was less than that in Therapy Group (six out of ten items). The other three items, "Go out to bank", "Have sense of direction" and "Understand instructions" were significantly different between 1997 and 1998 with the higher scores in 1998. These three items had the same results in the Therapy Group indicating that music therapy may have improved the skills related to these three items when controlling for different level of diagnosed mental retardation.

Table VII

Means and T-tests for Profound Therapy Group in 1997 and 1998

Dependent variables	1997	1998	t	P (1-tailed)
Initiation				
Caregiver responses (N=99)				
Initiate own activities	1.00	1.03	-0.35	0.72
Initiate group activities	0.65	0.57	1.27	0.21
Choose activities	1.83	1.66	1.87	0.07
Choose own friends	2.93	2.08	4.46	*0.00**
Choose food at home	1.69	1.71	-0.22	0.83
Choose food in restaurant	2.35	1.96	1.92	0.06
Choose how to spend money	1.51	1.40	1.16	0.25
Consumer responses (N=4)				
Choose clothes to buy	1.75	2.00	-0.21	0.85
Choose clothes to wear	2.00	2.00	0.00	1.00
Choose food at home	2.25	2.00	0.24	0.82
Choose food in restaurant	2.66	2.00	1.00	0.42
Choose own friends	2.00	3.00	-1.00	0.42
Choose how to spend money	2.25	1.75	0.58	0.60
Choose what to do	2.00	1.67	0.23	0.84
Integration				
Caregiver responses (N=99)				
Visit with friends/relatives	1.04	0.95	0.74	0.46
Visit supermarket/food store	0.71	0.54	1.99	*0.05**
Go out to a restaurant	2.81	2.88	-0.67	0.50
Go out to shopping	2.80	2.57	1.81	0.07
Go out to recreational activities	3.51	3.38	1.00	0.32
Go out to the bank	0.01	0.07	-2.51	**0.01***
Consumer responses (N=3)				
Visit family	3.00	3.00	0.00	1.00
Visit friends	2.00	3.00	-1.00	0.42
Visit advocates	2.50	0.50	2.00	0.29
Adaptation (N=99)				
Use silverware	1.86	1.58	2.48	*0.02**
Have sense of direction	0.96	1.27	-1.96	**0.05***
Use complex language	0.26	0.23	0.62	0.53
Recognize words	0.05	0.05	0.00	1.00
Understand instructions	0.37	1.00	-3.14	**<.01***
Recognize others	1.98	2.27	-1.42	0.16
Cognition (N=99)				
Attention to activities	0.89	0.89	0.00	1.00
Understanding of numbers	0.20	0.45	-1.36	0.18

* Statistical significant (p= .05, 1-tailed); The italic scores were higher in 1997 and the blackened ones were higher in 1998.

CHAPTER VII

DISCUSSIONS OF FINDINGS

Summary of Findings in the Statistical Design

Findings in the previous statistical design can be summarized as follows:

1). The main hypothesis is not supported since most of the means in 1997 were higher in 1997 than in 1998; that is, skills related to the selected items were not often improved and even decreased in 1998.

2). Music therapy was provided primarily for people with lower abilities.

3). Music therapy was less effective for people with profound diagnosed mental retardation than people with no or mild diagnosed mental retardation.

4). The same pattern was found in the Therapy, the Non-Therapy and the Non-Profound Therapy Groups in which caregivers indicated higher scores in 1997.

5). Consumers, however, expressed higher scores in 1998 for most of the Initiation and Integration items.

6). Particular skills related to items "Go out to bank", "Have sense of direction", and "Understand instructions" were found to be significantly higher (p=.05, 1-tailed) in both the Therapy Group and the Profound Therapy Group.

7). Skills related to the Cognition items were not improved both in the Therapy Group and in the Profound Therapy Group.

Overall, these findings indicate that music therapy does not appear to have a great impact on the people with developmental disabilities over the two-year period of time. The fact that skills did not improve and even decrease is also not supportive to the results from several previous studies (Aldridge, 1990; Alridge and Pietroni, 1987; Alridge and

70

Brandt, 1991). For example, Alridge and Brandt (1991) concluded that music therapy is valuable for stimulating emotions, enhancing coping responses and enabling recovery. The recovery goal was not reflected in current study, neither did the skill related to cognition (i. e. "attention to others") over the two years.

Several of the current findings, however, are similar to the results from some previous studies. That the music therapy program is mainly provide for the people with lower abilities, for instance, is similar to the studies such as Skille, Wigram and Weeks (1989) and Wigram (1993). Their findings indicated that music therapy was primarily provided for clients with cerebral palsy, anxiety and self-injurious behavior. The third finding in current study was that the music therapy is more effective for people with no or mild disabilities than for people with severe disabilities. This finding is similar to the findings from Aldridge and Brandt (1991) from which they concluded that one of the main values of music therapy is at the pre-disease stage, not at the stage before the disorder or symptom becomes acute and chronic disease or illness.

The fourth and fifth findings in current study are perhaps more related to the results in studies like Reason and Brown (1981), Hoskins (1987) and Payne (1993) in which the researchers began to emphasize the importance of exploring various methods such as video sampling and self-evaluation from clients to document the effects of music therapy.

The sixth finding in current study may also be similar to several previous studies. For example, Odell-Miller (1993) indicated that particular skills ("have sense of direction" and "understand instructions") were found to be improved significantly after a regular music therapy session for 3 months. Pavlicevic and Trevartten (1989) also concluded that

71

there was significant improvement in musical interaction rating scores and in formal psychiatric measures for people participating in regular music therapy sessions.

The general results of the current research appear to be consistent with previous studies on music therapy. This study and previous studies have shown that music therapy seems to be more effective for people with less disability when held in a regular session. Particular cognitive skills such as "understand instruction" and "have sense of direction" were found to be improved significantly. Also, current study and several previous studies indicated that music therapy is primarily provided for people with lower abilities but the recovery value from music therapy may not be apparent from music therapy. Furthermore, the current and previous research have emphasized the importance of obtaining self evaluation information from individuals in order to evaluate the impact of music therapy. But overall the main contention concerning the value of music therapy has not been supported in current study. Two of the findings (Finding 1 and 7) were not supportive of the findings in previous studies. This can be attributed to the specificity of the current research setting and further, it may reveal the lack of grounds for the comparison between different studies.

Focus Group Interview

After finishing the analysis of statistical findings, a focus group interview was conducted with six music therapists in the same state resource center where the quantitative data were being collected. All the music therapists were Board Certificate (BT) specialists with considerable amount of knowledge and experience with music therapy. The purpose of the interview was to collect qualitative interpretations of the quantitative findings in the previous statistical analysis.

For the finding of the decreased skill scores in 1998, music therapists provided several interpretations from their experiences. First, music therapist indicated that caregivers in 1997 might be different from the ones in 1998, thus resulting in the different scores in each year. Caregivers may express very different opinions about the skills related to the four dependent variables. So the changes in those items may not be due to the music therapy but due to the different views of caregivers. The comparison between the scores in 1997 and 1998 is generally problematic from the music therapists' point of view because the two groups may not be comparable due to the influences of the different caregiver's perceptions. The basic assumptions that the statistical design is based upon are not met in the first place. In other words, the different characteristics of the Therapy and Non-Therapy Group pair, and the Profound and Non-Profound Therapy Group pair rendered the comparison of the effect of music therapy seemingly impossible.

An example of different views from caregivers presented by the music therapists is that when caregivers were asked "does s/he feed self with fingers or must be fed?", one caregiver may indicate "no" based upon the observation that the consumer was not using his/her fingers feeding himself/herself. But for another caregiver, the answer might be "yes" because s/he might think the consumer was using his/her fingers grabbing food from another individual's plate, even though the consumer didn't feed himself or herself. Another example would be that when asked "do they choose what food to eat?", a caregiver may answer "no" even if consumers "choose what kind of food they eat *first*", "choose *not* to eat" or "choose to eat at the *vending machine*". Caregivers may not consider these choices as "initiating" to activities.

73

Music therapists expressed the concerns about how interviewers gathered the related information from individuals. For the decreased skill scores, they indicated second so interpretation such that the consumers may receive program for developing one specific skill each year; for example, 1998's goal is to develop "cooking skills" and 1997's goal is to enhance "making choices". There are different rehabilitative goals for individuals used almost in each year. So the fact that scores on one certain item in 1998 are lower than in 1997 may be due to the different Individual Rehabilitation Plans (IRPs) instead of the effect from music therapy. An Individual Rehabilitation Plan (IRP) is developed for each consumer annually by a group of therapists including the music therapist.

One music therapist also provided the third explanation for the finding of the decrease of mean scores in 1998 compared to 1997. She reasoned that this finding may be due to individuals' degenerated skills over the years. Consumers' physical condition may have been deteriorated in 1998 compared to 1997. The fact that the state resource center consists of people with severe physical disabilities may contribute to the general deterioration of consumers' physical conditions.

The fourth explanation regarding the finding not in favor of music therapy was related to the statistical design. Music therapists generally believed that individuals could benefit from music therapy programs like developing motor skills, developing coordination of object handling, socializing with therapists and with other individuals whom they don't normally interact with. But the consumers sometimes didn't demonstrate these skills in normal daily life; therefore, it is hard for caregivers to present these improved skills to the interviewers. Also, several of the music therapists believed that small changes may have been accomplished but the statistical analysis may not show it significantly different. This

74

may be due to the small number of consumers' responses (n=12-14). But it is also related to the fact that music therapy is being performed in an highly individualized manner so the generalizations would become problematic for the assessment.

In this state facility funding for music therapy has to be approved by the higher administrators. Music therapists expressed the dilemma they encountered when they tried to convince supervisors about the effect of music on people with disabilities. One therapist said, "saying my clients love music is not enough, we have to come up some tangible things". They have to adopt behavioral model to demonstrate clear-cut changes that music makes. Another music therapist expressed the frustration between their practice and the administration, saying "administrators don't come down to visit us and they are in the tower of somewhere." One therapist also expressed surprise that skills related to "cognition" variable ("attention to others" and "understanding of numbers") did not show improvement over the two years.

The comparisons between the findings from the statistical analysis and the interpretations from the music therapists are listed in the Figure II.

Figure II

Comparisons between the Findings from the Statistical Design and the
Interpretations from the Music Therapists

Findings from the statistical design	Interpretations for the findings from the music therapists
Findings in favor of music therapy	
Skills related to items "Go out to bank", "Have sense of direction", and Understanding instructions were improved significantly.	Not Mentioned
Findings not in favor of music therapy	
1. Most of the selected skills were not improved and even decreased in 1998.	1. Different Caregivers may have different views on the selected skills.
2. The same pattern was found in the Therapy, Non-Therapy and Non-Profound Therapy Groups in which caregivers indicated higher scores in 1997; whereas consumers expressed higher scores in 1998 for most of the initiation and integration items.	2. Consumers may receive one certain rehabilitative plan for each year. Thus the changes on the mean scores maybe due to the different plans not due to the deficiency of music therapy.
	3. The decrease of the mean scores in 1998 may be due to the degenerated skills of consumers' physical condition.
	4. Consumers sometimes don't demonstrate the selected skills in daily life; therefore, it is hard for caregivers to notice improved skills.
	5. Music therapy was carried out in an individualized manner; so the generalization may be inappropriate for the assessment.
Neutral findings	
1. Music therapy was provided primarily for people with lower abilities.	Not Mentioned
2. Music therapy was more influential for people with profound diagnosed mental retardation than people with no or mild diagnosed mental retardation.	Not Mentioned

During the interview, findings were presented to music therapists and discussed thoroughly. Music therapists did not discredit the appropriateness of using the statistical analysis due to the problems showed in the Figure II. Instead, they tended to disagree with the findings that are not supportive of the positive effect of music therapy by providing their interpretations on the findings, but gave tacit consent to the findings that were seemingly supportive for the music therapy used in the facility. The empirical complexity of the individualized music therapy program indicated by the music therapist clearly showed that it is hazardous to use the statistical methods to generalize sound findings. But the music therapists did not come to this conclusion. They instead only embraced the findings that were supportive of music therapy. And they selectively discredited those findings that were not in favor of music therapy, not the whole statistical design.

This type of selective thinking revealed two ideological features in the mindset of music therapist – distortion and conviction. As Eagleton (1991) wrote of ideologies as "denigrating ideas which might challenge it; excluding rival forms of thought, perhaps by some unspoken but systematic logic; and obscuring social reality in ways convenient to itself... [e.g.] masking or suppressing social conflicts, papering them over with an imaginary resolution of real contradictions" (p. 6; see also Putnam 1971; p. 655). This selective–thinking and distortion are the "end product of many operations viewed as ideological: legitimation, naturalization (the depiction of fabricated circumstances as 'natural'), popularization, 'illicit union of fact and value' (Adams 1989: 137; Minar 1961: 323), 'systematically distorted Communication' (Habermas 1984), the (unsubstantiated) claim to moral certainty (Adams 1989: 139; Naess 1956: 166), the use of unverifiable

truth-claims (Sartori 1969: 403). In all such cases, the description of ideology as [illegible] distortion rests on an implicit epistemological contrast between 'ideological' and [illegible] scientific, or truthful, forms of analysis" (cited in Gerring, 1997; p. 982). Music [illegible] therapists have exercised these operations -- legitimation, naturalization, popularization, systematically distorted communication and the use of unverifiable truth-claim -- in an [illegible] implicit or even unconscious manner. Furthermore, this type of selective thinking is [illegible] better understood as a set of root likes and dislikes rather than an assemblage of scientific abstractions. It is therefore an affective conviction rather than cognitive aspect of human knowledge.

This feature of ideology becomes clearer when one takes into consideration the fact that music therapy encounters great challenge for survival. Music therapy has not been required in the states' educational program. The federal law identifies it as a service related to special education, but no state requires it for educational programs. Music therapists realized that the diversity of music therapy's applications may offer a variety of work settings, that does not always mean there is work for music therapists. As a result, funding for music therapist positions may not be available even where openings should exist. Music therapists are undergoing challenges seeking funding from the state and federal governments, and third party payers.

This actuality (social context / social determination), on one hand, prevents music therapy research from developing scientific knowledge and leads it into a profession with a full range of ideological implications. On the other hand, music therapy practitioners have to create their own work by constructing the objectives, needs, goals, symptoms and treatment for the "needed" people.

If we move beyond the music therapy profession and examine the medical profession in general, we will find the similar process of constructing objectives and treatments in music therapy to the process of diagnosing disease and developing treatments in medical knowledge. Ludwig Fleck (1927), in his work "*Some Specific Features of the Medical Way of Thinking*", argued that the goal of medical knowledge is "the so-called diagnosis – the filling of a result into a system of distinct disease entities, and this assumes that such entities actually exist, and that they are accessible to analytic method" (cited in Lowy, 1989; p. 40). But in fact diseases are "ideal fictitious pictures, known as morbid units, around which the individual and the variable morbid phenomena are grouped, without, however, ever corresponding completely to them" (p. 40). Chalubinski (1874) also claimed that diseases were not natural phenomena but abstract units of classification created by physicians. Disease is "an artificial construction of the medical profession" (p. 39) to justify its own. Consider the following accounts cited in Hayward's (1974) book "Professionalism and Originality":

> "I discovered that [a well-known American physician] was rated so highly simply because he could cure the ills he personally caused... His first diagnosis when he finds that the patient is drivelling hypochondriac is 'gastric catarrh', 'gastralgia', or some other reverberating name which means nothing in particular but greatly impresses the patient. His first treatment in such a case ... is potassium iodide... with instructions to return if he feels nausea, headache, pain, or bad taste in the mouth. Now postassium iodide... causes these exact symptoms... consequently the dupe goes back for relief... and so the iodide is gradually reduced while the pocket-book is being relieved of its contents. In the course of the second or third week the patient wanders into the office once more. My friend now take pity upon him by withdrawing all the iodide, thus effecting a brilliant cure. The delighted patient tells his friends... of the clever doctors who has dragged him from the jaws of death" (pp. 36-37).

The same motives for "making medical work" and making music therapy work are 1) sheer profit and (2) to justify one's existence. Medical professional work may be "made"

merely to justify one's conscience or to let off one's professional activity. "Work" is

similarly made in the music therapy professions in which music therapists have naturally

adopted the strategy of creating clinical "practice" through their medical rhetoric and their

preoccupied "professional and ideological eyes".

In a report entitled "Music Therapy Update" from a Midwestern State Resources

Center where music therapy has been practiced for over nine years, a resident A's

objectives for music therapy are stated as follows:

> "OBJECTIVE #7.1: Using an augmentative communication system, A will make
> choices during each music activity in 75% of documented trials for 3 consecutive
> months by March 31, 1999.
> OBJECTIVE #7.3: Using a picture communication board, A will combine at least
> 2 symbols to form a response/make a comment in 75% of offered trials for a
> consecutive months by 2/28/99."

The report went to demonstrate the resident's "Tests and Observations", following

accounts appeared in the "Evaluation Results" category:

> "A tolerates proximity, tactile stimulation, and physical manipulation when
> needed to complete a new and/or unfamiliar task. He can follow routine, one,
> two, and three-part directions with verbal and gestural prompts. A can match like
> objects/letters/pictures, imitate the actions of others, as well as the movement of a
> given object. He can also complete a four-part visual sequence in random order.
> A can functionally manipulate objects appropriate to task, provided an initial
> demonstration of the task/activity. He initiates, continues/completes, and stops
> activities on cue. He will also indicate awareness of accomplishment by smiling,
> vocalizing and clapping/waving his hands" (Personal communication with one
> music therapist working a mid-western state resource center; March, 1999).

Jargon, redundancy and turgidity aside, this rhetoric ("language") provided a good

example of how music therapists created their professional work by transferring patient's

behaviors into simple ("simplicity") types of medical diagnoses through the "scientific

jargons". These ideological jargons and rhetoric is useful for defense against the laity and

for purposes of financial profit.

Music therapists may have been "trained" the "right" way to observe the phenomena (facts) which may appear scientific and transferable within the medical community. The observation is dependent on previous cognition and on the "thought style" of the observer's "thought collective". Such mechanisms of observation and of conclusion appear very frequently in medical practice and serves an empirical example of constructivist perspective. Music therapists, like physicians, are probably trained to observe and construct certain pathological and behavioral phenomena, and are familiar with those phenomena. They therefore have a strong tendency to make selective observations. The physicians' attention is usually directed only towards the phenomena that s/he has been trained to see, those with which s/he is familiar, and those which are the most frequent. We are able to perceive only familiar phenomena, because they are the most present in our mind and because we have for them a ready-made name and a ready-made theory.

The music therapy rhetoric reflected in the report served the function to quantify the complexity of human interaction into the accounts of numbers and percentages (i.e., "75% of documented trials for 3 consecutive months"). The accounts are susceptible to the observer's perspectives and can be easily manipulated in order to ensure the continuity of the services:

> "During Guitar Group, A gets out his own equipment and participates by strumming the guitar and changing chords. He also is asked to choose a song to play from various selections. However, when he is presented with 2 picture cards for song selection, he has difficulty making a choice. He usually points to each selection alternatively without choosing just one song. This is why Objective #7.1 was implemented on 2-26-98. This **Objective #7.1 states: Using an augmentative communication system, A will make choices during each music activity in 75% of documented trials for 3 consecutive months by March 31, 1999**...Overall, A has made progress on this objective since it began with a baseline of 58%. He has met the criteria several times but has not met them consecutively as the criteria states. This objective will continue until completion". (Personal communication with one music therapist working a mid-western state resource center; March, 1999).

Individual A involved in this report has no ability to communicate verbally and thus

the accounts regarding his behavioral changes are primarily relied upon the descriptions

from the practitioner of the music therapy profession without ever corresponding with the

person him/herself. Professionalization, in this sense, can be seen as "the process by

which producers of special services sought to constitute and control the market for their

expertise" (Larson, 1977; p. xvi).

Another important feature of music therapy ideology is the "treason of confusing

means with ends". Following accounts are excerpted from the home page of the

American Association for Music Therapy (AAMT):

> "What do music therapists do?
> Music therapists--Assess emotional well-being, physical health, social functioning,
> communication abilities, and cognitive skills through musical responses. Design music
> sessions for individuals and groups based on client needs using: music improvisation,
> receptive music listening, song writing, lyric discussion, music and imagery, music
> performance, and learning through music. Participate in interdisciplinary treatment planning,
> ongoing evaluation, and follow up.
>
> Who can benefit from music therapy?
> Children, adolescents, adults, and the elderly with mental health needs, developmental and
> learning disabilities, Alzheimer's disease and other aging related conditions, substance abuse
> problems, brain injuries, physical disabilities, and acute and chronic pain, including mothers
> in labor" (AAMT web-page: http://www.musictherapy.org/FAQs.htm)

It is evident here that the music therapy profession tends to regard its own interests as

of supreme importance ("dogmatism"). This feature may become typical when the

intention of developing a profession is ideological and financially driven. In the Postlude,

the "Miracle Stores of Treatment and Cure", of his book, *The Mozart effect*, music

therapist Don Campbell demonstrated a list of samples that music can heal: Abrasion,

Abuse, Aggressive and Antisocial behavior, AIDS, Allergies, ADD, Burns, Cancer,

Colds, Developmental Delays, Diabetes, Menopause, Overweight, Paranoia and War

Propaganda, Prejudice and Discrimination, Premature Birth, Schizophrenia, Stroke, Substance Abuse, Toilet Training, Tooth Problems and Writer's block. Among these examples, Toilet Training is worthwhile to demonstrate:

> "Like a lot of children, Sherri was not properly toilet trained. Desperate, her parents and teachers approached Mrs. A, a music therapist at the Rainbow Babies and Children's Hospital in Cleveland. Noting that Sherri would focus and settle down when she heard music, Lane ragged up a small portable toilet that play a tone. When Sherri urinated, "Mary Had a Little Lamb" would be played. Realizing that she had caused this, the little girl reacted gleefully, and stopped wringing her hands as she had done previously. "Eventually," notes Lane, in her book *Music as Medicine*, "she learned not only to go in the potty but also to pee slowly, so that she could make the music last longer." (Campbell, 1997; P. 277, name disguised)

This example seems laughable for common people but the music therapist involved took it as serious as it appeared to be. Consider the following study by the same music therapist, Mrs. A:

> "Mrs A.. has studied immune function in children given a single 30-minute music therapy session. In 19 subjects, a significant (P=.01) increase in salivary IgA occurred after the music session. In 17 controls, there was a small but not significant decrease in IgA levels. The finding indicates that music therapy plays a positive role in recovery, Lane said" (Marwick, 1996; pp. 269-270, name disguised).

The relationship between the secretion of salivary IgA and "recovery" aside, how to measure salivary secretion in different time periods during the day for the children and justify the "significant increase " or "decrease" remains problematic and incapable of outside examination.

By transferring seemingly normal human behaviors (i.e. Child's Toilet Inappropriateness) into pathological medical symptoms (i.e. Toilet Training), music therapists show a tendency to create "work" of a doubtful, useless, or mischievous kind, in order to prevent its abolition, to justify their existence as professionals through the

scientific protocols. These intentions are rather ideological in nature in the sense that

they serve as a conceptual mechanism to justify its own existence.

CONCLUSIONS AND SUGGESTIONS

As I have shown in the previous chapters, the process of developing a new medical profession, music therapy, may have inherently ideological features and intentions. These features have been shown in the process of developing music therapy knowledge, promoting a professional image through organizational strategies, and the case study probing the mindset of music therapy practitioners. These features of ideology have a great impact on the development of music therapy knowledge and practice. In this sense, ideology may give away to science; and music therapy and medicine may not be a science. As Thomas Osborne (1998) clearly pointed out:

> "medicine may be made up of regional rationalisms that have a scientific status, but medicine itself is not a science; in its epistemological spirit, it is rather a kind of ideology'. This may well be to stretch our normal understanding of what we might mean by ideology, entailing an inquiry not into the particular circumstances of specific medical ideologies, but into the extent to which it might be said that 'modern' clinical medicine is a collection of regional rationalisms that has more than merely an 'institutional' status, and which has a tendency to stray beyond the limits of its own epistemological norms. With regard to the first aspect of ideology, one would then ask if one could specify something like a general 'spirit' of modern medicine; a spirit that would be ideological not because it might be 'false' but in so far as it represented more than just the sum of the institutional realities of medicine. With regard to the other aspect, one would be inquiring into the ideological implications of medicine with regard to other disciplines, and in relation to other social practices; in short, one would be inquiring into the capacity of medical norms to stray beyond themselves, infiltrating into other forms of rationality" (pp. 259-260).

The extension of the ideological implications of medicine to music therapy has been discussed in the previous chapter. The rationality of medicine has been manufactured and widely distributed into all types of reasoning specifically the reasoning of therapeutic profession on the seemingly irrational field -- music appreciation. Music therapy has transformed a form of artistic experience into a form of scientific reality through the

process of "externalization", "objectivition" with ideological features and implications. In this sense, future analysis of social construction of reality will have to deal not only with the empirical variety of "knowledge" in human society, but also with the processes by which *any* body of "knowledge" comes to be socially established *as* "reality". Full understanding of constructivist perspective entails deep and detailed contextual nuance and dilemma from empirical knowledge and reality. This may expand the conception of human knowledge to the extent that it includes "everything that passes for 'knowledge' in society", whether it is the knowledge for the philosopher or for "the man in the street". The detailed analyses on the pragmatic strategies used in the process of professionalizing music therapy have suggested the interconnectedness of ideology and music implementation in the therapeutic field. The process of creating the music therapy profession has also revealed specific features of professionalization: the treason of professionalism, the self-concern of professionalism, the cultivation of complexity, and the cultivation of jargon. Professionalism seems to be the tool and means for music therapy to adjust itself into the medical ideology. This may be the case for any of the modern professions that are intended collectively to create a specialty through the construction of "scientific" knowledge. Music therapists have vigorously tried to construct a profession that has never been established in history before.

The previous chapters have shown the ideological features of constructing a profession that extends Berger and Luckmann's work. I have shown that perhaps the medical ideologies played a crucial impact on the process of constructing scientific knowledge. Ideologies in this sense are more similar to the concepts of "existential determination" or "social context" from which social realities arise. Ideologies not only

86

determine and influence the appearance of social realities, but also shape and even control the content of social realities that are allowed to appear--to the extent ideologies acquired the transformational ability that stray beyond their own origins and rationality. In the case of music therapy, ideologies have transformed a seemingly irrational subject (music appreciation) into a rational scientific profession (music therapy). This may be the fundamental power of the ideologies.

Furthermore, if we think of the music therapy profession as an identity, a concrete representation of what the profession is or should be, to the extent that the profession itself becomes the cornerstone or the sacred shrine for the music therapists to preserve or worship ("conviction" indeed), then the very notion of "holy melody" and "music priests" may be right around the corner. Modern ideologies have become religion-affected in the sense that a particular thought and belief pattern embodies values that are considered absolute by its adherents. "When a priest blesses water, it turns into holy water – and thus becomes the carrier of the most beneficent powers" (Szasz, 1976; p. xiii), when a music therapist worships music, it turns into "holy melody" and thus become the carrier of most beneficent power---healing. "For Christians the most sacred symbols is the cross and the most revered ritual is the Mass; for physicians they are the M. D. degree and the diagnosis of disease" (p. xiii); and for music therapists, they become the M.T. B.C. (Music Therapy Board Certificate) and the delivery of "holy music". The efforts developing an "irrational" art form into some kind of rational medical knowledge have transformed music appreciation into an identity between a modern sacred shrine and a "scientific" profession. This is probably totally outside of the music therapists' initial, intentional "ideologies".

Finally, if we move beyond the concept of social reality proposed by Berger and Luckmann, we might integrate ideology into the construction of social reality. Berger and Luckmann are essentially positivistic in treating "the social facts as things" for their view of the nature of social reality is greatly indebted to Durkheim. Even though they expressly claimed in their book that their approach is "non-positivistic". But social thoughts and ideas are in essence viewed from their perspective as "social facts" that are out there. The task of sociology of knowledge is then to analyze the processes of how these social realities are constructed. This perception of social realities as "objective facticity" naturally and logically render them as the central question of the sociological theory as "how is it possible that subjective meanings *become* objective facticity" (Berger and Luckmann, 1967; p.18). We humans have the natural tendency to learn how our own thoughts transform into the things we live in. But in the analysis of ideology in this thesis, the distinction between objective facticity and subjective meaning seems to become arbitrary and blurred. "objective facticity" (i. e. the music therapy practice) is by all means susceptible to "subjective meanings" (i. e. the medical ideology and the dominant scientific knowledge) and that human thoughts, ideas, or "social realities" are the products of our own consciousness. "Dualistic reductionism" on objectivity and subject meanings proposed by Berger and Luckmann is inherently the conceptual tool used to facilitate the "treatise-maintenance" in their own analysis. It is inseparable from the construction of their treatise. Similarly, previous analyses of the ideologies in constructing the music therapy profession have implied that the ideological elements essentially can not be separated from the process of constructing the social realities. Ideologies are, therefore, viewed as the integral elements in creating the "social realities'.

The subjective meanings (i.e. medical ideology) are the organic parts of the objective facticity (i.e. music therapy knowledge and practice).

Through the analysis of ideology I have explicitly tried to move beyond the dichotomy between "objective facticity" and "subjective meaning", between thought and underlying reality other than thought, or between reality and ideas. It seems to me that the dichotomy is essentially and existentially arbitrary, and it may also bear ideological implications in its own fuction. I have been convinced that the *processes* and the *outcomes* of the social construction of reality become the "reality" itself -- "reality" not in an *ontological* sense, but rather in the *existential* and *ideological* senses. There seems to be no distinction between human thought and the reality humans live in, between ideas and social contexts, between the illusions of certain objects and the objects themselves. Human thoughts and ideas are embedded in social contexts, and often times they acquire a determinative and transformational ability on constituting ideology and social contexts, especially when they have been legitimized under legal and political protocols (which is the case for music therapy). In this sense, *human knowledge and thoughts are the very immediate realities* we breathe in, smell of, and live on. There seems no single second in the human history that the object would stray away from the subject. We live in the world we construct, the world we create, and the world we are able to comprehend. "We can only think what our thought structures allow us to think". There is no realer than the real.

Realizing the demise of the dichotomy between the object and the subject would result in the fatal destiny for the "homocentrism", and the suicidal end for the superficial supremacy of human thoughts (valid or invalid, noble or base, theoretical or

89

commonsensical, true or false), including this realization itself. What can we do if our thought in this planet is not to justify our meanings of living or not living, not for one part of the human race but for the whole existence of our beings? What can we do if we can not "objectify" our experiences? And what can we do if we can not use preexisting language? Can you see yourself without the help of a mirror? Or, can you swallow you own tongue? We have to resort to the "third mind" to ensure that the second mind (we) saw the whole of ourselves correctly. Otherwise we have utterly no way of proving that the ideas in our mind fit the world outside. The mind cannot think backward. If we think we could, that would be as strange as a "self-digesting stomach" or a "self-swallowing tongue". There is absolutely no way the conscious thinker can step outside his/her cognitive apparatus and prove that his/her ideas represent or "mirror" the world. This is what I call "the dead of the object":

> "One would have to know what *being* is, in order to decide whether this or that is real (e.g., "the fact of consciousness"): in the same way, what *certainty* is, what *knowledge* is, and the like – But since we do not know this, a critique of the faculty of knowledge is senseless; how should a tool be able to criticize itself when it can use only itself for the critique?" (Nietzsche, 1967; p. 486)

Aren't we part of the reality we are in? Aren't we ourselves are the "realitieselves"?

The following sentiments by Nietzsche conclude this thesis:

> "What urges you on and arouses your ardour, your wisest of men, do you call it 'will to truth'? Will to the conceivability of all being: that is what I call your will! You first want to make all being conceivable: for, with a healthy mistrust, you doubt whether it is in fact conceivable. But it must bend and accommodate itself to you! Thus will your will have it. It must become smooth and subject to the mind as the mind's mirror and reflection. That is your entire will, your wisest men; it is a will to power; and that is so even when you talk of good and evil and of the assessment of values. You want to create the world before which you can kneel: this is your ultimate goal and intoxication."

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93

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OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD

APPENDIX A

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD

Date: May 17, 1999   IRB #:   AS-99-052
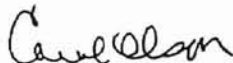
Proposal Title: "IDEOLOGY AND SOCIAL CONSTRUCTION OF REALITY: A CASE
                    STUDY ON MUSIC THERAPY"

Principal   Dr. Richard Dodder
Investigator(s):   Qiang Huang

Reviewed and
Processed as: Exempt

Approval Status Recommended by Reviewer(s):   Approved

Signature:

Carol Olson, Director of University Research Compliance

May 17, 1999
Date

Approvals are valid for one calendar year, after which time a request for continuation must be submitted. Any modification to the research project approved by the IRB must be submitted for approval. Approved projects are subject to monitoring by the IRB. Expedited and exempt projects may be reviewed by the full Institutional Review Board.

VITA

Qiang Huang

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Master of Science

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