Exploring Music Therapy for Filipino Autistic Children

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This study explored the use of music therapy as a means to enhance the therapeutic processes with autistic Filipino children. Using a clinical-descriptive and phenomenological approach, five autistic children were purposively selected to attend 12 individual music therapy sessions. Findings show that music therapy can be considered as a therapeutic intervention for children with autism because it addresses their primary concerns such as making connections, developing eye contact and verbalization, facilitating expression of feelings and modifying stereotypic behaviors.

This research explores and describes how music therapy can facilitate and enhance therapeutic efforts with autistic Filipino children. More specifically, it attempts to answer the following questions:

1) How can music therapy facilitate in making connections between the therapist and the autistic children?
2) How can music therapy facilitate the expression of feelings of autistic children?
3) How can music therapy facilitate verbalization in autistic children?
4) How can music therapy facilitate in developing eye contact with autistic children?
5) How can music therapy help in modifying stereotypic behaviors of autistic children?
6) How does music therapy foster learning of musical skills?

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Music has been used as part of the healing practices of the earliest tribes: the shaman and medicine man of primitive cultures to the ancient Hebrew, Egyptians, Chinese, Hindu civilization. Throughout the development of civilization, the relationship of music and healing has complemented the prevalent theory of disease (Davis, Gfeller & Thaut, 1992). It was the Greeks who started to advocate a controlled use of music to produce health, good character and high moral standards. Until the last few decades of the eighteenth century, music was still popular as a means of treating diseases. It was often incorporated with the general theory in medical treatment and was prescribed as a cure for various physical and psychological ailments.

However, a shift to a more scientific approach to medicine took place during the nineteenth century. As music developed as a performing art, so did medicine develop as a specialized science. Music and medicine again were associated with one another as scientific principles began to be applied to the study of the therapeutic effects of music. During the war years, music therapy was primarily used to boost the morale of returning veterans and was also used in the rehabilitation of leisure skills, socialization and physical and emotional function (Davis et al., 1992).

Today, the therapeutic use of music is applied to clients having a wide range of conditions and disabilities such as developmentally delayed or emotionally disturbed children. An interest in the use of music as an aid to stress reduction and relaxation is continuously explored by the Western world (Standley, 1986; Staum,1996; Jellison, 1996).

DEFINITION OF MUSIC THERAPY

For the purpose of this research I have adapted Bruscia's definition of music therapy (1984): *Music therapy is an interpersonal process involving therapist and client wherein a variety of musical experiences are all designed to help clients find the resources needed to resolve problems and increase their potential for wellness.*

This definition describes the main points in defining music therapy. First, *as an interpersonal process,* it involves a therapeutic relationship between the therapist and the client. Second, *using a variety of musical experiences,* this makes it unique from other interventions because it greatly depends on

music as a primary tool for the therapeutic experience. Third, its main purpose is *to help clients* in whatever concerns, be it in *resolving problems* or *increasing their potentials for wellness.*

With this definition I have emphasized three essential elements in music therapy; namely, the therapist, the client and music. The reliance on music makes music therapy different from any other form of therapy. But this is not to set aside the importance of a therapist. Bruscia explained (1989) that while music can be naturally healing without the help of a therapist, music therapy requires the skilled application of music by a therapist. Therefore, in considering music therapy as a process of intervention, it must involve both music and therapist. And just like any other form of therapy, the main priority of music therapy is to address the issues presented by a client.

In music therapy the client might choose to relate to the music, the musical instruments or the therapist. With this option, music therapy has the advantage of having a musical communication that can offer contact without closeness (Robbins, personal communication, October, 1999). This is considered an advantage since music can help the therapist make interventions that do not elicit some of the problematic dynamics that can emerge between the client and therapist (Aigen, personal communication, January, 2000). In other words, through the use of music in therapy, the client would not feel direct interaction with the therapist. Rather, she/he could have an indirect contact with her/him while making music together. The client can experience the music as calling out to her/him rather than feeling the personal demands of the therapist. Music then becomes a safe meeting ground for the therapist and the client because it lessens the emergence of a power struggle or the client resisting the therapist's expectations. On the other hand, the therapist could just constantly sing or provide music and "pretend" that she/he is just playing music for herself/himself.

MUSIC THERAPY PROCESS

Aside from the fact that music, as a phenomenon, speaks for itself and can express and communicate without the use of verbal language, music therapists have used various improvisational models of conducting the sessions: e.g., creative music therapy, free improvisation therapy, analytical

music therapy, and Orff-improvisation models. The music therapy session is highly dependent on the child/client and is full of improvisations and creativity. Due to the spontaneity of the process, there is no formula as to how the therapist musically interacts with the client. Wigram (1997) stated that the easiest way to understand what is occurring in music therapy is that it involves the development of a shared musical experience between the client and the therapist. This musical experience incorporates the establishment of a relationship of the therapist with the client, where the music that is created represents not only the personality and mood of both the client and therapist but also unconscious feelings and thoughts that will emerge. Thus, in doing a research for this domain called music therapy, researchers such as Kenneth Aigen, director of research of the Nordoff-Robbins Center for Music Therapy, prefer to conduct qualitative research. The limitations of experimental methods and statistical measurements are very restricting to the very essence of the music therapy process where factors such as creativity, nonverbal expression and human relationships play an important role (Aigen, 1995). It involves a great deal of creativity, improvisation and flexibility from the therapist which allows clients to explore and express themselves in the most creative and natural way.

As a therapist, I use the creative music therapy developed by American composer-pianist Paul Nordoff and British-trained special educator Clive Robbins. Thus the therapeutic approach referred to here is that of Nordoff-Robbins, which is largely improvisational.

Bruscia (1987) best described the methodological approach of Nordoff-Robbins as empirically-creatively directed – empirical because the therapist's responses are based on a continuous observation of the client's responses; and creative because the therapist's responses are musically created or spontaneously improvised. The creative music therapy is similar to the approach of Axline who developed non-directive play therapy. The acceptance of the child exactly the way he or she is and the child leading the way in a therapeutic process are just two significant identifiable similarities.

But instead of using toys, a non-directive music therapy session is equipped with musical instruments. The most appropriate instruments for

relating to children are simple percussion, cymbal, drum and piano. In addition, Clive Robbins' collaboration with his wife Carol employed Abraham Maslow's humanistic concept of personal maturation and self-actualization to their therapeutic goal.

One of the main themes of the Nordoff-Robbins approach is the focus on developing the emerging self of the child. The most important of it is the "music child." The "music child" is that part of the inner self in every child "which responds to musical experience, finds it meaningful and engaging, remembers music, and enjoys some form of musical experience" (Nordoff & Robbins, 1980).

Children find ways to learn and work on their musical-emotional experiences. The exercise of their newfound abilities in partnership with the therapist gives them great personal satisfaction and the character of the sessions is often joyful and exuberant (Nordoff & Robbins 1971).

The Nordoff-Robbins approach can be categorized into three main phases: namely, meeting the child musically; evoking sound or music-making responses; and developing musical skills, expressive freedom and interresponsiveness. Each phase is at a different level of development or readiness. With some clients an entire session of music therapy may be spent on one or two phases; with others, it can be a whole session of a single musical improvisation that may involve the three phases. For example, with a more reticent and lower functioning child who makes no sound or music, the therapist's effort might be focused purely on meeting the child musically and/or evoking some kind of response (Bruscia, 1987).

Each child's music becomes his or hers personally, and it is almost always borne out of the responses and events in the sessions. It is quite impossible to use one child's music for another especially in early stages of the therapy. As children progress from session to session the music for each one will gradually evolve as he/she develops through his/her experiences. As a child frees and order his/her responses and moves from one musical experience to another, he/she will progress naturally from that of being exceptional because of the organic emotional pathology imposed on them towards the universal (Nordoff et al., 1971).

There is no other way to best describe what the founders have experienced in their therapy session than with their own words:

> When therapy first begins, a child's response may be dull and his behavior rejecting. But each time he comes to the therapy room the music reaches out to him, regardless of his state—accommodating him, seeking out his sensitivities, expressing his mood or filling his psychic emptiness with the color and sounds of its harmonic melodic life. It dispels his fear and invites his trust. A particular theme becomes important, he remembers it, comes to anticipate it. As his involvement increases, his face shows a mobility of awareness and feeling; the music builds in intensity, catching his mood and leading it onwards (Nordoff & Robbins 1971).

THE AUTISTIC DISORDER

According to Kanner (1943) autism is mainly characterized by communication deficits, good but atypical cognitive potential, and behavioral problems such as obsessiveness, repetitious actions and unimaginative play (cited in Wicks-Nelson & Israel, 1997). Furthermore, the inability to relate to people and situations from the beginning of life is an important early indicator. Moreover, it is difficult to recognize autistic children just by their physical appearance since they appear normal and alert.

Similarly, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV, 1994), used by the American Psychiatric Association, and the International Classification of Diseases-10 (1993) used in the European countries (Siegel, 1996), both cite three main areas of autistic impairment: social interaction, communication, and stereotypic patterns or restricted behavior of an individual.

Howard Gardner (1994) in his book, *The Arts and Human Development,* (1994) cited a few instances of autistic children displaying musical abilities. The following instances were as follows: an 18-month-old child sang operatic arias, though he did not develop speech until 3 years of age; a 2 ½ year old child constantly listened to phonograph records but skipped over the parts that used the human voice; two autistic children went on to become professional musicians despite deep personality and intellectual disabilities; among 30 autistic children only one did not show a deep interest in music, and, among another group of four autistic children, one had extraordinary knowledge of recorded music, two were considered in the class of musical genius and the

fourth had an extensive repertoire of popular and classical music (Gardner, 1994).

In the Philippines, the Autism Society of the Philippines holds annual conferences where Filipino autistic children display a number of talents. Majority of them render musical performances as singing, band-playing, marimba playing and piano playing.

Having mentioned all these coincidences between autism and musical capacity, it is safe to assume then that children with autism might enjoy participating in a therapy which includes musical experiences that could address their impairments and possibly discover their musical capabilities as well.

In addition, taking into consideration the diversity of each culture, it is also important to note that Filipino autistic children were observed to be capable of showing and initiating affection through physical contact even at the very early stages of therapy (Carandang, 1992). In 1999, Eric Schopler, guest speaker during the 5th National Conference on Autism conducted by the Autism Society Philippines, noted two distinctive views regarding autism in the country – 1) Filipino parents and families of autistic children use humor, charm and prayer in coping with their situation, and 2) Filipino autistic individuals are more affectionate than any of the autistic individuals of other cultures that he had encountered (Schopler, 1999).

In the Philippines, Ma. Lourdes A. Carandang has been the leading researcher on autism. Her book *Making Connections* (1992) describes the group therapy program she and her colleagues use with autistic children and their families. Therapists use different therapeutic styles and entry points into the autistic child's world. One of the entry points is music. Music was used to help calm Daniel, an autistic child, when he cried and also to help lessen his hyperactivity. Singing has been the shared musical experience of Daniel with his therapist. As the therapist described it, "At first it was difficult because we didn't know his songs. And then we figured out that most of them were advertisements, so we had to be very alert to advertisements. So now, he just sings the first phrase, and I can jump in at once. We'd sing *Adidas*, the *Purefoods*, the *Del Monte* jingles with him and in the process, telling the child that (Even if you hum to yourself, I'll be here singing with you)" (Carandang, 1992).

Carandang (1992), explained that it is more important in the case of an autistic child to connect through his/her own activity or avenue rather than stop the activity and stop the connection. One has to connect first with the autistic child and then later modify or shape the behavior. It is also important to mention that it is the human factor, the therapist, using his/her own being as resource and reinforcer. The toys are limited for the autistic children because what is really used are relational human reinforcements.

MUSIC THERAPY WITH AUTISTIC CHILDREN

Research findings integrated with clinical observations in improvisational music therapy contribute to a richer understanding of how taking part in musical interaction, and being influenced by aesthetic properties of music itself, help autistic children gain self-awareness and relatedness to others that is cohesive and enables them to respond to other people in everyday social interaction (Trevarthen et al., 1996).

Trevarthen et al. further explained that the therapy which lies in music is thus directly connected to the innate musicality or innate responsiveness to music found universally, whether or not they are musically educated. This universal musicality appears to survive considerable intellectual or neurological impairment, indicating music's deeply-rooted biological origins (Alvin et al., 1991; Nordoff et al., 1977). Every individual, no matter how severe their emotional disturbance or mental/physical handicap, can show some response to music. According to Nordoff & Robbins (1971), the "music child" lies dormant in handicapped children who are unresponsive, uncommunicative or caught up in stereotypic behaviors. By awakening the "music child," the therapist helps the child become involved in the world while also developing various ego functions (Bruscia, 1987).

Trevarthen et al. (1996) also suggested that in spite of the serious impairment of their inability to relate with other individuals, autistic children respond to certain forms of music and musical stimuli. Moreover, past research has shown that some of the infantile foundations of their innate musicality remain intact and unimpaired (Sherwin, 1953; Nelson, et al., 1984; Buday, 1995). It is not surprising then, that such

deeply-rooted biological responses to music, when given opportunity, will enable autistic children to engage in building new experiences of affective and musical connectedness.

Using case studies, Alvin et al. (1991); Warwick (1995); Oldfield (1995); Howat (1995) and Nordoff et al. (1971, 1980) have contributed much to the clinical documentation of improvisational music therapy. They describe how music creates experiences of relationship, develops self expression, and enhances communication.

Nordoff and Robbins made a recording of their use of musical improvisation as therapy with autistic children. Several of their songs are still widely used today as part of the musical experience of a child in therapy. In one of their individual case studies, they improvised music to a remote six-year-old autistic girl, picking up her fleeting response and met her mood. This form of contact helped the child overcome her tendency to avoid communication. In another study of a five-year-old autistic boy, progress on music therapy was demonstrated when music met and matched the intensity of the boy's screaming which led to a singing-crying response and brought about awareness of himself. This began positive developments including playful babbling, conversational exchange, and spontaneous enjoyment. The musical relationship was one of acceptance and careful nurturing as well as challenge, expectation and confrontation intended to support the child's potential abilities and thereby diminished pathological or habitual features of responses (Nordoff et al., 1980). Another major contribution of Nordoff-Robbins team is the use of the child's reinstance as a medium to meet the "here and now" level of the child which can be the most indirect way of transmitting musical experience.

Method

This research is mainly exploratory and clinical-descriptive in nature. The exploratory nature of this research includes not only exploring music therapy as a new field and topic of research in the Philippines but also exploring music therapy in itself as a budding therapeutic clinical intervention for Filipino children.

In the same manner, the clinical-descriptive nature of this research is a phenomenological approach from the actual therapy sessions which I narrated, transcribed and described.

Thus, the primary method of inquiry used is the multiple-case study method. It is an in-depth study of the individual music therapy sessions of five autistic children whose cases will be presented and investigated separately.

In dealing with autistic children, I use the clinical framework of the Creative Music Therapy which does not prescribe a definite structure and standardized approach, but believes in developing each client's individuality and upholds the notion that in every individual lies the musical self which is called the music child. This therapeutic approach is similar to Axline's Eight Principles of Play Therapy. With this approach, I am allowed to be creative, spontaneous and flexible to make the therapeutic process flow in the most natural way through the use of music. Children, particularly non-communicative individuals such as autistic children can notably benefit from this approach because it can address their three primary concerns: impairment in social interaction, impairment in communication and restricted repetitive and stereotypic behaviors. With this music therapy approach, they are able to express themselves freely and they are acknowledged as creative, dynamic, growing and changing individuals.

In this study, each client went through 12 music therapy sessions. Each individual session was videotaped, viewed, transcribed, analyzed and then written in the form presented on the original research before moving on to the next client. Videotape transcripts were supplemented with the notes I wrote after each session. These notes have been of great help in capturing the feelings I had and the insights I have learned from that particular session. Also, note-taking before watching the video gave me an immediate perspective of what I think should be highlighted in the case presentation of the session, not to mention that there are certain sessions when the video can not capture the angle, the sound, and more importantly, the facial expression or feelings of the child. On the other hand, I watched the video several times for different purposes: First, for transcription; second, for observation of the client particularly in response to the music I improvised; third, for observation of the therapeutic relationship; fourth, for accounts of music, techniques and musical instruments used. These are all in relation to the main purpose of this research.

Sample

With the cooperation of their parents, I purposively selected all five participants to attend individual music therapy sessions. All children have been attending the group play therapy sessions with Dr. Ma. Lourdes A. Carandang when the individual music therapy sessions were conducted. It was during the group play therapy sessions where I initially got acquainted with the five children.

Research Procedure

A parent of the participant answered a demographic data information sheet during their first visit. I first met each of the participants with their parents for an hour in the music therapy room. This was done to assess the child's interest in the room's set-up, which was filled with different musical instruments.

Each individual participant had been assigned a weekly one-hour session with the therapist.

The participant was invited to go to the music therapy room while the parent or caregiver stayed in the waiting room during the session.

I greeted the child with a welcome song, "Good Afternoon/Hello *name of child* (twice) we'll have fun and play some music today." The room was filled with different musical instruments, namely, a piano, cymbal on a stand, djundjun drum, set of *kulintang, agong,* lyre and triangles on a stand. A cabinet contains the smaller instruments such as the bar chimes, woodbars, small drums, variety of beaters and drumsticks, etc.

During the session, the participant was free to choose whatever he/she wanted to do and I just followed and tried to create a musical experience out of the session. Sometimes there were musical pauses in the middle of the session to allow the child to continue or to try to do another thing. The therapy ends by fixing the room and singing the goodbye song which was either an improvised song which summarized what the child did, or with the words, "Goodbye *name of child* and see you next... we will have some fun and play some music again."

Data Analysis

All 12 sessions of each participant were videotaped. After each session, I wrote my observations and watched the videotape to further analyze what transpired during the session. I then wrote a detailed account of the sessions, including my personal reflections and the techniques I used in each session.

Results and Discussion

I have developed my own style in reporting my findings. In writing the original result section of this research, I have presented a new and innovative format of a narrative providing a detailed account of what went on during the therapy sessions. I highlighted the important moments of each session which addressed the research questions. However, in this paper, I will only indicate a summary of the five case studies and highlights written in boldface taken from the actual recordings and documentation of the 60 sessions, which I find relevant in answering the research questions. The techniques and musical instruments most commonly used in the five case studies and my personal reflections will also be included.

SUMMARY OF CASES

Listening and Creating Commercial Jingles with Anton

Anton was 8 years and 8 months old when I first observed him in the music therapy room. A handsome boy who is the youngest of two boys, he was diagnosed as having autistic features. Aside from his morning sessions in a special education school, he would attend speech therapy thrice a week and play therapy weekly. His mother would describe him as a child who has a tendency to hit himself when he goes into a tantrum. He loves to watch TV and listens to the radio (prefers radio stations such as 96.3 FM, 105.1 FM, and 97.1 FM).

Anton came in for therapy as a very hyperactive boy and had a television commercial in mind such as *Lady's Choice*. He was echolalic and produced the most number of verbalizations. He was the only one who evidently responded to my musical demonstration when he was able to imitate and play the rhythmic pattern plus verbalizing. He had the potentials of learning musical skills. Moreover, he brought to the music therapy sessions a

television commercial which made it easier for me to connect and interact with him as we composed a jingle or a simple tune for it. Among all the cases, Anton's case had a special musical therapeutic flavor because he was hyperactive most of the time and moved around a lot. This could be a deceiving sign of inattentiveness, but it was more of a façade. In his own way he was listening, learning, processing, internalizing what was going on in the sessions.

Play, Throw and Explore with Emily

Emily was 6 years and 3 months old when she first came into the music therapy room. Quite tall for her age, she was previously diagnosed as having autistic features, delayed speech, and delayed social relatedness. When she had her initial session with me, she had a regular schedule of SPED tutoring twice a week and speech therapy three times a week and weekly group play therapy sessions.

Emily came in for therapy with her pretty smile and graceful but sometimes jerky movements. Among all the cases, Emily's therapy sessions were more of combination of play and music therapy. Her musical inclination was evident in her responses, from her gestures to her attempts of trying an instrument. Throughout the sessions, she had her own play of throwing, fixing, and putting the musical things together in one place. I had to improvise a "throw and hit" playing using the paddle drum and ball to be able to interact with her. Her exploration of the musical instruments was also evident in earlier sessions. Unfortunately, later sessions became unproductive.

A Theme Song for Kevin

Kevin was 7 years old when his parents first brought him to me in my music therapy room. An only child, Kevin is a charming boy diagnosed as having autistic features and delayed speech.

His mother spent most of her time with him, patiently waiting in his SPED school and brought him to his therapy sessions (speech, occupational and play). The mother described Kevin as a very good boy. However, one of her main concerns about Kevin aside from his lack of speech was that he would cover his ears to loud sounds and even go into a tantrum.

Among all the cases, Kevin's case was the most interesting for a variety of reasons. First, the issue of spitting, farting and covering of ears were presented. Second, there was a session with his/her mother. Third, his last session was the only time he had nearly displayed a tantrum but was managed by the therapeutic process. Fourth, music I simply called *Kevin's theme* was created as early as the second session which became part of the succeeding sessions. Fifth, his musical experience with the piano was immeasurable. Finally, his musical exploration was tremendous. Lastly, Kevin showed that he could be focused and engaged on a single instrument.

Lara's Song and Her "1001" Smile

Lara was 9 years and 6 months old when the mother decided to consider individual music therapy sessions with me. Her mother wanted to know more about how to bring out her special interest in rhythm and music. Lara was previously diagnosed as autistic having limited verbalization, being delayed in toilet training and lacking socialization skills. She is enrolled in the afternoon sessions of a SPED school and has a regular schedule for occupational and speech therapy.

Among all the cases, Lara's case was unique in the sense that her music therapy sessions started sort of a second phase or a continuation of group play therapy. Establishing a connection was not a major concern during the first sessions. Sustaining and developing a more trusting relationship was the more challenging part of her individual music therapy sessions. In this case, my struggle was to always remind myself that I am a therapist more than an educator. For Lara, she used these sessions primarily for five purposes. First, for relaxation and enjoyment. Second, for listening and uttering or vocalizing sounds. Third, for responding to the music through her rhythmic tendencies. Fourth, for building trust and friendship with me. Fifth, for expressing feelings. Lara had shown potentials in verbalizing through singing. This was the only case where stereotypic behaviors were integrated much with the music which prompted me to assess through the use of improvised music how it could elicit and at the same time, modify her stereotypic behavior.

MMM is for Manuel, Mirror and Music

Manuel was almost 5 years old when his mother brought him to me. Manuel is a cute, well-dressed hyperactive boy, who is the oldest of three siblings. He was diagnosed as having autistic features and delayed speech. Manuel attends a special education school, play therapy, speech therapy, and occupational therapy. Manuel also has a weekly horseback riding lessons. His mother describes him as a child who loves to watch Disney movies and who can empathize with the characters of the movie. At that time, he also enjoyed listening to Disney tapes. He also can manipulate the TV, CD, and tape recorders at home. His mother further mentioned that Manuel enjoyed humming by himself, but her primary concern about Manuel was his limited speech.

The case of Manuel showed the gradual unfolding of a musical therapeutic relationship. The flexibility and spontaneity of the process became the primary technique of making this case an enriching one. The big drum has been the main source of our musical interaction. Other effects such as the beater, mirror, t-shirt, books, alphabet blocks were used as part of the therapeutic process. Manuel had shown potentials in learning to sing.

Highlights of the Cases

Citing specific situations in the cases will show how music therapy enhanced the therapeutic processes with each autistic child. The boldfaced specific points of the cases were presented in order to emphasize the following findings:

1. Music therapy facilitates making connections with the autistic child by meeting where the child is and reflecting it through music. The autistic child either responds to or initiates the connection with the therapist.
2. Music therapy accepts and identifies the child's expression of feelings by allowing the child to play the instruments.
3. Music therapy encourages the child's verbalization through singing and improvising music.

4. Music therapy helps increase the child's eye contact through playing and sharing the musical instruments.
5. Music therapy helps in modifying stereotypic patterns by change and variation in the improvised music.
6. Music therapy fosters learning musical skills by simply taking the natural stride of being in the sessions.

Music Therapy for Making Connections

It is important to emphasize that music therapy always begins where the child is. Nordoff et al. (1980), Warwick (1995) and Howat (1995) have stressed in their studies that in order to develop interaction between the child and the therapist, the therapist must be able to meet the child's own level. In making connections with the five autistic children, the choice of music or musical instrument used was dependent on the particular disposition of the child. Each particular child's response was unique in the way I created or played the music.

Take for example the case of Kevin, where a good therapeutic relationship was already established as early as the second session through improvised music I created in response to the child's presence – his bearing, facial expression, movement, mood and his interest on the E note. The improvised music, simply called *Kevin's theme* was based on Kevin's playful and inquisitive disposition which paved the way for the mood and direction of the succeeding sessions. Kevin did not only react positively by swaying, listening or humming to the tune. It also became a therapeutic tool in making Kevin initiate interaction, where he led me to the piano to play his theme. I started to improvise music. *Kevin's theme* was composed with the melody based on the E note, which Kevin was interested in playing during the first session. Aside from using the E note repeatedly on the melody, the tempo of *Kevin's theme* was based on the child's present mood of being playful, inquisitive and cheerful. As I played it, Kevin did his own thing of playing the triangle while jumping and listening to the music. When I stopped playing the music Kevin approached me looked at me and placed my hand on the piano as if asking me to play more. Kevin then used the cushion for his joyous jumping, swaying, dancing and twisting with the flow of the music. He responded very well to the

melody composed and I expressed this by singing "Kevin likes this kind of tune." I sometimes put variations to the music by changing the dynamics. When I played it loudly, Kevin covered his ears. When I played it softly, he jumped and just continued listening to it. As the therapy progressed, Kevin was able to trust me as he allowed me to guide his hand in playing the piano. This time he joined and sat near the treble clef and once again piano playing took place with an exchange of guiding each other's hand to play.

Lara's case, I was able to find a melodic motif which captured the sounds she uttered. *Lara's song* became a bonding music for Lara and myself. Lara responded very well to the light and enticing melody I created. I sang *Lara's song* and she looked at me with a cute smile and I said, "you like that." She walked to the board, looked at it and when she passed by me, I gave her the orange drum. She sat on the piano chair for a while, got a beater and went to cool herself on the air conditioner. When I played the barchime and sang *Lara's song*, she turned her back to look at me on the other side of the room as she held the orange drum near her face. Then she moved towards me, babbled a two-tone sound, "a-ha-ba-ha-ba ha-ne-um-pa-ta" and moved back to the aircon and smiled. I said "Yes you're singing with Tita Marisa, good." I started singing *Lara's song* again with intervals to see what she was going to do. She just listened and looked at me or at the mirror. At one point when I sang as I played *Lara's song* on the piano, she looked at me with a smile and followed it with swaying and going with the flow of the music.

Both cases have had a particular music that became a central theme of the therapeutic process. These particular themes became important as the children remembered them and anticipated them being played in the sessions. Nordoff and Robbins (1971) described the process thus: As the child gets more involved, his face shows a mobility of awareness and feeling; the music builds in intensity, catching his mood and leading it onwards.

For Anton's case, the combined rhythmic patterns of the drum and cymbal engaged him in the sessions. Drumbeating and cymbal striking matched his high energy and hyperactive disposition. One time, he joined my drumbeating by swinging the beater first before striking the drum. I matched his drumbeating by playing the *kulintang* and striking it with the same intensity that Anton did with the drum. He enjoyed this and continued on his own to strike the drum with both hands with a steady

beat, striking it 36 times. Every time he started jumping to hit his head on the piano cushion, I matched this with a drumbeat. He went back to striking the drum instead with his right hand while I played the barchime. He responded by imitating the rhythmic pattern I produced. At times, simply striking the drum or cymbal or both satisfied him. He did the rhythmic pattern twice on his own plus an alternate drum and cymbal strike. He was so happy that he had a big smile when he faced the one-way mirror. He started striking the drum with seven solid beats and started to go around it as I struck between his drum strike. We had a brief musical interaction with the paddle drum as we struck this together and took turns playing it. A connection with Anton in later sessions were established by making jingles of advertisements Anton would utter in therapy. He started saying, "Lady's Choice" I added, "always be the..." and he ended "the best" then he struck the lyre and I imitated what he did.

For Emily, establishing rapport was done simply by being at her side, observing her play and produce music with the instruments. She got the bell, drum, cabasa and castanet and let go of it on the floor. Occasionally, she went to the aircon to feel the air and moved around watching her feet feel the rubbermats. I provided a beat and observed her. After a while, she invited me to stay with her. I joined her with the buffalo drum. After I struck the buffalo drum I extended the drum to her and she tried striking it. Furthermore, carrying her while dancing became an intimate form of contact. So even if I knew that I should have set limits concerning carrying her to dance, I gave in and carried her. She made eye contact while we were dancing. In later sessions, making a connection meant adapting her solitary play of throwing and fixing into an improvised interaction of throwing and catching with the paddle drum and soft ball. At first she just played with the ball by herself as I used another ball to play the paddle drum. She responded to my invitation to play together and we got so engaged that we had fun. I made it more enticing as I sang an improvised song, *"up so high and down so low, sometimes it's just fun to throw it anywhere.* I also used the beater to strike the paddle drum first as a guide to where it should be aimed or I would count, 1...2...3... before she threw it. At one point, when we stopped, she initiated playing again. At another time, I positioned my paddle drum on three different heights and she was able to aim and

throw it on the paddle drum, producing good sounds. I would interject by singing and praising her.

For Manuel, the connection was made by joining his creative music play. The only time he allowed me to be part of his play with the drum was when he sat on it and wanted to slide and fall backwards, with me guiding his fall. He initiated this play and enjoyed it. I explained to him that I could guide his fall but he can also try to produce a sound first with his feet as I carried him. He would stomp his feet alternately on the drum for our drumbeat moment. I also explained and demonstrated that he can also use his hand just like his feet and beater to produce a sound. We did the feet drumbeating several times and he would clap afterwards with jubilation as he watched himself on the mirror. On another occasion, it was through accompanying his singing that we had our shared musical interaction. He signaled me to play the piano, and as I played a steady beat without words he pretended to sing moving his body to the beat of my piano playing, looking at himself sideways at the mirror. Other times it was just looking at ourselves on the mirror while dancing and jumping. As we faced the mirror, he held my hand as we swayed and swung our hands together.

These cases have shown that the therapeutic process was enhanced by simply allowing the autistic children to feel free in being themselves. The natural, spontaneous flow of music therapy give children room to be themselves. This is similar to Axline's Play Therapy wherein two of the basic principles are to accept the child completely and allow him/her to lead the way (Axline, 1969). Carandang (1992) specifically emphasized this kind of connection that one has to enter the world of an autistic child through his/her own activity or avenue rather than to end the activity and the connection.

Music Therapy and the Expression of Feelings

Allowing the child to be free and creative gives the child an opportunity to also express his/her feelings naturally in a safe place wherein music therapy accepts and accompanies this expression. The variety of human expression that can be communicated through music is highly diversified and virtually unlimited (Nordoff et al., 1971).

Whatever feelings brought to the therapy session by the child could be accompanied by music. The music therapy sessions of the five autistic children were generally enjoyable and pleasant. Almost all sessions of the five children showed the children's desire to be in the therapy session. They enjoyed themselves as they constantly explored the instruments and discovered their potentials. Music therapy had been beneficial to these autistic children since one of their impairments was the lack of spontaneous sharing of enjoyment with others. In the sessions they learned and developed self-awareness and shared their feelings. Take Manuel for example. He held my hand as we faced each other in front of the mirror jumping as high as we could, both of us shouting and laughing to our heart's content.

Kevin also shared joyful moments with me while playing the piano. He would put his chin on top of his playing hand or my playing hand just to feel the movement of the fingers playing and showed a delightful expression on his face as he explored the piano. Lara also has expressed light and enjoyable moments with me as we sat face to face. She began having a big smile when I sang teasingly. And she just went with the flow of the music through her body rhythm, tapping on the drum with the beater.

Emily, on the other hand was fascinated with the lyre. My lyre playing elicited a response of smiling and listening. It encouraged her to stop whatever she was doing to giving it a try. In session 5, Anton and I played a rhythmic pattern with the drum and cymbal. He showed his enjoyment with the cymbal as he repeatedly struck it and laughed as he enjoyed feeling the vibration.

Clive Robbins explained that one must not take the idea of pleasure and enjoying oneself lightly because to enjoy oneself has a profoundly deep meaning—to enjoy oneself *becoming*. He further added that it is not narcissistic, but just realizing one's own abilities and enjoying this marvelous unfolding of self (cited in Aigen, 1996).

One of the more memorable sessions with Manuel was his jubilant and triumphant moments in his "saliva bubble making" where the therapist's cymbal and drum roll joined and acknowledged the occasion. As he tried to make his bubble I played a suspenseful mood on the piano and then shifted to the drum and cymbal. He would occasionally look at me but go back to his play. He raised his arms as a sign of triumph and sat on the drum facing the mirror saying "ha, ha." I just had to give him a

cymbal strike and acknowledge his success in making a bubble before we said goodbye. At first I wanted to stop him from playing with his saliva by distracting him through music, but I did not want to spoil his fun and miss out on the opportunity by letting him feel welcome to do whatever he wanted in the session. It is also significant to mention that this particular session started with his whining and my improvised humming song prevented him from whining any further.

In Kevin's 12th session, he entered the therapy room feeling upset. But when I played his theme on the piano he was pacified and sat near the piano. One time he expressed his feeling by striking the cymbal loudly as a sign of protest when I invited him to strike it some more.

In the case of Lara, she displayed a tantrum when she wet her shirt and wanted to change it. I imitated her whining with *Lara's song* playing on the piano which made her stop. I have expressed empathy and intentions of intervening through my improvised music which accompanied and also altered the child's feelings. I tried to ensure that they do not leave the therapy room still upset or hurting.

The other cases of Anton and Emily have shown how music therapy was used for their emotional release as they did their own playing of the instruments. Anton used the drum for the release of his negative energy. He leaned on me and tried the barchimes while I explained that he could release all his pain on the drum. He tried doing this, and looked at me while he struck the drum. Then he made repeated loud beats, smiling. The same was observed with Emily. In session 2, she had a mouth sore and she used the lyre to release her pain and struck this hard and strong on a steady beat. When I knew that she was still hurting I struck the *kulintang* hard for her to imitate. She did by just striking the jingle clog hard on the rubbermat. After releasing their tension and pain, the children became contented and relieved. When this happens, the therapy has achieved its clinical goal. This is similar to Freud's concept of catharsis. Freud developed free association and interpretation to bring everyone to the emotional state of catharsis necessary for the cure (Thompson & Rudolph, 1996). In music therapy, one could be into a state of catharsis as shown in the examples above. Music therapy creates a musical-emotional environment with freedom to express and release one's energy.

As Paul Nordoff said: Music can express the child's emotions. Music can resolve the emotional conflict and change the child's mood and when that happens, it also changes the mood of the therapist, the mood of the room. So changing of mood is a very important clinical goal whenever it is necessary because everyone's mood is changed both internally and externally. It is a beautiful moment when you succeed in doing this (cited in Aigen, 1996).

Music Therapy and Verbalization

People with communication difficulties often show that they enjoy music and sound, and in some cases, are clearly more alert and less isolated when music is involved in the communication process (Oldfield, 1995). Children with autism are more likely to follow or imitate the sound or music initiated by the therapist. Somehow a song or music appeals to them more than the spoken language. Four out of the five children had limited speech when I first met them but it appeared that they were more motivated to verbalize in their music therapy sessions. Take for example the case of Lara who was more likely to engage herself in doing the request I asked her when I sang it rather than just saying it.

I would sing happily, "don't put the beater inside your mouth" and she would take it out and laugh. *Lara's song* also enticed her to verbalize and she clearly became more willing to join in singing. And she moved again to the mirror jumped and uttered "hum a mer."

Similarly, Manuel became more interested in verbalizing and vocalizing the ABC as I put some improvised melody to it. Even in the early part of his session singing *Country Road* and *Birthday Song* had paved the way for utterance of words and attempts to sing such as "home and belong." It was pleasing to hear him say not only his name but also my nickname when he said goodbye. Furthermore, the improvised songs and singing made him more attentive and communicative.

Even in protesting, Emily uttered sounds and struck the instrument loud and hard to release her pain. She also struck the *kulintang* hard and when she felt the pain again, she shouted "aaah." Emily even joined me in my improvisation of uttering sounds when it was in a song form. At one point, she joined in singing the "aah" part loudly as if suggesting singing it that way so I imitated her utterance.

Kevin also attempted to utter sounds when asking me to play music on the piano. He took my hand and led me towards the piano and uttered "piye piye." "Piano," I echoed. The same was shown in session 12: "play the piano, " I would mention and he would smile and respond "pe pepe peyan." He has also vocalized "pam pam pam" happily as his theme was played on the wood bars.

Anton, whose speech was echolalic, was eager in verbalizing some words drawn mostly from advertisements, knowing and anticipating that it would be created as a word game or jingle during the therapy session. He started saying "A is for *Alaska* B is for *Bear Brand* C is for *Carnation,* " and I replied by saying "A is for agong B is for Beater C is for cymbal and D is for drum." Sometimes he would verbalize a commercial such as *Lady's Choice.*

Music Therapy and the Development of Eye Contact

Music could also be a tool in developing eye contact with autistic children because it carries a certain appeal. Almost always, I used the instruments to generate a possible reaction from the children. Whether or not the music produced was appealing, one common reaction among the five autistic children was to gaze or look towards the direction of the sound. Eventually eye contact followed between us. Anton always initiated eye contact when he shared the drum with me. After this face to face, we shared the drum, and struck it together. He would look at me as he verbalized an advertisement which became my cue to make a jingle or a song.

Lara would look at me if she liked the improvised song I sang. Other times she had a mischievous look to check if I was looking, particularly when she was up to something like putting the beater inside her mouth. She had that look in her face but I just avoided it most occasions. When I paused she looked at me and after some time tinkered with the piano keys by raising her arm backwards. Her gaze was also an indication that she was listening and wanted me to play some more. She had very good eye contact, smiling occasionally when I played the paddle drum and *kulintang* singing to her, "Sing it loud, hum a merry tune..." I was improvising a song to entice her to sing along.

This was also true with Kevin as he would initiate eye contact when he wanted me to play or continue playing an instrument particularly *Kevin's theme* on the piano. Occasionally he played a note on the treble clef of the piano, as if expressing "I'm with you." Other than that he would also glance at me once in a while to show that he enjoyed listening. When relaxing music was played, he started swaying on his seat and occasionally looked at me. Kevin would also look at me as I demonstrated how an instrument was played. He initiated eye contact after I played the barchimes I invited him to try it. Then he attempted to imitate what I played and looked at me with joy and wonder as he placed his hand on the barchime to feel the vibration. Even when he was bothered by the music he would still look. Once in a while I checked if Kevin was still listening by playing a loud sound and he responded by covering his ears and looking at me distractedly.

Manuel would also look at me when we did an activity together. He initiated eye contact for the first time while smiling at me when we were in the middle of our drumbeats. Manuel would also make eye contact with me when sang. When I reached the word "home" he would sing the word too, facing me. On one occasion, he looked at me for approval. Manuel started playing softly and gently with his fingers and looked at me for assurance. Moreover, he responded when I called his name.

Emily would also take time to look at me when I produced a sound from an instrument. She knew what direction she would look when I played the maraca on my left hand. She would likewise initiate eye contact when we played an instrument together. She smiled and maintained good eye contact after we had a brief musical interaction with the paddle drum. Other times, she would look at me closely when she liked to be hugged or carried.

With all the children, music or playing the instruments had been an effective tool in developing nonverbal interaction such as eye contact. More than their glances, their smiles made me aware that music therapy could help these children in a positive way by encouraging them to be engaged and socially interacting.

Music Therapy and the Modification of Stereotypic Patterns

Among all the children, Lara had manifested the most number of stereotypic patterns of behavior, namely, putting the beater inside the

mouth, fidgeting of fingers, hand gestures, rocking, to-and-fro movement and awkward marching. But she also appeared to respond well to music and music therapy made altering her behavior manageable.

By providing and varying the music, I was able to control and modify the stereotypic behaviors of Lara and the other children.

When I sang requesting Lara not to put the beater inside her mouth, she would follow. "Don't put the beater inside your mouth," I sang and she took it out and smiled. Although until the last session she still continued doing so, it was considerably less frequent. Humming or singing her song became an alternative to biting the beater. Her to-and-fro movement eventually evolved into dancing with me. And her awkward marching was modified into a more defined movement of marching properly. She smiled and joined my singing by tapping the drum in a rather awkward way with the beat of the greeting song. Her rocking was modified into swaying. When I struck the paddle drum fast and loud with accents in between, her rocking turned into swaying. Although these manifestations still existed until later sessions, one could observe that music and rhythm became effective in minimizing these stereotypic patterns.

Moving to the music can be a liberating and a total experience. Alvin et al. (1991) described the music they used for Pamela as non-percussive with a flowing, flexible rhythm, provoking spontaneous freedom or movement just to counteract Pamela's rigidity of movement and set habits.

Music could influence the movements of Kevin. When Kevin was excited he would express this by jumping, flicking his fingers or spinning around. Once, I varied my piano playing and intervened by playing a grand chord of his theme. Kevin stopped spinning in response. Other times, instead of spinning he would spin the *agong* or cymbal. I observed that Kevin attentively listened to the music I created even when he was doing something on his own. Since he reacted to any slight change in the music, this became an entry point for me to intervene with manifestations of stereotypic behaviors. This was a good sign because managing change and variation without being agitated is something he could adapt in everyday life. Music therapy may make him more flexible and spontaneous.

Moving around and hurting himself were Anton's typical behaviors. Music was a good intervention for Anton since he could just sit

and listen or even try to play the drum along with me to refrain from moving around. One time he started hitting himself with the beater and uttered a "huu" sound. Striking the drum substantially altered head banging or hitting himself with the beater. I would demonstrate producing a loud and soft sound which made Anton familiar with the dynamics. He would eventually since he strike it hard just to release his energy and at the same time prevent him from hurting himself. He tried releasing his pain by repeatedly striking the drum.

Emily, on the other hand, loved to throw and fix the musical things on her own. But this was modified into an interactive play of throw and catch with the paddle drum and the soft ball. Occasionally, she still displayed her gestures but interactive play helped lessen this.

Music Therapy and Learning Musical Skills

It has been demonstrated that musical skills could be acquired since the children themselves were part of the musical experience. Aside from auditory stimulation, attentive listening could be developed. Moreover, handling of beaters and instruments could also be learned even without formal teaching.

All five autistic children were instructed on how to handle the beaters and instruments. The next time Lara struck it, it was done correctly. It is also important to mention how Kevin demonstrated attentiveness by being focused on the instrument he was interested in such as the piano, barchime and *kulintang*. Through the technique of imitating and acknowledging, the children were taught to handle the instruments appropriately. For Emily and Anton, making glissandos had been a source of fun and interaction while learning how to produce it on the lyre, xylopipe and barchime. Anton also displayed his acquired skill in drumbeating and in learning a rhythmic pattern. Anton, Kevin, and Emily also started to develop their hand-eye coordination. Other skills such as listening were part of the music therapy session. Singing or vocalizing was part of Lara's and Manuel's music therapy. Kevin also would utter "pom," matching the last note of his theme which could help develop his auditory acuity. The children have shown the ability to carry a tune easily which they tried to express through their vocalization attempts.

Other than these, movements such as swaying, clapping, shaking of maracas and playing the instruments properly were all part of their therapy sessions. Also, the natural and spontaneous flow of the therapeutic process directed the children to follow the beat of the rhythm and carry the tune without being asked to do so.

Techniques Used

I used the soliloquy technique in the sessions of the five children. In music therapy this technique is an effective tool in making a connection and developing communication without being intrusive. Unlike speech which is normally intended to be heard by another person, music could be soley for the one singing or playing the music (Oldfield, 1995). In the soliloquy technique, the therapist could pretend to simply sing or play music and in doing so, also entice her client to listen and respond. Children used to isolating themselves from others such as in the case of autistic children could take their time in responding to the therapist because they could decide whether or not the therapist is communicating with them or just simply playing for herself. They could take as much time as they like and respond when they are ready to communicate. Music has its own unexplainable charisma that could be attractive to autistic children. Autistic children could enjoy music with their therapist and bring them out of their isolation. Music and song could be useful in developing speech patterns or verbalization since it can capture the interest of autistic children. Moreover as Oldfield (1995) believed, once there is an established rapport between the child and the music therapist, the rhythm of the music and the impulse of movement can be channeled into more elaborate communication.

Teasing was one of the techniques that I also used. This socially accepted way of interacting had been an effective way of engaging the children to respond and to have a pleasant mood. It was a positive sign to see how the child also initiated teasing me, too. It was a good knowing that the child liked me and enjoyed relating with me. At first I was the one teasing them but in other cases some of these children started teasing me. Take for example when Kevin placed his hand on top of the xylopipe for me to strike, after which we both had our shared laughter. Teasing involved a

great deal of delicate intelligence from these children (Aigen, 1996). Kevin had to know the proper timing when I would strike the xylopipe so his teasing would effective. In a similar case, Lara was able to determine the proper combination and timing when I would strike the tambourine she was holding after I struck the instrument I was holding. Thus, she teasingly moved the tambourine away so I would miss hitting it. Teasing is a social skill that could be an important way of making contact and building relationships.

I included this technique in order to adapt to our Filipino culture; we love to tease, make a joke and use humor in our lives. The sessions also showed that these Filipino children can be affectionate. One way or another, all of them had demonstrated this Filipino trait by hugging or kissing me. Carandang (1992) also observed this trait of being affectionate during her group therapy session with Filipino autistic children even during the early stages of therapy. With this technique I also established my presence as "human relational reinforcer." This insight about human relational reinforcer was first presented by Dr. Carandang upon forming a group therapy program for Filipino autistic children. Human relational reinforcers are effective in connecting with the child in order to modify undesirable behavior for desirable ones. Thus, in music therapy, I used my own being as the primary instrument in therapy.

In dealing with autistic children I wanted to create an atmosphere that would elicit learning some social skills because one of their impaired features is effectively relating with people.

Sharing an instrument with the child or having musical interaction using one or more instruments did not only elicit some positive responses such as eye contact, but also allowed the child to experience a turn-taking situation in the most natural and creative way.

I would also like to emphasize that therapeutic skills still play a major role in music therapy over and above the use of music. The autistic child might choose to relate to the therapist or to the musical instruments and/or the music but the therapist is still responsible for reinforcing a behavior, action, and feeling. It is important for the therapist to be constantly attuned to the child's inclinations. As mentioned earlier, the three elements of music therapy are the therapist, the child and music. But the main priority of music therapy, just like in any other therapy, is to

help the client in whatever concerns he/she may bring to therapy. It is also relevant to mention that I have used music in therapy not only to make connections but also to shield myself when I wanted to constantly assess a child's readiness for a new sound or music such as changing the dynamics of song. When an autistic child did not respond positively to the change heard, the child may attribute it only to the music/musical instrument and not to me. Our therapeutic relationship was thereby not threatened but could be strengthened since a child could seek my support upon hearing an unpleasant sound—just like the first time Emily heard a loud cymbal strike. Thus, a trusting relationship is created. As Aigen (personal communication, January 2000) explained, music can help the therapist make interventions which lessen the chances of having a problematic dynamic between the client and therapist.

Overall, it is the natural flow of music therapy which enhanced the therapeutic processes for these five autistic children. The music therapy I designed for these children had no structure and order. The improvisations used were greatly dependent on the child's presence, making it unique and individualized. The natural therapeutic flow of each session brought out the music child in all of them.

Musical Instruments

Music therapy would not be possible without the use of the musical instruments. Different musical instruments each have their own attractive quality that these children found appealing. At the same time, I used these instruments as effective medium for therapy. The primary musical instrument I used was my own human voice. Singing became an effective "enticer" for making connections. Manuel, Lara, and Anton responded well to my singing. Somehow, they were also encouraged to join in.

Aside from this, the piano, with the variety and color of its tone could be the best medium in musically reflecting or accompanying whatever the child was doing. At other times, it was a source of imitation between us. Among all the children it was Kevin who was attracted most to the piano. He was not only fond of listening to my piano playing, he was also willing to learn how to play it and allowed me to guide his hands. With the piano, Kevin had displayed tremendous attention. Lara had her own interest on the piano, too. She explored this in a variety of ways even

sitting under it while listening and striking a note. And she would initiate contact by inviting me to play the piano for her. Manuel also had his own exploration of the piano, playing it on his own and asking me to accompany his singing.

The djundjun drum or the big drum had also been a great source of interaction. Sharing this instrument had been fun for Anton and me. The big drum offered a precise beat and a responsive rhythm. Anton had shown keen interest in producing steady beats. For Manuel, the big drum was used for his feet drumbeating which also became a bonding moment for us. The cymbal on the stand could draw the autistic children because it was stimulating. The vibration they felt when they struck and touched the cymbal somehow fascinated them. At first, the children were fearful of the clashing loud sound produced but once they were invited to strike it on their own, the cymbal had its own appeal to sustain their interest in striking it again. Among all the children it was Anton who explored and enjoyed this the most.

The *kulintang* had its own appeal for Emily and Kevin. Emily used this as part of her play and became a source of her exploration. Kevin also imitated me in striking this and we had a jamming session together.

The lyre, barchime, xylopipe, and woodbars were smaller instruments which could also produce melodies. These instruments were likewise effective in making a connection with Emily. Emily and Anton were attracted to the glissandos produced on these instruments. Making glissandos have been a musical exchange between these two children and myself.

My Journey in Music

I have always considered music as a therapy for myself and through it, I have grown to become the individual that I am now. All my life I wanted to share this healing power of music and doing this research has allowed me that. It always amazes me how one could be moved by just listening to music. Music is interpreted in so many ways depending on the listener. Music affects our lives without our being consciously aware of it. I strongly believe that in each and every one of us lies that musical child just waiting to be discovered. At the least I know that the musical child in each and everyone has that capacity to appreciate music. With this in mind,

I entered this profession in order to at least guide people in discovering not just the musical child in them but their inner potentials as well.

I wish to emphasize that I considered these five adorable children as my cotherapists. Through them that I saw how effective music therapy is. Moreover, it moves me deeply to see their warm smiles, laughter, and hugs during and after therapy when I knew that the music therapy for that day made a difference in their lives. They might have benefited from their music therapy but I know my gains were twice as much.

Kevin, Lara, Emily, Manuel, and Anton gave me a source of inspiration to continually discover and learn the therapeutic power of music. I know that somehow I have unlocked their potentials by just allowing them to be free, creative, and spontaneous. During the therapy sessions I have seen how they were gradually becoming and embracing music as part of their personal agenda.

Conducting music therapy with children entails great responsibility. It could be tedious and frustrating at times. But the fulfillment one could achieve after seeing how they could totally be engaged in music making and having a grand time celebrating the moment is a reward that always captivates my heart.

AUTHOR'S NOTE

This paper is based on the author's masteral thesis entitled, *Exploring the use of music therapy for Filipino autistic children* under the supervision of Dr. Ma. Lourdes A. Carandang. The names of the participants were changed except for Anton and Kevin whose parents allowed the author to use their real names.

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