Group Music Therapy in an Acute Mental Health Facility:
A Reflection and Strategy of Clinical Practice

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Abstract

Group therapy work in acute mental health facilities can be challenging to navigate due to external and internal barriers. Recognizing the importance of bringing purpose and intention to clinical work, music therapists strive to meet the needs of clients through music experiences. However, with so many diverse clients with different treatment needs, a music therapist plans for the unexpected. This study is a first-person, phenomenological, heuristic examination of my thinking process when planning 12 heterogenic group music therapy sessions for clients at an acute mental health facility. Data were gathered through journaling, music making, art expression, and guidance from professional supervision. A general format of planning and implementing group therapy was identified as pre-planning, planning, and in-the-session adaption. Several themes that can bring understanding and rationale for the planning process in clinical work emerged and these are discussed. Themes were consolidated into a creative synthesis, the metaphor of a tree, to represent the thinking process of planning a music therapy session in this clinical setting. The experience of the first-person research heuristic process is addressed, and further research areas are offered.

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Introduction

Music connects people from all walks of life and has the capacity to increase expression, strengthen relationships, and improve overall wellness. Understanding music's potential, music therapists help clients connect to themselves and others with and through music experiences. With intention and purpose, the music therapist plans and implements music based experiences to help each client reach his/her treatment goals (American Music Therapy Association [AMTA], 2014b). This process is as individualized as the music therapist and the client with whom the music therapist is working. Examining the internal cognitive and creative process of planning and implementing therapeutic music experiences may help to uncover further insight into the intention and purpose of the therapeutic process when posed with the internal and external challenges and resources of daily work as a music therapist (Bruscia, 2005).

Music's inherent aptitude to assist in forming connections and relationships can help guide clinicians as they work with their clients (Dvorkin, 1998). Much consideration goes into planning and implementing music experiences. Individual work is intrinsically client focused and can accommodate the in-the-moment client need to encompass his/ her individual domains with attention to multicultural issues (Egan, 2010; Jackson, 2013). However, group therapy clinicians identify that group therapy has increased opportunities for interpersonal growth and goal development if the setting is conducive to the client's treatment needs (Corey, 2012; Yalom, 2005). Group therapy models have been adapted to help establish therapeutic objectives in different clinical settings by related disciplines (Glenister, 1993; Grandison, Pharwaha, Jefford, & Dratcu, 2009; Yalom, 2005). However, music therapy research has not offered an introspective analysis of how a music therapist constructs, adjusts, and brings purpose to clinical work in an acute mental health facility.

Group music therapy is the primary mode of treatment offered in acute mental health facilities (Silverman, 2007). Group work can be extremely rewarding for clients, because much can be learned about one's self and others from the groups they form and the way each individual engages as part of the group (Burlingame, Fuhriman, & Johnson, 2001; Corey, 2012; Yalom, 2005). However, group work can present challenges for music therapists to make sure each client is receiving the best care within the group parameters and dynamics (Eyre, 2013a). It can be a struggle to cope with the challenges and access the benefits of group work with such a diverse population (Carr, Odell-Miller, & Priebe, 2013; Eyre, 2013a).

For mental health clientele in crises, inpatient facilities help clients with varying diagnoses, levels of functioning, and cultural backgrounds in an effort to stabilize and support their journey toward wellness (Eyre, 2013a). Unfortunately, symptoms related to a client's diagnosis can hinder their relationship development and connection to others, effectively stalling their ability to receive appropriate treatment and support (Eyre, 2013a; Hunt, 2013; Jackson, 2013). Music therapists strive to find ways to connect to their clients and help clients connect, develop, and reach treatment objectives through music experiences (Wolfe, 2000).

Music therapy literature regarding treatment of mental health clientele has focused on different music experiences and how specific populations respond, which offer clinicians evidenced-based practice and has uncovered new and creative insights (Carr, Odell-Miller, & Priebe, 2013; Edler, Ghrayeb, Machura, McNulty, & Meadows, 2012). However, limited research has been conducted regarding the internal process of the therapist as he/she navigates through unpredictable groupings and clinical work (Bruscia, 2005). Music therapists working in acute mental health facilities struggle when implementing treatment care because of limited time, space, advocacy, and the diverse clientele (Carr, Odell-Miller, & Priebe, 2013; Eyre, 2013a).

Without guidance of how to effectively accommodate all clients who may attend open group sessions, music therapists may be left with more questions than answers.

First-person research has been utilized to help understand a new perspective of clinical work, that of the therapist (Bruscia, 2005). By engaging in self-reflection, a clinician may be more capable of refining the intention of clinical work (Camilleri, 2001; Lett, 1995). First-person research, when executed appropriately, can yield valuable information into clinical impressions and help to positively impact the music therapy community and other helping professionals (Bruscia, 2005). Research has not yet been done to offer an inside look into how music therapists create, plan, and implement group music therapy in the ever-evolving mental health setting. As no literature offers a clinician focused introspection of group music therapy practice in an acute mental health facility, research in this area might open up understanding to how clinicians give intention and purpose to groups that can be a jumble of uncertainty.

Research Question

What is involved in the decision making process of how I plan music therapy groups for clients in an acute mental health facility?

Definitions

- "Group therapy is a method of psychotherapy in which the emotional reactions of members of the group to each other and to the leader are understood as being reflections of interpersonal conflicts of the individuals comprising the group" (Mann, 1953, p. 333). Group therapy is characterized by its ability to help form and establish multiple relationships to improve an individual's growth and problem solving skills (Yalom, 2005). The different types of group therapy include closed groups, in which no new members can join after the group has been established, and open groups,

which permit new members to join and may run indefinitely. Group therapy can also be classified into homogeneous groups and heterogeneous groups. Homogeneous groups imply that group members have factors in common, primarily similar diagnoses or issues, while in contrast, heterogeneous groups have more diversity related to problems of focus among the group membership.

- Music therapy is defined as "the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program" (AMTA, 2006, para. 1).
- An acute mental health inpatient facility refers to a short-term hospital setting that focuses on mental health treatment and care (Eyre, 2013a; Silverman, 2007). Inpatient facilities generally remain locked and secure as a safety precaution (Eyre, 2013a).

Purpose Statement

The purpose of this research project is to increase my self-awareness and provide a more comprehensive framework of how I plan and facilitate group music therapy programming with clients in an acute mental health facility.

Literature Review

Mental Health

In the United States, individuals with mental health concerns are diagnosed based on symptom duration and specific criteria using the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013). Prevalence of diagnosable mental health disorders for Americans over age 18 is estimated at 26.2 percent, about one in four adults, and a smaller portion of Americans suffer from a serious mental illness, about six percent, or 1 in 17 individuals (Kessler, Chiu, Demler, & Walters, 2005). Forty-five percent of persons with any mental disorder meet criteria for two or more disorders (Kessler et al., 2005). The *DSM-5* offers diagnostic criteria for different types of mental health conditions, including personality disorders (APA, 2013). Each diagnosis has different symptomology and different treatments.

Many individuals with a major mental illness also present with another mental health concern (Jackson, 2013; Murphy, 2013; Substance Abuse and Mental Health Services Administration [SAMHSA], 2010). In cases of persons with co-occurring disorders, a carryover of symptoms and treatment concerns require attention. The National Survey on Drug Use and Health (NSDUH) indicated that in 2009, 25.7 percent of all adults with serious mental illness also presented with substance use dependence and out of adults with substance use disorder, 42.8 presented with a co-occurring mental illness (SAMHSA, 2010). The study also suggested that among the 8.9 million adults with any mental illness and substance use disorder, only 13.5 percent received both mental health treatment and substance abuse treatment, while 44 percent received treatment for only one condition.

Patients in acute mental health settings present with diverse clinical diagnoses; however, to warrant an inpatient hospitalization, the patient must be in acute crisis (Eyre, 2013a). The patient may voluntarily seek treatment due to decompensating or relapse, or the patient may be committed to treatment by the court system due to a concern that the patient is a danger to him/herself or others. The current length of stay for hospitalized patients with serious mental health concerns has changed due to the process of deinstitutionalization and new psychotropic medications (Eyre, 2013b). In America, the average length of stay for a person with a serious mental illness in 2010 was 7.2 days (Centers for Disease Control and Prevention, 2014). The shift from long term care to short term care, precipitated a change in mental health treatment and has brought new challenges to providing services to patients, specifically related to accommodating needs and treatment concerns for all patients in the short amount of time allotted (Eyre, 2013a).

Treatment

In mental health facilities, a treatment team can consist of several different disciplines including psychiatrists, nurses, mental health technicians, social workers, occupational therapists, recreational therapists, art therapists, and music therapists. Different therapeutic approaches have been employed with this population including problem management and opportunity development (Egan, 2010), psychodynamic (Davies & Richards, 2002; Isenberg, Smith Goldberg, & Dvorkin, 2008), multimodal (Cassity & Cassity, 2006), recovery-oriented model (Eyre, 2013b; Solli, Rolvsjord, & Borg, 2013), medical model (American Psychiatric Association, 2013), compassion therapy (Braehler et al., 2013; Gilbert, 2009), transdiagnostic treatment (Chamberlain & Norton, 2013; Craske, 2012), cognitive therapy (Luce, 2001), cognitive behavioral therapy (Silverman, 2008), behavioral therapy (Silverman, 2007), relational

group psychotherapy (Erskine, 2013), and holistic practice (Lynch, Askew, Mitchell, & Hegarty, 2012). Each approach identifies different mindsets of treatment and varied insight into the client's experience and treatment needs. Comprehension of these approaches help clinicians understand and respond to members of a multidisciplinary team who may utilize these approaches.

While in acute settings, clients can receive individual time to speak with the psychiatrist, social worker, and other varied medical and supportive staff (Eyre, 2013a). However, with budding research about the benefits and cost effectiveness of group therapy, clients also receive varied therapeutic groups while on acute mental health units (Silverman, 2007). These are individualized to each disciplines' scope of practice and areas of strengths; however, each discipline approaches groups with a focus of helping clients reach treatment goals.

Group Therapy

The basis for group therapy is the fundamental idea that the group, as a whole, is a self-sufficient and an ever-evolving organism (Corey, 2012). When people engage in group experiences, the opportunity yields potential for growth in many domains of life (Burlingame, Fuhriman, & Johnson, 2001; Corey, 2012; Yalom, 2005). Corey (2012) identified six stages of the group therapy process that help deepen group connection. These stages are fluid and do not always move in a straight motion, but rather can fold in on each other and blur. While Corey explained group therapy as a more long term process, the stages of group therapy can still be understood in a shorter duration construct to help build a stable foundation.

Group therapy is advocated for its cost effectiveness of health care providers, opportunities of support and growth through interrelated connection, and help in diminishing shame or financial strain in seeking personal counseling (Corey, 2012; Yalom, 2005). Group

therapy, at its finest, helps to establish trust and cohesion so hope is possible (Corey, 2012; Yalom, 2005). The reasons for personal success in the group process are the 11 primary factors of the therapeutic experience that lead to positive change (Yalom, 2005). The primary factors of positive change include instillation of hope, universality, imparting of information, altruism, corrective recapitulation, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential factors.

The ideal group size is seven to nine patients, meeting consistently with clear motivation, and a common focus due to the therapist's development of a homogeneous group (Corey, 2012; Yalom 2005). Unfortunately, the reality is that there are many factors that lead to inconsistency in group membership (Carr, Odell-Miller, & Priebe, 2013; Eyre, 2013a; Yalom, 2005). For example in an acute inpatient setting, on a day-by-day basis on the same unit, it is likely a music therapist will have a different group of people each day. These challenges can hinder the group therapy progress. Other barriers include extrinsic and attitudinal challenges, such as limited administrative backing, untrained group leaders, and scheduling conflicts (Yalom, 2005). Perceived encroachment on professional territory can also hinder a group's success. However, with continued open communication, research, and advocacy, attitudes can adapt and change. Internal challenges can be more difficult to diffuse, because they are within the nature of the short term, acute setting. Internal struggles include rapid client turnover, diversity of pathology, limited time, limited group boundaries, and inconsistently scheduled group leaders. Other challenges include group interruptions, different levels of motivation, and client presentation (Carr, Odell-Miller, & Priebe, 2013; Eyre, 2013a; Yalom, 2005). Situationally, clients can present as closed and guarded, because they are in a crisis and therefore survival mode (Eyre, 2013a; Yalom, 2005). The group will be rich with diversity regarding treatment concerns and

goals, and each individual deserves not only the benefit of the group experience but individualized treatment toward recovery.

Yalom (2005), a prominent figure in group work literature, has attempted to understand the true benefits of group therapy work. Yalom developed a model for group therapy to offer insight and help mental health clinicians create and maintain a group on an acute mental health unit. This model focuses on observing and adapting to the clinical setting, including the intrinsic restraints, and creating appropriate set of group goals. For an inpatient acute group, the therapist must consider the life of the group to be only a single session. According to Yalom, to achieve the highest benefits from the single group, the therapist must be active, efficient, supportive, positive, and constructive. The therapist's responsibilities include maintaining a safe environment and redirect focus to the here-and-now experience through firm and decisive cues. In this model, a directive and clear therapist maintains a consistent group session protocol, and treatment members maintain adequate time and spatial boundaries, which promote the group's success.

Facilities have utilized Yalom's (1983) model of therapy on their acute mental health units with success. In a study conducted by Glenister (1993), an inner city, male only, inpatient ward established a working therapeutic communication group. The study determined that, while it may be difficult to establish a therapeutic group, the benefits outweigh the challenges. Challenges included staffing, leadership, and motivation of participants. Researchers suggested that motivation to attend group can increase due to an expectation of attendance, a belief in the benefit of group therapy, and if the group was led by a team member. Co-facilitation and supervision were advocated to help increase competency in leadership roles and provide solutions for staffing problems. While challenges were presented, the researcher suggested that

behavioral disturbances seemed to decrease due to having therapeutic groups on the unit. Another study conducted by nurses adapted Yalom's (1983) and Glenister's (1993) therapeutic group model. By adapting to their own needs and resources, nurses were able to establish a community group at an acute mental health facility for women (Paley et al., 2013). Surveys completed by clients at the end of the group session identified that the top four therapeutic factors gained by participants were group cohesiveness, universality, catharsis, and guidance.

Mental health practitioners including social workers, occupational therapists, and music therapists have attempted to find and understand ways to help clients reach treatment milestones. While each discipline's focus varies, due to education and practice, they find ways to overcome challenges and use internal and external resources to encourage group effectiveness. Through appropriate collaboration with the multidisciplinary team, the client is best served.

Social workers as members of the multidisciplinary team at acute mental health facilities acknowledge group therapy can be beneficial, because of the interconnectivity of life experiences (Wodarski & Feit, 2012). Being part of the therapeutic group allows opportunities for group members to gain self-worth and confidence in helping others and accessing the help they need (Braehler et al., 2013; Wodarski & Feit, 2012). Social workers continue to look for evidence-based treatment protocols of group therapy including effective treatment for specific clients, appropriate location and duration of group sessions, the role of the leader, and when interventions should be used to create effective change (Wodarski & Feit, 2012). Keast (2012) created a toolkit for single session groups in acute care settings that utilized a review of social work literature to determine best care practices. While this did not explicitly focus on inpatient psychiatric facilities, it did identify how social workers have established groups and offered strategies to cope with the challenges of single-session therapeutic groups. The key to

developing a successful group was support from all members of the multidisciplinary team. Keast also advocated for further research in understanding the leadership skills required of those facilitating single session groups.

Occupational therapists have also examined their role in inpatient care. In a survey conducted by Lim, Morris, and Craik (2007), patients at an acute mental health facility ranked their views and experiences of occupational therapy during their treatment. While only 28.6 percent of patients responded to the survey, the researchers concluded that occupational therapists need to provide more opportunities for patients to identify and reach individual goals at their facility. Group interventions were identified to be most beneficial if they were relevant, meaningful, and had an occupational focus; however, the researchers advocated that more individual programs be offered on an inpatient level as well. According to respondents of the study, *sports and gym* and *cookery* were identified as the most beneficial programs offered by occupational therapists. Other groups offered most frequently included arts and crafts, relaxation, and community meetings.

While a younger profession than some of the other mental health care treatments, such as social work and occupational therapy, music therapy has been established as beneficial member of the multidisciplinary team for acute mental health clientele (Eyre, 2013a; Gold, Solli, Kruger, & Lie, 2009). However, music therapists have different tools and methods of helping clients achieve treatment goals. These treatment tools, methods, and client-focused music experiences have proven helpful, even in short term care settings.

Music Therapy

Music therapy is defined as "the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed

professional who has completed an approved music therapy program" (AMTA, 2006, para. 1). Music experiences facilitated by music therapists have the potential to reach and connect with clients to help them reach treatment goals (Eyre, 2013a). Music therapists work with many different clientele including clients with neurological disorders, clients coping with medical and surgical problems, patients will developmental disabilities, patients with mental illness concerns, and more (American Music Therapy Association, 2014a). Music therapists practice in medical settings, mental health settings, geriatric facilities, children facilities/schools, and many more locations.

Clients can achieve a variety of treatment goals by engaging in music therapy. Treatment goals aim at positively impacting the clinical domains and are developed to improve life function, increase quality of life, and improve wellness (AMTA, 2014a). These domains include social aptitude, emotional understanding and expression, academic skills, communication skills, motor function, and leisure interests. Goals are developed depending on the treatment concerns of the patient and what would be appropriate to achieve wellness.

Music Therapy and Mental Health

According to the *2014 AMTA Member Survey and Workforce Analysis*, 20 percent of music therapists identified that they serve mental health clientele (American Music Therapy Association, 2014a). This was the highest percentage identified for a specific population. Of these music therapists, 12.6 percent identified that they worked in mental health facilities, which included child/adolescent treatment centers, community mental health centers, drug/alcohol programs, forensic facilities, and inpatient psychiatric units. While this survey only included AMTA members, this research demonstrated that a substantial percentage of music therapists work with clients who have mental health concerns and conduct sessions in mental health

settings. Eyre (2013a) identified that music therapists working in mental health operate primarily in psychiatric facilities. In response to a survey by Silverman (2007), music therapists indicated that they practiced using primarily behavioral or psychodynamic approaches, but considered their philosophy as eclectic.

Music therapists working in acute mental health have attempted to find ways to highlight music therapy's relevance in this setting. Wolfe (2000) addressed issues relating to working in an acute music therapy setting and offered ideas for assessment, treatment and skills training, monitoring or evaluation, and discharge planning. To demonstrate the effectiveness of music therapy, Hanser (1984) developed an assessment plan for group music psychotherapy using a cognitive behavioral model. While applications were available to prove the usefulness and goal oriented aspects of music therapy of individual clients, even in the short time span of single-session opportunities, it did not address aspects of the group process. However, Silverman (2010) advocated that music therapists working in mental health facilities become aware of all evidence-based practices including assertive community treatment, integrated dual-disorder treatment, family psychoeducation, illness management and recovery, medication management, and supported employment. Silverman suggested that by finding music therapy methods and music experiences that promote these evidenced-based protocols, music therapy can continue to remain current and valuable in psychiatric settings.

Music therapy goals for mental health clientele are varied and individualized. Emotional awareness may be addressed through exploration and identification of feelings, and music can help make positive changes in mood and emotional states (Eyre, 2013a). Communication and social skills can improve through increased self-awareness and spatial awareness, engagement in self-expression, learning how to interact with others socially, and working toward resolution of

conflicts to promote stronger peer and familial relationships. Music therapy experiences can also promote autonomy, help develop relaxation and coping skills, and improve focus, concentration, and attention. Problem solving skills and reality testing may also be treatment goals in the acute mental health setting. Wolfe (2000) highlighted treatment options such as improvement in relaxation/ anxiety management skills, verbal/ interaction skills, and leisure community skills. A survey of music therapists practicing in mental health identified socialization, communication, self-esteem, coping skills, and stress reduction/management as the primary goals (Silverman, 2007).

Various methods of music are utilized in music therapy with mental health clientele to help them reach clinical goals. Music therapy methods include receptive, re-creative, improvisational, and compositional music use (Eyre, 2013a; Hunt, 2013; Jackson, 2013; Murphy, 2013) all of which encourage the client to access their inherent musical selves. During a receptive music therapy method, clients listen to live or recorded music provided by the therapist or client. Re-creative music therapy methods involve incorporating pre-composed music into therapy sessions. The compositional music therapy method includes changing song lyrics of an existing song to create a new song or creating an entirely new song. Improvisation, as a music therapy method, is an in-the-moment organic music making technique. Improvisation can be non-referential, music creation without an external theme or idea connected to music production, or referential, when music is representative of a theme outside of the music itself.

Each of the methods of music (receptive, re-creative, compositional, and improvisation) can be used during individual treatment and group treatment. Music therapy is primarily offered in a group format at acute facilities (Silverman, 2007). This group format allows the intrinsic nature of the group to help clients connect to other individuals and provides clients with

opportunities for growth and development related to their treatment goals (Braehler et al., 2013; Corey, 2012; Yalom, 2005).

Group Music Therapy

While individual music experiences have merit and value, a connection exists in using a group process for effective treatment. Hunt (2013) identified group work as the most utilized treatment modality in treatment settings with schizophrenia and psychotic disorders. Group process affords clients an opportunity to connect to others (Murphy, 2013), and music can help people form relationships to decrease symptoms of depression and anxiety (Jackson, 2013). Group members can communicate reactions and interpretations of peer behavior, which allows for improved insight into problem situations and opportunities (Dvorkin, 1998).

Murphy (1992) suggested that group music therapy, following Yalom's (1983) model, has two parts: the music experience and the verbal process of feedback about the musical experience to connect the experience to a relevant aspect of the clients present condition. Through the interaction of the discussion, insight can be gained regarding interpersonal behavior and how this behavior affects the client outside of the therapy room. The role of the therapist is proactive in establishing the structure and boundaries to facilitate an environment that encourages and promotes an alliance between the therapist and the group members as well as an alliance between group members.

While advocacy and treatment team involvement have the potential to yield positive results in coping with some challenges such as the facility's limited understanding of music therapy (AMTA, 2014a), other challenges still present an issue for music therapists working in acute mental health facilities (Eyre, 2013a). As a clinician, much consideration accompanies planning for group therapy at an acute mental health facility including different treatment stages

of each client, goals, therapeutic factors, interruptions, varying diagnoses, levels of motivation, unit happenings, functioning level of group members, lengths of stay, limited time, and countertransference (Carr, Odell-Miller, & Priebe, 2013; Corey, 2012; Eyre, 2013a; Yalom, 2005). As a music therapist, more considerations exist including musical preferences, musical abilities, different music therapy methods/experiences, advocacy, musical culture, triggers, physical limitations in playing instruments, and the client's relationship with music (AMTA, 2006; Carr, Odell-Miller, & Priebe, 2013; Eyre, 2013a; Murphy, 1992; Wolfe, 2000).

Understanding and using different learning styles within cultures may contribute to success in understanding learned material (Dunn & Griggs, 1995). Music therapists strive to reach each individual in group sessions, and music therapy also has a component of education. Music therapists set up opportunities for clients to learn about themselves, learn new and healthy coping skills, and learn about forming and sustaining relationships (AMTA, 2006; Carr, Odell-Miller, & Priebe, 2013; Eyre, 2013a; Jackson, 2013; Murphy, 1992; Murphy, 2013).

A better understanding of how group music therapy is conducted in short term mental health settings can prove beneficial (Carr, Odell-Miller, & Priebe, 2013). Providing clarity to how music therapists construct groups with purpose and intention in lieu of the challenges and opportunities an acute mental health facility provides, can help current and future music therapists feel more competent, and can encourage a more introspective and purposeful application of didactic and experiential music therapy knowledge, theoretical orientation, and music skill. As no literature offers a clinician-focused introspection of group music therapy practice in an acute mental health facility, research in this area might open up understanding to how clinicians give intention and purpose to groups that can be a jumble of uncertainty.

Summary

In current research, it is clear that authors and researchers offer an ideal portrayal of group therapy, while the reality is that music therapists working in acute mental health facilities struggle when implementing treatment care because of limited time, space, advocacy, and diverse clientele (Carr, Odell-Miller, & Priebe, 2013; Eyre, 2013). Research is available for clinicians to learn about different diagnoses, music therapy methods, and goals (American Psychiatric Association, 2013; Eyre, 2013a; Hunt, 2013; Jackson, 2013), but research has failed to help clinicians facilitate group music therapy when clients who present with different diagnoses all attend the same group. Without guidance of how to effectively accommodate all clients who may attend open group sessions, music therapists are left with more questions than answers. Group therapy models have been adapted to help establish therapeutic objectives in different clinical settings by related disciplines (Glenister, 1993; Grandison, Pharwaha, Jefford, & Dratcu, 2009; Yalom, 2005). However, research has not yet offered an introspective analysis of how a music therapist constructs, adjusts, and brings purpose to clinical work to meet the needs of clients within the context of the acute mental health setting. The purpose of this research project was to increase my self-awareness and provide a more comprehensive framework of how I plan and facilitate group music therapy programming with clients in an acute mental health. I hoped that studying my thinking processes related to planning group music therapy sessions at an acute mental health facility would help improve my introspection and self-awareness skills. In acknowledging and learning from introspection, I hope my competence in providing appropriate care for present and future clients will improve with a clearer vision of intention and purpose.

Method

Design

To explore and give insight to this research question, I utilized first-person, phenomenological research. First person research is defined as "any method in which researchers or participants gather data from themselves, using processes such as introspection, retrospection, self-perception, self-observation, self-reflection, self-inquiry, and so forth" (Bruscia, 2005, p. 179). Phenomenological research is an interpretive study of the human experience (Seamon, 2000). The researcher is the primary source of data (Bruscia, 2005). This research aims to clarify and examine human situations, meanings, events, and experiences "as they spontaneously occur in the course of daily life" (Von Eckartsberg, 1998, p. 3) and is a "rigorous description of human life as it is lived and reflected upon in all of its first-person concreteness, urgency, and ambiguity" (Pollio, Henley, Thompson, & Barrell, 1997, p. 5). First-person research has been utilized to help understand the therapist's view of clinical work (Bruscia, 1995; Wheeler, 1999). First-person research, when executed appropriately, can yield valuable information into clinical impressions and help to positively impact the music therapy community and other helping professionals (Bruscia, 2005).

This research included poetry, music, and art created during different phases of the research process by the researcher to help uncover hidden themes. This aligns, in part, with arts-based research where art form is a primary resource from which to gain research data and discover themes. The aim in involving creative expression is to allow the creative expression to "evolve into recognizable patterns of meaning that bring together and integrate primary processes with cognitive thinking" (Austin & Forinash, 2005, p. 459).

I employed a heuristic process in first-person research. The heuristic process is the "internal search through which one discovers the nature and meaning of experience and develops methods for further investigation and analysis" (Moustakas, 1990, p. 9). This encourages the researcher to depend on internal resources using the full range of observations, thoughts, senses, feelings, and intuitions regarding the topic. Internal resources are engaged through self-dialogue, tacit knowing, intuition, indwelling, focusing, and recognizing the internal frame of reference. Mindfulness remains a key component in engaging in a psychotherapeutic relationship (Siegel, 2010), and this method emphasizes mindfulness when obtaining and examining data. The researcher gains an enriched sense of self-knowledge and self-awareness by participating in the heuristic process.

The heuristic process has informed different research endeavors where the researcher hoped to gain understanding about a specific human experience. While not an exhaustive list, some topics that have been explored include unconditional love (Hawka, 1986), the inner world of teaching (Craig, 1978), shyness (MacIntyre, 1983), and self-reclamation (Schultz, 1983). A particular study by Fenner (1996) combined heuristic research and first-person research by researching her own experience of therapy through artwork she created as a reflection of therapy. In completing the research, she concluded that she gained an opportunity to move from a perpetual stuck feeling, which in turn increased her well-being and personal insight (Fenner, 1996). Fenner identified that this process has self-growth possibilities that can impact both the therapist and client.

Participant

As the researcher, I was the only participant. I am a Board-Certified Music Therapist, and have been serving clients with mental health concerns for seven years. I am in my thirties.

The first three years of my clinical experience pertained to group music therapy work at a maximum security forensic facility for men who had been committed to treatment, because they were found to be not competent for trial or found not guilty by reason of insanity. The most recent years of my clinical experience have focused on group music therapy at an inpatient behavioral mental health facility for children, adolescents, and adults. I practice from a psychodynamic, humanistic, and Gestalt theoretical orientation, and believe that each person has the capability to connect with and through music. It is from this belief in the power of music's connection to each person that I find my role in helping clients meet their specific treatment needs.

This research included only my own experiences of working with adults at my current employment. This acute mental health facility serves diverse clients; each has been diagnosed with a major mental disorder. This research included individuals who were appropriate for group therapy. Those individuals who actively pursued ways to harm themselves or others were excluded from group therapy, since these individuals presented a danger to themselves, other group members, and the group process. However, group membership did include adult clients ages 18 through 70 with varying mental health disorders and personality disorders in various levels of functioning with different treatment concerns, cultural backgrounds, motivation, and preferences.

Procedure

I used different methods inherent to qualitative research to examine this research question, and I used a heuristic process. While not all linear, this procedure allowed me to reach toward an understanding of how I plan, execute, and evaluate music therapy groups in an acute mental health facility. The qualitative methods I used include a review and study of related

literature, self-inquiry, providing optimal sampling, prolonged and persistent observation, interpersonal analysis, consulting with experts, appraisal, bracketing, perceptual description, reflexive journaling, field journaling, and engaging in expressive devices. Each of these methods is more clearly defined below and placed in different phases of the heuristic research process.

Phase one – initial engagement. The initial engagement, as described by Moustakas (1990), is the first phase, and began at the onset of this project. The initial engagement involves a "passionate concern" (p. 27) that compels the researcher to examine a phenomenon "that holds important social meanings, and personal compelling implications" (Moustakas, p. 27). By utilizing knowledge, tacit awareness, intuition, and context, a question formed with clearly defined terms. To continue this phase, a review and study of literature was conducted, specifically related to planning and facilitating music therapy experiences and clinical goals in acute mental health. Learning from others' research promoted clarity of different music therapy methods and also differentiated the way each method was used to increase successful opportunities of progress toward the specific goals and variables studied. This knowledge helped increase my competence in understanding how music therapists approach their clinical group work and fueled my interest in learning more about my own.

Phase two – immersion and incubation. During phase two, I completed the next two phases outlined by Moustakas (1990). These included immersion and incubation. Immersion promotes an intimate relationship with the question "to live and grow in knowledge and understanding of it" (Moustakas, p. 28). After intense pursuit of understanding, the researcher is encouraged to have an incubation period to clear the mind and allow for "another level of expansion [by enabling] the tacit dimension and intuition to continue to clarify and extend

understanding on levels outside immediate awareness" (Moustakas, p. 28-29). In the give and take of single-minded concentration verses rest, new information can be discovered.

In phase two, I examined my own process of planning and implementing music therapy experiences at an acute mental health facility. I cumulated data from three music therapy sessions I facilitated each week to reach a total of 12 heterogeneous group music therapy sessions to provide an optimal sampling (accurate representation) to reflect a typical group format of an inpatient acute mental health setting. I gathered data for 4 weeks. This prolonged and persistent observation was geared to increase self-awareness of personal clinical practice, and helped increase personal reflection of intention and clinical strategies.

As this was a new process for me, I consulted with experts by utilizing professional supervision to provide support in gathering valuable insight, which improved the quality of my data. Supervision contributed by offering guidance, encouraging self-inquiry, addressing clinical blind spots, and integrating the professional and personal experiences that arose during the research process. During the first week of this process, after each music therapy group session, I met with a professional supervisor to discuss my experience and rationale of planning and facilitating the music therapy session. After the first week, I met with this same supervisor once a week to discuss the three sessions facilitated within the respective week for the remainder of the study.

I attempted to honor the organic nature of reflection and encourage the potential unfolding of growth to occur by utilizing one form of self-reflection after each music therapy group that I planned and facilitated. Heuristic data is generally gathered through dialogue and discussion with the person experiencing the phenomenon (Moustakas, 1990). As this research was conducted as a first-person phenomenological study, data was obtained through

opportunities of self-inquiry (or self-dialogue) to assess and give a voice to my experiences, concerns, thoughts, beliefs, and so forth associated with this phenomenon in the form of reflexive journaling (of personal feelings related to thoughts or reactions to the research process), expressive devices (such as art or music), and field journaling (to identify significant events or observation in recording or analyzing data). This observation also included an interpersonal analysis of the relationships of participants involved during the study.

Phase three – illumination and explication. The illumination and explication phases of heuristic research occurred in phase three of this research. Illumination is a "breakthrough into conscious awareness qualities and a clustering of qualities into themes inherent in the question" (Moustakas, 1990, p. 29). Data gained from phase two was appraised. This process aimed to open up my understanding or dispel distorted misgivings of the phenomenon. Moustakas identified that illumination may unearth a new awareness, modify an old idea, synthesize disintegrated understandings, or may create a new understanding of a life experience that has been present, yet remained outside of direct sentience.

I fulfilled the explication phase by bracketing (acknowledging and reporting my perspective on the phenomenon) to retain awareness of biases or preconceptions that may have tainted the assembly, examination, or interpretation of the data. I examined my internal frame of reference, also identified as the epoche or stance of the researcher, by focusing, self-searching, indwelling, and self-disclosure. After biases were bracketed, a perceptual description yielded as an objective view of the reality of planning and implementing of group music therapy for clients in an acute mental health facility.

Phase four – creative synthesis. The final phase, identified as creative synthesis in heuristic research, allows the researcher to harness the whole experience (Moustakas, 1990).

Information was examined to discover themes that emerged. Themes were examined through continued reflection and documentation to provide a narrative description and artistic design that represented the process of planning music therapy group sessions for clients in an acute mental health facility. In completing the creative synthesis, I continued to examine how these findings related to the available music therapy literature and self-reflections.

Data Analysis

Heuristic research data is generally examined throughout the research process (Moustakas, 1990). Data for this study was used as foundational bricks to identify underlying commonalities to assess the essential nature of the phenomenon (Seamon, 2000). Heuristic data analysis advises focusing on one interaction (or interview) at a time to give a voice to those individual/personal experiences and then branching out to form connections between each encounter (or other interviews) with the phenomenon (Moustakas, 1990). Data from this research were examined in a similar method. Each session was examined separately to give full attention to the individual experience and to identify themes that emerged. After each session's data were examined individually and chronologically, the session data were examined as a whole within the week. Finally, the data were examined as a whole within the entirety of the research data collection. As part of the immersion and incubation phases of research, data was examined as they were still being collected, with periods of reflection and rest.

The procedure aimed to maintain methodological integrity as defined by Bruscia (1998). I provided attention to responsiveness of the process and how it naturally unfolded with flexibility, completeness of data for a holistic portrayal of the phenomenon, and exercised fidelity by maintaining focus in both the design and implementation of the study. In providing these aspects to the study, I maintained interpersonal, personal, and aesthetic integrity. It was

suggested by Bruscia that "these standards hold researchers accountable not merely for methodology, but for their entire way of being and interacting within the study" (p. 196).

Ethical Precautions

I adhered to the ethical requirements laid out by the American Music Therapy Association in the AMTA Code of Ethics (2014a) to protect the rights of all involved in this study and ensured the ethical gathering and examination of the data. I followed the ethical guidelines and best practices for both the AMTA (AMTA, 2014b) and the American Counseling Association, specifically the Association for Specialists in Group Work (Thomas & Pender, 2007), in planning and facilitating group sessions. Professional and academic supervision also provided assurance in maintaining these ethical parameters. I submitted a proposal regarding this study to the Institutional Review Boards of Saint Mary-of-the-Woods College and the acute mental health facility where I work, made the suggested changes, and followed the approved document. Data was collected and maintained in a safe place on both a personal computer with a passcode and secured office space. Any reflections or reactions to clients written in journals remained secure and client names were not used. A contract between my professional supervisor and me reflected understanding of confidentiality, as outlined in the AMTA Code of Ethics (2014a).

Results

I collected data by writing in journals, creating music, and engaging in art expression. In an effort to follow the heuristic research process, I followed the phases outlined in my methods section. While it was not a linear journey of discovery, I honored the intention of the phases and offered appropriate time to actively engage in the experience and times of rest for continued reflection. Each research phase will be addressed individually to identify data that was found in that specific phase. Themes will be discussed and offered as a way to answer the original inquiry "What is involved in the decision making process of how I plan music therapy groups for clients in an acute mental health facility?"

Phase One – Initial Engagement

Initial engagement, or passionate concern, ignited for me through my experience working as a music therapist in an acute mental health facility. I began to consider all I do when trying to meet the needs of so many diverse clients. Specific internal and external challenges operated, at some points, as obstacles, but then the challenges opened opportunities for creativity and innovation. Planning sessions was and remains an important aspect of my work. Through assessments, both an electronic chart and collaboration with multidisciplinary team members, I strived to identify a goal pertinent to those clients on the unit that day and to find a way to eliminate as many barriers as possible that may prevent a client's participation. I found this to be a puzzle to be solved each day, because the construction of group membership and dynamics would change daily. In meeting this challenge each day, I began to question what I consider and examine in my thinking process when planning for groups and attempting to include each individual's treatment needs and specific domains through the group setting.

I continued this phase throughout the research in examining articles that specifically related to planning in music therapy and specific music therapy methods and music experiences for different treatment needs. Through continued research and supervision, I discovered resources that discuss planning and executing music therapy experiences. Attempting to understand the planning of music therapy experiences for clients is a process that some researchers have tackled.

One way to think through the process is by creating and utilizing a decision tree. Decision trees offer a strategic rationale for clinical based music experiences, which focus on clients' affect and verbalizations as a guiding point (Eyre, 2008; Thompson, 2013). Eyre (2008) developed a decision tree for music therapists working with clients being treated for chronic kidney disease in an individual setting, and Thompson (2013) created a decision tree of her work in group music therapy treatment for women with breast cancer. Through keen observation and presence in assessing the client, a music therapist could reasonably identify the appropriate music therapy method and music experience for the client using a decision tree. This is not seen as prescriptive, but rather as a strategy with many variables to help validate treatment care. However, in order for the decision tree to be effective, the music therapist must remain vigilant of continued assessment of the client(s) or the output of the experience may be misguided.

Another way to perceive the planning process is through a transactional model constructed by Ghetti (2011), who offered an understanding of working with clients undergoing medical procedural support. In this transactional model, multifaceted variables such as procedural demands and both personal and contextual variables were considered to impact the client's perception of the procedure. The role of the music, client responses, and the role of the therapist combine in a lens, which filters the client's experience of the procedure. The filtering

process then gives insight to the client's perceptions of pain/anxiety, perceptions of the procedure, coping approaches and resulting behaviors. The music therapist then uses this outcome to facilitate in-the-moment procedural support appropriate to client's needs.

While it is clear that assessment is important, Bruscia (2001) specifically addressed strategies of listening to a client's music as a way of determining different types of improvisation to utilize. Bruscia observed that while listening is an important concept in all therapy, music therapy especially offers clients a chance to be heard, not only through verbal expression, but also non-verbal and musical expression. In listening to the client, the therapist will be able to determine the appropriate improvisation to help the client work through treatment goals. Understanding these concepts helped me look at the different avenues of the planning process, and offered an opportunity to examine my own in comparison.

Completing phase one (initial engagement) gave a perception of how other clinicians bring purpose and context to their clinical setting. Each of the clinicians work in diverse populations and have varied clinical experience; however, it is clear that the concept of understanding thinking processes related to treatment planning has been explored. Learning from others' applications of planning and adaptive strategies helped as I moved through the phases of examining my own thinking processes.

Phase Two- Immersion and Incubation

Phase two began with periods of immersion with some time set aside for incubation to process the material. Immersion included spending time to reflect during each planning opportunity, after planning was completed, and at the conclusion of each session used in the research. For the first week, I met with a professional supervisor after each group music therapy session used in the study to examine more closely my thinking process related to pre-planning,

planning, and adapting. For the subsequent 3 weeks, I met with my professional supervisor at the end of the week. This totaled six meetings with the supervisor, each supervision session lasting about 1 hour. I also engaged in some form of reflection to examine the research question. This data included a journal entry of creative writing, art expression, music creation, or a combination thereof after either panning for each session, or after the completion of each session depending on time/relevance. I also maintained a journal of my experiences of supervision and what ways it may have affected my decision making.

Periods of rest, during incubation, were set up to move away from the intensity of active engagement. I allowed myself 2 days each week for incubation while completing the study. This was determined as necessary to gain some distance from the experience, which at times was exhausting and time consuming. During periods of rest, I focused on self-care to motivate and prepare myself for the continued active engagement. At times it was difficult to set aside the pursuit for more data, but incubation proved beneficial to allow a clearer understanding of the topic completed during illumination and explication (phase three).

Each day required a different assessment process as a result of the cycle of turnaround in admissions or discharges, which changed the group dynamic and need. Although differences may be obvious in situations of discharge and admission, each day was also different, because each day a patient had the potential to include new treatment concerns or improved symptoms resulting from treatment. These changes needed to be honored and addressed during the assessment. My clinical decisions followed a general outline, as identified below. The outline had three distinct stages: pre-planning, planning, and adaptation within the session and are identified in Table 1.

Table 1: Outline of Planning Stages

Preplan	Reviewing unit census	How many clients are on the unit? How will this impact what I can do?
	Reviewing assessments form other disciplines	Perception of clients from the treatment team members: • General functioning level • Medical diagnosis • Psychosocial information • Precipitating factors
	Correspondence with treatment team members	Perception of clients from the treatment team members: • Current interaction with staff • Current interaction with peers • Unit happenings
	Knowledge from previous music therapy sessions	How did the client respond to music? How did the client interact with peers? What barriers prevented participation? Assessment of client domains.
Plan	Group goals	• Increase engagement in therapeutic activities • Decrease isolation • Alleviate hospital-related anxiety • Increase interpersonal awareness
	Individual goals	• Increase understanding and recognition of internal and external resources • Promote emotional identification • Promotion of autonomy • Identify wellness factors • Relationship development and boundaries • Increase coping strategies • Relapse prevention • Increase communication • Enhance self-image • Improve reality orientation • Promote self-expression • Increase stress/anger management techniques

(Plan Cont.)	What music therapy method will eliminate the most barriers to participation?	• Receptive • Re-creative • Composition • Improvisation
	What music experience will best support the goal?	• Song discussion • Music listening • Group singing/group playing • Lyric replacement as a group, dyads, or individual • Referential improvisation • Non-referential improvisation
	Will another art expression help support the metaphor of the music or goal?	• Movement • Art • Poetry
Adapting in a session	Questions to assess.	How are clients presenting as I walk on the unit? How are the clients relating to me (verbally and musically)? How are the clients relating to each other (verbally and musically)? How are the clients relating to music? Are there noticeable reactions related to trigger sounds or instruments? Is the room/group safe? What barriers still exist? What strengths does the client bring to this group? How can these strengths be utilized to reach group or individual goals?
	Domains assessed through client behavior, affect, and responses (both musical and nonmusical).	Cognition Communicative Cultural Physiological Psychological Social Spiritual

Pre-planning. Pre-planning began by reviewing different assessments from different disciplines, reaching as may different viewpoints as possible. This included electronic documentation from various disciplines, correspondence with treatment team members, and understanding of clients from previous music therapy sessions. I first accessed how many clients were in treatment on the unit using an electronic chart (specifically Epic) used at my facility. Having an understanding of the number of clients who may attend the group began the planning process because of limited space in the group room. Certain experiences were more difficult, due to limited space in the group room. Although I have an option to take some clients off the unit to a different group space, I used the designated group room on the unit as the primary location of group music therapy to ensure all patients would have access to music therapy. Some clients were restricted to the unit for medical and environmental safety precautions, so leaving the unit for group therapy would prohibit some clients from the opportunity to engage in treatment experiences. Maintaining this group space also helped provide confidentiality and cohesion for the group.

After I assessed the number of clients on the unit, my next step was to review individual assessments and progress notes in each client's chart. This gave insight into the perception of clients from the treatment team members such as social workers, psychologists, nurse practitioners, nurses, mental health technicians, and recreation therapists. This information included the client's general functioning level, medical diagnosis, psychosocial information, and the precipitating factors that led to admission. This documentation operated as my primary assessment source, unless I had previously worked with the client. After gathering information from the electronic chart and consultation with treatment team members, I engaged in pre-

planning. Through pre-planning, I identified who was most likely to attend the group and how music therapy may help both the client's individual goals and the group as a whole.

Planning. Planning began when I had as much information afforded to me through the electronic chart, consultation, and previous experience working with clients. I started with an overall group goal, and then found ways to adapt the experience to help clients meet individual goals. Group goals included increased engagement in therapeutic activities, decreased isolation, alleviation of hospital-related anxiety, and increased interpersonal awareness. Individual goals included increased understanding and recognition of internal and external resources, promotion of emotional identification, promotion of autonomy, identification of factors related to wellness, relationship development and boundaries, increased coping strategies, relapse prevention, increased communication, enhanced self-image, improved reality orientation, promotion of self-expression, and increased stress/anger management techniques.

Music experiences were able to address both individual and group goals. For example, an improvisation experience can address a group goal of *increased engagement in therapeutic activities*, but also help address individual goals for each client in the room such as *increasing self-expression* of emotions, *communication skills* for another client who struggles with interrupting other, while simultaneously impacting goals related to *recognizing internal and external resources* for another through discussion of the experience, all during the same time of helping to improve a client's *self-image* through recognition that his/her body was able to work to make music with the group. Most experiences had a psychoeducational component, and many included an alternative form of creative expression such as poetry, art, or movement to help illustrate music metaphors.

Adapting in the session. While third party information helped in the pre-planning and planning stages, assessment was ongoing and continual throughout the session which led to modifications to my plan. A key source of information was ascertained through observing the client on the unit prior to the session and within the session. For the in-person group assessment, I asked myself questions such as: How are the clients relating to me (verbally and musically)? How are the clients relating to each other (verbally and musically)? How are the clients relating to the music? I also assessed if any trigger sounds or instruments were impacting clients. Answering these questions helped me identify how to proceed with the session both at the beginning and throughout the session.

I had to identify how clients were presenting and work from this perspective. For example, if all the clients came into the session guarded with little interaction between each other or me, I facilitated a check-in experience to help clients become more interactive with one another to assist in providing a safe feeling for continued group process. If clients came in talkative and animated with each other verbally but were guarded with me, I would explain more about my role in the session and allow the group more opportunities to maintain and strengthen the connection they had to help facilitate insight. In assessing how they interacted with music, I was able to estimate their level of comfort with music and their relationship with music. If clients were experimenting with sounds and instruments as other clients were coming into the room, I would leave room for more open exploration. If clients were passive and resistant to exploring instruments, I would use one instrument, rather than all of them, during a check-in experience to help model, establish trust, and provide a safe and less overwhelming experience. In this situation, if more instruments were used later in the session, they may feel safer since they had at least one tentative experience with an instrument. Assessment was ongoing for all of

these questions to help further deepen the group experience and facilitate a successful music therapy session.

To identify each client's domains, I observed each client's behavior, affect, and responses (both musical and nonmusical). When assessing the cognitive domains, I relied on verbal and musical input to assess components such as abstract thinking, comprehension, focus, memory, and organization. To assess the communicative domain, I identified cultural dialect and both non-verbal and verbal capabilities. The aspects of the cultural domain such as the age, ethnicity, gender identity, and nationality were assessed primarily during the early stage of pre-planning. However, more understanding surfaced in how the client's culture impacted his/her interactions with others and music during the session through observation of mannerisms, tone, eye contact, and expression with peers, myself, and the music. The physiological domain was assessed through behavioral symptoms such as fidgetiness, restlessness, tension, breath control, hyper-verbal responses, and detox symptoms, as well as mobility. Insight related to the psychological domain came from observation of the client to assess a client's level of anxiety, presence of internal stimuli, mood congruence, affect, mood stability, and self-awareness through musical and nonmusical mannerisms. Social interaction and the spiritual domain were assessed to determine how each client interacted with peers, myself, and to something greater than themselves. I also assessed the safety level in the room by looking for boundaries, aggression, intrusiveness, and respectful attitude. At this point, I questioned if I felt safe and if the clients appeared to feel safe, because feeling safe in the room would determine the success of the therapy process. This remains true for all clients; however, in an inpatient unit, a heightened sense of insecurity is present due to clients being in acute crisis. If the group was not safe due to any factors, I would defuse or eliminate the factors before proceeding.

During this in-person assessment, I began by appraising if any barriers existed that would prevent clients from engaging in the group session and anything that could cause harm. My task as the music therapist was to remove obstacles that prevented participation and examine what each client brought into the session which may positively impact the session. Through continued assessment of the clients' musical, verbal, and nonverbal responses, I determined how to adapt or move forward with the current plan. This allowed continued assessment opportunities throughout the session and helped me respond accordingly. As new assessment information was considered, decisions were made to support the client's overall treatment process, engage clients in a music-based experience, and maintain safety in the group room. Assessment information also helped me establish the type of directive I offered. I began with more structured and concrete ideas for the session, allowing less structure and more abstract metaphors as the assessment of the group warranted.

Overall, the logical progression of pre-planning, planning, and adaptation as needed in music therapy sessions helped me understand my thinking processes. It also helped establish a timetable of what I needed to assess prior to facilitating a session. Thinking through and identifying my general guidelines in my planning process helped me establish a foundation by which to dive deeper into themes related to my personal planning process. These themes were discovered in phase three, illumination and explication.

Phase Three - Illumination and Explication

Phase three, illumination and explication, resulted from my data gathered in phase two. By examining each journal entry, art expression, and reflections of musical expression, my planning processes became clearer. As insight increased, themes emerged. Within the planning

phases of pre-planning, planning, and during the session, issues to consider developed. These issues to consider are identified in Table 2 by the phase in which the issue emerged.

Table 2: Issues to Consider Related to the Planning Phases

Phase	**Issues to consider**
Pre-planning	Assessing the negative Meeting both group and individual goals
Planning	The type of music therapy method Alternative creative methods Situational factors The use of live verses recorded music
During the session	Adapting Planning under pressure

Pre-planning. Assessment was identified as the primary step for developing session plans. The majority of the assessment used in the pre-planning and planning stages came from electronic charting and consultation with treatment team members. Through reflection and supervision, issues to consider were identified that related to my preliminary assessment techniques. These included assessing the negative and striving to reach group and individual goals.

Assessing the negative. Through continued reflection, I came to realize that during the preliminary assessment, I more often found negative aspects of clients, rather than positive attributes. In reflecting on the sources, I found that much of the electronic documentation focused on observable symptoms that corresponded with a client's diagnosis. For example,

charting routinely identified if a client was violent, disorganized, intrusive, or responding to internal stimuli, rather than ways he/she displayed motivation, engagement in treatment interventions, or strengths. Some positive indicators of the client's strengths that were accessible through electronic sources were if the client voluntarily sought treatment, the client's level of education, and if the client had a solid support system. As I noticed this pattern, I found that I assessed the strengths of clients more during the session and adapted appropriately based on how the client's strengths could positively impact the group and his/ her own treatment concerns. Noticing this information also inspired me to add more of the client's observed strengths in my documentation so that a source would be available to represent this aspect of the client's role in treatment.

Meeting both group and individual goals. In my planning, I looked at individual goals of clients as well as group goals. If each individual was working toward a different goal, I would attempt to find a way to help the client, through an overall group goal with individual goals built into the process. However, there were times that I valued individual goals over group goals, and times I focused on group goals over individual goals. In the acute mental health facility, maintaining group cohesion can be challenging due to interruptions from treatment team members and several unknown variables. I adapted my focus based on the need at the moment; however, my main focus was keeping the group to run in a safe and therapeutic manner. It was my belief that by maintaining the group, individual goals could be achievable. In contrast, if a client's individual goals took precedence over the group goals, then the group was a disservice to other group members. If individual goals were not able to be addressed within the group setting, opportunities could be afforded for individual meetings with other members of the treatment team or myself at a time congruent with treatment protocol.

Planning. When planning music therapy experiences, I found issues to consider related to which music experiences I employed and why. Music experiences can be receptive, re-creative, improvisation, or composition. Understanding how often I used each method and why gave insight into my thought process and what I view as the benefit of each music experience method. These include the type of music therapy method, alternative creative methods, situational factors, and the use of live verses recorded music.

The type of music therapy method. Out of the 12 music therapy sessions, I employed a receptive music experience nine times. Five of those nine times did not include another use of music. The second most common music therapy method was composition, in five out of the 12 sessions. I employed a re-creative music therapy method four times and an improvisation experience only twice. Some methods were employed in a logical progression. The most common was the use of a receptive method leading to a compositional method or improvisation. Many of the experiences combined several music therapy methods; however, no observable pattern of music therapy methods that I employed together developed. This may have been due to the limited sessions examined during the research.

I examined why I employed certain music therapy methods. This analysis led me to create a decision tree to highlight how a client presented, what music therapy method I generally utilized (receptive, composition, re-creative, improvisation), and the benefits of using the music therapy method. Client presentation included affect, behavior, ability to read and write, trust in the treatment process, and motivation. Looking at how the client presented helped me determine what might be the best course of action. This process of assessment also helped eliminate barriers to participation and encourage rapport in music therapy. The decision tree, or action plan, is outlined in Table 3.

Table 3: Decision Tree to Determine Music Therapy Method

Client Presentation	**MT Method**	**Benefits**
Passive Guarded Limited trust in treatment process Indifferent	Receptive	Offers range of participation choices Offers time for rapport development Reading/writing skills are not necessary
Able to read and write Willing to engage Motivated	Composition individual------ group----------	Relapse prevention plan to be composed A list of coping skills can be constructed Focus on one line at a time Provides structure Provides focus Group cohesion Support of the group Less requirement for individual writing
Confusion Limited focus Limited abstract thinking Restless	Re-creative	Quick and active engagement in music Predesigned structure Group cohesion Reality orientation
Guarded Difficulty communicating verbally Difficulty expressing emotions	Improvisation	Reality orientation Expression of feelings Writing and reading skills not necessary

In examining the types of music experiences I use and why, I found that I utilized receptive music experiences when I observed or assessed clients as passive, guarded, with limited trust in treatment process, and indifferent. I utilized this experience to allow clients to maintain some distance from the experience if they needed this space. This permitted the client to engage without feeling required to actively play an instrument or speak in a session. Some of the receptive experiences included song analysis. I encouraged clients to first focus on the song, identify what the singer was experiencing, and the tone of the song. With developing rapport, clients may then have been willing to find and discuss themes in the song that related to their current experience. I primarily employed a compositional music experience as an opportunity

for self-expression and to develop relapse prevention plans for clients that exhibited moderate to high motivation. Compositional songwriting was utilized if the client was able to read and write and was willing to engage actively in a music experience. I generally used individual songwriting through a fill-in-the blank system to allow clients to focus on one line at a time, for structure and increased focus. Re-creative music experiences were utilized if goals warranted clients to be quickly engaged in the music experience for increased rapport with instruments or their voice through a safe container. In my perception, the use of re-creative music experiences offered predesigned structure for those with confusion, limited focus, limited abstract thinking, and those who were restless. The re-creative method encouraged cohesion with the music and with the group through the shared musical expression of a known song. I utilized improvisational music experiences to improve reality orientation, offer expression of feelings, and provide musical engagement without the necessity of reading/ writing skills or verbalizations for those individuals who may be guarded, have difficulty communicating in verbal processing, or need something more than words to express emotions.

Alternative creative expression. Six of the sessions I facilitated included another expressive medium, including movement, art (drawing and watercolor), and poetry. Of the expressive media, I employed two-dimensional artistic expression the most. Incorporating other creative media into sessions offered continued reflection and expression for clients and offered a chance for continued music exploration without words and without continued sound. Art also allowed clients to explore metaphors related to song themes discussed during verbal processing. Each art expression was geared to help clients express the music experience or their relationship to the music.

Situational factors. Several situation factors became more pronounced as I completed this study. These situational factors included times of sessions (morning or afternoon), happenings on the unit, new medication being administered and monitored, space in the group room, the structure of the unit, and interruptions from treatment team members. Each of these factors influenced my decision making. While I cannot control these situational factors, I continued to find ways to help the group remain cohesive and therapeutic, despite these situational factors. This led me to contemplate about certain music experiences I chose to employ and those I do not. For example, treatment team staff were more likely to interrupt and pull people from group in the morning; therefore, I did not offer relaxation experiences in the morning group, as the disruptions would be intrusive and startle clients, which would be counterproductive and contraindicated. Furthermore, as all clients on the unit were welcome to attend music therapy group sessions as part of their unit schedule, I had to provide experiences for clients for whom music therapy may be contraindicated due to past trauma with instruments or sound sensitivities. In this situation, I ruled out what would be contraindicated and found an experience to fit all those attending the session, and remained mindful of unknown triggers of others.

Live versus recorded music. I employed both live and recorded music in music therapy sessions. The primary reasons for the use of recorded music were the following: When movement was utilized as an expressive medium, if I was unable to reproduce the music in an authentic way due to instrumentation and sound quality, if limited space prevented me from playing the music and using an art expression, and if I needed to model playing instrumentation with a recording during a re-creative experience. I engaged in live music making during improvisations, when the pre-composed song would be used for composition later in the session,

to convey or own the message of the song, and to adapt to the needs of the clients by modifying the music qualities in the moment. I avoided recorded music if a client exhibited thought projection as part of his/her diagnosis symptoms.

Sessions were planned with the music in mind, specifically how the music would be presented to help facilitate the session. I did not use both recorded music and live music within the same session during this research. This was in part due to limited space to carry more equipment. However, I primarily wanted to present congruence throughout the session. For example, if I was facilitating a song discussion of two songs, I would not play one song live and one that was recorded. Factors were analyzed regarding the appropriateness of using recorded or live music, as identified above, and occasion did not arise for me to incorporate both forms together in a session.

During the session. When facilitating group music therapy two primary themes emerged. These themes were discovered in supervision and reflected upon in continued journaling and art expression. These themes included adapting and planning under pressure.

Adapting. The major theme during the session was a deeper insight into how much I adapt my session plans to meet group or individual clients' needs in the moment. While I adapted and responded differently in each session, I completely adapted and reworked the pre-planned session plan in only five of the sessions during this research. In these situations and any situation where I had to adapt in the moment, I was afforded only the materials (both external and internal resources) I brought into the session with me. External resources included additional recorded music through an MP3 player, instruments, lyric sheets, paper, art materials, writing utensils, and so forth. Internal resources included my acquired knowledge from experience in the field, continued education, and research studies. I also looked toward intrinsic

knowledge or a gut feeling, my creativity, and my overall hope for the group and each client in the group to help adapt to in-the-moment clinical need.

Planning under pressure. At times, I found myself planning under the pressure of limited time or of being observed, which influenced my session plans. I would have been more comfortable having time to think through the situation and to have brought more resources with me. However, I found that despite wishing for what could be or could have been, as the session progressed, I was too focused on the clients and group process to become distracted by what could have been or who was observing me. At times, performance anxiety was present for a portion of the session, which may have been felt by clients. In situations where I had limited planning time, I employed music experiences, specifically improvisation, which allowed more versatility and more open adaptations to consider should the session need to be adapted. At all times, I needed to remain conscious of the music as my co-therapist and trust that music would be able to help. However, trust in the music was most noticeable in these cases, as I observed the group's reaction to being in the music experience.

As identified above, themes and issues to consider related to my thought processes in planning music therapy sessions for clients came to light, which gave a logical and practical explanation. However, these were not the only themes that emerged during this research process. As personal reflection of my work continued, two main topics with developing themes arose including my perception of music therapy as a treatment modality and how I felt completing this research.

Themes about group music therapy. Through reflexive journaling, music making, and art expression, themes emerged as I examined my own view about music therapy in this clinical setting. These themes included: 1) the foundation of therapy: hope, creative expression, and

universality; 2) the role of my theoretical orientation: flexibility; 3) the role of the group: providing connection; 4) the role of music: nourishment for positive change; 5) and my responsibility as the therapist: self-awareness.

The foundation of therapy: Hope, creative expression, and universality. This research increased my awareness of what music therapy can mean for clients at an acute mental health facility. It also encouraged me to examine what I, as a music therapist, strive to offer each client in a group setting. I found that my main focus in therapy, the main purpose I go to work, is to provide hope. I believe that providing clients with a unique and authentic means of self-expression and focusing on universality can help to inspire hope. Offering opportunities for self-expression demonstrates a value for each client's voice and perspective. The universality within the group setting can open opportunities for clients to connect to others, to themselves, and to music.

In diving further into my rationale of treatment methods for the individuals I serve, I believe that mental health disorders are isolating disorders. For example, individuals with psychosis either avoid others or others avoid them due to uncommon and unpredictable behaviors. Substance use disorders may start socially, but ultimately become isolating, because of the addiction to the substance over anything and anyone else. Substance use is also an isolative disorder, because limited connection can be accomplished when people disconnect from emotions. The use of the substance prohibits emotion, and numbing emotion diminishes connection to himself/herself and others. Because mental health disorders are isolating disorders, providing a safe place to connect, to feel included in a shared music experience, and to authentically express can be therapeutic and healing.

The role of my theoretical orientation: Flexibility. This research highlighted how my theoretical orientation can at times conflict with the facility's orientation. My clinical practice comes from a psychodynamic, Gestalt, and person-centered approach. I am informed by my theoretical approach to understand that more comes into the session than is in the conscious (psychodynamic), each person needs to engage in creative expression to be healthy and well (Gestalt), and each client has the insight within himself/herself to change (person-centered). This approach at times juxtaposed the medical, behavioral model employed by my work's facility. However, I found that I was still able to work within my theoretical approach as I engaged in session planning and group facilitation, but I adhered to the approach the facility used while documenting. When I communicated to treatment team members during in-person consultations, I used terminology from both theoretical approaches (mine and theirs) to help give an identity to my approach but maintain congruency with other team members through language they utilized. Just as each discipline is different and has value, so too can theoretical orientations of treatment team members differ. It is in working together with respect and understanding that the client is best served.

The role of the group: Providing connection. Belonging to a group brings an opportunity for connection. Different from universality, group dynamics brings insight into the roles clients' play and the way they interact with others, which in turn acts as an opportunity to improve connections and relationships outside of the music therapy session. Group not only provides an opportunity to learn from each group participant, but also learn from the relationships that form. This connection can decrease feelings of depression and isolation, and help clients build on acquired knowledge from other group members. This knowledge and cohesion can branch out and assist clients in connecting insight and understanding of treatment

goals. This experience of feeling connected can also encourage clients to find ways to develop supportive relationships outside of the session.

The role of music: Nourishment for positive change. Two schools of thought are present in the music therapy community related to the role of music in music therapy: music in therapy verses music as therapy. For those who practice from the idea of *music in therapy,* music assumes the role of a stepping off point for further verbal processing. The music, in this case, helps establish therapeutic rapport and brings therapeutic material to be further discussed by the clinician. In contrast, *music as therapy* offers the idea that music itself is the catalyst for positive change in the client. Music is the therapeutic agent. I find that I employ both principles in facilitating music therapy groups for acute mental health clients.

Practicing as a music therapist has given me an inside look into the power that music has in helping people connect. Music provides an in-the-moment expression of topics difficult to express otherwise. The triangulation format of the relationship between the client to him/herself, the client to the therapist, and the client to the music offers several opportunities for connection. This opportunity increases when the session is conducted in a group setting where more triangular relationships connect together in the moment. Music, itself, offers added possibilities for connection which can promote wellness along the spectrum of client domains (cognitive, communicative, cultural, physiological, psychological, social, and spiritual) and gives a voice to the client's experience.

This inspired me to question my relationship to music, and my trust in the music as my co-therapist. It also made me question my ability to help clients recognize music's ability to encourage and facilitate change. In thinking further on music as the agent of change, I began to question the role of music. Do music therapists have one more therapeutic agent of change than

Yalom (2005) was able to identify, or is music's presence in the session another relationship in the group room that increases the therapeutic agents of change he previously identified?

My responsibility as the therapist: Self-awareness. I found that in completing this research that my self-awareness increased. As my self-awareness increased, I identified where countertransference may play a role in my clinical work. I identified that the main components I incorporated into every session were hope, authentic expression, and universality may come from my countertransference. These concepts were examined further to determine how countertransference may play a role in this foundational opinion of music therapy. Other areas of countertransference that were identified included healthy conflict, safety/security, inclusion, and ending the session on the positive.

While countertransference can help clinicians become more empathic toward clients, it is the responsibility of the therapist to examine these within him/herself to determine if the therapist is serving the best interest of the client, or if the therapist is enacting what he/she needs in the session. I explored these concepts through music making, journaling, and art expression to help understand how countertransference played a role in sessions I facilitated. Through this process, I have a renewed interest in self-awareness and insight for both my professional and personal benefit. I found that examining my thinking processes had a positive impact on my clinical skills, job satisfaction, and prevention of burnout.

Engaging in the research process. Engaging in this research required trust in the research process, support in the form of supervision, and self-care. Trusting the process came more readily when new information presented itself to be examined, but was a struggle when it seemed no new information was being discovered. Support proved to be helpful not only during the research process of gathering data, but also by helping me observe the data through a new

lens. Self-care was also a form of support that aided me throughout this process. Self-care insured that I would be alert, attentive, and engaged throughout the process so that data would be articulated and examined appropriately.

This research process required me to repeatedly ask the question: Why did I do that? Due to this line of questioning and the experiences I had while engaging in this research, several emotions emerged that were explored through creative expression such as art, music making, poetry, and journaling. While this research did not directly examine how I would feel about putting a microscope to my work, it certainly played a role in my experience. The primary emotions that emerged and were explored through this process included exhaustion, self-doubt, confusion, excitement, surprise, intrigue, inspiration, and an increased desire for further self-discovery. Exploring these feelings helped me grow in my verbal and creative expression of these concepts and promoted genuine empathetic responses when clients explored emotions similar to those I experienced.

Overall, the experience of engaging in this research was one with consequence and purpose, and it helped to clarify my intention and clinical perspective. I felt more engaged in the decision making process and more in touch with my creative intuition. This mindfulness, allowed for rejuvenation related to my principals, values, belief in the power of music, and perspective of music therapy in this clinical setting.

Phase Four – Creative Synthesis

Trying to understand my thinking processes when planning group music therapy sessions for clients at an acute mental health facilities proved to be both enlightening and complicated. The themes established in phase three helped me create a visual representation of how I think about the planning process and potential for music therapy. Through my art creation, I identified

patterns that represented a well-known symbol, the tree. It is through the tree that I can offer a visual representation of my thinking processes (Figure 1).

Figure 1: Creative Synthesis- Tree

The tree is its own living and thriving entity, much like that of a well-established group. It has a history, is capable of growth, but can also be easily unearthed without the right support and stability. Aspects of the tree help to make the tree stronger as it faces challenges. Challenges can include both internal and external barriers of the group process or personal struggles. However the tree can remain grounded by the roots. The roots, in this example, represent my three main focal points of music therapy: having a voice through creative

expression, universality, and hope. These roots hold the tree steady and provide a solid foundation.

The trunk of the tree represents my theoretical orientation. The trunk offers enough flexibility to withstand stormy winds, but has a strong presence in the overall look of the tree. People observing group sessions can tell from which theoretical orientation(s) the clinician is operating. This is as present and clear as a trunk on a tree. Through the trunk, branches form. The branches interconnect, continuously reaching and weaving in and out of each other. This represents the relationships, from one grow many, that can develop through the foundation and flexibility afforded to their development.

The growth and stability of the tree represents the group growth. While groups may be small due to new membership at each session, the foundation and trunk remain stable and supported, ready to help facilitate growth. The tree can go through seasons, much like clients do. At times, trees can be blossoming (spring), fertile (summer), dry (fall), or unassuming (winter). People also go through seasons where they may just start to feel new growth or they feel full and bountiful. In contrast, people can feel withered up or not notice themselves producing anything of substance at times. However, as seasons come and go, new growth is observed.

Despite the strength and adaptability of a tree, it would not grow or survive without nourishment. This is the same in the group process. The nourishment for the tree is music. Nourishment comes in many forms (such as sun, water, and fertilizer) and this represents the many different methods of music (receptive, re-creative, improvisation, and composition). Different nourishment is needed during different seasons. While all clients may be experiencing different seasons, the life of the tree helps establish a place for growth. If group therapy is a social microcosm of a greater whole, then clients can leave with the foundational experiences of

the roots, trunk, branches, and nourishment. By experiencing music therapy, clients may be able to apply this same foundation, flexibility, and connection to aspects outside of the group room.

In completing this research, the best way to describe my perception of my current clinical process is through the tree. The symbolism and metaphor of the tree has unending applications when trying to describe my thinking processes of planning and facilitating music therapy session. I plan by starting at the foundation, the roots ground my concept of music therapy, and work my way up through my theoretical orientation toward interconnection and relationships nurtured and grown through music experiences. The symbolism and metaphor may help other music therapists to identify their own construct of the group process. This symbol may provide a visual representation of how they build a solid foundation of therapy, are informed by their theoretical orientation, and how they perceive the role of music in group music therapy.

Discussion

This research offered a snapshot into my thinking process of planning group music therapy for clients at an acute mental health facility. This was an honest portrayal of how I planned 12 heterogeneous groups at this stage of my clinical proficiency. Planning for group music therapy sessions at an acute mental health facility can be a challenging process. As a result of this research, I know that my thinking processes will further develop as my clinical experience increases, as I pursue continued education (both formal and informal), and as I engage in persistent self-exploration, as evidenced by the changes that have already transpired.

After completing this research, I can comprehend with more fluidly my thinking processes when assessing clients prior to and during group music therapy sessions. Most specifically, I have a better understanding of the benefits and limitations of information acquired through third party treatment team members' documentation and consultation. The insight offered by third party treatment team members diminishes the redundancy of questions the client would have to answer, especially during a short-term stay. Other treatment team members' information also offers insight into how the client is interacting with other members of the treatment team and their level of involvement/motivation in treatment. However, a music therapy assessment offers a *musical* assessment of the client, which other treatment team members are unable to provide. By asking the right questions (either out loud or to myself) and observing the nonverbal, verbal, and musical responses to these questions, I was able to assess clients' varying domains and motivation level toward group music therapy. This then helped me determine if the plan that I developed was appropriate and to what extent it may need to be altered.

I also have a better understanding of how I adapt to provide appropriate therapeutic music experiences for clients in-the-moment within the group music therapy session. This knowledge helped provide a focus on my external and internal resources and how they play a role in facilitating sessions. Pre-planning and planning stages established the barriers that may have prevented clients from engaging in sessions and the external resources available to combat these; in contrast, adaptation was more often the product of internal resources. I began planning more possible adaptations prior to the session, but also find creative ways to use the materials brought into the session. I was surprised how often my internal resources guided my clinical practice through what some would call a gut-feeling or intuition. However, when this intuition was dissected, it was discovered that the ongoing assessment and client's interaction with music helped facilitate these decisions. Understanding these reactions and adaptations came from didactic learning, clinical experience, scholarly article research, and from my musical and creative self.

This was not an easy process. As the participant, a swirl of emotions became interchangeable with the experience (most prominently self-doubt, confusion, surprise, intrigue, and inspiration), which were identified and worked through with the assistance of support and creative expression. After engaging in this process, I can wholeheartedly attest to the benefits of genuine and focused self-reflection. The more I understood my clinical thought processes, the more my work as a music therapist was better articulated. Having a refreshingly new, insight-oriented understanding of group music therapy at an acute mental health facility has helped inform my practice in relation to the foundation on which I place music therapy groups, the role of my theoretical orientation and how it informs my practice, the role of the group process, and

the role of music. This helped bring a stronger sense of purpose and intention to each group music therapy session I facilitated.

The heuristic research process aims to unearth hidden information for the “aha” moment. Valuable information related to my thought processes and emergent themes in pre-planning, planning, and adapting during sessions afforded me a new outlook on my practice as a music therapist. Several important insights about my work as a music therapist were identified throughout this process including a decision tree of why I employ different music therapy methods (Table 3) and a visual representation of my perspective of group music therapy (Figure 1). This information gave me an opportunity to improve my planning process and re-define myself as a music therapist. Strengthening my self-awareness has encouraged me to continue developing as a music therapist and has offered insight into my true intention and view of music therapy as a treatment modality.

This research also brought to light the importance of music therapists increasing their internal resources, specifically self-awareness. While factors can exist outside of a music therapist’s control (such as limited space/time and diverse clientele), several internal resources can help the music therapist provide therapeutic music experiences for clients. Increasing examination, knowledge, and skill development of these internal resources can help clinicians struggling to adapt to this clinical setting. Internal resources include, but are not limited to, creativity, musical competency, understanding client domains, knowledge about music therapy, comprehensive understanding of theoretical orientations, and self-awareness. This study aimed to offer an examination of one internal resource a music therapist can improve and develop: self-awareness.

Self-awareness has the potential to open understanding to clinical work, and can help clinicians accurately judge their capacity to offer therapeutically responsible treatment. This awareness can be assessed through examining clinical practices, professional supervision, and creative outlets. The information someone learns about himself/herself may not always be flattering; however, this knowledge, like skill, can never be taken away. After one gains increased self-awareness, it remains up to that individual what he/she will do with this new understanding: to grow or remain static.

Continued research is needed from music therapists serving in this setting to examine how they plan and adapt to the acute mental health setting. Specific research related to what music therapy methods are employed and for what reason warrants further research. I encourage practitioners to take the time to engage in a process of self-awareness to further develop their own clinical skills to continue to understand how they bring intention and purpose to their clinical setting. This area of research is desperately needed to provide a foundation for exploring this question further and for continued development for music therapists and the music therapy field.

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Appendix A: Music Therapy Supervision Contract

Music Therapy Supervision Contract
for the purpose of masters thesis
"Group Music Therapy in an Acute Mental Health Facility:
A Reflection and Strategy of Clinical Practice"

This document is intended to establish parameters of supervision, assist in supervisee professional development, and provide clarity in supervisor responsibilities including the responsibility of the supervisor to protect the client.

This contract between Kathleen Murphy, MT-BC (supervisor) and Lauren Stoner, MT-BC (supervisee), signed on _______________(date) serves to verify supervision and establish its parameters.

I. Competencies Expectations
A. It is expected that supervision will occur in a competency-based framework
B. Supervisee will self-assess clinical competencies (knowledge, skills, and values/attitudes) related to planning and facilitating group work in music therapy
C. Supervisor will compare supervisee self-assessments with their own assessments based on observation and report of clinical work, supervision, and competency-instruments

II. Context of Supervision
A. Supervision will begin, the first week, with one hour of individual supervision after each group music therapy session the supervisee facilitates as part this research study.
B. Supervision will continue throughout the research phase after the first week. The supervisor and supervisee will meet for one hour of individual supervision at the end of each week for three weeks to discuss music therapy sessions facilitated within the respective week.
C. Supervision will conclude for this research project with a follow-up supervision meeting to discuss information related to the thesis topic and professional development.
D. Supervision will consist of multiple modalities including creative (art/music) expression, journal entries related to thesis, instruction, modeling, and mutual problem-solving.

III. Evaluation
A. Feedback will be provided in each supervision session.
B. Feedback will be related to thinking processes related to planning and facilitating group music therapy sessions and music therapy competencies.

IV. Duties and Responsibilities of Supervisor
A. Oversees and monitors all aspects of client case conceptualization and treatment planning
B. Develops supervisory relationship and establish emotional tone
C. Assists in development of goals and tasks to achieve in supervision specific to assessed competencies
D. Challenges and problem solves with supervisee

E. Identifies theoretical orientation(s) used in supervision and in therapy and takes responsibility for integrating theory in supervision process, assessing supervisee theoretical understanding/training/orientation(s)
F. Identifies and builds upon supervisee strengths as defined in competency assessment
G. Introduces and models use of personal factors including belief structures, worldview, values, culture, transference, and countertransference in therapy and supervision
H. Ensures a high level of professionalism in all interactions
I. Identifies and addresses strains or ruptures in the supervisory relationship
J. Establishes informed consent for all aspects of supervision
K. The supervisor distinguishes administrative supervision from clinical supervision and ensures the supervisee receives adequate clinical supervision
L. Clearly distinguishes and maintains the line between supervision and therapy
M. Discusses and ensures understanding of all aspects of the supervisory process in this document and the underlying legal and ethical standards from the onset of supervision

V. Duties and Responsibilities of the Supervisee
A. Upholds and adheres to American Music Therapy Association Ethical Principles and Code of Conduct
B. Comes prepared to discuss topics related to planning and facilitating group music therapy, questions, and literature on relevant evidence-based practices
C. Brings to supervision personal factors, transference, countertransference, and parallel process, and is open to discussion of these.
D. Identifies goals and tasks to achieve in supervision to attain specific competencies
E. Identifies specific needs relative to supervisor input
F. Identifies strengths and areas of future development
G. Understands the liability (direct and vicarious) of the supervisor with respect to supervisee's practice and behavior
H. Discloses errors, concerns, and clinical issues as they arise
I. Raises issues or disagreements that arise in supervision process to move towards resolution
J. Provides feedback to supervisor on supervision process
K. Responds non-defensively to supervisor feedback
L. Consults with supervisor or delegated supervisor in all cases of emergency

Procedural Aspects
A. Although only the information which relates to the client is strictly confidential in supervision, the supervisor will treat supervisee disclosures with discretion.
B. There are limits of confidentiality for supervisee disclosures. These include ethical and legal violations, indication of harm to self and others
C. If the supervisor or the supervisee must cancel or miss a supervision session the session will be rescheduled.
D. The supervisee may contact the supervisor at ______________________________________

E. The supervisor may contact the supervisee at ______________________________________

This contract may be reviewed at any time as indicated by supervisee or supervisor. Revisions will be made only with consent of supervisee and approval of supervisor.

We, Lauren Stoner, MT-BC (supervisee) and Kathleen Murphy Ph.D., MT-BC (supervisor) agree to follow the directives laid out in this supervision contract and to conduct ourselves in keeping with our Ethical Principles and Code of Conduct, laws, and regulations.
Dates Contract is in effect: March 16, 2015- April 21, 2015