

8-2011

Theoretical orientations applied by music therapists working in adult psychiatric inpatient settings

Angel A. Park

This research was completed as part of the degree requirements for the [Music Therapy](#) Department at Molloy College.

Follow this and additional works at: <http://digitalcommons.molloy.edu/etd>

 Part of the [Music Therapy Commons](#)

Recommended Citation

Park, Angel A., "Theoretical orientations applied by music therapists working in adult psychiatric inpatient settings" (2011). *Theses & Dissertations*. 22.

<http://digitalcommons.molloy.edu/etd/22>

This Thesis is brought to you for free and open access by DigitalCommons@Molloy. It has been accepted for inclusion in Theses & Dissertations by an authorized administrator of DigitalCommons@Molloy. For more information, please contact tochter@molloy.edu, thasin@molloy.edu.

THEORETICAL ORIENTATIONS APPLIED BY MUSIC THERAPISTS
WORKING IN ADULT PSYCHIATRIC INPATIENT SETTINGS

A THESIS

Submitted in partial fulfillment of the requirements
For the degree of Master of Science
In Music Therapy

by

Angel A. Park
Molloy College
Rockville Centre, N.Y.
2011

MOLLOY COLLEGE

Theoretical Orientations Applied by Music Therapists

Working in Adult Psychiatric Inpatient Settings

by

Angel A. Park, MT-BC

A Master's Thesis Submitted to the Faculty of

Molloy College

In Partial Fulfillment of the Requirements

For the Degree of

Master of Science in Music Therapy

August 2011

Thesis Committee:

Dr. Seung-A Kim, AMT, LCAT, MT-BC
Faculty Advisor

August 2011
Date

Dr. Kathleen Murphy
Committee Member

August 2011
Date

Evelyn Selesky
Department Chair

August 2011
Date

Abstract

The purpose of this study is to examine the theoretical framework (i.e., cognitive-behavior, psychodynamic, humanistic) used by music therapists during group music therapy sessions for adults residing in inpatient psychiatric hospitals. Three participants were interviewed via Skype. A descriptive analysis was used to identify each participant's theoretical orientations, methods of assessment, treatment, and evaluation, while his or her perspective on the benefits and challenges of implementing each respective theoretical orientation was also noted. The results showed that regardless of theoretical orientation, all participants use improvisation to assess and evaluate clients' progress for treatment. Each theoretical orientation inherently contains its own benefits and challenges. In addition, crossovers between the three theoretical orientations are observed. While the participants appear to work under their stated orientations, they find it necessary to adapt some principles and interventions of other theoretical orientations, due to the complex nature of the population and the facility's philosophy. The implications for music therapy are discussed.

Keywords: adults, group music therapy, mental disorders, theoretical orientations

Acknowledgements

This thesis could not have been written without Dr. Seung-A Kim, who not only served as my supervisor, but also encouraged and challenged me throughout my academic progression. She and Dr. Kathleen Murphy, my other committee member, guided me throughout the thesis process, never accepting less than my best efforts. I thank them both.

TABLE OF CONTENTS

	Page
ABSTRACT	3
ACKNOWLEDGEMENTS	4
LIST OF TABLES	7
THEORETICAL ORIENTATIONS	8
Personal Motivation	
Significance	
Need for Study	
RELATED LITERATURE	16
Definition: Mental Disorder	
Inpatient Psychiatric Settings	
History	
Overview of Assessment	
Treatment Planning	
Evaluation	
Theoretical Orientations	
Cognitive-Behavior Theory and Music Therapy	24
Psychodynamic Theory and Music Therapy	30
Humanistic Theory and Music Therapy	36
Problem Statement	
METHOD	41
Participants	
Design	
Data-collection Procedure	
Materials	
Data Analysis	
RESULTS	44
Participant A: Cognitive-Behavior Theory and Music Therapy	
Participant B: Psychodynamic Theory and Music Therapy	
Participant C: Humanistic Theory and Music Therapy	
DISCUSSION	58
Assessment	
Treatment	
Evaluation	
Benefits	
Challenges	

CONCLUSION 66

- Summary
- Limitations
- Implications for Music Therapy Practice
- Implications for Music Education and Training
- Recommendations for Future Study
- My Future Plan

REFERENCES 70

APPENDICES

A 75

B 76

C 78

D 79

List of Tables

Table

1. Demographic Information 45

2. Benefits and Challenges 57

Theoretical Orientations

For centuries, rituals, ceremonies, and spirit exorcisms of shamans have incorporated music as an integral part of treatment (Boxberger, 1962; McGuire, 2004). The link between human beings and music continues to evolve today. Therapeutic gains through music include, but are not limited to: tension reduction, modification of mood, and increased attention span (Tyson, 1981).

Although music has been used as a treatment modality for over 200 years, I often encounter people who still ask how music is used in a therapy session. Typically, my response has been, “It is complex.” I would then go on to provide examples of how music may be used as an effective approach to treat clients with mental illness. In addition, after conversing with co-workers, friends, family members, and students, I have concluded that many people are still unaware of the function of music therapy, despite its growing popularity, and unfamiliar with the purpose it serves in psychology.

While attending the graduate music therapy program at Molloy College, I became interested in the effects that music therapy has on adults residing in inpatient psychiatric units. During my internship, I worked with adults diagnosed with mental disorders. From working in this setting, I observed that no two music therapists worked alike, as each therapist exhibited his or her own personality and tenets when interacting with clients. Music therapists incorporate different theoretical orientations based on their own respective training and education. Clinical practice is influenced by many philosophies including humanism, cognitive-behaviorism, and existentialism. In observing these differences, I began to reflect on my own education and clinical experiences and how they have influenced my work as a music therapist. My interest in the dynamics and

theories of music therapy motivates me to examine the varying theoretical orientations that music therapists use in their clinical work.

I continue to expand my knowledge and practice as a music therapist by training in the Bonny Method of Guided Imagery and Music (BMGIM). BMGIM allows clients to explore their inner personal experiences through guided imagery upon reaching an altered state of consciousness. BMGIM is primarily conducted in a dyadic session between the therapist and client. A trained BMGIM therapist first guides the client to a state of total relaxation before playing carefully selected classical music in its specified order to evoke images, sensations, feelings, and memories as the client explores deeper levels of consciousness (Ventre, 2002). However, in inpatient psychiatric settings, it is difficult to provide BMGIM services as clients who present with acute psychotic symptoms generally struggle to maintain focus and risk being overstimulated (Bonny, 2002).

Nonetheless, I am continuing to explore this unique model of music therapy as I believe that individual's personalities are created from past experiences and ambitions of personal growth. This is supported by Jungian theory which evolved from Freudian theory. Jung primarily uses two methods to conduct therapy; dream analysis and active imagination (Meadows, 2002). He worked with archetypes and the collective unconscious by integrating and understanding all of a client's experiences (Neher, 1996; Meadows, 2002).

Personal Motivation

Currently, I am a music therapist working within a 36-bed, acute inpatient unit. The primary theoretical orientation for the hospital is based on a cognitive-behavior model.

The treatment team includes psychiatrists, nurses, social workers, psychologists, counselors, music therapists, psychiatric assistants, and a recreation therapist.

Clients admitted to this facility are diagnosed with various mental disorders such as schizophrenia, personality disorders, mood disorders, substance-related disorders, and anxiety disorders. The length of hospitalization differs from client to client but the average hospital stay is generally ten days. The primary focus for the treatment team is to provide rapid stabilization for a wide range of acute psychiatric symptoms, which may require the use of psychotropic medications. Upon discharge from the acute unit, clients are referred to an appropriate level of care to continue with necessary treatment based on their needs. In conjunction with psychotropic medications, group services are provided for clients on a daily basis, which include music therapy, group psychotherapy, counseling for the mentally ill and chemically abusing (MICA), medication and nutrition education, discharge planning, and recreation therapy. Additionally, individual services are available upon request from clients or if the treatment team decides that a client may benefit from both individual and group sessions.

The music therapy program is part of the “Activities Department.” Due to the rapid turnover within the unit, individual music therapy assessments are not officially documented in medical charts: instead, a general assessment is used for the entire department. Assessments are typically completed within 48 hours and include information on the client’s reason for admission, previous and current level of function, leisure activities, history of work, education, treatment, substance use, and family information, which is collected through client-therapist interviews and observations made in group services throughout the day and around the unit. Music therapy groups are

provided three times a week and the client has the choice to accept or decline participation in the group services. The role of music therapy is to help clients manage symptoms of their illness and stabilize their mood. Music therapy experiences can address psycho-educational issues and develop awareness of self and others (Bruscia, 1998).

The following goals are addressed during a music therapy session: developing healthy coping skills, exhibiting relatedness with others, and fostering self-expression. Musical experiences are designed at two levels of music therapy practice: one being the supportive, activity-oriented level, and the other being the insight re-educative level based on the client's overall level of functioning. A here-and-now focus is encouraged for clients to recognize what is occurring within the group and to individually stay on task with their personal goals throughout their hospitalization. Typical music experiences include music assisted relaxation, free improvisation, music and movement, drum circle, song discussion, and song-writing.

When I facilitate a group, my approach varies. Sometimes, I provide structure for groups and at other times I offer opportunities for clients to direct how they want to use the group in a particular moment. I believe clients wish to have their thoughts and feelings validated, and should always be granted this right. To meet the needs of the clients, I find myself drawing from three theoretical orientations: cognitive-behavior, humanistic, and psychodynamic. Additionally, I also incorporate Wheeler's (1983) three levels of intervention: activity, re-educative, and re-constructive.

I consider myself to be a nurturing person who displays patience and genuine concern for others. These traits transfer into my clinical practice and are received by my

clients. However, I am still developing my perspective regarding which theories I strongly prefer to draw from in practice. For instance, I am learning how to foster the therapist-client relationship from a more psychodynamic perspective by incorporating transference, countertransference, and resistance into my practice. Although this was an approach that I was interested in as a student, it is one that I am conflicted with practicing in the workplace, wherein many inpatient psychiatric units approach their treatment with the cognitive-behavior model.

Research has demonstrated the efficacy of cognitive-behavior interventions in acute care settings (Leichsenring & Leibing, 2003; Silverman, 2008; Silverman, 2009). Silverman's (2008) research has demonstrated the effectiveness of combining psychotropic medication in single psycho-educational sessions as part of treatment. These findings have led me to question both the benefits and challenges of this approach. For instance, how much information and learned skills are clients able to retain within one session? How do they apply these skills independently? Do clients expect instant gratification per session? For this reason, I have begun to wonder if my approach is effective in a fast-paced environment in which rapport needs to be established quickly due to the rapidity of new admissions. As a new clinician, this can be a challenge when trying to foster therapist-client relationships and I carefully observed how staff members interact with clients. Clients are aware of the differences in interactions amongst staff with other clients. Jones (2006) discussed the importance of all treatment team members working together as a group and supporting the facility's policies. The situations I face at work led me to believe that my approach and interactions with clients should not be overlooked.

While client services that are provided within acute care are increasing, the length of stay is decreasing. This change makes it difficult to provide continuous services. Yalom (2005) describes this as “the revolving-door that is here to stay, [and] even as the door whirls ever faster, clinicians must keep their primary focus on the client’s treatment” (p. 483). The emphasis on short-term hospitalization has led to many music therapy services providing supportive, activity-oriented therapy (Davis, Gfeller, & Thaut, 2008).

There is no formula for selecting activities for groups. Rather, music therapists ultimately provide treatment according to the needs of the individuals diagnosed with mental disorders, and to assist them in meeting their goals. Even a nurse promoted the use of music in treatment so that “the individual [may] evolve toward healing as he or she rhythmically interacts with the environment” (Covington, 2001, p. 61). She recognized that clients diagnosed with mental illness struggle in areas of communication, socialization, self-expression, and coping skills. Therefore, music therapists need to consider each client’s age, cultural background, developmental level, and level of functioning in order to accommodate to each individual client’s needs per session (Davis et al., 2008).

Significance

Attending conferences has provided me with insight into the role and function of music in groups when working with individuals in a mental health field. Conference presentations of clinical work, for example, have exposed me to the variety of theoretical orientations utilized in music therapy practice.

These presentations, as well as Silverman’s (2007) research, suggest that theoretical orientations most commonly used in adult psychiatric settings include

cognitive-behavior, psychodynamic, and humanistic orientations. Each of these orientations provides music therapists with a framework for developing assessments, treatment planning, and evaluating the client's progress.

Clinicians may gain insight by becoming aware of the different orientations and techniques incorporated in achieving goals for each theoretical orientation. The information gathered will educate those in the music therapy field, as well as professionals in related fields (e.g., psychology, nursing) and may also increase the willingness to incorporate music therapy within a psychiatric setting.

Need for the Study

There have only been three music therapy research studies so far that have examined music therapists and their theoretical orientation when working with adults residing in an inpatient psychiatric setting (Cassity, 2007; Choi, 1997; Silverman, 2007). Silverman (2007) noted that there is a lack of quantitative research and only limited literature regarding psychiatric music therapy. This includes a discussion of theories and music therapy interventions utilized with clients in qualitative case studies (Austin, 1996; Bruscia, 2006; Hadley, 2003), and books (Bruscia, 2002; Gabbard, 2005; Unkefer & Thaut, 2007; Wigram & Backer, 1999). The quantitative studies seem to emphasize the movement in evidenced-based practice for cognitive-behavior therapy. Other resources provide case study examples in individual or group settings as well as general information on how theoretical orientations are incorporated within music therapy sessions.

Choi (2008) examined music therapists' theoretical awareness within their practice and identified what factors influence their specific theoretical orientations. Overall,

participants in this study indicated that while they incorporate a variety of approaches from different orientations, most therapists tend to identify with a primary approach. This particular primary approach seemed to vary based on area of practice (e.g., chronic psychiatric inpatients versus outpatients). Choi suggested that it might be difficult for music therapists to choose one theoretical orientation to guide their clinical work. In reality, “music therapists provide meaningful music experiences to enhance a client’s well-being” (Choi, 2008, p. 108). Regardless of the musical experience, however, therapists are responsible for understanding the theories that influence their practice.

Silverman (2007) reported on the orientations and techniques utilized by music therapists who work in a psychiatric setting. The results showed that 61% of music therapists work within one specific orientation, whereas 39% of music therapists consider themselves to be eclectic. The data also indicated that music therapists practiced with the cognitive-behavior orientation (21%) most often, compared to the use of humanistic (14%) and psychodynamic (6%) orientations, while the biomedical orientation was ranked the lowest at 1% usage. In addition, the author noted that some music therapists answered both psychodynamic and behavioral as their orientations in the survey. When combined, this could be considered an eclectic approach. Due to the format of the research, no further explanation on the reasoning was explored. This led me to consider which techniques from these two orientations were incorporated within therapy sessions and, more broadly, how music therapists developed their orientation.

In summary, within music therapy, there has been limited research conducted on how music therapists inform their clinical work in relation to a theoretical orientation. Gaining this information from experienced clinicians will provide a deeper understanding

of music therapy clinical practice.

Therefore, the purpose of this study was to gather information directly from music therapists who have aligned themselves with cognitive-behavior, psychodynamic, or humanistic theory. Only cognitive-behavior, psychodynamic, and humanistic theoretical orientations are explored in this study. These theoretical orientations are chosen for two reasons. Firstly, these are the theories that I am drawn to in my clinical work. Secondly, these theories are cited to be the most common orientations in Silverman's (2007) study.

This pilot study examined how music therapists use their chosen theoretical orientation to inform and carry out their clinical work. Understanding the basis of psychological foundations, as well as music therapy experiences and techniques can help us to further demonstrate the benefits and challenges that various psychotherapies portray when working with a psychiatric population.

Related Literature

Definition: Mental Disorder

Mental disorder is defined by the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* (American Psychiatric Association [APA], 2000):

A clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. This syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event. (p. xxxi).

The client manifests distress in social or occupational functioning on a daily basis. Behaviors and emotions are considered inappropriate or problematic when frequency, duration, and intensity are higher than others experiencing the same situation (Gfeller & Thaut, 2008).

Inpatient Psychiatric Settings

Length of inpatient treatment for adults diagnosed with mental disorders varies from short- to long- term hospitalization. Clients are admitted to psychiatric facilities based on symptoms of psychosis, mania, anxiety, or depression (Gfeller & Thaut, 2008). Upon admission, each client's treatment plan, including length of stay, is individualized. In short-term psychiatric facilities, clients in immediate crisis are stabilized and then referred to outpatient programs to continue with their treatment (Silverman, 2007). Long-term care is either provided in correctional facilities or state hospitals for those who present with difficulty functioning in the community (Gfeller & Thaut, 2008).

History

Treating people who presented with symptoms of depression began in 1789 (Peters, 2000). Exposing them to live and recorded music demonstrated modification in "their moods and behaviors" (Peters, 2000, p. 245). The same year, an article titled "Music Physically Considered" was printed in *Columbian Magazine* discussing the influence of music and how it regulated emotional conditions (Crowe, 2007). Nearly 100 years later, the New York City Charities Commissioner and the hospital's medical doctor supported this experimental form of therapy; allowing those with mental illnesses to

attend live concerts and receive individual sessions which alleviated suffering (Davis, 1987).

After World War I, as the field of psychiatry grew, music was officially recognized as a form of therapeutic treatment to assist with the recovery process during World War II (McGuire, 2004). Music therapy then evolved from psychiatric hospitals into other settings as a means to assist and care for the mentally ill in the United States (Tyson, 1981).

Near the end of the nineteenth century, a mental health reformer named George Adler Blumer advocated for music therapy (Davis, 1987). He hired musicians to perform for clients as treatment at Utica State Hospital in New York. By the early- to mid 20th century, music was promoted as alternative treatment by doctors in hospitals (Peters, 2000). Short-term hospitalizations became the primary mode of treatment secondary to introductions of psychotropic medications in the mid-1950s and the Community Mental Health Center Act (Public Law 8-164) passed by the United States Congress in 1963 (Peters, 2000). This movement promoted community based treatment centers to expand its mental health services. As a result, music therapy has become widely accepted in treating clients with mental disorders (Michel, 1985).

Over the years, the following interventions have been frequently incorporated in music therapy groups of the psychiatric population: music assisted relaxation, improvisation, song writing, lyric analysis, and music and movement (Silverman, 2007). Music therapists provided these experiences to help promote clients' physical, mental, emotional, or spiritual health. Specifically, the structure and organization in music

activities affects the individual's ability to exhibit human behavior that is accepted in the community (Clair & Heller, 1989). Tyson (2004) discovered that live music elicits involuntary and positive responses to restore interest, which is used as a motivator to help clients build relationships and reintegrate into the community.

Following Silverman's footsteps, Cassity (2007) made in-depth observations and noted a specific increase in music interventions related to "drumming, anger management, behavior, mood elevation or stabilization, and cognitive problem solving" (p. 88). She suggested that by 2016, cognitive-behavior orientation would become the predominant theory that music therapists apply to their practice. Stiles, Barkham, Mellor-Clark, and Connell (2008) replicated Cassity's quantitative study with an adult outpatient population based on the three theoretical orientations; cognitive-behavior, psychodynamic, and humanistic. Over a three-year period, data was collected on participants' psychological assessment and treatment, and organized according to each therapist's theoretical orientation. Despite significant differences observed between each theoretical orientation from instatement to termination of therapy, all clients demonstrated measurable progress. Specifically, their study acknowledged that while clients receiving intervention based on cognitive-behavior orientation exhibited a decrease in symptoms by the end of therapy, treatment focused less on interpersonal relationships in comparison to that of psychodynamic and humanistic orientations. Accordingly, Cassity also predicted that while CBT would gain popularity, techniques based on psychodynamic and humanistic perspectives would equally remain in use. Some therapists argue that "all good therapists are eclectic" (Choi, 2008, p. 108). One's

approach may vary based on his or her training, their facility's primary approach, previous schooling and clinical experiences, cultural considerations, and their client's goals (Choi, 2008; Gfeller & Thaut, 2008). Many music therapists consider themselves to be eclectic because therapeutic techniques and methods are secondary to their clinical composition and each client's individual needs (Choi, 2008).

Overview of Assessment

There are a variety of methods that a music therapist can employ to assess a client's current level of functioning (e.g., social, cognitive, emotional, vocational, communication, and physical skills) to develop an individualized treatment plan (Unkefer & Thaut, 2002). A primary method is interviewing. The format of the interview may be structured or unstructured (Unkefer & Thaut, 2002). It is a music therapist's goal to gain information regarding the client's past musical experiences, preferences, inducers of stress, or any pertinent information. Standardized formal assessments are also available. Cassity & Cassity (1995) created the Psychiatric Music Therapy Questionnaire, which asks clients multiple questions based on their behavioral perspective. Braswell et al. (1983; 1986) developed a "Music/Activity Therapy Intake Assessment" based on the Joint Commission requirements.

In addition to verbal interviews, music therapists have the unique privilege of assessing clients through music. Music therapists observe behaviors through musical interventions. Michel and Rohrbacher (as cited in Unkefer & Thaut, 2002) stated "music is a form of human behavior" (p. 158). Through structured or unstructured improvisation as a solo, duet, or group performance, music therapists assess clients' interactions with themselves, others, and music to obtain their current level of

psychosocial functioning (Unkefer & Thaut, 2002). Another means of assessing clients is through structured and free-flowing music experiences, such as the Music Psychotherapy Assessment created by Loewy (2000) which identifies and assesses relationships, achievements, cognitions and dynamics.

Ultimately, music is utilized as a form of assessment. However, the music therapist's perspective varies based on their theoretical orientation. For instance, a cognitive-behavior therapist is interested in how clients process information provided to them, as well as their subsequent behavioral outcome (Gfeller & Thaut, 2008). A psychodynamic music therapist is interested in the intra- and inter- personal relationships each client demonstrates with oneself, others, and music. Lastly, a humanistic music therapist is interested in the internal, rather than the external, influences of each client. Thus, the music therapist has assessed the client's of acceptance, responsibility, and flexibility in response to environmental changes (Unkefer & Thaut, 2000).

Treatment Planning

Types of music interventions used in sessions are based on clients' interests, needs, and abilities (Peters, 2000). Information is gathered during the assessment to assist music therapists in creating and planning sessions. Wheeler (1983) classified three levels of music therapy interventions for individuals diagnosed with mental disorders: supportive, activity-orientated; insight music therapy with re-educative goals; and insight music therapy with re-constructive goals.

Supportive, activity-oriented music therapy sessions are generally structured and product-oriented. The activities implemented in sessions encourage clients to learn

and adapt to new patterns of behavior and response by “developing new coping skills, improving self-confidence, and learning more adaptive responses to emotions”

(Crowe & Justice, 2007, p. 28). The music therapist structures and plans sessions by selecting activities based on an individual’s social, physical, cognitive, and emotional functioning level prior to the sessions. The space, equipment, pacing of the session, type of music, and materials incorporated are also important considerations.

Additionally, the music therapist has the option of allowing clients to provide input during the sessions. This level of intervention is recommended for individuals who are experiencing temporary crisis, dealing with severe anxiety or severe mental disorders, and exhibiting regressive and delusional thoughts (Crowe & Justice, 2007).

Insight music therapy with re-educative goals focuses on eliciting immediate emotions or reactions through music. Verbal and musical interactions are intertwined throughout sessions. The role of the music therapist is to select music for sessions that evoke emotions, memories, and reactions. The therapist must have the skills to listen and respond empathetically so that clients are encouraged to acquire alternate attitudes, behaviors, and values that relieve anxiety and tension (Unkefer & Thaut, 2002).

Selecting songs and understanding how songs are utilized in sessions is a critical pre-requisite for any successful therapy session. Bruscia (1998) believes songs are important because 1) clients have relationships with songs; 2) songs connect clients to the people, situations, and emotions in their lives; 3) clients have personal associations and meanings with songs; and 4) songs can access certain psychological material and emotions within clients. Thus, implementation of songs triggers verbal

expression and fosters further discussion. Types of song interventions include song performance, song reception, lyric analysis, song reminiscence, song collage, song improvisation, song parody, and song-writing (Bruscia, 1998, p. 120).

Reconstructive, analytical, and cathartic- oriented music therapy focuses on uncovering, reliving, or resolving subconscious conflicts. The music's primary job is to elicit unconscious materials related to the present or the past, and work towards reorganizing the personality (Wheeler, 1983). Thus, the music is important for eliciting the repressed material of the unconscious. To achieve this, music therapists may require advanced training at this level, such as BMGIM and Analytical Music Therapy (AMT).

Evaluation

Progress is tracked by music therapists on a daily or weekly basis from musical and nonmusical observations gathered during group sessions. Nonmusical observations gathered include facial expressions, verbal interactions, and body language. Rhythm, texture, dynamic, melody, harmony, and musical phrasing through improvisation are all examples of musical observations that are analyzed by music therapists (Bruscia, 1987). In addition, clients' musical development throughout the course of therapy, thus far, is interpreted to adjust treatment goals, as needed.

To measure progress, the amount and type of change a client has shown in behavior and cognition since the beginning of therapy is compared by a cognitive-behavior – oriented therapist (Corey, 2009). On the contrary, clients' self-reports regarding their quality of life, including awareness in their ability to express, interpret, and share feelings in relation to their unconscious are interpreted by

psychodynamic – oriented therapists (Corey, 2009). Additionally, the types of images and change of content within their dreams are also used to assess their quality of life. Lastly, clients' receptivity to the music and willingness to explore their relationship to musical instruments, themselves, and others are carefully noted (Bruscia, 1987). A client's ability to develop a sense of trust, adapt to new experiences and continue working towards personal development is assessed by a humanistic – oriented therapist (Corey, 2009).

Despite daily or weekly evaluations in inpatient psychiatric settings, there are also other factors that have effected the course of treatment and termination. One uncontrollable factor is when a client has reached their plateau before completing their predetermined course of treatment. In such situations, treatment is permanently discontinued if the individual resides in a long-term facility. In a short-term facility, treatment is provided with the sole intent to reach and maintain the client's mental stability until they are discharged to an appropriate treatment center. Another influential factor is insurance coverage and eligibility, which predetermines one's treatment period (Gfeller & Davis, 2008).

Theoretical Orientation: Cognitive-Behavior Theory and Music Therapy History

Today, cognitive-behavior therapy (CBT) is recognized as an innovative form of psychotherapy (Segal, Whitney, Lam, and CANMAT Depression Work Group, 2001). Originally, CBT was used strictly to treat clients diagnosed with depression, but its use has since been expanded to treat a variety of mental illnesses (Silverman, 2008). Many of the behavioral interventions utilized in CBT were first developed in

the 1950's (Corey, 2009). At that time, clinicians believed that clients with mood disorders were exposed to fewer positive reinforcements in their immediate environment. Behavioral interventions treated symptoms of social withdrawal and anhedonia. Later, throughout most of the 20th century, cognitive theorists shifted treatment to assist clients in changing their automatic and maladaptive ways of thinking that caused depressive moods (Segal et al., 2001). Eventually, contemporary theorists found a way to successfully combine cognitive and behavioral techniques to “maximize pleasure and minimize pain” (Corey, 2009, p. 278).

In 1955, Albert Ellis, founder of Rational Emotive Behavior Therapy (REBT), began to persuade his clients to confront their greatest fear; emphasizing that cognitive, emotive, and behavioral techniques intertwined in therapy (Ellis, Shaughnessy, & Manhan, 2002). REBT, an active and directive form of CBT taught clients to select more functional outcomes to situations in their lives by fully accepting themselves and others (Ellis et al., 2002).

Fundamentally, clients' thoughts and behaviors are influenced by their beliefs and attitudes on how they perceive life situations. In order to prevent self-defeating actions, CBT is defined as a collaborative relationship between client and therapist that focuses on changing cognitions to produce desired changes in affect and behavior. Goals for clients are achieved within limited time and educational based treatment (Corey, 2009).

Principles

Cognition and the process of learning are the main focus and are supported by several core principles of CBT. One principle is to enable clients to organize their

cognitive contents, or schema (Peters, 2000). By organizing one's schema, an individual is able to recognize the consistency in his or her daily thoughts including continuous negative thoughts or events related to the negative thoughts. A second CBT principle is accuracy where clients quickly learn what makes them feel good or bad through skills learned in therapy. A third principle is self-aggrandizement, or positive association which is added onto an individual's experiences. Incorporating these aforementioned principles into everyday life can influence an individual's thoughts, and ideally change maladaptive behaviors.

Techniques

The cognitive-behavior techniques are used to treat an individual's thoughts, behaviors, and emotions. Cognitive-behaviorists believe clients possess irrational thoughts about themselves and others (Corey, 2009). When beginning CBT, clients' motivations are typically low and they may have difficulty identifying specific thoughts and behaviors that lead to emotional distress. For example, a client may say, "No one will ever love me," but he or she cannot describe how this irrational thought is connected to specific behaviors and emotions (Corey, 2009, p. 282). Therefore, the first task is to help clients recognize the specific consequences of their behaviors, which will also aid in reducing their distress (Darrow, 2004).

This task may be achieved by applying Ellis' principles of REBT. Ellis proposed a model of cognition known as the ABC model: A is the "activating event"; B is the "belief"; and C is "the consequence of emotions/behaviors" (Ellis as cited in Corey, 2009, p.278). The goal is to change clients' thinking by helping them understand the source of their irrational thoughts. Homework assignments are given,

and clients are encouraged to practice coping skills of responding and modifying their views (Segal et al., 2001). Behaviorally, by implementing these skills, clients will increase their feelings of gratification.

Rational Emotive Behavior Therapy utilizes emotive techniques, which teach clients to accept themselves as who they are. Rational emotive imagery is a technique used to create new emotional patterns (Ellis, 2001a). The goal of rational emotive imagery is for clients to reach a point where negative events do not have an impact on their emotions and thoughts. The technique works by exposing clients to imagine a scenario with the worst outcome, and to feel the associated negative emotions intensely. By experiencing the unhealthy feelings of the situation first, their understanding of the process involved in changing their behavior in the situation becomes clearer. This then assists clients in changing their negative thought process to experience healthy feelings about the negative situation. In addition, role playing is incorporated into REBT. Clients rehearse select behaviors or thought processes to show how they would handle themselves in certain situations. The goal is to work through irrational beliefs related to unpleasant feelings. Even in role playing, emotive, cognitive, and behavioral components are incorporated (Corey, 2009). A psycho-educational method can be incorporated into therapy. Clients are educated on the process of therapy and techniques implemented in the beginning. Therapists have found that clients are likely to comply with the treatment if clients are aware of the techniques used (Ledley, Marx, & Heimberg, 2005).

Goals

The primary goal of the therapist is to reduce the symptoms presented by a

client by systematically changing the client's automatic and maladaptive ways of thinking (Segal et al., 2001). For instance, cognitive-behaviorists have stated that clients diagnosed with chronic depression have difficulty generating empathy. Clients will "talk at" others rather than "talk with" them (Segal et al., 2001, p. 308). Common goals in CBT include being able to differentiate between realistic and unrealistic goals, and healthy and unhealthy goals (Corey, 2009).

The Role of Therapist

To help clients modify their thought processes and behaviors, therapists play an important role in guiding clients towards making healthy decisions for themselves. The therapist's role is to identify and challenge clients' self-defeating ideas, so they are able to accept the truth (Unkefer & Thaut, 1991).

The therapist first presents a client with specific tasks and demonstrates to the client through these tasks how irrational thoughts are incorporated into his or her life. Activities are presented to help clients learn how to replace the irrational "should phrases" to "must phrases" (Corey, 2009, p. 277). Afterwards, the therapist explains to the client that he or she is solely responsible for creating and sustaining his or her unhealthy and unrealistic thoughts. This happens when the therapist helps the client to modify his or her thoughts by confronting the client further with his or her beliefs. The client is now challenged to develop a rational philosophy of life. This is a teaching process that can occur between a therapist and a client while they are building a rapport (Corey, 2009).

The Role of Music

Within music therapy sessions, verbal processing is incorporated to discuss

ideas and clarify thoughts. Additionally, music experiences that require clients' participation are often selected. For instance, music is the primary agent used to alleviate the distress clients experience frequently when learning techniques (e.g. music assisted relaxation, progressive muscle relaxation). Overall, music is not used in a context to explore clients' repressed emotions, but structured for clients to adapt impulsive behaviors (Bruscia, 1998).

Music Therapy

One experience commonly implemented in CBT to alleviate stress is music-assisted relaxation (Darrow, 2004). The selection of music for relaxation should have predictability. The music can both be familiar or preferred by the listener, and have recognizable patterns throughout (Crowe, 2007). Techniques for relaxation help the client to restructure cognitively and change his or her distorted thoughts. These techniques are efficient and results have been visible in a short period, which then reduces the cost of therapy.

Another music therapy intervention is songwriting. This can be used to help clients reframe irrational thoughts. The therapist can provide structure for the clients to follow while encouraging them to create their own words to the song. The song then becomes a guide and a tool for the clients to refer in post sessions when irrational thoughts/beliefs enter their minds (Unkefer & Thaut, 1991). Clients will have this tool to use independently in becoming aware of their distorted thoughts.

Similarly, lyric analysis, which focuses on lyrics of a song, helps clients focus on relevant issues, concerns, beliefs, and coping skills. Songs can bring about a change in the clients' emotional state. This can help clients to clarify their thoughts and to gain a

sense of control. Or, sometimes the emotions can be overwhelming for clients if they are in denial. The therapist can direct or guide the discussion of the clients' thoughts and interpretations of the lyrics after listening to a recording or live performance (Crowe, 2007).

As discussed throughout this section, many experiences can be provided to assist with the cognitive processing and to change any irrational beliefs in order to help clients build realistic perceptions of themselves. Within the experiences, modifications may be made to allow maximum participation from the clients. Instrumental or lyrical repetition may help clients become aware of their thoughts and behaviors (Unkefer & Thaut, 2002).

Theoretical Orientation: Psychodynamic Theory and Music Therapy

History

The psychodynamic theory was originally derived from neurologist John Hughlings Jackson and Sigmund Freud's analytic approach (Gabbard, 2005). Freud is the founder of the first theoretical orientation and has greatly influenced contemporary practice. The Freudian view began with psychoanalytic theory. Freud's theory developed from his medical training in neurology. Freud believed that children moved through a fixed sequence of psychosexual stages (oral, anal, phallic, latency, and genital) in their development into adults.

Building on Freud's theory, more modern views emerged: Adlerian theory, Erikson's psychosocial stages, and Jung's personality theory. From these, the psychodynamic orientation was formed. Although each theorist had their own theories regarding human interaction and development, all three believed that an individual functions at various levels of awareness, the idea of which was derived from Freud

concept of the id, ego, and superego.

Principles

The id, ego, and superego are the main elements in Freud's psychoanalytic theory of personality (Corey, 2009). The id, also known as the pleasure principle, is the element of the personality that is demanding, insistent, and blind. The ego, which is known as the reality principle, regulates and controls the personality. The ego's responsibility is to think logically and formulate a plan of action to satisfy needs. The superego is the personality's judicial branch. The super ego strives for perfection and is concerned about whether a person's action is good or bad, right or wrong. Thus, inhibiting impulses by the id and persuading the ego to target realistic goals is a way to strive for perfection.

As repressed memories, desires, or experiences surface into the conscious, the body physically experiences anxiety. In order for the body to protect itself and deter any repressed thoughts, feelings, or memories from surfacing, the ego-defense mechanism helps the individual cope with the anxiety by adapting to a style of life that befits the individual to partake. Hence, the ego-defense mechanism either denies or distorts reality, or functions on an unconscious level (Corey, 2009).

Techniques

Techniques in the psychodynamic model include dream analysis, interpretation, free association, analysis of resistance, and analysis of the transference and countertransference processes (Unkefer & Thaut, 2002). Since the unconscious cannot be studied directly, dreams are considered symbolic representations of an individual's unconscious needs, wishes, and conflicts. Free association, known as "slip of the tongue,"

is a technique that uncovers the unconscious where all repressed memories, desires, experiences are stored (Corey, 2009; Unkefer & Thaut, 2002).

Resistance may interrupt the therapeutic process and prevent the client from uncovering the unconscious, as s/he may be reluctant to partake completely in the free association process. This is when interpretation can be effective. The therapist can help a client understand that his or her behaviors are manifested in dreams, free associations, and resistances, which are the sources of his or her neuroses or psychoses. This type of treatment is used to enable the ego to accept new material, which then assists in the process of uncovering unconscious thoughts and feelings quicker (Corey, 2009).

Transference and countertransference relationships are important constructs of psychodynamic theory (Bruscia, 1998; Corey, 2009; Gabbard, 2005). Bruscia (1998) defines transference as "...whenever the client interacts within the ongoing therapy situation in ways that resemble relationship patterns previously established with significant persons or things in real-life situations from the past" (p. 18). Transference attitudes exhibit quickly through exaggerated behaviors, such as defensiveness, hostility, or attempt to control a situation (Corradi, 2006). Bruscia (1998) defines countertransference as when a therapist reacts to a client's behavior based on the way s/he reacted towards similar encounters experienced in the past. Historically, the core therapeutic process occurs because of the transference and countertransference relationships that unfold. Presently, transference is not the primary focus of therapy, as it was in classical psychoanalysis (Corradi, 2006). Essentially, today, the clinician only examines the transference if it exemplifies the psychopathology that is affecting the client's life and relationships (Corradi, 2006).

Goals

Initially, the goals for non-psychotic clients include: decreasing anxiety and depression; decreasing feelings of isolation and alienation; defining and expanding personal identity; and creating new ways to represent internal states, feelings, and ideas (Gfeller & Thaut, 2008). Later on, with continuous treatment in a long-term setting, clients may have the opportunity to gain insight into the cause of their distress; to uncover, identify, and work through their unconscious personality conflicts; and to strengthen their egos (Corey, 2009; Peters, 2000). This is supported and facilitated through the clients' relationship with their therapists, along with musical experiences and verbal discussions (Choi, 2008).

Role of Therapist

The main role of the therapist is to foster the transference relationship and to make interpretations for their clients (Unkefer & Thaut, 2002). In classical psychoanalysis, the therapist assumed the "blank-screen approach" (Corey, 2009). This is when the therapist presents him- or herself in a blank state to prevent self-disclosure so that he or she can foster the transference relationship. After establishing a rapport with the client, the therapist immediately becomes both the listener and interpreter, listening for gaps and inconsistencies in stories while interpreting the meaning of dreams and free associations that are being presented.

Over time, the "blank-screen approach" has evolved, and therapists are now viewed more as allies and active supporters (Unkefer & Thaut, 2002). Post-Freudian therapists demonstrate this through exemplifying qualities, such as self-confidence and controlled emotional warmth.

Role of Music

Psychodynamically, music is used in therapy to help build relationships between therapist and clients (Bruscia, 1998). Music experiences are tools that help clients feel comfortable in the company of another person, and to rediscover creative and playful sides of themselves. Clients do not have to feel obligated to actively partake in the music. Rather, music can motivate clients to ease into the therapeutic relationship without the control of the therapist. Together, the music therapist and music can assist clients in working with their defense mechanisms (Pederson, 2002).

Music Therapy

Improvisation is a primary method used in psychodynamic sessions to provide clients with an opportunity to freely express their emotions (Unkefer & Thaut, 2002). An example of the use of instrumental improvisation within the psychodynamic orientation is described in a case study by Miller (2006). In treating a client with schizophrenia, Miller focused on live interactive music, to enhance the awareness of the challenges that were occurring within the client's relationships. Additionally, Miller emphasized that the instrumental improvisation reflects the client's mental and emotional states and reveal the changes that need to occur internally. Miller discussed relationships formed among the therapist, client, and music. As each member played the instrument individually and together as group, the music allows transference to occur (Miller, 2006). As Corradi (2006) states, the goal of therapy, the job from a psychodynamic psychotherapy perspective is to assist with making a clear connection and to restore the effects of the past. It is important to bridge the past and present emotionally and intellectually.

Analytical Music Therapy (AMT), founded by Mary Priestly uses techniques taken from psychoanalysis (Eschen, 2002). Together the music therapist and clients improvise with or without a focus and then discuss thoughts, feelings, and inner experiences regarding the improvisation (Priestly as cited in Pederson, 2002). The AMT therapist provides clients with a wide range of musical possibilities through “melody, rhythm, harmony, texture, dynamic, timbre, and sound of the clients’ music” (Pederson, 2002, p. 68). The therapist and clients improvise on themes verbally discussed: an association of a place; feelings of emotions in the present; a dream or a representation of a symbol; a body part and what it wants to play in the moment; an energy transitioning from one character to another; and part of the clients’ past. Improvisations can be viewed symbolically (Pedersen, 2002). Through improvisation, clients’ id, ego, and superego become balanced as their awareness of repressed memories and other defense mechanisms are brought out.

Vocal psychotherapy also makes use of improvisation (Austin, 2007). Austin advocates using the voice for improvising, singing and dialoguing. Allowing the client to spontaneously sing imitates the free association method created by Freud and allows the client to create or sing their mind with no censorship (Austin, 1996). Austin associates the client’s musical improvisation as his or her own verbal communication. Thus, the client’s improvisation can also reflect how he or she functions and organizes psychologically. Austin described music as a language “...that gives symbolic expression to unconscious contents and intrapsychic processes” (p. 38). The intrapsychic process can stimulate materials of the client’s past and present life through music making.

The Bonny Method of Guided Imagery and Music (BMGIM) is a receptive method in which the client images to music “in an expanded state of consciousness” (Bruscia, 2002, p.38). As clients image, repressed materials begin to seep into the consciousness. For example, clients may see representations of significant others during their childhood. Therapists trained in BMGIM, provide clients with a safe environment by demonstrating qualities of “attunement, empathy, and support” (Bruscia, 2002, p. 231)

Theoretical Orientation: Humanistic Theory and Music Therapy

History

The development of humanistic psychology is credited to Carl Rogers and Abraham Maslow. Rogers’ nondirective therapy is based on his belief in the power of free will and self-determination (Corey, 2009). Therapists who use this approach avoid self-disclosure when counseling clients and focus on clients’ verbal and nonverbal communications by reflecting and clarifying to “help the clients become aware and gain insight into their feelings” (p. 166). As Rogers’ theory evolved, humanistic counseling shifted from a focus on nondirective counseling to client-centered therapy, which involves monitoring how clients behave in their own environment and emphasizes the importance of the client-therapist relationship. Rogers became more interested in openness and trusting one’s experience. His person-centered approach is ultimately concerned with, observing “how people obtain, possess, share, or surrender power and control over others and themselves” (p. 167).

Maslow (1943) believed that emotional and behavioral disorders occur because individuals fail to find meaning in their lives. He proposed a hierarchy of needs, stating that people are motivated to fulfill their basic needs first before moving forward. The

levels of need in the hierarchy include: physiological, security, social, esteem, and self-actualizing needs (Corey, 2009). Smither (2009) viewed the humanistic theories of Rogers and Maslow as an optimistic approach to life's issues as it focuses on the self-actualization of one's potential.

Principles

One of the main constructs in humanism is self-actualization. Rogers' shared that congruence or genuineness, unconditional positive regard, acceptance, and accurate, empathetic understanding are characteristics that help a relationship grow and change through a here-and-now interaction (Corey, 2009; Peters, 2000).

Congruence is a key quality in a therapist to have because it is important to be genuine and authentic during a session (Corey, 2009). In this way, the therapist is modeling an example of a human being working towards realness. This will facilitate the development of a trusting client-therapist relationship. Another key quality in the therapist is the ability to communicate unconditional positive regard toward the client. The therapist simply accepts the client as him/herself, and thus, the client is free to have and express any feelings. A third key quality in a therapist is displaying accurate empathy. Displaying empathy allows the client to become more aware of his or her present experience, to look at his or her past experiences from a different perspective while modifying his or her self perceptions of self, others, and the world, and to increase his or her confidence levels in making choices (Corey, 2009).

Goals

Humanistic therapists strive to help their clients achieve a greater degree of independence and integration by focusing on the person him/herself and not the person's

issues (Corey, 2009; Unkefer & Thaut, 2002). Clients learn on their own how to cope with current situations so that they can utilize these coping skills in the future. In order to reach the goal, the environment must be favorable for the individual to become a fully functioning person. As part of the therapy process, according to Rogers, clients must accept who they are first: This is known as a client becoming actualized. Rogers characterized this process as someone who becomes open to the experience, achieves trust in him/herself, develops an internal source of evaluation, and is willing to grow (Corey, 2009).

Techniques

Based on these principles, the qualities that music therapists display play a major role in the development of their relationship with their clients. The music therapist's resourcefulness, the capacity for constructive change, self-awareness, and uniqueness, all contribute to techniques implemented in humanistic perspective (Cain, 1986).

Therapeutic techniques include building a trusting relationship to assist clients in making choices, building an internal frame of reference, and taking personal responsibility in finding purpose in life (Corey, 2009; Peters, 2000). The music therapist provides unconditional positive regard by conveying a warm acceptance that encourages clients to move forward within the therapy process (Corey, 2009; Smither, 2009). As a result, the music therapist accepts and respects the client for who he or she is. The qualities of the therapist, such as open-mindedness and having interest in exploring new aspects of human behavior, best facilitate client change (Rogers, 1961).

Role of Therapist

Broadley (1997) suggests that a humanistic music therapist's priority is not to learn

the client's personal history or render a diagnosis. Instead, the music therapist's priority should be to possess active listening skills, and to respect, understand, and accept the client as he or she presents him/herself. Rogers stated that the therapist's attitude plays a more significant role in facilitating a change in the client than does knowledge, theories, or techniques (Rogers, 1961). The therapist's role is to create a supportive environment and to be available for the client. Thus, the relationship between the client and therapist must be real.

Role of Music

Within a humanistic orientation, music can be used both in therapy and as therapy. Music is the primary agent with which to assist clients in relating and engaging in music experiences. Examples of musical interventions from a humanistic perspective that are utilized with the adult inpatient psychiatric population are process oriented music performance and group improvisation (Unkefer & Thaut, 2002). Clients have the opportunity to partake in creating music with others to build relationships.

Rogers' three concepts can be implemented in these types of interventions, and particularly in improvisation. Clients have the freedom to express their thoughts and feelings either vocally or musically. The therapist accepts those thoughts or feelings and demonstrates empathy through the improvisational techniques of reflecting, imitating, pacing, and synchronizing with the clients to demonstrate unconditional positive regard (Bruscia, 1998; Corey, 2009; Unkefer & Thaut, 2002).

Music Therapy

Creative Music Therapy, developed by Nordoff and Robbins (1977) is based on humanistic theory and anthroposophy. According to Nordoff and Robbins, music is used

as a tool to elicit and identify the client needs. Then, the work towards actualization begins through various methods of active music playing by improvising or simply listening (Bruscia, 1998). In order to assist and stimulate the clients towards the actualization process, the music therapist must be skilled in improvisational techniques, especially because music and musical expression is represented “as direct manifestations of the self” (Aigen, 1998, p. 296). The aims of improvisation encourage the clients to take responsibility and to make choices freely. They become less isolative as they engage in the process of music and enjoy it (Bruscia, 1991).

In summary, there is minimal literature available on the topic of theoretical orientations in music therapy. Past findings have alluded to many music therapists working with the psychiatric population and by incorporating CBT, psychodynamic, and humanistic orientations into their therapy. However, the implementation and framework varies among individual music therapists. The study that I have conducted will enhance the understanding of the three most widely practiced theoretical orientations in music therapy.

Problem Statement

The purpose of this study is to examine the theoretical framework (i.e., cognitive-behavior, psychodynamic, humanistic) used by music therapists during group music therapy sessions for adults residing in inpatient psychiatric hospitals.

Sub-problems are:

- 1) How do music therapists currently use the framework of their theoretical orientation to assess and treat adult psychiatric inpatients?
- 2) What are the benefits to music therapists of practicing with their theoretical

framework?

- 3) What challenges have music therapists encountered practicing within a given theoretical framework?

Method

Participants

Through purposive sampling, potential participants were referred to the researcher by her faculty mentors. Participants were invited via e-mail with an attachment including the necessary information regarding the study and the method of collecting data (See Appendix B & C). The participants interested in the study were asked to respond to the researcher via e-mail within two weeks of receiving the invitation. A second email, reminding the potential participants to respond, was sent at the end of the first week. After receiving all of the responses, a total of three music therapists (one from each theoretical orientation: cognitive-behavior, psychodynamic, or humanistic) currently practicing in the United States volunteered for the interview, as they all met the research criteria listed below. Participants were each scheduled for a ‘Skype’ interview based upon the researcher and participant availability.

Criteria for these participants include:

- current board certification (MT-BC) and/or licensure for creative arts therapist (LCAT)
- no association or familiarity with the researcher, such as from previous encounters as a music therapy supervisor or professor
- must work or have worked with the adult inpatient psychiatric population in the United States for two or more years

- primarily conducts group sessions on an adult inpatient psychiatric unit
- strongly identifies with one specific theoretical orientation (i.e. cognitive-behavior, psychodynamic, or humanistic)
- willing to discuss their clinical music therapy group sessions with the adult inpatient psychiatric population

Upon formulating this research design, the following study was reviewed and approved by the Institutional Review Board of Molloy College (see Appendix A).

Design

A descriptive analysis was conducted to gain a better understanding of the benefits and challenges of using a defined theoretical orientation, when working in a group setting with adults diagnosed with psychiatric disorders. In order to obtain information, participants participated in a semi-structured interview.

Data-collection Procedure

Initial emails were sent to each participant inviting them to participate in the study. Attached to this email was information including details about the study as well as, the informed consent form and an audio consent form. Interviews for the study were conducted between the months of January 2011 through June 2011.

Background information (e.g., the music therapist's years of experience, theoretical orientation, hours of music therapy groups conducted per week, and any advanced training) was received from each participant at the beginning of the interview. Interview questions were then asked in the following order as described below. Follow-

up questions were asked for clarification or to receive further information regarding the participant and his/her work. The interview questions were as follows:

1. Please describe your clinical work (including assessment, treatment, and evaluation process) in relation to your theoretical orientation.
2. What are the benefits and challenges you experience based on your theoretical orientation?

During the interview, in order to clarify and gain further information, the researcher used various interview techniques such as: reflecting, prompting, and transitioning between major topics, to assist with the fluidity of the interview. In addition to these techniques, the researcher also made note of certain statements made by the participants, especially when they seemed to emphasize music therapy practice with the adult psychiatric population based on specific theoretical orientations. After the interview, a follow-up e-mail was sent to each participant, in order to check for accuracy and clarity with regards to the statements and/or salient points from the interview. The interview information was recorded as received, while the post interview information was transcribed after listening to each recorded interview session.

Materials

A tape recorder was used during Skype interviews for reliability when transcribing post interview.

Data Analysis

The data was analyzed using the constant comparative method (Merriam, 1998) as adapted by Murphy (2007), and Smeijsters & Aasgaard (2005):

1. Verbatim transcriptions were made of all 3 interviews. If relevant, the researcher's notes (e.g., non-verbal observations, interpretation) written during and after the interviews were included in the transcription.
2. The transcripts were read several times to understand the interviewee's thoughts and responses.
3. The transcripts were culled: Any responses that are redundant and irrelevant to the questions or comments were eliminated.
4. The transcripts were segmented and coded.
5. The codes were categorized into salient points.
6. The salient points were sent to the participants for member checking to determine validity of interviewee's thoughts and statements (Lincoln & Guba, 1985).
7. Themes were identified based upon the salient points.
8. The original transcripts and the themes were reviewed to double check for any contradiction.

Results

The purpose of this study was to examine the theoretical frameworks that music therapists use when working with adults that are diagnosed with mental disorders. The research questions focused on how music therapists currently practice within their theoretical orientation, including benefits and challenges they faced.

Participant A (cognitive-behavior) is employed in a long-term facility, whereas participants B (psychodynamic) and C (humanistic) are employed in short-term facilities.

All three participants reported working for more than four years with adults diagnosed with mental disorders.

The demographic information is below (Tab

Table 1: Demographic Information

Participant	Theoretical Orientation	Education	Advanced Training	Years of Experience	Inpatient Setting & Average Length of Stay
A	Cognitive-Behavior	Bachelor's in Music Therapy	Level II Guided Imagery in Music	15	Acute: 7 days
B	Psychodynamic	Bachelor's and Master's in Music Therapy	None	17	Long-Term: 5-10 years
C	Humanistic	Bachelor's in Counseling and Master's in Music Therapy	Vocal Psychotherapy	4	Acute: 14 days

The following results are presented as a synopsis of each participant's interview. Each synopsis includes the following sections: assessment, treatment, evaluation, benefits and challenges.

Participant A: Cognitive-Behavior Theory and Music Therapy

Participant A has been working with the mental health population in the current hospital site for twenty years; five years with the pediatric population and fifteen years with the adult population. He was introduced to the cognitive-behavior model while working in this setting. The hospital and the rehabilitation department follow a Dialectical Behavior Therapy (DBT) model, a form of CBT. There are two other music

therapists, who work part-time, in addition to Participant A, who works full-time. Also, there is one full-time drama therapist employed under the same department. While therapists provide a variety of treatment programs throughout the day, emphasis is placed on DBT skills such as regulating emotion and acceptance. As a result of experiencing positive outcomes in therapy, Participant A built his clinical strengths under the cognitive-behavior approach.

Assessment

In Participant A's hospital, a standardized music therapy assessment is not used. Instead, Participant A's rehabilitation services department created an assessment tool for therapists to interview clients. Information such as: reason for hospitalization, social and emotional skills, functional skills, abilities, levels of impairments, and leisure interests are obtained. Upon assessment, clients are assigned to one of two tracks by Participant A. He described these tracks as follows: "In the higher functioning track are [clients] struggling with depression or anxiety; that don't have a formal thought disorder, or aren't overtly manic. [In the lower functioning track are clients] who struggle more with acute symptoms such as, paranoia, delusions, or thought derailing, thought blocking, confusion, or mania" (personal communication, June 20, 2011).

In addition, daily assessment is implemented by reading nurses' notes, and observing clients' behaviors and gathering information from them in community meetings. This is primarily executed in the morning so that staff can decide on what interventions will be implemented for clients that day.

Treatment

Treatment interventions are planned after receiving information about the clients

during the community meeting. Participant A reported: “[The therapists] observe the clients and check in with how they are doing in that meeting. That guides us in what kind of interventions we are going to use later. Generally, I approach with a musical or non-musical activity. As the material comes up in group, I reflect on what the clients talk about and how it ties in with the cognitive therapy skills. Then we deal with an actual experience on what happened a week ago and what will happen next week” (personal communication, June 20, 2011).

Approximately three to four groups are offered daily and each session is scheduled for 50 minutes. Group titles are: “Distress Tolerance Skills”, “Mindfulness”, “Emotion Regulation”, “Stress Management”, and “Dual Diagnosis/Substance Abuse Groups.” Participant A explained that music therapy interventions are incorporated within the aforementioned groups: “We do a lot of song-writing, or poetry writing set to music. [Clients] write statements in a structured group about their hopes, distresses, and worries. Then, together, we put the statements into a poem and set that to music. For ‘Emotion Regulation’ group, we do a series of songs in a songbook and the [clients] are asked to identify the emotions they think are expressed in the music, and [compare and contrast] that [with] the emotions they are feeling and experiencing in the moment. In the context of that, we have a discussion on: How do you recognize emotions? How do you feel them? Somatically in your body, do you notice them?” (personal communication, June 20, 2011).

Improvisation is another music therapy intervention that is used. Participant A provided a step by step explanation of an improvisation session utilizing Orff-based instruments as follows: “I set the instruments out for the clients and play them in advance

so the clients have an idea of what they sound like. Then I ask the clients to choose something that they are interested in. While the clients are testing out the instruments, I [watch] to see who has musical skills, interest, or is hesitant to play. This information, gained by observing for a few seconds, helps guide me in terms of shaping the music therapy improvisation. Usually in context of either ‘Mindfulness’ or ‘Emotion Regulation,’ I’ll either start with a pattern [on the bass xylophone], or if I’m noticing someone who is ready to step into it, I’ll invite that person to join in and drop out as [he or she] chooses. The improvisation typically goes from 3 to 4 minutes then 10 to 12 minutes. I notice how it evolves and changes by looking around to see who is playing, in what way, who is listening to who while noticing the effect of the people playing, and how the music comes to a close” (personal communication, June 20, 2011).

Evaluation

Due to the short stay on the acute unit, daily evaluation is important to monitor progress. Informal meetings with other therapists are held daily. Participant A explained: “We notice any changes, improvements in the clients, and how they responded to a particular intervention. It’s important for us to observe changes and improvement to determine if the client is ready [for discharge]” (personal communication, June 20, 2011).

Benefits

Participant A shared confidently on the benefits of working in a cognitive-behavior approach: “Efficacy summarizes this orientation. I want to do what works. In DBT, I have quite a bit of freedom to use expressive arts so it isn’t constricting. As [DBT] has evolved in the country [United States], clients’ mental health improves quickly; however, [clients] eventually drop out of treatment because they get frustrated with it” (personal

communication, June 20, 2011).

Challenges

Participant A expressed frustrations about frequent relapses amongst clients. He stated that within his particular site, there were “many clients who have been in treatment for years.” He continued by explaining that the clients who deal with serious long term conditions evoke frustrations frequently during group sessions. He explained that emotions have to be monitored as some clients may seek support from external means. Therefore, Participant A provided clients with an existential-humanistic approach. Yalom’s existential factor on Altruism encouraged clients to reach out to each other and to not give up. He emphasized the importance of client to client support because “the therapist can't offer. It's important to pay attention to the existential factors because it is a life long struggle for many of our clients” (personal communication, June 20, 2011).

Therapist B: Psychodynamic Theory and Music Therapy

Participant B is part of a rehabilitation department, consisting of two art therapists, two occupational therapists, two addiction counselors, and 12 recreation therapists. Her main focus within the psychodynamic orientation is to assist clients to recognize their transference through music. By gaining insight into their issues, clients are able to work towards their goals. Participant B emphasized that along with building a deeper understanding of herself and the significance of countertransference, treatment was most effective when “the cause of their maladaptive behaviors” is addressed (personal communication, May 17, 2011).

Assessment

Upon receiving a referral from psychiatrists, social workers, or nurses at her

facility, Participant B reviewed the client's chart, conducted a verbal interview, and invited the client to a group music therapy session as part of her assessment process. Although published assessment measures are not utilized, Participant B has personally designed an assessment tool suitable for the setting. Included in the assessment is the client's relationship with the rest of the group within the session, observations of the client's relatedness to music, and his or her ability to express thoughts through songs, musical improvisation, and vocal improvisation. Specifically, in a music improvisation assessment, Participant A noted client's ability to maintain a steady beat, repeat phrases on instruments, level of dependency on the therapist, and the client's relationship with the music.

During the vocal improvisation assessment, Participant B explained how clients interact and respond to the music with their voice: "I get on the piano and invite them to sing with me. Some people refuse to sing, or hum. Sometimes, people rap. I want to see what they do musically, and I [observe] the quality of their behaviors and their music" (personal communication, May 17, 2011).

Aside from simply assessing the client's musicality, other factors are considered. If some form of resistance occurs from either the music therapist or client, countertransference or transference can be present. Participant B has worked through this resistance by bringing in a familiar experience to introduce clients on music therapy. She explained "If they aren't feeling safe, then I need to let them feel safe. So I'll ask, 'What do you want to do' If they have no clue and not do anything, then I'll say, 'Just breathe with this music. You do it all the time.' When they do that, it gives them a sense of participating in the music, but they are not forced to do it" (personal communication,

May 17, 2011). Then, she allowed clients to take the lead as she attempted to connect with clients' emotional and mental states at that moment.

Treatment

Music therapy groups are provided daily, with approximately 15 group meetings per week. Groups are formed based on client's skills and needs. A common goal for all clients is to gain an understanding of themselves through interactions with others to assist with the self-awareness process. In order to assist clients in working towards their goals (as mentioned in the assessment section), transference and counter transference are an important aspect of treatment. Participant B stated: "I am very aware of the transference issues that come up musically. I try to use [them in] working towards their goals; to help them understand or move towards their goals" (personal communication, May 17, 2011).

Aside from incorporating transferences that occurred in group sessions, Participant B discussed how she works through countertransference after the sessions: "I do a lot of self-care things where I improvise, cry, or write a song about how I am feeling. I also go to peer supervision and receive supervision from an art therapist [at my facility]. So, during sessions, I'm more aware of [the countertransference]. Sometimes I'm not aware of it until after [the sessions or even] or a week later" (personal communication, May 17, 2011).

Treatment also involved assisting clients in emotionally bridging the gap between their past and present. Various music interventions (i.e., song-writing and analyzing songs) are used to bring up issues related to the client's past. "Songs provide them [with a perspective] other than saying this happened to me, or I did this, or I felt this. Instead, the clients say, 'I can understand why I felt that way because I've felt it once.' Songs allow

them to [explore a] topic, memory, thought, or feeling” (personal communication, May 17, 2011).

Participant B utilized all three levels of practice in her treatment (supportive/activity-oriented, insight-re-educative, and reconstructive/analytical and catharsis-oriented music therapy). “I feel that I work in all of those levels at various times. Definitely insight is a major long term goal for my population. There have been individuals with whom I worked in a more cathartic or analytical way usually through improvisation” (personal communication, May 17, 2011).

Evaluation

Participant B has evaluated her clients’ weekly by re-assessing their relationship to themselves, others, and music through improvisations. Opportunities were provided for clients to explore various emotions (e.g., fear, hesitancy, etc.) related to their week on the unit or upcoming discharges. Participant B explained: “Sessions are predictable in the beginning, however to assist the transition musically, clients are pushed out of their comfort zone through musical changes within the improvisation” (personal communication, May 17, 2011). The improvisation is guided by what the clients are providing. Sometimes, Participant B initiated the change and transition to challenge the clients’ comfort level within the musical interaction. This method is most prominent in evaluating a client’s readiness for discharge; eventually transitioning clients from long-term inpatient care into the community.

Terminating with clients who are being discharged is an important process, especially in a long term facility. Participant B noted that, unfortunately, she does not always have the opportunity to terminate, due to unforeseen circumstances. For example,

a client may continuously decline while attending an assigned group. Or a client's psychosis may be affecting the group process due to non-compliance with medication at the facility, at which point the client is excused until further notice. Participant B described her experience with termination as follows: "I often feel that my termination is not really guided by what we are doing, but more so what is happening externally in the clients' lives, such as the course of their court cases" (personal communication, May 17, 2011).

Benefits

Participant B shared that the process which occurs amongst the music, music therapist, and clients creates a unique dynamic in each session: "Together, we can create an environment to help facilitate their understanding of themselves, their expression, and their reception of acceptance. Many of them don't feel the acceptance anymore, but the music allows them to feel accepted. So it's the fact that when they are playing, they hear themselves and I'm playing with them" (personal communication, May 17, 2011).

Challenges

When countertransference impeded during a session, Participant B faced challenges. She related to a time in a group session when controlling behaviors were exhibited by a client. Participant B attempted to foster her countertransference musically to continue the process and provide a therapeutic space for the other clients. However, the musical process was interrupted and verbal directives were provided to the group due to Participant B's reaction towards the controlling client. As a result, Participant B approached this group differently than her norm. She elucidated: "I wanted to find a balance where [the client] could feel that he had self control, and that he was connecting

to others, but not controlling them, and not allowing that to feed into his narcissism. I really struggled with how to keep the music going and how to musically intervene instead of verbally. I wanted to protect one particular client and redirect the controlling client musically. I felt that a verbal redirection would cause him a narcissistic injury and might result in anger or acting out. At first, I thought it would be good for him to feel that anger and to process through it, but it wasn't appropriate during that group and would have perhaps been a negative experience for everyone. I ended up having to give directions so that each group member had a chance to lead the group. I was frustrated because within that group, the clients' needs were diverse, and it was frustrating trying to find a balance where I could musically address one client's avoidance and aggressiveness without feeding into his anti social issues, while still focusing on the other clients. I am still working on my countertransference issues with this particular client in relation to our 'power struggle' in the music" (personal communication, May 17, 2011).

Therapist C: Humanistic Theory and Music Therapy

Participant C has been working within the Creative Arts Therapy department in a hospital employing 20 therapists that provides art, dance, drama, and music therapy. Creative arts therapies are provided on different units throughout the hospital. Participant C and a leisure therapist provide services on the acute inpatient unit. Although the average stay is typically two weeks, depending on a client's discharge plans, a client can be hospitalized for six months or up to one year.

Assessment

Participant C reported that within 72 hours of a client's admission, an individual verbal assessment is conducted. The following information is obtained: reason for

admission, education, marital status, legal history, life skills, leisure activities, and family background. During the assessment, Participant C also assessed the client's attention span and ability to participate in groups. Information collected for the assessment is used by the entire Activity Therapy department.

Furthermore, Participant C assessed clients musically through instrumental improvisation at the beginning of any group music therapy session. The musical improvisation provided an opportunity for clients to express themselves immediately. As clients contributed in the improvisation, Participant A formulated observations of clients' overall present level of functioning.

Treatment

Music therapy groups are offered three times a week for 45 minutes each session. Participant C stated: "Because some [clients] are not stable, their attention span fluctuates. Therefore, even though [sessions are] scheduled for 45 minutes per session, groups sessions can last less than 45 minutes or more. I respect the [clients'] current state and what they want to do. I rely on the clients to tell me" (personal communication, June, 9, 2011). Depending on clients' reaction or presentation of themselves in groups, Participant C identified this level of practice as supportive/activity-oriented and insight/re-educative goals.

Instrumental improvisation, songs, and vocal work are three primary interventions utilized in music therapy groups. The therapeutic process developed throughout sessions because the music therapist offered space for clients to express their current status, mentally and emotionally, through improvisation. Participant C reported that he leads the group at the beginning of most sessions, and then allows clients to take control of the

group. He provided an example of a vocal intervention: “I use techniques like vocal holding and toning. In the beginning, I ask [the clients] to deeply breathe in and out. When breathing out, we make sounds together on syllables like “ah” or “ooh.” Then gradually, we build up cohesion. When clients reach [a cohesion of sound], they take leading roles in that process. Some clients make a different sound and others may follow that. Because [clients] are only here for two weeks, I focus on using the voice and improvisation to help them express their thoughts” (personal communication, June 9, 2011).

Evaluation

Participant C’s weekly progress notes include evaluations of each music therapy group by examining clients’ attention spans, levels of participation, awareness of their personal issues and thoughts, and their ability to express themselves; in relation to their symptoms and what they have learned in psycho-education groups. Based on Participant C’s notes, he meets with the treatment team to discuss clients’ discharge plans.

Benefits

According to the humanistic perspective, providing space and freedom for self-expression of clients’ emotions are important. The focus is on clients’ gaining confidence through support to assist them with their own therapy process. The therapist is simply a facilitator if the clients, for instance, exhibit uncertainty in the middle of an improvisation. The benefit of working in this theoretical orientation allows clients to support one another and to explore thoughts without fear of disapproval from the therapist.

Challenges

Although support and safe space are provided in groups, therapist's face the challenge of knowing how much involvement is needed. Due to the intensity of an acute unit, clients' involvement in treatment is important for continuous evaluation. Participant C stated: "When [clients] are quiet and passive, they need a lot of encouragement to speak up. Resigning from participation is okay, but this is a place where I want [clients] to develop something within a short amount of time." (personal communication, June 9, 2011).

Refer to Table 2 for an outline of benefits and challenges.

Table 2: Benefits and Challenges

	Benefits	Challenges
Participant A (Cognitive-Behavior)	CBT demonstrated efficacy. Music is incorporated into cognitive-behavior techniques to enhance the experience for the clients.	Clients experienced immediate satisfaction, but have difficulty continuing with treatment post discharge because clients may have difficulty generalizing skills taught in music therapy to everyday living.
Participant B (Psychodynamic)	Facilitated therapy sessions to allow the clients to bridge their past and present, and to acknowledge transferences to help facilitate the therapy process deeper.	Participant B struggled to use countertransference in a therapeutic space to direct a session through music experiences when her feelings were impeding in the moment towards a client.
Participant C (Humanistic)	Participant believed clients need their own space and freedom to take personal responsibility in their treatment.	Clients who were withdrawn in participating in therapy sessions, the therapist struggled to decide how much he should direct those clients within a short period.

Discussion

Finding a participant who designated his or herself as a cognitive-behavior orientated music therapist was a challenge. Many prospective participants were either psychodynamic or humanistic oriented music therapists. This particular challenge in locating a music therapist who claimed to practice using exclusively cognitive-behavior techniques was surprising, as most recent studies (Cassity, 2007; Choi, 2008; Silverman, 2007) reported that the majority of music therapists practice under CBT. Fortunately, I was able to find music therapists from each of the theoretical orientations to interview.

All three participants shared similar music interventions using improvisation and songs in music therapy with adults residing in inpatient units. However, each therapist highlighted different aspects of intervention that assisted their clients in reaching their goals. It was clear that each music therapist incorporated his or her own style based on his or her training and experiences. According to the responses of each therapist, while all appeared to work under their self-declared orientation, they were not doing so exclusively. For instance, Participant A, of cognitive-behavior orientation, incorporated existential-humanistic theories into his clinical work when encountered with clients who were relapsing and seeking support. Participant B, of psychodynamic orientation, commented that clients have their own responsibility to participate in their treatment, which is supported by humanistic theory. Participant C, of humanistic orientation, included a CBT goal during group sessions, such as coping skills. Additionally, all three participants had difficulty identifying key observations produced by the clients during music therapy interventions. Furthermore, they struggled to correlate their clinical work with their respective orientations. However, all three participants acknowledged their

own integration of the different theories, despite their professional commitment to one particular orientation. Similarities and differences between all three participants in the areas of assessment, treatment, evaluation, benefits, and challenges are discussed in the following sections.

Assessment

To perform an assessment, all three participants conducted a verbal interview and an informal music assessment. While all three music therapists obtained information on clients' social, cognitive, emotional, vocational, and communicative levels, they used different methodologies to do so. Both Participants B and C assessed their clients through improvisations. However, each held different focuses. Participant B observed the relationships amongst the clients within group sessions, whereas Participant C observed what the clients were producing musically and their motivation to participate in therapy. Participant B incorporated both verbal interviews and musical assessments with her clients, which demonstrated a more balanced method of assessment than Participants A and C. Another similarity amongst the participants is the absence of emphasis on a client's physical abilities; specifically, gross and fine motor skills, range of motion, postural stability, etc. This consistency amongst all three Participants and their respective therapies is secondary to the stress placed on improving a client's mental health. Participants A and C further validate this point as they state that their main treatment objective is to stabilize their clients' psyche in time for discharge. As such, the aforementioned is a universal goal in all other acute inpatient psychiatric units (Gfeller & Thaut, 2008).

Types of assessments used throughout the course of treatment are a direct result of

a facility's average length of stay. For instance, while the majority of the clients at Participant B's long-term facility were admitted for a minimum of five years, clients in Participants A and C's short-term sites were admitted on an average range of seven to fourteen days. Due to the relatively short duration of treatment provided in the latter facilities, verbal interviews served as the primary form of assessment and interaction upon admission.

Treatment

Treatment for clients in Participant B's facility spans several years as it is provided in a long-term facility. As the same groups of clients collaborate weekly in group therapy sessions, all group members continuously build rapport with each other throughout the treatment period. Conversely, Participants A and C have felt interventions to be rushed because clients reside in their facilities for a short period of time. Attendance for sessions fluctuated depending on the new admissions and discharges that occur daily, which made the progress in sessions challenging because of the unpredictability in turnover. Due to the length of short-term hospitalization, Participant C, in particular, may find it frustrating to practice exclusively in the humanistic approach.

Aside from the length of hospitalization of the facilities and the participants' respective theoretical orientations, clients' immediate level of function and needs as well as participants' personal beliefs appeared to impact the participants' decision in implementing music interventions. Participant A planned activities based on the topics clients reported in the morning. Music would not always be used in some sessions to promote change in the clients' thoughts and behaviors because Participant A believed in incorporating other expressive modalities to educate clients about various skills to

function in the community. Contrarily, Participant B allowed the music therapy process to occur naturally. Sometimes, based on clients' presented symptoms, she provided the clients with themes to structure the beginning of the session then allowed the therapy process to unfold through the use of transference and countertransference. She advocated for her clients to accept responsibility in promoting their personal health, which overlapped with the humanistic orientation. Still, Participant C provided his clients with opportunities to musically improvise to help clients adapt to their surroundings which then addressed their goals. Additionally, two music therapy interventions, Participants B and C utilized were improvisation and songs with verbal discussion in music therapy groups. Participant B used songs as a tool to facilitate communication of thoughts, feelings, memories, and clients connecting with each other through a shared experience. Similarly, Participant C stated that using songs are a way to "reach someone's heart" to connect with others through a collaborative activity of singing (personal communication, June 9, 2011). Participant C promoted and encouraged clients to take initiative and to work together as a group through suggesting and singing songs. Ultimately, all the music therapists always observed clients' attention span and readiness to participate.

The participants identified several goals and objectives for improvisation. Participant B utilized transference and countertransference issues that may arise during a musical improvisation to facilitate the therapeutic process by offering clients an opportunity to communicate with other group members and express their thoughts and feelings musically rather than verbally. Also, improvisation is utilized with the purpose of assisting clients with their transitions out of the facility. While all these points are important Participant B interestingly did not discuss other aspects relating to a

psychodynamic perspective. For instance, improvisation may represent the unconscious mind, the psychodynamic theory, in which the id manifested itself and the ego is strengthened. In the case of Participant C, he viewed improvisation as a time for clients to interact and connect with one another. Clients became aware of the importance of listening and their connection with their immediate environment, which is similar with the humanistic orientation on working towards relationships and becoming aware of oneself.

In addition, Participant A chose to focus on the behavioral and cognitive changes that music can bring for each individual. Structured improvisation is used to promote awareness in each individual to emphasize changes in behavior and cognitive thinking. Participant A emphasized to his clients their role in treatment and what changes they needed to make in order to successfully work together as a group. Also, he knowingly incorporated Yalom's (2005) existential theory for clients to support one another and provide a space for them to relate. Perhaps, Participant A's training in level two for GIM may have impacted his perspective that clients need more than just skills in treatment.

Overall, each participant struggled to explain how his or her principle and constructs of his or her theoretical orientation translate into the function and role of music. While listening to participants, I noticed hesitancy in their ability to provide clinical music therapy examples to support their respective theoretical orientation. I am convinced, as a researcher, how pertinent level of training and experience is needed within the field of music therapy.

Evaluation

Participants A, B, and C, struggled to provide a coherent description of their

individual evaluation processes. All participants reported using their own personal observations rather than a standardized format or evaluation tool. Specifically, Participant A focused on his clients' response to either musical experiences or other non-musical activities. Frequently, results of client evaluations were discussed with other therapists to determine if the skills and techniques taught in a short period of time had an immediate effect on the clients.

Participant B used music improvisations, the same assessment tool during the initial interaction, to evaluate her client's progress in therapy. Due to Participant B's long-term setting, her clients had the advantage of numerous and repeated evaluations that assisted in preparing for discharge. This allowed Participant B to adequately prepare clients with the skills to transition out of the therapeutic setting without abruptly terminating services as often noted in Participant A and C's facilities.

Participant C monitored level of participation in music therapy groups as his primary form of evaluation. Additionally, he also relied on clients self-report of their progress and the skills learned in group therapy sessions. This practice of having clients take responsibility of their treatment is consistent with both the humanistic and CBT perspective.

Benefits

Contrary to the participants' difficulties explaining their personalized evaluation methods, participants spoke freely about the specific benefits of their relative theoretical orientation. Additionally, they agreed that music is the primary therapeutic tool that assists clients in progressing towards their goals. The following benefits were noted of upon completing analysis of each participant's responses:

- Within the cognitive-behavior orientation, clients are provided with guidance that assists them to build skills associated with coping, regulating emotions, and building mindfulness. Discussing clients' experiences and reactions to direct musical intervention during group sessions allow clients to grow and become aware of how their personal experiences effect their actions, feelings, and thoughts.
- Within the psychodynamic orientation, group therapy sessions are facilitated so that clients can bridge their past with their present reality. It is imperative that this connection is made as this allows an opportunity for clients to also focus on their inter/intrapersonal relationships. As many of the clients exhibit antisocial behaviors, music therapists overcome this challenge using improvisations or songs so that empathy may be experienced in response to each others' reality.
- Within the humanistic orientation, clients are provided the opportunity to make decisions surrounding their therapy activities. In inpatient settings, resources are generally limited, which, in conjunction with being on a locked unit, causes clients to exhibit frustration. Thus, in group music therapy sessions, clients are highly motivated to make decisions independently and actively participate in their treatment, which further improves prognosis and effectiveness of humanistic therapy.

Challenges

While clear differences regarding the benefits between each theoretical orientation were noted, this was not observed for challenges. Specifically, Participants B and C

expressed similar challenges and shared examples of deterring from their respective orientations during encounters with clients who are highly resistant to the treatment method of the respective orientation. Participant B reported instances of personal struggle to continue providing treatment based solely on psychodynamic orientation when clients insufficiently responded to interventions focused on eliciting countertransference.

Participant C considered clients' diagnoses in such situations where as Corey (2009) highlights the therapist within a humanistic orientation should focus solely on the client and not the symptoms he or she is presenting. Participant C interchanged between the Humanistic and CBT orientations because he may have felt pressured from his facility to demonstrate efficient changes in his clients. Thus, he conducted therapy sessions educating clients on health coping skills.

Participant A expressed frustrations of seeing clients relapse. Post discharge, clients may experience difficulty regulating their emotions or thinking positively without the reinforcement of music or similar resources they used when hospitalized. Music motivated clients to participate in their treatment in group sessions, but the connection between music and learning skills may not have always been transferable for clients to understand. Relapse is a consistent issue psychiatric facilities experience. Similar frustrations have been expressed by mental health workers (Appelby, Luchins, Gibbons, & Hedeker, 1993; Cleary, 2004) servicing clients in various types of facilities under the facility's philosophy. Despite uncontrollable situations that occur within therapy sessions, Rogers (1961) summarized that the therapist's outlook impacts the client's want and need to change, rather than the required knowledge, theories, or techniques necessary as a therapist.

Conclusions

Summary

The purpose of this study was to examine how music therapists, based on their respective theoretical orientations, implement music experiences into their clinical work. I also examined the benefits that these music therapists receive and the challenges that they face. Three music therapists who work in adult psychiatric settings were interviewed. They provided clinical examples of group sessions related to their theoretical orientations and explained their assessment, treatment, and evaluation processes. After receiving information, a descriptive analysis method was employed analyzing data and creating a synopsis.

Limitations

This study has three limitations. First, the setting of the inpatient facility could be either acute or long-term. The similarities and differences in the clinical work of Participant A was harder to compare than the work of Participant B and C, due to the differences in average length of stay. Second, the information regarding non-verbal communication such as, facial expressions and body language during the interviews, may have been valuable, if videoconference or face-to-face interaction were available. Third, the participants reported pertinent information themselves. Therefore, it may have been their subjectivity that influenced the findings of the study.

Implications for Music Therapy Practice

The findings of this study are limited to demonstrating how music therapy services are provided in an inpatient setting. Additional findings include an emphasis on the therapists' influences, and their personal preferences in conducting music therapy groups.

Choi (2008) iterates the importance for therapists to be aware of their theoretical orientation. Perhaps due to the diverse nature of the population, an eclectic approach is necessary to conduct music therapy sessions. Working under the same model as the employee's facility is important as it may provide music therapists the opportunity to receive further education in servicing their clients, in which the therapist may feel supported by the facility. Applying the same orientation as the facility may help keep the multidisciplinary team consistent when providing treatment for the clients.

Implications for Music Therapy Education and Training

Choi (2008) emphasizes that music therapists are responsible for understanding the role of music as a clinical tool and how theoretical orientations influence their practice. Based on the responses of the three participants, it is evident that their level of training and their clinical experiences has influenced the development of their orientation. As a result of training and experience, clinicians can better explain their beliefs and principles regarding how they provide treatment for their clients. Likewise, students currently training should begin to consider their influences in their clinical practicum.

An important factor in becoming an effective clinician depends on the theoretical orientation and advanced training of an individual. Thus, advanced training is recommended for music therapists such as, Nordoff-Robbins Music Therapy (NRMT), Analytical Music Therapy (AMT), and Guided Imagery and Music (GIM). I hope that continued education and advanced trainings will help music therapists communicate how music therapy goals can translate into nonmusical goals while emphasizing the benefits and cost efficiency of having a music therapy program in an inpatient psychiatric unit.

Lastly, supervision is imperative when working with the mental health population. Students and professionals should seek supervision to continue growth within their clinical practices. Supervision also enables one to gain insight for his or herself while examining how their theoretical approach shapes and effects a group therapy session. Each clinician is responsible for being aware of the treatment he or she is providing for his or her clients.

Recommendations for Future Study

Future studies should closely examine how music therapists within the same orientation view their clinical work, as well as compare the similarities or differences behind the styles and techniques used. These types of examinations can enhance the theoretical understanding, and also demonstrate how to effectively implement psychological theoretical orientations within music therapy. It is vital that we continue to conduct studies on this topic. Learning directly from music therapists about their clinical work will not only help further the education of those in the field, but in other professions as well.

A heuristic study would be beneficial for music therapists to have a greater understanding of the perspective from a client, and how the therapists' clinical work is being perceived. The participant, who is also the researcher, participates in three different sessions respective to each theoretical orientation to report on his or her experience. As clinicians, it is important to receive feedback from the people directly participating in treatment.

My Future Plan

From interviewing other music therapists in the psychiatric field, I am inspired and

encouraged to continue on my career path as a clinician providing music therapy services to clients diagnosed with mental disorders. Reflection on my own work occurred continuously throughout the research process, as I listened to the participants' stories and related to their descriptions of the experiences they have had in their clinical work. Continuing clinical supervision is important for me as I will be seeking support and feedback from my colleagues, who are experienced music therapists. Furthering my training in BMGIM is an interest of mine, although I may not be able to use BMGIM directly with the inpatient psychiatric population. I would like to learn more about the different techniques in BMGIM to help mold me as a clinician. A psychodynamic approach to music therapy continues to entice me as a clinician and I would like to primarily work under that orientation. However, based upon the participant's interviews, I understand the importance of being flexible in a session and perhaps adapting other theoretical orientations to serve the needs of my clients at the moment.

I hope that other music therapists who practice in a similar setting can relate to the music therapists who have shared their stories with me. Perhaps this will encourage therapists to reflect on their own clinical work and how they have been conducting therapy sessions. Lastly, I hope that the findings of this study may provide more insight on how other music therapists align their clinical work with their respective orientation, and provide effective services for adults residing in inpatient psychiatric settings.

References

- Aigen, K. (1998). *Paths of development in Nordoff-Robbins music therapy*. Gilsum, NH: Barcelona.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (text revision). Washington, DC. Author.
- Appelby, P. N., Luchins, D. J., Gibbons, R. D., & Hedeker, D. R. (1993). Length of stay and recidivism in schizophrenia: a study of public psychiatric hospital patients. *The American Journal of Psychiatry*, 150, 72-76.
- Austin, D. (1996). The Role of Improvised Music in Psychodynamic Music Therapy with Adults. *Journal of Music Therapy*, 14 (1), 29-43.
- Bonny, H. L. (2002). Sound as symbol: Guided imagery and music (GIM) in clinical practice. In L. Summer (Ed.), *Music Consciousness: The evolution of guided imagery and music* (pp. 131-140). Gilsum, NH: Barcelona Publishers.
- Boxberger, R. (1962). Historical bases for the use of music in therapy. In E. H. Schneider (Ed.), *Music therapy 1961* (pp.125-166). Lawrence, KS: Allen Press.
- Braswell, C., Brooks, D. M., Decuir, A. A., Humphrey, T., Jacobs, K. W., & Sutton, K. (1983). Development and implementation of a music/activity intake assessment for psychiatric patients: I. Initial standardization procedures on data from university students. *Journal of Music Therapy*, 20(2), 88-100.
- Braswell, C., Brooks, D. M., Decuir, A. A., Humphrey, T., Jacobs, K. W., & Sutton K. (1986). Development and implementation of a music/activity therapy assessment for psychiatric patients: II. Standardization procedures on data from psychiatric patients. *Journal of Music Therapy*, 23(3), 126-141.
- Broadley, B. T. (1997). The nondirective attitude in client-centered therapy. *The Person-centered Journal*, 4(1), 18-30.
- Bruscia, K. E. (1987). *Improvisational models of music therapy*. Springfield, IL: Charles C. Thomas.
- Bruscia, K. E. (1998). *Defining music therapy* (2nd Ed). Gilsum, NH: Barcelona Publishers.
- Bruscia, K. E. (Ed.). (1998). *The dynamics of music psychotherapy*. Gilsum, NH: Barcelona Publishers.

- Bruscia, K. E. (2002). A psychodynamic orientation to the bonny method. In K. E. Bruscia & D. E. Grocke (Eds.), *Guided imagery and music: The Bonny method and beyond* (pp. 225-243). Gilsum, NH: Barcelona Publishers.
- Cain, D. J. (1986). Editorial: A call for the “write stuff.” *Person-Centered Review*, 1(2), pp. 117-124.
- Cassity, M. D. (2007). Psychiatric music therapy in 2016: A delphi poll of the future. *Music Therapy Perspectives*, 25(2), 86-93.
- Choi, B. C. (1997). Professional and patient attitudes about the relevance of music therapy as a treatment modality in NAMT approved psychiatric hospitals. *Journal of Music Therapy*, 34, 277-292.
- Choi, B. C. (2008). Awareness of music therapy practices and factors influencing specific theoretical approaches. *Journal of Music Therapy*, 45, 93-109.
- Clair, A. A., & Heller, G. N. (1989). Willem Van de Wall (1887-1953): Organizer and innovator in music education and music therapy. *Journal of Research in Music Education*, 87(3), 165-178.
- Cleary, M. (2004). The realities of mental health nursing in acute inpatient environments. *International Journal of Mental Health Nursing*, 13(1), 53-60.
- Corey, G. (2009). *Theory and practice of counseling and psychotherapy* (8th ed.). Belmont, CA: Thomson Brooks/Cole.
- Covington, H. (2001). Therapeutic music for patients with psychiatric disorders. *Holistic Nursing Practice*, 15, 59-69.
- Crowe, B. J., & Colwell, C. (Eds.). (2007). *Effective clinical practice in music therapy: Music therapy for children, adolescents, and adults with mental disorders*. Silver Spring, MD: American Music Therapy Association.
- Darrow, A. (2004). *Introduction to approaches in music therapy*. Silver Spring, MD: American Music Therapy Association, Inc.
- Ellis, A. (2001a). *Feeling better, getting better, staying better: Profound self-help therapy for your emotions*. Atascadero, CA: Impact Publishers.
- Ellis, A., Shaughnessy, M. F., & Manhan, V. (2002). An interview with Albert Ellis about rational emotive behavior therapy. *North American Journal of Psychology*, 4(3), 355-366.
- Eschen, T. E. (2002). *Analytical music therapy*. Philadelphia, PA: Jessica Kingsley Publishers.

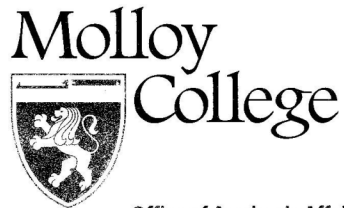
- Gabbard, G. O. (2005). *Psychodynamic psychiatry in clinical practice* (4th ed.). Arlington, VA: American Psychiatric Publishing, Inc.
- Gfeller, K. E., & Davis, W. B. (2008). The music therapy treatment process. In Davis, W. B., Gfeller, K. E., & Thaut, M. H., *An introduction to music therapy theory and practice* (p. 424-429.). Silver Spring, MD: American Music Therapy Association, Inc.
- Gfeller, K. E., & Thaut, M. H. (2008). Music therapy in the treatment of behavioral-emotional disorders. In W. B. Davis, K. E. Gfeller, & M. H. Thaut, *An introduction to music therapy theory and practice* (pp. 209-246). Silver Spring, MD: American Music Therapy Association, Inc.
- Hadley, S. (Ed.). (2003). *Psychodynamic music therapy: Case studies*. Gilsum, NH: Barcelona Publishers.
- Jones, A. (2006). Multidisciplinary team working: Collaboration and conflict. *International Journal of Mental Health Nursing*, 15(1), 19-28.
- Leichsenring, F. & Leibing, E. (2003). The effectiveness of psychodynamic therapy and cognitive behavior therapy in the treatment of personality disorders: A Meta-Analysis. *American Psychiatric Association*, 160, 1223-1232.
- Lincoln Y. S. and Guba, E. G. (1985) *Naturalistic Inquiry*. Sage, Newbury Park, CA.
- Loewy, J. (2000). Music psychotherapy assessment. *Music Therapy Perspective*, 18(1), 47-58.
- Meadows, A. (2002). Distinctions between the Bonny Method of Guided Imagery and Music (BMGIM) and other imagery techniques. In K. E. Bruscia & D. E. Grocke (Eds.), *Guided imagery and music: The Bonny method and beyond* (pp. 63-83). Gilsum, NH: Barcelona Publishers.
- Merriam, S. B. (1998). *Qualitative research and case study applications in education* (Rev. ed.). San Francisco: Jossey-Bass Publishers.
- McGuire, M. G. (Ed.). (2004). *Psychiatric music therapy in the community: The legacy of Florence Tyson*. Gilsum, NH: Barcelona Publishers.
- Michel, D. E. (1985). *Music therapy: An introduction, including music in special education* (2nd ed.). Springfield, IL: Charles C Thomas.
- Miller, H. O. (2006) Group improvisation therapy: The experience of one man with schizophrenia. In K. E. Bruscia (Ed.), *Case studies in music therapy* (pp. 417-431). Gilsum, NH: Barcelona Publishers.

- Murphy, K. (2007). Experiential learning in music therapy: Faculty and student perspectives. In A. Meadows (Ed.), *Qualitative inquires in music therapy: A monograph series* (pp. 31-61). Gilsum, NH: Barcelona Publishers.
- Neher, A. (1996) Jung's theory of archetypes: A critique. *Journal of Humanistic Psychology*, 36, 61-91.
- Nordoff, P., & Robbins, C. (1977). *Creative Music Therapy*. New York: Harper and Row Publishers.
- Peters, J. (2000). Music therapy for adults who have mental or behavioral disorders. In J. Peters (2nd ed.), *Music therapy an introduction* (pp. 237-264). Springfield, Illinois: Charles C. Thomas Publisher.
- Pederson, I. N. (2002). Analytical music therapy with adults in mental health and in counseling work. In J. T. Eschen (Ed.), *Analytical Music Therapy* (pp. 64-84). Philadelphia, PA: Jessica Kingsley Publishers.
- Rogers, C. (1961). *On becoming a person*. Boston: Houghton Mifflin.
- Segal, Z., Whitney, D., Lam, R., & CANMAT Depression Work, G. (2001). Clinical guidelines for the treatment of depressive disorders. III. Psychotherapy. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie*, 46, 307-378. Retrieved from EBSCOhost.
- Silverman, M. J. (2007). Evaluating current trends in psychiatric music therapy: A descriptive analysis. *Journal of Music Therapy*, 44(4), 388-414.
- Silverman, M. J. (2008). Quantitative comparison of cognitive behavioral therapy and music therapy research: A methodological best practices analysis to guide future investigation for adult psychiatric patients. *Journal of Music Therapy*, 45(4), 457-506.
- Silverman, M. J. (2009). The effect of single-session psychoeducational music therapy on verbalizations and perceptions in psychiatric patients. *Journal of Music Therapy*, 46(2), 105-131.
- Smeijsters, H., & Aasgard, R. (2005). Qualitative case study research. In B. L. Wheeler (Ed.) *Music Therapy Research (2nd Ed.)* (pp. 440-457). Gilsum, NH: Barcelona Publishers.
- Smither, R. (2009). Existential and humanistic psychotherapies. In D. C. S. Richard & S. Huprich (Eds.), *Clinical psychology: Assessment, treatment, and research* (pp. 309-326). Burlington, MA: Elsevier Academic Press.

- Stiles, W. B., Barkham, M., Mellor-Clark, J., & Connell, J. (2008). Effectiveness of cognitive-behavioural, person-centered, and psychodynamic therapies in UK primary-care routine practice: replication in a larger sample. *Psychological Medicine, 38*, 677-688.
- Tyson, F. (1981). *Psychiatric music therapy: Origins and development*. New York: Fred Weidner & Sons.
- Unkefer, R. F. & Thaut, M. H. (2002). *Music therapy in the treatment of adults with mental disorders: Theoretical bases and clinical interventions*. St. Louis, MO: MMB Music, Inc.
- Ventre, M. (2002). The individual form of the Bonny method of guided imagery and music. In K. E. Bruscia & D. E. Grocke (Eds.), *Guided imagery and music: The Bonny method and beyond* (pp. 29-35). Gilsum, NH: Barcelona Publishers.
- Wheeler, B. L. (1983). A psychotherapeutic classification of music therapy practices: A continuum of procedures. *Music Therapy Perspectives, 1*, 8-12.
- Wigram, T. & Backer, J. D. (1999). *Clinical applications of music therapy psychiatry*. London: Jessica Kingsley Publishers.
- Yalom, I. D. (2005). *The theory and practice of psychotherapy* (5th ed.). Cambridge, MA: Basic Books.

Appendices

Appendix A



1000 Hempstead Ave., PO Box 5002, Rockville Centre, NY 11571-5002
www.molloy.edu

Office of Academic Affairs
T: 516.678.5000
F: 516.256.2261

Date: February 23, 2011
To: Angel Park
From: Lillian Bozak-DeLeo, Ph.D.
Chair, Molloy College Institutional Review Board

I am pleased to inform you that your proposal, "Theoretical Orientations Applied by Music Therapists Working in Adult Psychiatric Inpatient Settings" has been approved by the Molloy IRB. You may proceed with your project.

Good luck with your research.

Lillian Bozak-DeLeo, Ph.D.

Informed Consent

Researcher:

Angel Park, MT-BC
(516) 395-3687
apark08@lions.molloy.edu

Faculty Advisor:

Seung-A Kim, PhD, AMT, LCAT, MT-BC
(516) 678-5000 x6348
skim@molloy.edu

Title: Theoretical Orientations Applied by Music Therapists Working in Adult Psychiatric Inpatient Settings

Dear (participant's name) ,

My name is Angel Park and I am a graduate student at Molloy College, located in New York. For my thesis, I am currently conducting a study regarding how music therapists apply their theoretical orientation (i.e., cognitive-behavior, psychodynamic or humanistic) when working with adults who have psychiatric disorders and reside on an inpatient hospital unit.

You have been recommended as a potential participant by music therapy educators as meeting the following criteria: 1) a board certified or licensed music therapist, 2) have been working as a music therapist in the United States for two or more years on an inpatient psychiatric unit, 3) provide music therapy in a group setting, 4) identifies strongly with one specific theoretical orientation: cognitive-behavior, psychodynamic, or humanistic and 5) is willing to discuss the benefits and challenges of using your theoretical orientation to inform your clinical work.

If you meet the criteria as mentioned above, you are invited to participate in this study. Should you agree to participate in this study; you will be asked to partake in a 30 to 60 minute Skype or phone interview which will be arranged at a mutually convenient time. This interview will be audio-taped (see below).

There is no foreseeable risk inherent with this study. However, if at any point during the interview you feel uncomfortable, I will check in with you before continuing with the interview. Additionally, you will have the opportunity to decline questions that you do not feel comfortable answering. After the interview, if necessary, you may be contacted via e-mail to follow-up for clarifications and/or salient points.

Please note that you will not be compensated for the study nor will there be a charge. Your confidentiality will be strictly maintained throughout with the use of pseudonyms. All the information collected will be kept in a secure and locked drawer in my office. Only I will have access to this information.

The Institutional Review Board at Molloy College has reviewed the study. If you have any questions about the study, please feel free to contact me at the number listed above. You may also contact my thesis advisor, Dr. Seung-A Kim at the information provided above. In addition, questions regarding your rights and confidentiality about the research may be directed to Ms. Lillian Bozak-Deleo at (516) 678-5000 x6608.

This thesis addresses a vital area of study and may provide information to music therapists and other related professionals regarding how group music therapy is utilized with adults who reside on an inpatient psychiatric unit. Your participation in this study is totally voluntary and you may withdraw at any time without penalty.

Please take the time to read, sign, and return (via e-mail) the attached informed consent. By returning this e-mail attached with the electronically signed consent forms, you consent to participate in this study. I will send another e-mail within a week as a reminder if you have not responded to this invitation.

Thank you.

Angel Park

Angel A. Park, MT-BC

Participant's signature

Date

Appendix C

Permission to Audiotape

Researcher:

Angel Park, MT-BC
(516) 395-3687
apark08@lions.molloy.edu

Faculty Advisor:

Seung-A Kim, PhD, AMT, LCAT, MT-BC
(516) 678-5000 x6348
skim@molloy.edu

Project Title: Theoretical Orientations Applied by Music Therapists Working in Adult Psychiatric Inpatient Settings

Date: _____

I, _____ (participant's name) _____, hereby agree to have my Skype or phone interview recorded for its full duration of 30-60 minutes. I give permission for the recording to be used from January 2011-December 2011. At no time will my name be used.

I understand that the recording will be used for research purposes only pertaining to this study. Additionally, I understand that I can withdraw from the study at any time. Upon request, the recording will not be used. I understand that I will not be paid for being recorded or for the use of the recordings. If I want more information or have questions or concerns regarding the recording, I can contact the researcher and/or faculty advisor at the contact information provided above. By signing below indicates my voluntary consent to be audio taped.

Signature

Date

Appendix D

Reminder E-mail

Dear (participant's name) ,

My name is Angel Park and I am currently conducting a study as part of the requirements for my Master's Degree in Music Therapy from Molloy College in New York. This is the one week reminder e-mail regarding a study I have recently invited you to participate. The topic of this study is how music therapists apply their theoretical orientation (i.e. cognitive-behavior, psychodynamic, or humanistic) when working with adults who have psychiatric disorders and reside on an inpatient hospital unit. This study addresses a vital area of study and may provide information to music therapists and other related professionals regarding how group music therapy is utilized.

Attached are two consent forms. If you meet the criteria and are interested in participating in this study, please sign the forms and return them to me at apark08@lions.molloy.edu by (date). Thank you for your consideration.

Sincerely,

Angel Park

Follow-up E-mail

Dear (participant's name) ,

Thank you for participating in this study regarding music therapist's theoretical orientation and experiences in group music therapy sessions with adults who have psychiatric disorders.

This is a follow-up e-mail regarding the interview. Attached are statements and salient points you have provided throughout the interview. Please read the attachment and respond by clarifying or agreeing the statements.

Thank you,

Angel Park