Planning for Spontaneity: Music Therapy Session Preparation, Structure and Procedures

Peri Strongwater
Lesley University, pstrongw@lesley.edu

Follow this and additional works at: https://digitalcommons.lesley.edu/expressive_theses

Part of the Social and Behavioral Sciences Commons

Recommended Citation
https://digitalcommons.lesley.edu/expressive_theses/49

This Thesis is brought to you for free and open access by the Graduate School of Arts and Social Sciences (GSASS) at DigitalCommons@Lesley. It has been accepted for inclusion in Expressive Therapies Capstone Theses by an authorized administrator of DigitalCommons@Lesley. For more information, please contact digitalcommons@lesley.edu, cvrattos@lesley.edu.
Planning for Spontaneity:

Music Therapy Session Preparation, Structure and Procedures

Capstone Thesis

Lesley University

April 30, 2018

Peri Strongwater

Music Therapy

Jason D. Butler, PhD, RDT-BCT
Abstract

Current research in the field of music therapy regarding productivity and efficiency is limited to exploring theoretical concepts and is lacking on the effects of implementing said theories. It will be advantageous for music therapists to adopt streamlined processes for recurring responsibilities such as session planning, preparation and post-session processing. Increased productivity in these endeavors will permit more time allocated towards more valuable undertakings. To expand upon the emerging data and to contribute to the field’s current understanding, this writer has designed a session structure model exclusively for music therapists to use in their clinical practices. A worksheet-based template was found to be a productive method in which to efficiently design session plans. Additionally, the template was useful as a processing tool to support documentation, evaluation and organizational needs for treatment plan development. Results indicated that using this template is a viable option for increasing preparedness and efficiency before, during and after music therapy sessions. The positive consequences of using the model suggest that music therapists may benefit from more succinct preparation and processing practices and supports the need for future research.

Keywords: session plans, session planning, session structure, lesson plan, hello song, goodbye song, ritual, professional skills, preparation skills, intervention design, program development, time management
Planning for Spontaneity:
Music Therapy Session Preparation, Structure and Procedures

Introduction

The intention of this thesis is to identify the recurring segments of music therapy session planning, preparation and post-session tasks and integrate them into a concise template, as guided by current literature and personal experiences of this writer. A deeper understanding of pre-existing models in music therapy was needed before considering the elements necessary to include in this system. Generally, an effective course of action would start with large-scale program development, move to treatment plan development, then session planning and intervention design. A treatment plan is an outlined agenda of interventions chosen to meet a client’s needs, strengths and preferences. A session plan can be defined as a single session or meeting between the individual or group and therapist, with time spend working towards the clinical goals of the treatment plan. Session structure can be defined as the organizational framework within sessions, and the similarities that can be found between sessions.

This thesis will focus on understanding the mechanisms supporting productive session preparation and processing. The end goal is to have a final product representing a protocol applicable to multiple populations, locations and clinical goals, to be used as a pre-session and post-session tool. This will be especially beneficial for my work, as I am (at the time of writing) working at multiple locations. The session planning template is to be used at all sites, including my internship at a trauma-informed boarding school for adolescents, my music specialist
position at a geriatric hospital, and in leading multi-generational and early education music programs. Another intention is to increase productivity by introducing shared systems connecting all job locations. Regardless of population or location, all of my music therapy work can be condensed to the following stages: planning and preparation, the music therapy session itself, and post-session processing. Post-session processing includes recurring procedures such as reflection, documentation and follow-up communication.

Another function of session planning is to allow space and opportunities for creativity and spontaneity. For therapists, reviewing occurrences and observations from in-session work may lead to information regarding which environmental or clinical elements best supported their client in their creative expression or facilitated a meaningful moment. The nature of music therapy represents the constant cycle between creative, free-form work in the here-and-now and thoughtful, intentional or controlled practice. Music therapy work often emphasizes creativity, improvisation and the significance of the present, contrasting the concept of music therapy as a systematic process. As a structured experience, “music therapy is purposeful, temporally organized, methodical, knowledge-based, and regulated” (Bruscia, 1998a, p. 26). Music therapy is both imaginative and regulated. The experiences and interventions may be designed and control by the music therapist, but one cannot plan for unpredictable moments of expression and illumination. As music therapy is goal-oriented, every choice made by the clinician must have a purpose and work towards achieving client goals. Music, as a standalone occurrence, is the organization of sound over time. Similarly, a music therapy session is the organization of musical experiences in a structured, time-based setting. This inquiry will examine the elements and variables that construct sessions, and will consider theories of structure and organization within and adjacent to the field.
Literature Review

This review will highlight the current literature as it pertains to the topic of session planning and session structure in music therapy and related fields. The literature review will begin with a theoretical alignment to provide foundation for the research question of identifying and organizing elements within and between music therapy sessions, then will compare utilizations of structure in the fields of mental health counseling, education and music therapy. This literature review will conclude with examining common internal components and external elements of music therapy sessions.

Foundation

One philosophical perspective of the importance of structure is discussed by Beer (1990) through discussing the significance of ritual. Ritual is identified as the repetitions of an action, and the changes that occurs within repetition. Moving between repetition and innovation provides the structure in which clinical work occurs. Routines provide “a sense of security and familiarity, feelings essential for any in-depth work. The routine becomes a flexible structure within which possibilities for change and newness are endless” (Beer, p. 39). When designing a session plan, one must remember that the structure isn’t set in stone, variations will occur naturally. The choice of when to enact a ritual precisely as planned or to deliberately change will depend on the client’s needs.

Similarly, Wheeler et al. (2005) provide general guidelines for organizing session plans while emphasizing that the ability to adjust prepared plans and accommodate changes in session is essential.

Many music therapists follow a basic three-part sequence: (a) some type of warm-up or introductory experience, (b) one or more experiences comprising the main
part of the session, and (c) a closing or wrap-up experience. Following this structure provides a dependable framework that can be comforting to clients, can contribute to the meaning of the therapy session, and can help the therapist achieve consistent outcomes. (p. 108)

Although many variations will be found across differing methods, most session structures can be reconsidered to fit this model, identifying opening, main portion, and closing experiences.

**Mental Health Counseling**

Similar to the three stages of beginning-middle-end, the RUC helping process model also consists of three stages; known as Relating, Understanding, and Changing (Nelson-Jones, 2002). These stages are illustrative of both the overarching treatment process and the individual sessions. The Relating stage occurs before session and at the beginning of session, when the counselor focuses on building and maintaining the therapeutic relationship. Understanding is the main time spent in session, where the client and counselor assess and agree on the client’s goals. Changing includes preparing the client to manage current problems out of session and the termination process.

Nelson-Jones (2000) also developed a model outlining four phases within individual counseling sessions, based on the Changing stage of the RUC helping process model. The first phase, Preparing, includes evaluating previous sessions, consulting with colleagues, preparing helping strategies, ensuring on-time arrival and setup. Next, the Starting phase includes meeting and greeting, re-establishing the relationship and establishing session agendas with the client. The middle phase is comprised of Coaching, made up of client involvement and delivering helping strategies. Last in the Ending phase, which includes review of progress, discussion of future application and dismissal. Although these stages are based on traditional talk therapy,
without utilizing music or arts-based interventions, these stages demonstrate similar phenomena’s in music therapy due to the shared significance of developing a therapeutic alliance, and the utilization of pre-planned interventions to achieve treatment goals.

The music therapy treatment process is reminiscent of traditional psychotherapeutic models, generally understood as consisting of three basic steps; assessment, treatment and evaluation (Wheeler et al., 2005). This process can be divided further to include Referral, Assessment, Treatment plan development (definition of goals and objectives), Treatment, Documentation, Evaluation and Termination (Davis et al., 2008). Another model for treatment plan development was provided by Parsons (1986) and consists of seven steps;

1. Complete assessment
2. Identify client’s clinical needs and problems
3. Set long-term goals
4. Set objectives
5. Plan appropriate interventions
6. Write progress notes
7. Review and evaluate

Although, Parsons’ method was designed for adult psychiatric patients outside of music therapy settings, the steps generated are applicable to other populations and therapeutic modalities as well. Again, this paper will focus on the treatment stage, specifically the individual sessions when the therapist meets with the clients. It is important to note that although these writers are speculating as to what a productive therapy session contains, there is yet to be research that measures said productivity. Future research is needed to support these theoretical concepts of structure in mental health counseling.
The ARC (Attachment, Regulation and Competency) model for treating adolescents who have experienced trauma indicates the importance of building routine into therapy sessions (Blaustein & Kinniburgh, 2010). A sample talk therapy session plan includes an opening check-in, a modulation activity, a structured activity, a “free choice” activity and a closing check-out. The opening check-in is an opportunity for the client to report their current mood or recent life updates. The purpose of the modulation activity is to regulate the energy levels of the client, supporting a stable affect. The structured activity would be the main goal-oriented component of the therapy session, followed by an opportunity for the client to demonstrate decision-making abilities and feel empowered. The check-out ritual may include another modulation activity, cleaning up session materials or verbally processing current emotions. The ARC model is used to guide practice by all clinicians at Pelham Academy, the internship placement of this writer. Observations indicated that only the “check-in” and “check-out” interventions are used regularly by all clinicians, while the other activities are utilized depending on client needs.

**Education**

Although music therapy and music education are two separate fields, similarities will be considered in support of the research question. Music therapists and teachers both develop plans, coordinate resources, facilitate experiences, support change, and attain goals. Thus, the expanse of curriculum and lesson plan research available may support the development of music therapy session design. The Hunter Model, a popularly used lesson plan template, includes seven elements to be used in any order;

- Objectives
- Standards
- Anticipatory set
Objectives are similar to clinical goals, every lesson plan and every session plan needs to serve a purpose - although that purpose may not necessarily need to be communicated to clients, depending on the population. Anticipatory set is when the teacher gathers the students’ attention and focus, which is also important in music therapy. Modeling and guided practice in education is when new information is presented and students are given the opportunity to apply what they have learned. This may be compared to the middle sections in music therapy, where the goal-oriented interventions occur.

Another lesson plan model (Cunningham, 2009) outlines eight phases:

1. Introduction
2. Foundation
3. Brain activation
4. Body of new information
5. Clarification
6. Practice and review
7. Independent practice
8. Closure

In the introduction phase, a purpose is set and communicated to the students, and students regulate in order to pay attention. The foundation phase is a time for checking on previous knowledge and clarifying questions. This may be beneficial in the therapeutic session to draw
connections to previous sessions. In phases three through seven, students are engaged and active, then given an opportunity to practice on their own, a useful opportunity to prepare students for future work. These activities parallel the active engagement phases of music therapy sessions, or the client-chosen activity of the ARC model. The closure phase is when information is reviewed, summarized and connected. Other key elements of this lesson plan model include time allotment, supply list, resource information and predetermined questions – all elements relevant to the therapeutic process.

The Music Together (Guilmartin & Levinowitz, 2010) lesson planning model for early education music teachers outlines several guidelines for music classes, some mandatory and some flexible. All classes must begin with the hello song ritual, followed by a song meant to focus children’s attention. The next few activities can vary, generally including instrumental play, seated movement and large movement. There is always a high-energy free-choice instrumental play-along song, followed by a soothing lullaby. Every Music Together class ends with the ritual goodbye song. This lesson plan template is designed to support energy building through the first three-quarters of the class time, with peak energy occurring during the play-along song, and energy ebbing during the lullaby and goodbye song. Although this model is designed for music education purposes, the use of ritual and observation of energy levels demonstrate applicability to clinical environments.

**Structure in Music Therapy**

Many of the various branches of music therapy theory have their own approaches to structure within the music therapy process. Three major approaches within the music therapy field include psychodynamic music therapy, Bonny guided imagery and music (GIM) and Nordoff-Robbins’ Creative Music Therapy. In psychodynamic music therapy, clients explore
their conscious and unconscious problems, as similar to psychodynamic and psychoanalytic therapy practices. Musical experiences are used to facilitate the therapeutic process. In a psychodynamic music therapy session there is no outlined structured, but there are seven main methods for song selection, including song performance, song improvisation, induced song recall, song communication, and song writing. Therapists draw from these categories to decide the structure of a psychodynamic music therapy session (Bruscia, 1998b). In the specialized technique of GIM, trained music therapists facilitate active music listening experiences for their clients with the intention of allowing images, symbols and deep emotions to arise from the unconscious (Nolan, 1983). Four stages make up GIM sessions, which generally range from 90-120 minutes;

1. Preliminary conversation to establish rapport
2. Induction, for relaxation to support concentration
3. Music listening period
4. Integration and review of experiences (Bonny, 1978)

In Nordoff-Robbins music therapy, associated largely with early childhood and/or autism spectrum populations, a typical 30-minute session usually begins with a musical greeting song as the child is transitioning into the room, Then, the music therapist engages in an improvisatory music-creation phase based on the child’s movements and responses with the intention of creating a shared musical experience with the child. Then, the therapist may use precomposed piece of music designed and chosen to meet therapeutic goals. Nordoff-Robbins sessions typically close with a goodbye song (Guerrero & Turry 2013) Nordoff-Robbins sessions may also be considered as a three-part process; opening song, musical activities, and closing song (Beer, 1990).
Regardless of the foundational approach, session plan structures will be largely depending on the client population. For example, Frisch (1990) suggests that highly structured musical activities are helpful for psychiatric adolescent populations, as strengthening impulse control is a common goal for many patients in this population. She suggests striving for a balance between allowing for freedom of choice and expression within carefully constructed guidelines. Too little structure can result in high levels of anxiety in psychiatric patients, thus leading to detrimental behaviors. She also reports that over-structuring a session may also be unproductive.

If the therapist projects an over-controlling quality or requires rigid adherence to rules and directions, marked reluctance to attend the music therapy session and resentment toward the therapist may follow. Achieving a balance within the session between freedom and limit setting, direction and nondirection, is essential. The patients’ reactions and behaviors will reflect the state of balance or imbalance (p. 25).

It is important to note that there were no research findings indicating that an over-structured can be unproductive beyond conceptualizations, similar to the lack of research measuring productivity. Conceptual claims have been made, but a current weakness in this field is the limitation of quantitative research looking at beneficial or detrimental additions to therapy sessions. At this time, there were no studies of effectiveness in using these models.

A model presented by Weissman (1983) outlined the structure for planning music activities specifically for seniors in long-term care facilities. Thirty musical activities were assessed for their relationship to treatment goals of the following categories; sensory, perceptual-motor, cognitive, physical fitness, self-image and social. The model identifies a six-step
framework for planning individualized music activity programs. The second step has been expanded in support of the research question.

1. Determine purpose
2. Design individualized music activity programs
   - Identify client’s needs
   - Determine goal(s) of the intervention
   - Determine behavioral objectives / output displayed by client
   - Choose a musical activity to support behavioral outcome
   - Identify what actions to be observed.
3. Plan for implementation
4. Plan for evaluation
5. Observe and record
6. Evaluate the program (p. 65)

This model is more fitting for an aging population, who may not be as capable as verbal processing, or may not require as much freedom for creative expression, as previously mentioned adolescent psych patients.

Pellitteri (2000) describes a model for group sessions with children in special education as having ideally 4-8 participants, seated in a circle. Sessions follow the typical three part structure of starting with a hello song to support transitions from earlier activities, and ending with a goodbye song to provide closure. Time between this established structure is spent on musical activities such as playing instruments, singing or moving. Activities are chosen by the music therapist to meet the clinical goals of the participants.
Stephens (1984) identifies a four-part session structure as her model, designated for improvisational group music therapy sessions with adults. The first component is the warm-up, in which members arrive and group cohesion is promoted. The next stage is for verbal discussion, followed by the main phase and ending with closure. Gardstrom (2007) expanded on Stephens’ model, outlining an eight-step session structure specific to verbal, adult groups partaking in improvisational interventions.

1. Introductory Discussion
2. Verbal Check-In
3. Sound Vocabulary (introduction to instruments + musical information)
4. Warm-Up Improvisation
5. Brief Discussion
6. Core Improvisation Experience
7. Verbal Processing
8. Verbal of Musical Closure (p. 78)

Analyzing and comparing the identified structures within existing music therapy models is beneficial to understanding the elements considered in pre-session preparation, in-session structure and post-session processing. Further research in comparing and contrasting elements will be examined in the next section.

**Common Elements in Music Therapy Sessions**

Previously discussed structure patterns in music therapy and related fields have varied depending on the foundational approach or needs of the population served. However, there are some universal considerations that span population-based approaches, regardless of site or
location. Literature providing information regarding elements, variables and factors within music therapy sessions will be reviewed next.

Hadsell (1993) identified six elements of external structure in music therapy sessions, which are time, space/equipment, choices, materials, instructions and activities. These six elements are present in all music therapy sessions. Hadsell also notes that three levels of structure – maximum, moderate, and minimum – can be applied to the elements of external structure. Again, the amount of structure is specific to the client, environment and purpose.

Wheeler et al. (2005) also identified valuable common considerations for designing a music therapy session, including identifying;

- what is important for the client(s)
- what the client(s) can gain from a music therapy session
- feelings or reactions towards the client(s)
- how music can help or support the process
- what ethical concerns may arise

Two main questions are indicated for music therapists to ask themselves when planning sessions, “What do I do to meet the needs of the client? … naturally leadi[ing] to the questions: How do I do what is required to meet the clients needs?” (p. 97). Additional variables to be considered in this planning process include identifying the following needs; medical, physical, environmental, musical, communication and emotional. Other environmental factors include deciding what to do regarding room arrangement, equipment, instruments and materials. Further considerations for session structure will be dependent on the population and location, but will tend to include client diagnosis, personality, developmental level and needs.
Music therapists from Aalborg University outlined four steps to a music therapy session; focus attention, regulate arousal level, dialogue and conclusion (Ridder & Mette, 2004). Attention is focused through the use of hello songs if working with children, or using a song to provide contextual cues to orient the client. The purpose of the beginning stage of session is to establish a structure through stability and cues. After focusing attention, the music therapist regulates the client’s arousal level to moderate, with the function of maintaining attention throughout session. Interventions in this phase are chosen to either stimulate or calm the client. Only after clients are focused and regulated can dialogue begin. Dialogue is the phase in which psychosocial needs are addressed. The intention of the final concluding phase is to provide stability and security, ensuring the client will transition appropriately out of session.

As discussed, “hello songs” and “goodbye songs” are often used in music therapy to open and close sessions. These songs provide non-verbal cues to facilitate inclusion, establish a musical environment, establish therapeutic contact, promote musical communication, focus attention and minimize anxiety during transitions (Kantor & Kruzikova, 2016). Hello songs are regularly used in Nordoff-Robbins creative music therapy and developmental therapy with children, but the ritual of using a song as an opening to focus attention, orient client to time and place and regulate energy is often used with older populations, especially in group settings. In a treatment program for middle-school and high-school students with emotional and behavioral disorders, hello songs are used at the beginning of every session to provide each student an opportunity to express their current mood, to establish group cohesion, and to permit therapists and teachers an opportunity to assess each participant (Sausser & Waller, 2006). Although a hello song is often clinically chosen as an opening ritual, it is important to note that the popular
phrase “hello song” does not necessarily mean a song or involve salutations, but may also be used as an opportunity for improvisation or verbal processing (Wheeler et al., 2005).

Clinical improvisation, previously mentioned as one of the four main intervention categories in music therapy, is the act of spontaneously creating musical materials for a therapeutic benefit and is commonly utilized by most working music therapists regardless of population or location. However, the amount of structure and organization given to an improvisation varies depending on the needs of clients, to parallel the elements considered in structuring a session timeline. One model (Beer, 2011) outlines improvisation design on a spectrum, with one end representing unrestricted improvisation and the polar end as highly structured improvisation. In an unrestricted improvisation, no time limit is set, goals may include exploration or supporting self-esteem. In a highly structured musical activity, clear instructions and parameters are communicated, and goals may include impulse control or practicing social skills. Other factors identified for improvisational intervention design are determining group or individual, age of client(s), client backgrounds, physical abilities or deficits, environmental restrictions, degree of psychosis or other mental illness, level of chaos, attention span, goals, trust or group cohesion, instruments available and time constraints. These elements, here described as variables of intervention design, are also important consideration when determining session structure. Furthermore, this model establishes guidelines for setting up improvisation interventions, including the following:

1. Setting the physical environment
2. Creating an atmosphere of trust and safety
3. Create an experience geared towards needs and interests
4. Give verbal instructions
5. Decide to meet the client’s energy or present alternative
6. Establish a relationship in the music
7. Work
8. Closure
9. Notes/Planning (p. 125)

Beer recommends using time immediately following session to write notes, revise goals and notate musical phrases/chords to be introduced in later sessions.

These methods collectively shape theoretical evidence attesting to the significant presence of structure within music therapy sessions. The general three-step approach described by Wheeler et al. (2005) provides a flexible framework by which other models may be adapted or perceived. Essential elements to be considered when implementing a collective structure, include the elements of external structure (Hadsell, 1993), needs of the client (Wheeler et al., 2005) and variables of intervention design (Beer, 2011). Both the macro stages of session structure and the determining micro factors will be considered when designing and implementing a session template to be utilized in clinical music therapy work.

Methods

To expand upon the emerging data and to contribute to the field’s current understanding of session structure and productivity, a session template was designed and assessed through the following methods. The only participant was this writer, a music therapy graduate student at Lesley University. The template was designed with the intention to suit individual and group sessions in multiple locations with various populations, and were utilized at Pelham Academy (this writer’s internship site, a trauma-informed therapeutic residential school), Newbridge on the
Charles (one of this writer’s work sites, a chronic care geriatric hospital) and Strongwater Studios (this writer’s early childhood music education business) from 2/7/18 to 4/15/18. Tested templates were reviewed after use, and I kept records of my responses. Reflections were made on the usefulness, applicability, and challenges of the session template. Progress was tracked using a clinical log and the online program WorkFlowy. Additional data was gathered in the form of handwritten reflections on separate unused printed templates. These findings were used to make edits between upgrades. At time of writing, there were four templates used, referred to henceforth as Template 1.0, 2.0, 3.0 and 4.0.

Session templates were designed using Microsoft Word and Google Docs, and were printed onto white 8.5” x 11” paper. The template was one sided for easiest access and reference, and was made to be concise and minimal, so a quick glance during sessions would suffice for information gathering as not to disrupt session flow. The session template was printed, and then details pertaining to the clients, goals and interventions were written in by hand during the session planning process.

Information gathered from the literature review was summarized in a single table, to better understand the theoretical divisions of session structure (See Appendix A, Theoretical Model Comparison). The components of nine models were categorized into Wheeler’s (2005) three generalized sections; beginning, middle and end, labeled in the template as introduction, middle and closing. Further reductions were made in best efforts to reframe and condense session elements into a concise format. The first template (see Appendix B, Session Plan Template 1.0) provided space for the following sections.

• Introduction
  
  ○ Opening (Hello Song / Ritual)
The session template also included space for the following pre-session information: location, population, client(s), age, date/time, location, diagnosis, goals, preparation, and materials. At the bottom of the template was a section for noting the date and time when attendance or progress notes had been submitted, and to provide a place for a signature. Signing this template signifies that the session and all proceeding steps have been completed to this writer’s utmost ability. Future designs of the template (2.0, 3.0 and 4.0) are variations of this first version and can be referenced in Appendix C, D and E.

Results

Session Template 1.0 was used seven times over four days, for four individual sessions and three group sessions, from 2/7/18 to 2/11/18. While using the template, I started thinking about my sessions in a different way, drawing connections between populations and locations that I hadn’t noticed before. Although I used opening and closing rituals in many of my sessions previously, I was now making sure to include them consistently in all sessions, and keeping a better track of time to ensure enough time for the closing rituals. Feedback from clients was positive surrounding opening and closing rituals. Surprisingly, I found myself jotting down notes after sessions right onto the work sheet, finding it was a quick and easy way to review session
until I had the time to sit down for proper documentation of progress notes. This unexpected positive outcome influenced this thesis tremendously, moving the concentration away from session planning specifically, instead looking at the larger systemic process, understanding the repetitive tasks within a music therapist’s workload with the intention of increasing efficiency. Within my workload, this included weekly occurrences such as writing progress notes, taking attendance at larger groups at the hospital and writing reports to my supervisor.

Therefore, Template 2.0 (see Appendix C) included more space for notes to use for pre-session preparation and post-session processing. For example, a client asked me to learn a new song I had never heard before, and I was able to write down the title, *Tumbalalaika* for later referencing. Template 2.0 outlined the following structure for session planning, removing the categorizing column (intro, middle, closing) to save space as the divisions can be easily assumed; opening ritual, regulation / check-in / warm-up, main section, check-out and closing ritual (See Appendix C).

Session Template 2.0 was used eight times from 2/14/18 to 2/17/18, for three individual sessions and five group sessions. It included a condensed information section to allow more room for session plan and notes sections. This was achieved by removing population, age and diagnosis, as this information is easily available in the client’s digital charts. Also, I decided that I wanted the template to be “safe” for client’s eyes, meaning they should be able to view the sheet, ask questions, or even make changes depending on the clients. This was implemented after reviewing my data responses, and noting that two of my individual clients at Pelham and one of my private lesson students had taken interest in the template, which had been kept on a clipboard off to the side. I reflected on how I didn’t want the template to feel like a secret, especially at Pelham, where the adolescent clients are often very involved in their own treatment and clinical
goals. However, not all clients are aware of or accepting of their diagnoses, so I removed the diagnosis section. Again, this information is easily accessible in the digital charts. Space was also gained by merging the “Preparation” and “Materials” section, since they often overlapped. The Goal section remained as a reference for session planning, but only client-friendly goals were recorded. Lastly, a space for post-session notes was added to include room for additional plans and next steps. Some samples of post-session notes from the data collection include prepare C / Em chord printout and deliver to J.G, discuss incentive plan with primary clinician and prepare/print lyrics for D.W. As predicted, this was especially useful for referencing before future sessions. For example, I am only at the geriatrics hospital once a week, and it can be difficult remembering all of the notes and prompts from the previous week. I was easily able to pull out the session templates and access the reminders I had made to myself for materials to prepare and tasks to complete the following week.

The column for extra note space in 2.0 was used for jotting down client quotes, keeping attendance, recording instances when the session had gone off plan, and once even as a space where I recorded my own emotional reaction to a session afterwards. The “next steps” space at the bottom of the page was used for writing reminders for upcoming treatment meetings, song lyric preparation, songs clients asked me to listen to, materials to bring, emails to send, points to discuss with the team, and other tasks to complete. These findings further indicated the usefulness of the template as a systems-based resource, in addition to its original function as a pre-session tool designated for planning and preparation.

Session Template 3.0 (see Appendix D) was used four times on 2/24/18, and was quickly updated to Template 3.1, which was used eight times from 2/28/18 – 3/3/18. Templates 3.0 and 3.1 utilized a smaller font size to make more room for handwritten notes, and a decreased line
size to be more aesthetically pleasing. I also added the categorical label “Main Structured Work / Optional Free Choice” to the session planning section. One of my individual adolescent clients at Pelham has taken a strong interest in reviewing the session plan before every session, and he suggested labeling it that way so that other clients could know they have the option to advocate for their own interventions. This was great feedback, as I always try to communicate to my clients that they can always make requests, but that information may not always be understood fully. With the template, the session plan is clearly outlined for the working therapist to access, and for interested, high-cognitive functioning clients to access as well, clinical needs and goals depending.

To improve efficiency, goals and rituals from repeating sessions were typed and printed in the template to save time spent writing it out before each session. For example, one individual music therapy session at Pelham Academy always began with the opening ritual of the student vocally improvising while I supported her on acoustic guitar. This was typed into a Google Doc so I would not have to write it out every time. The goals for the dementia groups at Hebrew Senior Life were constant, so they were also typed into the Template in font size 10 to save space. These group goals included increase trust, support cognitive functioning, improve relationships with other group members and increase awareness of environment.

It was important to have the goals pre-printed on every template to serve as a reminder for the purpose behind every music therapy intervention, especially during the times that sessions strayed from the plan. As spontaneity is an integral part of music therapy treatment (Bruscia 1998a), the music therapist has a responsibility to adapt interventions depending on client or group mood or behavior in the present moment. Throughout the entire duration of this research period with Template 3.0 and 3.1, there were often times when the session plan was not followed
in-session. For example, in a multi-generational group on 3/2/18 (Template 3.1), only five out of the planned ten interventions occurred. This was due to the fact that many variables changed in the moment. The group was significantly larger than I had planned due to a concurrent activity being cancelled, with new group members arriving after I had already began. Also, a volunteer joined in last minute playing the piano, allowing me more bodily freedom as I did not need to play guitar the entire time. When planning for sessions, the music therapist should always keep in mind that not all may go according to plan. Reflecting on where the plan deviated may provide valuable insight to the client’s treatment.

The final version of the template (4.0) was used thirty-two times over six weeks, with the same format and pre-printed goals from previous templates. More pre-printed information was included for recurring information, with sections left blank if it changed week to week. Groups at Hebrew Senior Life were always at the same time and in the same location, with the same goals. I did not need to write detailed progress notes, so the notes section was used for attendance and brief notes to include in my daily report to my supervisor. The next steps section included pre-printed “Attendance” and “Update Report.” For Pelham Academy, the session date/time and location were always left blank due to the changing schedules and locations. Goals for individual clients were pre-printed as were the initial for group members, as group membership was the same on a weekly basis. Pre-printed next steps included “submit progress note.” Handwritten notes varied from session to session, including observations (BS had low energy throughout entire group) client quotes (I cried when everyone clapped), reflections (very future-oriented today) and other notes to reference when writing progress notes and preparing for future sessions.
The worksheet-based template was found to be a productive method on which to efficiently design session plans and provided a resource for gathering and reviewing information. Furthermore, the template was also useful as a reference tool to support evaluation and organizational needs for treatment plan development. This template is a viable option for increasing preparedness and efficiency before, during and after music therapy sessions. A current limitation of this study is the lack of measurable data on efficiency, but reflections of this writer indicate that the session template can be used to promote more productive work.

Discussion

Findings from this study indicate that it may be beneficial for working music therapists to use a structured template for each music therapy session facilitated to support more productive pre-session planning and preparation and post-session processing. The positive consequences of the model suggest that music therapists may benefit from more succinct preparation and processing practices and supports the need for future research. Similar to the theory discussed earlier by Beer (1990), a predictable routine provides familiarity and ease, but will require flexibility to meet the changes that arise within and between sessions. This applies to the session plan and structure of the music therapy session itself, and to the routines created by the music therapist to prepare for and process session occurrences. Opening and closing rituals such as hello and goodbye songs allow for sessions to be bookended in familiar expectations, signaling time and place to nonverbal clients, and permitting for easier transitions in and out of session (Kantor & Kruzikova, 2016). When rituals are repeated across multiple sessions and variables arise, information is provided to the music therapist about the client and environment that may be beneficial to treatment plan development.

In addition to streamlining the process for session planning, the template also provides support for writing more detailed progress notes. Therapists can review the session plan, notes taken
during or after session, and can reflect on when the plan was not followed and why. This information can provide valuable insight to the client’s affect, orientation and environment. This information may also provide information on the therapeutic relationship and process. The session template has the potential to better inform clinical practice by providing a system to utilize for recurring pre- and post-session tasks such as session planning and documentation. This method provides a resource for busy professionals to utilize in order to better develop sessions and ensure that clinical goals are being met throughout the treatment plan.

The significance of this topic is supported by common anecdotal challenges experienced by music therapists, such as using instruments, props and materials which can be difficult to transport, locate or share. This is represented on the template in the planning and materials section. Advance planning will identify needs earlier, allowing more time to gather and transport materials or supporting easier communication with collaborators. For example, in order to download songs for sessions at Pelham Academy, I needed to use a specific laptop that was shared with two other clinicians, and it needed to be connected to the internet by Ethernet cable in specific locations – it was a very time consuming process. When I was able to get the laptop, I only had it for a few minutes, but it was easy for me to access which songs I needed because they were all easily accessible on my template sheets.

Oftentimes music therapists don’t have an office or access to storage space, some use their cars as an instrument closet. Identifying what equipment to bring is very important, especially if traveling between sites or sessions. Session planning may be especially useful for the job-juggling music therapist, for example, a session with the theme of “Autumn Leaves” may be applicable for preschool settings and in memory care geriatric units, allowing materials to be used in multiple sessions. Proper planning and procedures can support efficiency and reliability and can reduce lost time, anxiety and confusion. Practicing a streamlined process for session
planning and preparation regardless of location or population may increase productivity, allowing for time saved be better spent on more valuable assignments. This time may be especially important for a music therapist that has limited or unpaid preparation time.

The template also provides a space for treatment goals, to include when complete pre-session planning and preparation tasks. Identifying and working towards goals was a significant element for many models discussed in the literature review section, in mental health counseling (Nelson-Jones, 2002), education (Wolfe, 1987) and music therapy (Weissman 1983). The inclusion of treatment goals is one important variable that separates music therapy from therapeutic music. Having the goals within view for intervention design and also in-session provided a level of insurance that the clinical goals were being met. Our responsibility is to ensure that the treatment plan is being followed and the goals and objectives are being met, and the session plan is designed to support those goals (Wheeler et al., 2005). However, session plans are rarely followed exactly as written. The balance between spontaneity and structure depends, as always, on the needs and goals of the clients. My clinical group at Pelham is very high-energy, with fast-paced movement interventions and loud music. This can be dysregulating for the clients, so to provide containment and outline expectations we follow the structured interventions every time. Written check-in to practice mindfulness and regulate energy, verbal check-in to support group cohesion, low-energy movement intervention to stretch muscles, building to a high-energy dance/drumming interventions and ending with written check-outs. These interventions are representative of the previously discussed ARC model, which suggests using an opening check-in, a modulation activity, a structured activity, and a closing check-out (Blaustein & Kinniburgh, 2010).
Conclusion

Future research on this topic should aim to involve and collaborate with other music therapists, such as considering their perspectives and habits of session planning and processing, or inviting them to use the template-based system and gathering information on what worked and what didn’t. As the intention of this study was to create a universal method for use with varied populations and locations, future research may consider supporting a series of templates to provide options that are better suited for specific clinical needs or locations. Expansions of this topic may consider measuring efficiency through time spent in pre-session planning and post-session processing. Future research may consider moving towards a better understanding of how to measure productivity in therapy. This project is intended to contribute to the literature surrounding session structure, clinical planning and preparation skills, post-session processes and efficiency in music therapy. Ultimately, the findings and results of this method are valuable considerations in developing a better understanding of structure in and surrounding music therapy sessions and promoting a more productive clinical practice in music therapy work.
References


Guerrero, Nina & Turry, Alan (2013) Nordoff-Robbins music therapy: an expressive and
dynamic approach for young children on the autism spectrum. in Kern, P & Bumpal, M.
(eds) Early childhood music therapy and autism spectrum disorders. (pp. 130 - 144)

Princeton, New Jersey: Music Together LLC.

11(2). 61-65.

Kantor, J. & Kruzikova, L. (2016) Qualitative content analysis of “hello songs” composed for
children by music therapists in the Czech Republic and USA. Social Welfare:

Britain: SAGE Publications.


Music Therapy. 3(1). 43-51.

Parsons, P. (1986) Building better treatment plans. Journal of Psychosocial Nursing and Mental
Health Services. 24(4) 8-14.


degenerative diseases. Music Therapy Today. 6(4), 596-611.


### Appendix A: Theoretical Model Comparison

<table>
<thead>
<tr>
<th>Author</th>
<th>Session Structure Sections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wheeler et al 2005</td>
<td>Warm-Up / Introductory Main Part Closing / Wrap-Up</td>
</tr>
<tr>
<td>Nelson-Jones 2002</td>
<td>Preparing Middle Ending</td>
</tr>
<tr>
<td>Blaustein &amp; Kinniburgh 2010</td>
<td>Opening check-in Structured activity Free Choice Activity Closing check out</td>
</tr>
<tr>
<td>Bonny 1978</td>
<td>Preliminary conversation, establish rapport Relaxation, Support concentration Music Listening period Integrate/Review experiences</td>
</tr>
<tr>
<td>Stephens 1984</td>
<td>Warm-Up Verbal Discussion (Check-in) Main Phase Closure</td>
</tr>
<tr>
<td>Gardstrom 2007</td>
<td>Introductory Discussion Improvisation Verbal or Musical Closure</td>
</tr>
<tr>
<td>Ridder-Mette 2004</td>
<td>Focus attention Dialogue Conclusion</td>
</tr>
<tr>
<td>Beer 2011</td>
<td>Setting physical environment Meet clients energy or present alternative Closure</td>
</tr>
<tr>
<td></td>
<td>Create atmosphere of trust and safety Establish a relationship in the music Notes</td>
</tr>
<tr>
<td></td>
<td>Create experience geared towards needs and interests Work Planning</td>
</tr>
</tbody>
</table>
# Appendix B: Session Template 1.0

<table>
<thead>
<tr>
<th>Location:</th>
<th>Population:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client(s):</td>
<td>Session Date/Time:</td>
</tr>
<tr>
<td>Age:</td>
<td>Session Location:</td>
</tr>
<tr>
<td>Diagnosis:</td>
<td></td>
</tr>
</tbody>
</table>

## Goals:

### Preparation:

### Materials:

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Plan</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intro</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opening (Hello Song/ Ritual)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Check-In</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Warm-Up / Regulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Middle</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Closing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Check Out / Integration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Closing Ritual</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Attendance/Progress Note Completed/Submitted:**

Session Plan Template 1.0 Created: 2.7.18
## Appendix C: Session Template 2.0

<table>
<thead>
<tr>
<th>Site:</th>
<th>Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session Date/Time:</td>
<td>Session Location:</td>
</tr>
<tr>
<td>Client(s):</td>
<td>Goals:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session Plan</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening Ritual</td>
<td></td>
</tr>
<tr>
<td>Regulation Check-In Warm-Up</td>
<td></td>
</tr>
<tr>
<td>Check Out</td>
<td></td>
</tr>
<tr>
<td>Closing Ritual</td>
<td></td>
</tr>
<tr>
<td>Next Steps:</td>
<td></td>
</tr>
</tbody>
</table>

Attendance/Progress Note Completed:

Session Plan Template 2.0 Created: 2.14.18
Appendix D: Session Template 3.0

<table>
<thead>
<tr>
<th>Site:</th>
<th>Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session Date/Time:</td>
<td>Session Location:</td>
</tr>
<tr>
<td>Client(s):</td>
<td>Goals:</td>
</tr>
</tbody>
</table>

**Session Plan**

<table>
<thead>
<tr>
<th>Opening Ritual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation Check-In Warm-Up</td>
</tr>
<tr>
<td>Main Structured Work (optional free choice)</td>
</tr>
<tr>
<td>Check Out</td>
</tr>
<tr>
<td>Closing Ritual</td>
</tr>
</tbody>
</table>

**Next Steps:**

**Attendance/Progress Note Completed:**

Template 3.0 Created: 2.22.18
### Appendix E: Session Template 4.0 Sample

<table>
<thead>
<tr>
<th>Pelham Academy</th>
<th>Music Therapy with JG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session Date/Time:</td>
<td>Session Location:</td>
</tr>
<tr>
<td>Goals: (A) identifying healthy emotional and/or physical boundaries that lead to positive pro-social interactions (B) better manage the emotions that lead to problems as evidenced by developing a list of at least 10 effective coping strategies for regulating different emotions and impulsive behaviors (C) develop a strong and stable personal identity as evidenced by the ability to define at least 5 positive qualities of self, and utilize these in activities daily (TEAM) apply for fresh air, find activities to join consistently (Primary Clinician) explore “parts” of self</td>
<td></td>
</tr>
<tr>
<td>Preparation/Materials:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session Plan</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening Ritual</td>
<td>Journal: Quadrant Spread (or) pick a song to sing</td>
</tr>
<tr>
<td>Regulation Check-In Warm-Up</td>
<td>Update Mood Tracker</td>
</tr>
<tr>
<td>Main Structured Work (Optional Free Choice)</td>
<td></td>
</tr>
<tr>
<td>Check Out</td>
<td>ID positive thoughts from today/session</td>
</tr>
<tr>
<td>Closing Ritual</td>
<td></td>
</tr>
<tr>
<td>Next Steps:</td>
<td>□ submit ehana note</td>
</tr>
</tbody>
</table>

Session Complete / Signoff: Template 4.11, Modified: 3/7/18