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Experiences of Single-Session Improvisational Group Music Therapy: Therapist and Patient Reflections from Inpatient Psychiatry

Yu-Ying Chen
Lesley University, ychen12@lesley.edu

Experiences of Single-Session Improvisational Group Music Therapy: Therapist and Patient Reflections from Inpatient Psychiatry

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Yu-Ying Chen

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Student's Name: Yu-Ying Chen
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In the judgment of the following signatories, this Dissertation meets the academic standards that have been established for the Doctor of Philosophy degree.

Dissertation Committee Chairperson: Mitchell Kossak, PhD February 15, 2019

Internal Committee Member: Michele Forinash, DA February 15, 2019

External Committee Member: Kana Okazaki-Sakaue, PhD March 23, 2019

Director of the Ph.D. Program/External Examiner: Robyn Cruz, PhD March 23, 2019

Final approval and acceptance of this dissertation is contingent upon the candidate's submission of the final copy of the dissertation to the Graduate School of Arts and Social Sciences.

I hereby certify that I have read this dissertation prepared under my direction and recommend that it be accepted as fulfilling the dissertation requirement.

Mitchell Kossak
_____
Dissertation Director

I hereby accept the recommendation of the Dissertation Committee and its Chairperson.

Sandra Walker
_____
Dean, Graduate School of Arts and Social Sciences

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ABSTRACT

The purpose of this study was to explore therapists' and patients' experiences in order to draw a composite picture of single-session improvisational group music therapy. This phenomenological study included ten therapist participants and nine patient participants. Each participant engaged with a single-session group musical improvisation and verbal discussion in a pre-designed protocol. The data analysis was conducted in three stages. In the first analysis stage, participants' verbal feedback and discussion were analyzed using Moustakas's (1994) method, yielding key words with quotations. In the second stage, Moustakas's (1994) method of analysis was also adapted for an analysis of the music, yielding key words with music excerpts of significant moments. In the third stage, the researcher conducted a composite review of keywords and significant quotations as well as significant musical moments. The data were comprehensively reviewed, reflected on, clustered, and thematized (Moustakas, 1994), yielding the following five themes: (a) the therapist's experience of work in inpatient psychiatric care, (b) the patient's experience of hospitalization in inpatient psychiatry, (c) participants' experiences of group musical improvisation in single session, (d) participants' challenges in single-session improvisation, and (e) therapeutic components in single-session group improvisational music therapy. This study found that, given the reality of short stays and rapid turnover in this setting, unplanned single-session groups occur. This study demonstrated how, through this single-session group musical improvisation, participants in this setting were able to find the sense of safety and structure they needed to amplify and process their emotions, thoughts, and issues. Nonetheless, this study also noted the difficulties and challenges that participants experienced with this treatment modality, meaning that a range of creative arts therapies or conventional verbal interventions ought to be integrally and comprehensively considered.

CHAPTER 1

Introduction

The purpose of this study was to explore therapists' and patients' experiences and feedback in order to draw a composite picture of single-session improvisational group music therapy as a reflection on music therapy practice in inpatient psychiatry. Each improvisational music therapy group in inpatient psychiatric care is considered to be a single-session therapy group (Yalom & Leszcz, 2005). This study systematically investigated the experiences of creative arts therapists and inpatients with diagnosed mental illness while participating in single-session group musical improvisation. Participants engaged with group musical improvisation and verbal discussion in a pre-designed protocol of single-session group music therapy (described in detail in the method section). A qualitative research approach, specifically phenomenological inquiry, was used for data collection and data analysis; data (music and verbal) were collected from six groups (19 participants in total). A phenomenological study is a research method used to "describe the common meaning of multiple individuals' lived experiences of a concept or phenomena" (Creswell, 2013, p.76). For this study, single-session therapy was defined as a specific form of therapy conducted by therapists to address clients' presenting concerns within one face-to-face session (Paul & van Ommeren, 2013; Talmon, 1990).

Music Therapy in Inpatient Psychiatric Care

Psychiatry is the field of medicine concerning psychological diagnoses and symptoms, including Schizophrenia, Major Depressive Disorder, Bipolar Disorder, Schizoaffective Disorder, psychotic symptoms, anxiety, depression, anger and other negative emotions. While medication is the central treatment tool in clinical psychiatry, music therapy has been applied to

inpatient psychiatric care for the past few decades (Silverman, 2015). Music therapy has been used extensively in inpatient settings to help people with severe mental illness improve quality of life, alleviate negative symptoms, reduce anxiety, manage psychosis, and improve socialization; the effects of music therapy on mental illness have also been demonstrated in a number of studies (Gardstrom et al., 2013; Hayashi et al., 2002; Hsu & Lai, 2004; Silverman, 2003; Solli et al., 2013).

According to the Rights of Inpatients in New York State Office of Mental Health Psychiatric Centers (2012) and section 580.6(a)4 of Operation of Psychiatric Inpatient Unit of General Hospitals (n.d.), appropriate programs, groups, and therapies should be provided to address treatment goals for all inpatients. Consequently, in most adult inpatient psychiatric care facilities in New York City and New York State, a number of activity therapy groups are provided daily by activity or creative arts therapists of different therapy modalities, including music, art, dance/movement, drama, and recreation. These activity therapy groups are comprised of various protocols such as utilizing the creative arts, discussing coping and life skills, and socializing during open leisure time. Improvisational group music therapy is one commonly used protocol. Music therapy improvisation is an extensively applied music therapy technique and plays a central role in music therapy clinical practice, addressing a broad range of therapeutic objectives and goals (Carroll & Lefebvre, 2013; Silverman, 2015). Improvisation is the core of creative process, connected with openness to uncertainty and the experience of being "in the moment" (Sajnani, 2013, p. 77). Nachmanovitch (1990) pointed out that improvisation is the art form of connecting and reflecting an experience that constitutes the whole of everyday life: "The most common form of improvisation is ordinary speech. As we talk and listen, we are drawing on a set of building blocks (vocabulary) and rules (grammar) for combining them"

(Nachmanovitch, 1990, p. 17). Music and speech have structural acoustical similarities: pitch, duration, timbre, intensity, and inflection patterns (Thaut, 2005). In music, improvisation structures these elements in the moment to extemporize melodies and harmonies within the rhythm.

The Influence of Current Trend of Inpatient Psychiatric Care

Over the past few decades, the length of stay for inpatient psychiatric treatment has declined. Several studies have documented a gradual decline in the length of stay for inpatient psychiatric care throughout the 1980s and 1990s (Hudson, 2004). According to the Centers of Disease Control and Prevention (CDC, 2015), the current average length of stay for inpatient psychiatric care is 7.2 days. The decline in length of stay has resulted in rapid patient turnover (Hudson, 2004), and patients might experience only one session of improvisational group music therapy during the course of hospitalization. Therefore, it is difficult to set ongoing or continuous group goals because it is almost impossible to foresee the combination of group members in each session (Thomas, 2007). While improvisational group music therapy in adult inpatient psychiatric care is conducted in a single-session modality, the potential still exists to address some goals in a single-session or "one-off group" (Pavlicevic, 2003).

The current trend of shorter stays in adult inpatient psychiatric care has resulted in the focus of single-session modalities. Researchers from various disciplines have suggested that single-session modalities can be effective for patient care and treatment (Diskin & Hodgins, 2009; Feldman & Dreher, 2012; Doyle, 2015; Filip, 1994; Lavarenne, 2013; Silverman, 2011). However, limited studies (Silverman 2015) have focused on single-session improvisational group music therapy in adult inpatient psychiatric care from therapists' perspectives. Group music therapy improvisation is not about making music for public consumption; rather, it is a

process of experiencing elements of music for participants to increase their understandings of self, relationship, and life issues (Silverman, 2009; Stephens, 1983). Researchers have suggested that music therapy improvisation is primarily used in groups in adult inpatient psychiatric care (Loth, 2002; Thomas, 2007).

The Findings of Preliminary Research

Through this researcher's pilot study (Chen, 2019), the therapist's experience of implementing a single-session group improvisational music therapy in inpatient psychiatry was explored. Three participants in the pilot study currently work as music therapist in inpatient psychiatry; they shared their experiences of working in this setting and their thoughts and feelings about how a single session group improvisational music therapy session might influence patients. The data collection of this pilot study included the following three stages: (a) an individual phenomenological interview (Moustakas, 1994), (b) a group musical improvisation, approximately two weeks after individual interviews, and (c) a group post-session interview. Two analysis cycles were conducted. In the first analysis cycle, a descriptive coding method (Saldaña, 2013) was used to code the interviews, yielding key words with quotations. Ferrara's (1984) method of analysis was used to analyze improvisational music playing, yielding key words with music excerpts. In the second analysis cycle, the researcher conducted a composite review of keywords and significant quotations, as well as music excerpts. The data were comprehensively reviewed, reflected on, clustered, and thematized (Moustakas, 1994), yielding the following four themes: (a) work in adult inpatient psychiatric care, (b) the concept of the single-session model, (c) music as a means of therapy, and (d) the formation of structure in single-session group improvisational music therapy.

The findings suggested the significance of single-session group improvisational music therapy practice in inpatient psychiatry because they showed that playing music in a group provides a safe space for people to explore and connect with each other in a short period, and this improvisational group music therapy tends to be a single-session experience. In addition, the pilot study also explored the single-session modality in music therapists' experience of working with patients in an inpatient setting. The finding of this pilot study also highlighted how the use of the single-session modality is often unplanned in this setting. Participants (both therapists and patients) in the pilot study did not realize that they had been practicing a single-session modality until they read the literature provided to them by this researcher.

Through reflection on their work, participants clarified that the effect of music therapy on patients might not be clearly exhibited after just one session; nonetheless, patients' takeaways of single-session experiences of group improvisational music therapy can be significant. One of participants described this takeaway and therapist's role in this setting as "plant[ing] a seed [that will] hopefully later grow into something beautiful" (Chen, 2019, p.159).

This researcher's pilot study also suggested that music is a unique experience that each person perceives differently, reflecting that person's experiences and issues. In music therapy improvisation, each instrument or tone represents an individual issue or thought; while the music is played, all of these different sounds, thoughts, and issues are woven together; the entire process of finding structure, harmony, cohesiveness, change, and resolution can clearly take place within the present moment, which reflects the characteristics of a single session — a course of being present in the moment.

This pilot study, however, suffered from a few limitations; one was that the study focused on therapists' experiences of implementing single-session group improvisational music therapy

in inpatient psychiatric care without addressing patients' experiences. In this dissertation study, the researcher compared therapists' and patients' experiences and feedback in order to draw a composite picture of single-session improvisational group music therapy as a reflection on music therapy practice in inpatient psychiatry.

The Need of Current Research

This study was important because experiences of creative arts therapist and patients while participating in group musical improvisation in one session was investigated systematically to reflect music therapy practice in inpatient psychiatric care, which is widely conducted in single-session modal (Thomas, 2007). In the pre-designed protocol of single-session improvisational group music therapy for this study, as described in detail in the method section, participants first shared their experience of clinical practice (therapists) and hospitalization (patients), as a theme to be processed verbally and then musically as participants engaged in musical improvisation, leading to the verbal discourse on the musical response and overall group process. The data (musical and verbal) were collected throughout this pre-designed protocol of improvisational music therapy group. The results of this study will help therapists learn more about the experiences of all the participants with different perspectives and backgrounds and enable therapists to adapt goals and treatment plans of improvisational group music therapy accordingly when applying this method in one session in the setting of adult inpatient psychiatric care.

The focus of this dissertation was on single-session group music therapy improvisation to reflect today's music therapy practice in inpatient psychiatry. For the therapist groups, the researcher set a protocol of single-session research groups outside inpatient psychiatric care to mirror a single-session situation, which has been happening in inpatient psychiatry as described by Talmon (1990). For the patient groups, inpatients with diagnosed mental illness who were

compliant with medication were recruited to participate in a single session of improvisational group music therapy in the setting of inpatient psychiatric care to reflect their first-hand lived experience. The rationale of participant's recruitment and data collection was described in detail in the method section below. The researcher explored participants' experiences in single-session group music therapy improvisation to reflect the effectiveness of group therapy within one session. This exploration also looked at the distinctive value of the single-session group process.

Research Guiding Question.

This research explored therapists' and patients' experiences while they participated in single-session group improvisational music therapy. Reviewing the literature, it is evident that single-session improvisational group music therapy has not been extensively explored through qualitative study taking into account both therapists' and patient's perspectives (Silverman, 2015). Considering all these factors and perspectives, the guiding question of this dissertation study is:

> What is the experience of creative arts therapists and inpatients with diagnosed mental illness while participating in single-session improvisational group music therapy?

CHAPTER 2

Literature Review

The aim of this literature review was to establish the importance of previous studies on single session treatment, group therapy, group music therapy, and recent change and issues in adult inpatient psychiatric care. This literature review also identified a need for further research. It was organized and clarified by considering the following aspects: (a) music therapy in adult inpatient psychiatric treatment; (b) concepts and studies of single-session therapy; (c) concepts and studies of group therapy; and, (d) music therapy improvisation.

Music Therapy in Adult Inpatient Psychiatric Treatment

On inpatient psychiatric units, staff members from different disciplines, such as psychiatrists, social workers, nurses, psychologists, and creative arts therapists, work together in an often fast-paced environment where patient turnover rates have increased to reflect shorter stays (Kalseth et al, 2016; Park et al, 2015; Silverman, 2009). Working in inpatient psychiatric units, these staff members consistently experience a variety of issues, including concerns related to safety, aggression, violence, burnout, excessive workload, and stressful professional relationships with co-workers and patients (Hallett, Huber, & Dickens, 2014; Kelly et al., 2016; O'Connor, Neff, & Pitman, 2018; Slemon et al., 2017). Meanwhile, patients hospitalized in inpatient psychiatric units may experience feelings of confinement and restraint; not being cared for; loss of control, autonomy, and normality; and senses of fear, stigma, isolation, and rejection. Conversely, patients may also feel safe, supported and cared for; may experience healing as a result of treatment; and may regain a sense of control and learn to manage their mental health (Johansson & Lundman, 2002; Jones & Mason, 2002; Katsakou & Priebe, 2007; McGuiness et al., 2018; Seed, Fox & Berry, 2016; Thineault et al., 2010). In light of this, the need for support

and structure should be provided in acute inpatient psychiatric care, stressing the importance of program clarity and positive relationships between caregivers and patients (Bola & Mosher, 2003; Johansson & Eklund, 2004; Thineault et al., 2010). Importantly, in addition to staff members and patients, insurance providers represent an invisible but influential third party involved in the treatment process; these insurance providers consist of private insurance companies and government benefit agencies (Thomas, 2007; Silverman, 2009). Considering these factors, work on psychiatric units is becoming increasingly complicated and intense.

Despite this intense and complicated situation in inpatient psychiatric treatments, hospitalized patients with diagnosed mental illness are continuing to benefit from music therapy in treatment. Carr, Odell-Miller, and Priebe (2013) conducted a systematic review of 98 studies and reports from different countries on music therapy with adult patients admitted for treatment of acute symptoms in psychiatric care. The results suggested that while there are difficulties in managing rapid patient turnover and fostering initial engagement, patient adherence to music therapy remains high. Moreover, according to these researchers, music therapy can be effective in reducing psychiatric symptoms and improving interpersonal interaction. In addition, the researchers found and posited that structured active music production, such as improvisation or playing pre-composed music, plays a dominant role in music therapy for inpatient psychiatric care.

That said, in the current working environment on psychiatric units, a creative arts therapist or music therapist provides various group programs to meet the different goals of patients (Thomas, 2007). The following discussion first addresses the shorter length of stay for inpatient psychiatric patients. Subsequently, guidelines of music therapy in mental health from

the American Music Therapy Association (AMTA) will be reviewed, as well as a number of studies on music therapy in inpatient psychiatric treatment.

Recent Development of Inpatient Psychiatric Treatment

Several studies have documented a gradual decline in the length of stay for inpatient psychiatric care throughout the 1980s, the 1990s, and the 2000s (Black & Winokur, 1988; Hudson, 2004; Ithman et al, 2014; Lee, Rothbard, & Noll, 2012; Lieberman et al. 1998; Silverman, 2009; Sturm & Bao, 2000; Thomas, 2007; Watanbe-Galloway & Zhang, 2007). Hudson (2004) indicated that hospitals in Massachusetts progressively shortened the length of stay in the 1990s. At that time, these hospitals could not keep up with increasing demand for psychiatric acute care due to an increased number of readmissions associated with a greater number of discharges. Watanabe-Galloway and Zhang (2007) found that the average length of hospitalization for patients with serious mental illness in the United States declined from 12.8 days to 9.7 days in the years 1995 to 2002. As Thomas (2007) noted, in most inpatient hospital settings, the length of stay for acute psychiatric care has been reduced to seven to 10 days or less. Lee, Rothbard, and Noll (2012) indicated that the average length of stay was 10.0 ± 3.0 days based on the sample of 106 hospitals from which 45,497 adults with serious mental illness were discharged in 2006. Ithman et al. (2014) revealed that the median length of stay was nine days and the average length of stay was 14.6 days with a range of one to 189 days based on the sample of 391 inpatients at an acute care psychiatric hospital located in Central Missouri from January 2006 to September 2009.

There are a number of reasons for shortened hospitalizations; however, the two most important ones are improved medications and financial factors. The advancement of pharmacotherapy has reduced the need for inpatient care, which has decreased length of stay

(Silverman, 2009; Sturm & Bao, 2000). Ultimately, the high costs of inpatient hospitalization, which both private and federal insurance will no longer sustain, have drastically shortened length of stay (Black & Winokur, 1988; Silverman, 2009; Thomas, 2007).

Professionals working on psychiatric units need to constantly revise goals, interventions, and the existing concepts of therapy to adapt to the increased patient turnover rates. While adapting to the current work environment in adult inpatient psychiatric care, basic standards of clinical practice must be met.

Standards of Clinical Practice for the Music Therapist Working in Mental Health

According to the AMTA (2013), the standards of clinical practice are the rules for measuring the quality of service. Music therapists, when conducting music therapy, follow a general procedure, comprising: (a) referral and acceptance; (b) assessment; (c) treatment planning; (d) implementation; (e) documentation; and, (f) termination. However, as will be noted, these standard practices are often adjusted or truncated in the context of inpatient treatment.

Regarding referral and acceptance, a client is considered to be a candidate for music therapy when "a cognitive, communication, psychological, educational, social, or physiological need might be ameliorated or prevented by such services" (American Music Therapy Association, 2013). The music therapy assessment includes the general psychological, cognitive, communicative, social, and physiological categories focused on the client's needs and strengths. The assessment also determines the client's responses to music, musical skills, and musical preferences as well as cultural aspects, including ethnicity, religion, socioeconomic status, and gender identity.

After the assessment, the treatment plan is established according to the AMTA (2013) guidelines. The music therapy program plan is designed to

> (a) help the client attain and maintain the maximum level of functioning, (b) comply with federal, state, and facility regulations, such as Health Insurance Portability and Accountability Act (HIPPA), a regulation of privacy**,** (c) delineate the type, frequency, and duration of music therapy involvement, (d) contain goals that focus on assessed needs and strengths of the client, (e) contain objectives, which are operationally defined for achieving the stated goals within estimated time frames, (f) specify procedures, including music and music materials, for attaining the objectives, including music, instruments, and musical elements, from the client's culture as appropriate, (g) provide for periodic evaluation and appropriate modifications as needed and optimize, according to the best professional judgment of the Music Therapist, (h) change to meet the priority needs of the client during crisis intervention, (i) comply with infection control procedures , and (j) Incorporate medical precautions as necessary.

Concerning the implementation of treatment based on AMTA standards, the music therapist should:

> (a) strive for the highest level and quality of involvement consistent with the functioning level of the client - the Music Therapist's provision of music will reflect his or her best abilities as a musician, appropriate musical instruments and materials, as well as the best possible sound reproduction equipment should be used in music therapy services, and the Music Therapist will make every effort to ensure safe and quality of client care, (b) use methodology that is consistent with recent advances in health, safety, and infection control practices, (c) maintain close communication with other individuals involved with

the client, (d) record the schedule and procedures used in music therapy treatment, (e) evaluate the client's responses periodically to determine progress toward the goals and objectives, and (f) incorporate the results of such evaluations in subsequent treatment, (g) Consider the psychological effects of therapeutic separation as termination of services approaches.

Regarding documentation, the music therapist documents the client's referral to music therapy, assessment, placement, treatment plan, and ongoing progress in music therapy in a manner consistent with federal, state, and other regulations and policies (American Music Therapy Association, 2013). Music therapists terminate services when the client has attained the stated goals and objectives, fails to benefit from services, can no longer be scheduled, or is discharged.

In accordance with the standards of clinical practice, music therapists strive to provide the highest level of quality when writing the treatment plan, implementing therapy, and carrying out termination. However, for many music therapists working on inpatient psychiatric units today, some standards cannot be effectively achieved. Due to patients' instability upon admission, it can be difficult to conduct a comprehensive assessment. Additionally, owing to rapid turnover, the treatment process frequently cannot be thoroughly implemented. As Thomas (2007) indicated, "acute care essentially demands assessment and treatment of clients simultaneously" (p. 128).

Considering this limited length of acute inpatient psychiatric care, music therapists must revise their interventions. Single-sessions of music therapy are becoming more common during hospitalization. In light of this, the reality and concept of single-session therapy are discussed in the following section.

Concepts and Studies of Single-Session Therapy

Several reports and studies have postulated the effectiveness and importance of single-session therapy. The theories and methodologies of single-session therapy will be reviewed by focusing on its development, as well as on a number of studies and case reports. Various studies on the utilization of music therapy practice in single-session therapy and other fields of the helping professions will then be discussed and reviewed.

Development, Studies, and Reports of Single-Session Therapy

In 1990, Talmon coined the term *single-session therapy* (SST) in a book with the same tile, which included a number of case reports and studies of unplanned single-session treatment due to early termination or dropout. A single session, as Talmon (1990) indicated, was viewed at the time as a failure and the patient was labeled as a no-show (if it was the second appointment), dropout, prematurely terminated, or given other negative or derogatory assignments. In his book, Talmon described his interest in this topic, as he explained the process of forming the concept of single-session therapy. He called all 200 patients with whom he had conducted a single session (often an unplanned one), and found that 78% of them stated that they got what they wanted out of the single session and felt better or much better about the problem that had led them to seek treatment. He found that a significant number of patients actually benefited from single-session therapy.

In fact, before Talmon (1990), numerous studies or case reports suggested that premature termination and one session of treatment could result in positive outcomes. One well-known example of single session therapy was the case of Katharina (as cited in Talmon, 1990). Freud treated Katharina in a single session during one of his vacations on an Austrian mountaintop. Grotjahn (1980) described a successful single-session treatment of a 45-year-old depressed

physician who expressed gratitude for the insight he had gained, and, in a follow-up interview, reported a stable and satisfactory home and work life. Grotjahn attributed the success of the therapy to its having brought into consciousness repressed conflicting emotions. Saul (1951, as cited in Rockwell & Pinkerton, 1982) offered the case example of a successful single-session therapy of a woman with hypochondria who reported that she was tremendously relieved in one interview and could handle future difficulties. Littlepage et al. (1976) reported that, based on data that were collected via telephone interviews, clients who dropped out of outpatient therapy treatment did not evaluate the service differently from clients who completed the entire recommended course of treatment.

Malan et al. (1975) found that single-session patients who were followed up with two to nine years after their therapy in London's Tavistock clinic demonstrated from therapist's evaluation not only evidence of improvement in daily coping mechanisms, but also, unexpectedly, evidence supporting the therapeutic effects of single interviews. Silverman and Beech (1984) found that the satisfaction ratings of single-session and multi-session clients were highly similar and remarkably favorable. Hence, single-session therapy has been a potentially successful treatment modality in mental health and helping professions. Bloom (2001) concluded, "The literature on single-session psychotherapy that has appeared in the past two decades has suggested that it is a field worthy of continued investigation" (p. 83).

More recently, studies indicate that the single-session modality could be potentially effective for various therapy techniques, such as motivational interviewing and behavior modification treatment, with different populations (Basoglu, Salcioglu, & Livanou, 2007; Diskin & Hodgins 2009; McCambridge & Strang, 2004). Diskin and Hodgins (2009) conducted a randomized clinical trial to test the effects of a single motivational interviewing session on

reducing gambling behaviors in individuals who expressed concerns about their gambling. Researchers indicated that single-session motivational interviewing served as a brief intervention for people who wished to cut down or quit gambling. The study was a randomized clinical trial that tested the effect of a single-session motivational interviewing compared with a control interview for reducing gambling behaviors. Participants (N=81) were followed up at 1, 3, 6, and 12 months post—intervention. For dollars gambled per month, a significant main effect was found for intervention, $F(1,84) = 5.28$, $p < .03$; the motivational interviewing group spent few dollars gambling at all follow-up periods compared with control interview group. For days gambled per month, a significant main effect was found for intervention $F(1,80) = 3.83$, $p < .05$; the motivational interviewing group spent fewer days gambling than the control interview group. This study indicated the effect of motivational interviewing on reduction in gambling behaviors.

Similarly, McCambridge and Strang (2004) tested the effectiveness of a single session of motivational interviewing on alcohol, tobacco, and illicit drug use, proposing that it would reduce the use of these substances and increase the awareness of drug-related danger among young people. The clustered random trial was conducted, allocating the 200 participants into either motivational interviewing (n = 105) or non-intervention education-as-usual control conditions (n = 95). For change in cigarette smoking over three-month study period, the intervention group decreased by 21% on this measure, from 31.9 to 25.2 cigarettes per week while the control group increase by 21% from 35.0 to 39.4 cigarettes per week. For change in alcohol consumption over three-month study period, the intervention group decreased on this measure from 12.7 to a mean of 7.7 alcohol unit (a half pint of 3.5% beer being 1 unit in Britain) in the week while the mean number of alcohol unit per week among the control group increased by 12% from 12.7 to 14.2 units in the week. For change in cannabis use over three-month study

period, the mean frequency of use decreased by 66% in the intervention group from 15.7 times per week to 5.4 while the control group increased on this measure by 27% from 13.3 to 16.9. This study provided substantial evidence that young people appeared to benefit from a single session of motivational interviewing, which led to beneficial reduction in substance use.

Basoglu, Salcioglu, and Livanou (2007) examined the efficacy of a single session of behavioral treatment for earthquake survivors on reducing post-traumatic stress disorder (PTSD) by exposing participants to simulated tremors in an earthquake simulator and self-exposure instructions. Thirty-one earthquake survivors with PTSD were assigned either to a single session of behavioral treatment (n = 16) or to repeated assessments (n = 15). Assessments in the treatment group were at 4, 8, 12, 24 weeks and 1 – 2 years post-treatment. The repeated assessment cases were assessed at baseline and 4 and 8 weeks after trial entry, after which they received the same treatment and followed up at 4, 12, 24 weeks and 1 – 2 years. Improvements rates were 40% at week 4, 72% at week 12, 80% at week 24, and 80% at 1 – 2 year follow-up on the measure of fear and PTSD. The study provided evidence of the efficacy of a single session of behavioral treatment on reducing fear and PTSD among earthquake survivors.

Research has examined single-session music therapy treatment with promising results. Rosenow and Silverman (2014) explored the effects of a single session of music therapy on inpatients in an adult bone marrow transplant (BMT) unit. Two studies were included in this research. In the first of two studies, participants recovering from a BMT (N = 50) completed Likert scale questionnaires regarding the effects of live music on their anxiety, nausea, fatigue, pain, and relaxation. In the second study, a randomized controlled trial with pre and posttests was utilized to determine how music therapy might affect fatigue (N = 18). The researchers examined the immediate effects of single-session music therapy on BMT patients' fatigue

compared to standard care alone (Rosenow & Silverman, 2014). The results indicated that patients participating in music therapy sessions showed immediate and significant improvements in fatigue, anxiety, and relaxation from pre- to post-test, with effects lasting to follow-up, as repeated measured ANOVAS showed statistically significant improvements in measures of relaxation: $F(2,86) = 27.00$, $p < .001$, anxiety: $F(2,86) = 23.87$, $p < .001$, and fatigue: $F(2,86) = 19.28$, $p < .00$. Participants indicated that they would like to receive music therapy again in the future. One limitation is that the results may have been biased due to the dual relationship, in that researchers were also the practicing clinicians. Moreover, the condition and single session of each participant varied, which could have influenced the results. Nevertheless, the results support the potential impact of single-session music therapy as a treatment approach

Concepts and Studies of Group Therapy

Another impact of shorter length of hospitalization is that group therapy dominates inpatient acute psychiatric care. This is because there is often not enough time for individual sessions due to the short length of stay (Thomas, 2007). Group therapy treatment is economical in that it can benefit more patients per hour (Scaturo, 2004). Additionally, as mentioned above, in most adult inpatient psychiatric care facilities in New York City and New York State, a number of activity therapy groups are provided daily by activity therapists or creative arts therapists to fulfill the requirement of the Rights of Inpatients in New York State Office of Mental Health Psychiatric Centers (2012), in which appropriate programs are expected to be included in each patient's basic treatment plan. In addition, groups must be provided to fulfill section 580.6(a)4 of Operation of Psychiatric Inpatient Unit of General Hospitals (n.d.): "The programs provided by the unit shall include diagnostic and active treatment, including but not

limited to individual and group psychotherapy, acceptable somatic therapies, psychiatric nursing care and a therapeutic milieu…"

Moreover, as Schermer and Pines (1999) pointed out:

> Group has come to play an important role in the treatment of psychotic disorders…Group therapy received a strong impetus in both the USA and England via the treatment of traumatized soldiers at 'Veteran's Administration' and military hospitals during and after World War II. (p. 15)

Concepts of Group Therapy

Several researchers and authors have suggested that group therapy can effectively help people develop skills and insights to cope with difficulties and solve problems in their lives (Corey, 2014; Gladding, 2015; Schermer & Pines, 1999; Whitaker, 2001; Yalom & Leszcz, 2005). Corey (2014) posited that group "is frequently more effective than the individual approach. This effectiveness stems from the fact that group members not only gain insight but practice new skills both within the group and in their everyday interactions outside the group" (p. 5). Day (2014), however, argued that "the group is a therapeutic setting in which each member learns from experience with others in relationships significantly distinct from their relationships in the everyday world" (p. 25).

That said, groups are social and living systems where group members acquire support and energies, instill hope and a sense of belonging in one another, extend interpersonal learning through group cohesiveness, and further establish self-awareness and problem solving skills (Forsyth & Diederich, 2014; Yalom & Leszcz, 2005). Corey (2014) articulated potential goals of the group experience as follows:

> (a) to increase one's awareness and self-knowledge in order to develop a sense of one's unique identity; (b) to recognize the commonality of members' needs and problems and to develop a sense of connectedness; (c) to help members learn how to establish meaningful and intimate relationships; (d) to assist members in discovering resources within their extended family and community as ways of addressing their concerns; (e) to increase self-acceptance, self-confidence, self-respect, and to achieve a new view of oneself and others; (f) to learn how to express one's emotions in a healthy way; (g) to develop concern and compassion for the needs and feelings of others; (h) to find alternative ways of dealing with normal developmental issues and of resolving certain conflicts; (i) to increase self-direction, interdependence, and responsibility toward oneself and others; (j) to become aware of one's choices and to make choices wisely; (k) to make specific plans for changing certain behaviors; (l) to learn more effective social skills; (m) to learn how to challenge others with care, concern, honesty, and directness; and, (n) to clarify one's values and decide whether and how to modify them. (p. 6)

A group therapist's overall purpose, as Whitaker (2001) addressed, is to enable and assist each individual in a group to achieve personal benefit through making as full use of the potentials of the group.

All these goals and purposes of group therapy are meant to help each group member to enhance self-awareness, develop social skills, and express emotion appropriately, as well as for the group leader to provide a safe space. Therefore, Corey (2014) also argued that group leaders require "specific leadership skills and the appropriate performance of certain functions. Like most skills, leadership skills need to be learned and practiced" (p. 22). Corey (2014) delineated the essential group leadership skills as follows:

(a) active skills; (b) restating; (c) clarifying; (d) summarizing; (e) questioning; (f) evaluating; (g) giving feedback; (h) suggesting; (i) protecting; (j) disclosing oneself; (k) modeling; (l) linking; (m) blocking; and, (n) terminating.

Group leadership skills can be trained, but personal characteristics cannot be overlooked, including interpersonal skills, responsiveness, presence and engagement. There are also factors involved in the timing and judgment of therapists while implementing these skills to create a safe group climate and space, as well as structure positive group dynamics (Corey, Corey & Corey, 2010; DeLucia-Waack, 2010).

Yalom's Therapeutic Factors

Yalom's concepts of group therapy have been particularly influential in the helping professions. From Yalom's perspective, there are 11 therapeutic factors (Yalom & Leszcz, 2005):

(a) instillation of hope; (b) universality; (c) imparting information; (d) altruism; (e) the corrective recapitulation of the primary family group; (f) development of socializing techniques; (g) imitative behavior; (h) interpersonal learning; (i) group cohesiveness; (j) catharsis; and, (k) existential factors. (pp. 1-2)

These factors have been the predominant standard for examining and understanding therapeutic dynamics in group therapy; however, there have been authors who have criticized the validity of these factors (Kivlighan Jr. & Kivlighan III, 2014). Crouch, Bloch, and Wanlass (1994) pointed out that the therapeutic factors "overlap, making it difficult to classify an event into one therapeutic factor or another" (p.305). According to these authors, the therapeutic factors are also "unbalanced in their content" (Crouch et al., 1994, p. 305); there were rank-ordering studies to examine the therapeutic factors (Garcia-Cabeza & Gonzalez de Chavez,

2009; Hsiao et al., 2004; Kennair, Mellor & Brann, 2016; Shechtman & Haveli, 2005; Sribney & Reddon, 2008), which reflect the levels of importance being perceived differently in accordance to the populations, age, setting, and the length and stages of treatment. Moreover, Kivilighan Jr. (2011) found that an individual's perception of therapeutic factors was not significantly related to session depth or smoothness, which reflected that group leaders' primary function should not be focused on individual group member change. The impact and effect of these factors differ from group to group (Erdman, 2009), which suggests that there might have been inconsistent validity of the therapeutic factors.

Group Therapy in Inpatient Psychiatry

On inpatient units, therapy groups contain new patients as well as those preparing for discharge (Leite, 2003). Therefore, some group members will be present for the first time, and others will be terminating treatment. The composition of group membership is different for each session (Yalom & Leszcz, 2005). Moreover, Kriss and Mulligan (2013) argued, "the inpatient group therapist faces the daunting task of working with individuals during an acute phase of illness" (p. 21). In inpatient psychiatric care, patients are admitted with an extensive range of diagnoses and psychopathology. As a result, it can be challenging to lead a therapy group that is inclusive of all levels of functioning. Furthermore, group membership often differs for each session, which affects group cohesion and also presents challenges to the therapist. Hence, in terms of groups in inpatient psychiatry, Yalom & Leszcz (2005) stated that "the inpatient group therapist must consider the life of the group to be only a single-session" (p.488).

Treatment plans and group therapy interventions must be adapted to consider the shorter duration of hospitalization and range of diagnoses in inpatient psychiatric care (Cook et al., 2014; Yalom & Leszcz, 2005). In Yalom's (1983) book *Inpatient Group Psychotherapy*, he

stressed the importance of modifying structures and techniques, offering support, and focusing on the here-and-now moment of therapy. In terms of the concept of *here and now*, Corey (2014) added, "group work emphasizes interpersonal communication of conscious thoughts, feelings, and behavior within a here-and-now time frame" (p. 5). Group therapists need to modify their techniques by assessing the clinical setting, formulating realistic goals, being mindful of time frame and efficiency, providing a supportive atmosphere, and implementing external structure and stability (Yalom & Leszcz, 2005).

There have been several studies that have addressed these issues in inpatient psychiatric care, including the adaption of evidenced-based group therapy (Snyder, Clark, & Jones, 2012). Snyder and colleagues (2012) studied psychologists working in the state psychiatric hospital system of North Carolina who applied and adapted evidence-based group therapy approaches in different settings and with different populations. The results of the study indicated that psychologists and psychology directors provided various therapy approaches that focused on improving social skills, relaxation techniques, and psychoeducation. Group therapists and psychologists identified a need to adapt group protocols to fit patients' needs. These modifications included choosing more achievable goals, adding more repetition and reminders, slowing the pace of the presentation, and being more active.

Additional research has posited that structured systematic psychoeducation for inpatient groups enhanced participants' knowledge about mental illnesses and treatment (Duman, Yildirim, Ucok, Er, & Kanik, 2010). This study found that patients with chronic mental illness ($N = 62$) were able to learn complex materials presented in a short and well-structured group program during an inpatient stay. Similarly, Cook, Arechiga, Dobson, and Boyd (2014) postulated that a process-oriented psychoeducational (POP) treatment model is suited for

inpatient psychiatric acute care, and outlined a future study based on an integration of various studies.

Several studies have examined the effectiveness of inpatient group therapy for patients with psychiatric illness. Kösters, Burlingame, Nachtigall, and Strauss (2006) explored the effectiveness of inpatient group therapy in a meta-analysis of 24 controlled studies and 46 studies with pre/post measures published between 1980 and 2004. The effectiveness of inpatient group therapy was found in controlled studies (d = 0.31), as well as in studies with pre–post data (d = 0.59). Owen, Speight, Sarsam, and Sellwood (2015) conducted a review of studies on group cognitive behavioral therapy (CBT) for psychosis. While research of group CBT for psychosis has been widely conducted with outpatient populations, this review focused on inpatient treatment. There were 10 located studies examining inpatient group CBT for psychosis; two of the studies were randomized controlled trials, two were cohort studies, and the remainder were pre-/post-intervention studies. The findings from all the studies suggested that there were positive effects of group CBT, such as the reduction of distress associated with psychotic symptoms, increased knowledge of symptoms, decreased affective symptoms, and reduced readmissions over several years.

The aforementioned theory and research on group therapy encompassed different theoretical orientations and diagnoses; however, they had common limitations in that the researchers did not report the duration of the effects. This could be because of the difficulty of following up with people with severe mental illness, who are often transient, homeless, incarcerated, and difficult to track (Draine, Salzer, Culhane, & Hadley, 2002). Moreover, the aforementioned studies reflected the emphasis of behavioral psychology for group work in inpatient psychiatric care.

The Application of Creative Arts Therapy Groups in Inpatient Psychiatric Care

In addition to psychoeducation and traditional psychotherapy groups, creative arts therapy groups are also widely applied in inpatient psychiatry. Körlin, Nybäck, and Goldberg (2000) explored the potential of creative arts therapy groups in a 4-week inpatient psychiatry program comprising different weekly modalities of body awareness, guided imagery and music (GIM), art therapy, occupational therapy, and verbal group therapy. The researchers noted that creative arts and non-verbal psychotherapies were thought to help patients' access, give form to, and integrate experiences, memories, and emotions that they may not have been able to directly verbalize. Artistic expression was thought to link non-verbal experience and verbalization. Three self-rating forms, the SCL-90 (Hopkins Symptoms Check List-90), the IIP (Inventory of Interpersonal Problems), and the SOC (Sense of Coherence scale), were administered immediately before and after the 4-week treatment, as well as six months after discharge from the unit. Among participants ($N = 43$), the SCL-90 profile showed a significant improvement in Global Severity Index , $p < .001$, and other subscales such as Anxiety, $p < .05$, and Interpersonal Sensitivity, $p < .01$. IIP scores showed a significant improvement in all subscales such as Exploitable, $p < .05$, and Overly Expressive, $p < .01$. The results of the study indicated significant improvements in most outcome measures. A post-discharge follow-up measurement was a major strength of this study.

Montag et al. (2014) investigated the effect of psychodynamic art therapy for the treatment of patients with schizophrenia during acute psychotic episodes in inpatient psychiatric treatment. In this study, patients with schizophrenia ($N = 58$) were randomized to either 12 twice-weekly sessions of psychodynamic group art therapy plus treatment as usual or to standard treatment alone. Effects of both models were assessed at baseline, immediately post-treatment,

and 12 weeks post-treatment. Fifty-five percent of patients were randomized to art therapy while 66% of patients received treatment as usual. Art therapy was associated with a significantly greater mean reduction of positive symptoms, $F(1, 32) = 11.698$; $p < .01$, at post-treatment and, $F(1, 30) = 6.96$; $p < .05$, at follow-up compared to standard treatment. Art therapy was also associated with a greater mean reduction of negative symptoms, $F(1, 30) = 7.82$; $p < .01$, at follow-up compared to standard treatment. The results indicated that participants in the art therapy group showed significant improvement, $F(1, 29) = 5.632$; $p < .05$, in levels of emotional awareness, particularly in their ability to reflect others' mood states. The results support the use of art therapy for patients with schizophrenia receiving inpatient care.

Kriss and Mull (2013) reported a case study of a collaborative story-writing exercise in inpatient group psychotherapy. They theorized that collaborative story-writing creates a playground where patients with a wide range of functioning levels and psychiatric diagnosis can explore deeper interpersonal issues in a safe context. Although this was not an empirical research study, it presented the promising use of a creative arts therapy intervention with patients on an inpatient psychiatric unit.

The aforementioned studies and reports exhibit the potential of creative arts therapy groups to improve patient’s emotional awareness, interpersonal dynamics, and psychosocial functions. In addition, creative arts have the potential to extend the dimensions of group psychotherapy by using a variety of artistic elements to create a safe space and group cohesiveness. Creative arts can also enhance self-awareness, which resonates with and actualizes more aforementioned goals and purposes of group therapy (Corey, 2014; Whitaker, 2001). That said, because of the primacy of behavioral and psychoeducation-oriented group work in the inpatient setting, further interdisciplinary communication and advocacy might be

needed to develop creative arts therapy groups in this setting. In addition, while the aforementioned studies addressed the effects of creative arts therapy groups in inpatient psychiatric care, the experiences of a single-session model, which is the main focus of the present study, was not explored in these studies.

Single-Session Group Therapy

A number of studies and case reports have shown single-session group therapy to be a promising treatment intervention (Doyle, 2015; Filip, 1994; Lavarenne, 2013). Group dynamics fostered in single-session group therapy have been deemed to potentially promote healthier ego boundaries (Lavarenne, 2013). Psychoeducational group therapy can help patients with eating disorders develop new and positive alternatives within one session (Doyle, 2015). In addition, single-session art therapy can be sufficient to gain benefits, such as awareness of one's emotions (Filip, 1994).

Lavarenne (2013), in a group case study, reported on a single outpatient group psychotherapy session conducted with six individuals with schizophrenia or schizoaffective disorder who were characterized by fragile ego boundaries. The report theorized that the group dynamics promoted healthier ego boundaries and eventually improved self-differentiation and tolerance to close interpersonal contact. While this case study presented the potential benefits of single-session group therapy on reconstructing fragile ego boundaries, the sample was relatively small, and the definition of ego boundary can be vague and abstract.

Doyle (2015) presented the work of single-session groups with hospitalized patients with eating disorders. Protocols for single session groups were developed to support patients receiving inpatient psychiatric treatment, and the goals of these single session groups were to increase awareness of life challenges, reduce their sense of defectiveness, and develop coping

skills. Groups were mostly psychoeducational, and at times implemented a cognitive behavioral therapy framework for developing new and positive alternatives. Patients generally found that the process of participating and exchanging perspectives to be helpful, and they indicated that the short duration of these groups was experienced as an advantage because it did not require them to commit to a series of sessions. This report was focused on patients with eating disorders; therefore, the utilized protocols may not be applicable to patients with psychosis or other acute psychiatric symptoms.

Filip (1994) described her work as an art therapist in a psychiatric hospital where the patients' average stays ranged from 7 to 14 days. They were only able to attend a few group sessions, making it difficult to examine the value of such brief treatment. She indicated that it was necessary for clinicians to modify treatment plans and goals to the short-term setting. Anecdotally, she found that one session could sufficiently educate patients about art therapy and help them gain awareness of their feelings and emotions. A single art therapy session could also identify problems as well as the goals for therapy. Moreover, a positive first experience with therapy may encourage patients to seek additional treatment. While this report indicated the efficacy of single-session model, the author was unable to follow up on patients' progress after discharge, which is a significant limitation of most of the published reports and studies on single-session treatment.

Single-Session Music Therapy Groups

Mungas and Silverman (2014) investigated the immediate effects of a single 45-min wellness group on the affective states of university students. The participants were undergraduate and graduate university students from various majors ($N = 50$). The experimental condition entailed a drumming protocol ($n = 17$). The researchers located participants of the

control group (n = 33) from two introductory classical guitar classes. The researchers used the Quick Mood Scale at pre- and post-test. In addition, participants in the experimental group gave post-session comments regarding the drumming intervention. Participants in the drumming condition were more likely to describe themselves as less anxious, less depressed, and less aggressive. This result indicated that active drumming could be more effective for reducing negative affective states in university students compared to guitar class. In this study, generalization is an issue due to lack of randomization and a relatively small sample size.

Jones (2005) investigated and compared the effect of a single session of song writing and lyrics analysis on emotional change in people who were chemically dependent. Three females and 23 males randomly attended either a songwriting group (n = 13) or a lyric analysis group (n = 13). The researchers used pre- and post-tests to measure mood; the Visual Analog Mood Scale containing 11 emotion variables was completed before and immediately after sessions. A two-way ANOVA on pretest data revealed no significant differences between the songwriting and lyric analysis groups, $F(1, 264) = 1.08$; $p > .05$, while significant differences were indicated among the emotional variables post-intervention, $F(10, 264) = 3.52$; $p < .05$. Song writing and lyric analysis were both successful in inducing emotional change after a single session. Additionally, both groups experienced significantly increased feelings of acceptance and joy/happiness/enjoyment while significantly reducing feelings of guilt/ regret/blame, as well as fear/distrust. Overall, 75% of participants considered music therapy to be a significant tool in recovery. However, in this study, 23 of the 26 participants were male, so the results may not generalize to female clients.

Single-Session Music Therapy Groups in Inpatient Psychiatry

Two studies by Silverman (2009; 2011) illustrate the effectiveness of a single-session music therapy group in inpatient psychiatric facility. Using a randomized controlled trial with only a post-test, Silverman (2009) explored the effect of a single session of a psychoeducational music therapy group on life satisfaction, knowledge of illness, and perception of treatment compared to a psychoeducational session without music. One hundred and five participants whose typical length of stay was three to five days were included. Three *t*-tests for independent samples were conducted to determine differences between groups. No significant differences emerged between groups with music therapy and with no music in the measure of helpfulness, enjoyment, and comfort, $F(3, 100) = 1.54$; $p > .21$, as well as in the measure of life satisfaction and pyschoeducational knowledge, $p > .05$. However, the music therapy group tended to have slightly higher mean scores on all aforementioned variables, suggesting music therapy can be just as effective as psychoeducation.

Silverman (2011) investigated the effect of a single-session group music therapy with the goal of increasing assertiveness through role-playing for psychiatric inpatients. Participants (N = 133) were cluster randomized into one the following conditions: experimental condition (assertiveness music therapy group), control condition (assertiveness group with no music), and another control condition (music group with no assertiveness). Four separate analyses of variance (ANOVA) were conducted to determine differences between the three treatment groups after the first session of treatment was completed. The results showed that a higher percentage of patients in both the assertiveness music therapy group (39.62%) and music group with no assertive conditions (42.55%) considered music to be helpful and therapeutic. The researcher

concluded that single session assertiveness-directed music therapy can be an effective intervention and protocol in acute psychiatric units.

These two studies showed that single-session music therapy could be effective in the inpatient psychiatric setting despite ever-shortening stays (Silverman, 2009; 2011). However, the focus of these two studies was to elicit behavioral and cognitive changes through behavioral psychology, psychoeducation, and assertiveness training, which parallels the methods of verbal group therapy. Music, in these two studies, was not the main treatment component. That said, according to a summary of music therapy studies with adult psychiatric patients in *Music Therapy in Mental Health for Illness Management and Recovery* (Silverman, 2015, p. 239 – 249), as well as a systematic review of music therapy in adult inpatient psychiatric care (Carr, Odell-Miller, & Priebe, 2013), it is clear that there are a limited number of studies on the effects of single-session improvisational group music therapy in inpatient psychiatric care.

Music Therapy Improvisation

Ansdell (1995) regarded improvisation as the main tool music therapists use to involve clients immediately in a "creative musical experience" (p. 2). Music therapy improvisation involves one or more people in a creative process and experience of exploring, establishing, and communicating interpersonally in an immediate musical moment and space (Ansdell, 1995; Pavlicevic, 2000). It also involves the motion of tones and elements of music, which are essential in the process of music making as well as in music therapy improvisation (Ansdell, 1995; Zuckerkandl, 1969).

Definition of Music Therapy Improvisation

In music therapy, improvisation is regarded as the process of music making that may generate, reflect, and portray the authenticity of the relationship and interaction between people,

even in cacophonous and dissonant sounds (Pavlicevic, 2000). Sutton (2018) found that improvisation in music and in everyday conversation have similarities at deeper and structural levels, pertaining to temporal, sequential and structural features of conversations and musical improvisation. Furthermore, as DeBacker and Foubert (2016) indicated, the music in music therapy improvisation is "located within the patient's and therapist's immediate presence. In this relationship, the intrinsic value of the musical experience is the primary effect of the music itself" (p. 113). Improvisational skills are also mandated in American Music Therapy Association (AMTA) educational competencies (2009): (a) improvise on percussion instruments; (b) develop original melodies, accompaniments, and short pieces extemporaneously in a variety of moods and styles, vocally and instrumentally; and, (c) improvise in small ensembles (AMTA, 2009, p. 30). Additionally, Bruscia (2012) described music therapy improvisation as follows:

> When music therapy involves improvising, the client "makes up" music spontaneously while playing an instrument or singing, extemporaneously creating sound forms, melodies, rhythms, or entire pieces…As the sounds emerge, the client follows them up with more sounds and gradually shapes them into something meaningful…This process of spontaneous music-making taps into every human being's natural propensity to create and respond to sounds expressively and aesthetically…Improvising is simply playing around with sounds until they form whatever patterns, shapes, or textures one wants them to have, or until they represent or mean whatever one wants. (p. 17)

In light of this, improvisation can be deemed not only as a music making process, but also a self-actualizing and exploratory one, through being in the music and playing in the sounds (Carroll & Lefebvre, 2013). Improvisational music therapy involves musical communication and interpersonal communication within music, which is a vehicle for emotional catharsis and

emotional self-expression (Aigen, 2005). It is a process of music making in the moment with other people (as a group or with therapists and clients), which involves listening intently and responding to the listening (Aigen, 2005); Ansdell (1995) argued, "the vital component of improvisation…is the quality of listening" (p.125). This process of music making in the moment is a medium of aesthetic experience, communicating intimately and creatively with others in the music to achieve nonmusical end and a number of goals such as developing social skills, expressing emotions, resolving conflicts, and improving impulse control…etc. (Aigen, 2005; Ansdell, 1995; Dewey, 1934).

Music therapy improvisation is a process of experiencing elements of music for participants to increase their understandings of self, relationship, life, and issues. It provides a forum and a safe space for group members to meet one another through spontaneous, co-created form; "this highly fluid musical event may well draw from traditional and culturally-based musical styles and idioms although its primary focus is an interpersonal one" (Pavlicevic, 2000, p. 272). It provides "a new experience of creativity, communication and beauty there can be a glimpse of the possibility of growth, potential and transcendence" (Ansdell,1995, p.22). Music therapy improvisation also provides an experience of being connected in time and space, including sequences of regulation, mutually coordinated by therapists and clients through musical elements such as rhythmic change (Trondalen, 2005). Music therapy improvisation involves finding, reflecting, stimulating, and motivating clients' innate strengths using musical means to redirect and reinforce the client's musical, emotional, physical responses, where the therapist and the client move with rhythm, travel with melody, and immerse in harmony (Bruscia, 2012; Carroll & Lefebvre, 2013; Pavlicevic, 2000).

On the elements of music in improvisational music therapy, Ansdell (1995) indicated that music becomes meaningful as "one or more people build a structure of rhythms, melodies and harmonies within an overall form" (p,26); therefore, in this study, these three musical elements (rhythm, melody and harmony) will be a focus. Zuckerkandl (1969) further proposed a concept of the motion of tones to elucidate this musical structure of rhythms, melodies and harmonies. The motion of tones shares a common base with a succession of words as Zuckerkandl (1969) point out, "Successions of words are sentences if they express a meaning. It is the meaning that turns vowels and consonants into words, words into sentences" (p.16). He indicated that tones are related to one another; two tones can make an interval, and succession of tones can be a scale or melody. In this sense, harmony is made up of two or more tones (Zuckerkandl, 1969). A tone is not yet music; it is at best a premise of music. Okazaki (2011) argued, "A musical tone itself is living identity with complex dimensions as it gets layered to take the forms of melody, intervals and harmony. The dynamic motion and action in the tonal world are layered as well" (p.146). Thaut (2013) further indicated, "Rhythm in music is the core element that binds simultaneity and sequentiality of sound patterns into structural organizational forms" (p, 4). In this sense, music begins when a second tone has followed the first (Zuckerkandl, 1959) and when tones move with rhythm as Spring & Hutcheson (2013) indicated that "rhythm operates on several levels to move music through time and to generate musical form" (p. 5).

Brief History of Music Therapy Improvisation

As previously discussed, improvisation is a widely employed music therapy technique and plays a central role in music therapy clinical practice, addressing a broad range of therapeutic objectives and goals concerning emotion, socialization, coping, language, and physical function (Carroll & Lefebvre, 2013; Silverman, 2015). Improvisation was applied in

music therapy not long after the profession was initially developed in the United States and the United Kingdom. In the 1960s, Paul Nordoff and Clive Robbins developed their way of working with disabled children and later formed an approach called Nordoff-Robbins Music Therapy. Forinash (1992) noted that clinical improvisation is the basis of the Nordoff-Robbins approach to music therapy, which rests on the assumption that in every child, regardless of ability or disability, lives an inborn musicality and musical sensitivity.

Meanwhile, Juliette Alvin (Alvin & Warwick, 1991) developed her approach of free improvisation therapy as she and her colleagues founded the British Society for Music Therapy in 1958. Alvin worked with children with developmental delays as she proposed the ideas of musical freedom, hearing and listening, and the power of sound; she subsequently argued that musical improvisations could reveal subconscious processes (Alvin & Warwick, 1991). Around the same period, Mary Priestly (1994) developed the psychodynamic approach known as Analytic Music Therapy in a large psychiatric hospital in England, applying musical improvisation to explore patients' issues. Priestley (1994) argued that "the guided expression of music reduces patients' resistance to denied or split-off emotion, as it can lower the threshold of consciousness…this expression brings with it vivid memories and inner images" (p. 7).

In 1987, Bruscia published *Improvisational Models of Music Therapy,* which was the first textbook delineating different approaches of improvisational music therapy. Wigram (2004) authored *Improvisation: Methods and Techniques for Music Therapy Clinicians, Educators and Students* to further address diverse methods of improvisational music therapy for music therapy professionals and learners. In addition, there are other music therapists who integrated various schools of psychology and ideas from different disciplines into improvisational music therapy. Austin (2008) addressed the power of voice in improvisation by integrating toning, vocal

holding, and free associative singing with the concepts of analytic psychotherapy. Similarly, Warnock (2011) argued that considering interrelationships among the voice, the self, and mother-infant relation, voice in improvisational music therapy can be a manifestation of the individuation process, a container of chaos, and a transitional object. Moreno (2005) has integrated psychodrama and music improvisation to enable people to develop spontaneity and creativity in order to better confront their problems and issues.

Studies of Music Therapy Improvisation

Several studies have demonstrated the potential of music therapy improvisation on attunement, flow optimal experience (Csikszentmihalyi, 2008), and mindfulness. Kossak (2008) conducted a study on attunement and embodiment as explored through sound and rhythm. He explored the professional experiences of musicians and creative arts therapists in free form improvisation, addressing the relationship between attunement and improvisation. One implication of this study suggested the importance of space and safety: with enough safety, one can get through phases, "achieving attunement through free structured sound and rhythmic improvisation" (p. 141). Furthermore, Metzner et al. (2018) conducted a quantitative study to specify and quantify rhythmic attunement processes within free improvisations in the early phase of psychodynamic music therapy in order to investigate its predictive value for therapeutic change. Twenty-one in-patients with psychosis were recruited for the study. Participants received five sessions of individual improvisational music therapy. Statistical analysis suggested that the occurrence of initial rhythmic attunement in the first session predicted the further decline of psychotic symptoms, and it was evident that organized rhythmic attunement affords beneficial effects to patients with psychosis through improvisational music therapy.

As opposed to achievement of attunement in improvisation, when one is unable to establish a sense of safety and space through improvisation (e.g., dissonance or cacophony may prevent one from achieving attunement during the improvisation), he or she is not able to experience relational attunement; this can be thought of as "misattunement" (Kossak, 2009, p.16). Spiegel, Severino, and Morrison, (2000) argued that "empathic attunement results in a state of joy and excitement, misattunement results in a drastic diminution of joy and excitement" (p.26). Jerak, Vidrih, and Žvelc (2018) further indicated that attunement draws client's attention to the present time, embodiment, spontaneity, and intersubjective interaction, leading to the experience of oneness in the group while misattunement triggers unpleasant feeling, lack of spontaneity, resistance of interaction with others, and sense of exclusion. Nonetheless, Kossak (2009) suggested that "misattunement may be an important and necessary stage of psychological development…where a re-experiencing of mistuned moments allows for new awareness, a shift in consciousness, and where new actions and reactions can be integrated" (p.16). In therapy, therapists have to provide care, a sense of safety and support; however, it is also important for therapists to confront and challenge clients so that changes can be made, and a stable structure can be established (Johnson, 2018; Kossak, 2015). In light of this, purposeful misattunement (Stern, 2000) was proposed to describe this challenging and confrontation as Johnson (2018) further elucidated that purposeful misattunement is "an intentional departure from the expected as a means of effecting a change in the other, or as a way of communicating a specific feeling to the other person" (p.254).

Wilhelmsen (2012) qualitatively investigated music therapists' experiences of flow (Csikszentmihalyi, 2008) during improvisation in music therapy as Csikszentmihalyi and Rich (1997) stated, "Musical improvisation, under ideal conditions, is an excellent vehicle for the flow

experience" (p. 49). In this study, five music therapists were interviewed, and three themes emerged as follows: flow, therapist, and working therapeutically. Participants spoke of the importance of experiencing flow during music improvisation. The theme of "therapist" described therapists' musical relationship with flow and their clinical intentions. The final theme of working therapeutically discussed their therapeutic implications. The findings suggested that flow is an experience that can help promote health and new possibilities when facilitating music therapy.

Similarly, Fidelibus (2004) explored the concept of mindfulness in the practice of music therapy clinical improvisation. He investigated therapists' experiences of clinical improvisation in the moments when the music feels like it flows. He proposed that mindfulness in clinical improvisation is "a cyclical process that can happen in the flash of a moment or over a sustained period of time" (p. 204). The implication of these studies is that the experience of music therapists in clinical improvisation involves a continual process of attention to the present musical moment, cultivating mindfulness (Fidelibus, 2014; Wilhelmsen, 2012).

Similar to this researcher's (Chen, 2019) aforementioned pilot study, a few researchers have examined the benefits and experiences of music therapy improvisation by exploring accomplished musicians', professional artists' and therapists' feedback and reactions to this intervention. Inada (2011) explored a case of a musically accomplished client who was part of improvisational group music therapy in an outpatient psychiatric treatment setting. Inada provided indirect therapeutic intervention involving musical improvisation where this patient initially exhibited the stance of "soloist", being uninterested in the reciprocal responsiveness for group music making. In the later phase of group treatment, this patient was able to play supportive music; instead of playing only assertive melodies, this patient played recurrent

resonant harmonies. This researcher found that this change occurred when the therapist facilitated the development of the group by modelling collaborative improvisation, rather than by intervening directly.

Seabrook (2018) explored the experiences of professional artists in clinical improvisation by using qualitative content analysis. Eighteen participants were recruited for this study, including thirteen musicians, two authors, one actor, and two visual artists; none of the participants had any prior experience with clinical improvisations, while four participants had prior musical improvisation experience. Participants participated in either individual or group clinical improvisation; following this, participants immediately engaged in structured interviews with the researcher. A qualitative method was conducted to analyze the data, yielding four themes: (a) requirements of engaging in clinical improvisation; (b) experiences of self; (c) relationship with the music therapist; and (d) a unique experience for classical musicians. This study found that professional artists shared identical experiences of clinical improvisation in ways congruent with those who have specific health and well-being needs such as depression, AIDS, dementia, or neurological challenges. Professional artists can therefore benefit from clinical improvisation to address health and well-being needs.

Arnason (1998) conducted a qualitative study to systematically investigate music therapists' experience in an improvisational music therapy group in order to discover and understand different facets of the group and the musical process. Five music therapists were recruited in this study. Arnason's own experience as a music therapist and researcher and participants' experiences related to their clinical work outside the group was explored in this study. Eighteen group sessions were conducted to give music therapists the experience of being clients and of using the musical and creative experience for therapeutic purposes. The

improvisational experience includes musical improvisation, artwork, and use of metaphors and imagery.

Arnason (1998) used naturalistic inquiry to generate information grounded in the improvisational process, that is closely associated with the realities of participants' group experience, and that illuminates the different aspects of musical improvisation. A method of data analysis emphasizes the researcher's use of self and utilizes intuition in the reflexive process of data collection and interpretive analysis. Creative narrative forms are used to textually interpret verbal, musical, and metaphorical data. An evolving descriptive method of musical analysis was used to describe the music itself and to elucidate participants' experience with the music and their responses to the music. This study conceptualized participants' experiences of connection among them and qualities of their interaction with the music. The aesthetic characteristics of the group's music were described, and the significance of musical identity, group process, group space, and group impact were identified. In addition, group members' imagery in relationship to the music and the art work was discussed. In this research, the researcher's roles as therapist and researcher and the impact of these roles on participants' group experience were also explored. However, the participants in this study were only music therapists, which was not diverse. Future studies might find it more useful and comprehensive to compare and include music therapists' and other adult participants' experiences and feedback.

Further research has examined the benefits and experiences of music therapy improvisation for individuals with a range of illnesses. Solli (2008) presented the improvised use of popular music through the case of a young male patient with schizophrenia in an inpatient psychiatric ward in Norway. Throughout seven months of weekly improvisational music therapy session, Solli played a drum set while the patient played the electric guitar. Significant progress

developed in the interplay throughout this treatment process; the patient's global and mental state gradually improved. Solli elaborated the advantages of improvised use of popular music. Patients could feel more connected and supported within their cultural context and identity through improvised use of popular music, which can potentially strengthen a weakened sense of self–awareness. Moreover, this case study revealed that the groove in the improvised use of popular music affords essential stances in meeting the therapeutic needs of patients with schizophrenia.

Albornoz (2011) investigated the effect of group improvisational music therapy on depression in adolescents and adults with substance abuse issues. The intent of this study was to discover the effectiveness of improvisational music therapy in treating the depression that often accompanies substance abuse. Participants were 24 Spanish-speaking patients receiving treatment at a substance abuse facility in Venezuela. Participants completed the Beck Depression Inventory (BDI) and the Hamilton Rating Scale for Depression (HRSD) and were randomly assigned to experimental or control groups, each consisting of three cohort groups recruited over a 9-month period. The experimental group received 12 group improvisation sessions over a three-month period; meanwhile, the control group received treatment as usual. Post-test measures were completed at the end of each three-month treatment cycle.

The experimental group was significantly less depressed after treatment than the control group, as measured by the HRSD (Albornoz, 2011). Improvisational group music therapy led to statistically significantly greater improvements in psychologist-rated depression (HRSD), p =. 024, compared with the regular treatment program alone; improvisational music therapy exhibited a clinically significant effect. However, this study was conducted in Venezuela; the result might not be generalizable to other cultures. Also, the sample size was small with absence of a depression assessment tool for substance abuse.

Pothoulaki, MacDonald, and Flowers (2012) explored the psychological processes involved in an improvisational music therapy program for cancer patients through interpretive phenomenological analysis. This study was an exploratory investigation into the experience of cancer patients participating in a music therapy intervention program at a Hospice in Scotland. The program adopted the Nordoff-Robbins approach, utilizing group improvisation methods and two group leaders. Each session was 60 min and occurred twice weekly over six weeks. Participants were outpatients in the hospice program who were all suffering from cancer, but not at a terminal stage, and they visited the hospice during the day for recreational purposes.

Experiences of the intervention and concomitant psychological processes were explored using retrospective semi-structured interviews with open-ended questions conducted in the last week of the music therapy sessions. Interpretative phenomenological analysis was employed for the analysis of interview data. Recurrent themes that that emerged from the analysis were: (a) playing the instruments; (b) group interaction/dynamics; (c) self-confidence; (d) relaxation: 'haven,' 'escape,' and 'being carried away;' (e) stress relief; (f) importance of the group; (g) positive feelings and the musical experience; (h) illness-forming a strong bond; and, (i) free expression-communicating through music. These recurrent themes were focused on the experience of the music therapy sessions, but all the themes were related to the experience of cancer. The results of this study suggested that "positive moments, feelings and creative experiences can perhaps help people to increase their hope and build an attitude that could contribute in regaining their sense of control and constructively resolve such important issues" (p. 64).

Also utilizing the Nordoff-Robbins approach, the researchers investigated the clinical-musical responses of music therapists while improvising with clients, and specifically examined

the therapist's consciousness moment-to-moment. Five Nordoff-Robbins music therapists (n_{male} = 3; n_{female} = 2) were asked to review their selected memorable individual sessions, and describe: (a) what they perceived about themselves while improvising; (b) what they perceived about their clients and their music while improvising; and, (c) how they musically responded to these apprehensions and perceptions. This study was informed by phenomenology, focusing on therapists' experiences of clinical improvisation. The themes that emerged regarding the therapists' interpersonal awareness were as follows:

> (a) empathy toward the client; (b) things about the co-therapist; (c) awareness of feelings; (d) awareness of stamina; (e) intuition; (f) musical ideas/ inspiration; (g) musical freedom; (h) tension; (i) searching; (j) listening; (k) internal voice/ transpersonal guidance; and, (l) faith in the music/ in oneself. The themes that emerged regarding perceptions about the clients were as follows: (a) observations of client responses; (b) client– therapist relationship; and, (c) client's growth. The themes that emerged regarding perceptions about the music were as follows: (a) clinical use of the music; (b) musical techniques; (c) musical intentions; (d) receiving the music; and, (e) feeling about the music.

The implications of the study are that therapists' emotions and experiences of clients often impact their perceptions and musical decisions, despite the diversity of thought among contemporary Nordoff-Robbins practitioners regarding dynamics such as countertransference and transference in therapy (Cooper, 2010).

The aforementioned studies and theories suggest that music therapy improvisation can be an effective technique in the field of music therapy within various settings and with a wide range of populations. Music therapy improvisation draws on diverse concepts from psychology and

philosophy; in this context, music provides different possibilities, safety, and space where therapists and clients establish rapport, work on issues, and develop insights and ways to cope.

Conclusion

Overall, improvisational group music therapy has been widely applied in acute inpatient psychiatry. With the recent developments of inpatient psychiatric care regarding shorter lengths of stay, changes to traditional treatment options are necessary. Single therapy sessions are increasingly becoming the reality during inpatient hospitalizations. Therefore, single-session therapy, once considered to be failed treatment, is now regarded as a viable treatment approach. The single-session model should be considered when implementing the treatment of improvisational group music therapy in inpatient psychiatry. Moreover, given that the single session model is different from brief treatment models, new perspectives will continue to be generated. It is imperative to develop theories and research on the single-session approach for music therapy treatment in inpatient acute care to enhance the effectiveness of music therapy on hospitalized people with mental illness.

CHAPTER 3
Method

As previously mentioned, in this researcher's pilot study (Chen, 2019), the researcher illuminated music therapists' experience of implementing single-session group improvisational music therapy in inpatient psychiatric care. For this dissertation study, it was determined that clinicians would benefit from a more comprehensive exploration of both patients' and therapists' experiences of working within a single-session model. Hence, a phenomenological study was used in this study in order to describe the common meaning of multiple individuals' lived experiences of a concept or phenomena (Creswell, 2013). The objectives of this dissertation study were (a) to systematically explore and understand the experience of two following categories of participants in order to reflect music therapy practice in inpatient psychiatry: creative arts therapists who currently work or have worked in inpatient psychiatric units, and inpatients with diagnosed mental illness who are compliant with medication, and (b) to help therapists adapt goals and treatment plans of improvisational group music therapy to adult inpatient psychiatric care.

Participants

To further comprehensively explore the therapists' and patients' experiences, two categories of participants were recruited as follows: (a) creative arts therapists who currently work or have worked in inpatient psychiatry, such as music therapists, art therapists, drama therapists, and dance/movement therapists; and (b) inpatients with diagnosed mental illness who are currently compliant with medication.

In the researcher's pilot study (Chen, 2019), all the participants were music therapists; for the dissertation research, participants included not only music therapists and patients but also other creative arts therapists. In addition to music therapists, there were other creative arts

therapists of different modalities working in this setting, such as art therapists, drama therapists, and dance/movement therapists. There was clinical and musical significance to recruiting creative arts therapists besides music therapists in this dissertation research. All the creative arts therapists who work in inpatient psychiatry are required to run groups, and their work experience might connect to the findings of this researcher's pilot study; that is, participants, the music therapists in the researcher's pilot study (Chen, 2019), did not realize that they had been practicing single-session groups at work and the same might be true for other creative arts therapists. Moreover, other creative arts therapists can possibly give broader musical perspectives compared to music therapists in single-session improvisational group music therapy, as in real-world situations, group participants often have different levels or aspects of music backgrounds.

In terms of inpatient recruitment, this researcher looked for inpatients with diagnosed mental illness who were compliant with medication because the mental status of inpatients who were not compliant with medication might not be consistent and stable for them to thoroughly reflect their in-depth experience of music making. In addition, the diagnosis of in-patients was not included in the criteria for recruitment in order to mirror the reality of inpatient psychiatric care because, in fact, patients with different diagnoses are admitted indiscriminately in the same inpatient psychiatric unit. Consequently, groups in this setting can include patients with different diagnoses, a wide range of psychopathology, such as Major Depressive Disorder, Bipolar Disorder, Schizoaffective Disorder, and Schizophrenia.

Nineteen participants were recruited according to the above-mentioned criteria and requirement. The following is the demographic information of participants; pseudonyms were used for confidentiality. (please see table 1).

Table 1
Demographic information of participants

Therapists	Gender	Approx. years of practice	Disciplines
Anna	F	10	dance/movement therapist
Abe	M	10	drama therapist
Acadia	F	10	dance/movement therapist
Barbara	F	5	dance/movement therapist
Bella	F	3	art therapist
Brenda	F	20	art therapist
Candice	F	20	activity therapist
Caroline	F	2	music therapist
Cecilia	F	15	music therapist
Cora	F	5	art therapist
Patients	Gender	Age	Reasons of admission
David	M	30	deterioration of psychotic symptoms
Debbie	F	43	Paranoia, auditory hallucinations
Dulce	F	28	increased suicidality, substance abuse
Eda	F	54	command auditory hallucination
Edwin	M	60	psychotic and irritable
Elliot	M	21	Paranoia, command auditory hallucinations
Fay	F	44	command auditory hallucinations
Fabian	M	35	Suicidal ideation
Felix	M	23	Homicidal ideation

Three therapist groups were facilitated by a board-certified music therapist, Justin, other than this researcher, and each group contained at least three (but not limited to) participants; three patient groups were conducted by this researcher because of the hospital policy and confidentiality. The clinical rationale and orientation of the two group leaders for this study were humanistic or client-centered in nature, i.e. each individual participant made his and her decision to choose a musical instrument as it best fit their needs and desires at the moment, and these researchers allowed participants to initiate the music. A pre-designed protocol of group music therapy, described in the section on data collection below, was adhered to in all groups of this study. In terms of the instruments, both melodic and percussion instruments were provided for participants to choose at the time of the group session in order to reflect real situations in

music therapy groups in inpatient psychiatric units. That is, group participants chose the instruments which parallels what happens in inpatient music therapy groups.

The sessions took place in a conference room at a hospital in a metropolitan area of the northeastern United States for therapists' groups and a group therapy room in an inpatient psychiatry unit where patient participants were recruited. Creative arts therapists were included in three groups, while inpatients are included in another three groups. These creative arts therapists were identified via personal contacts or other referrals. Inpatients were recruited by contacting patients themselves and in consultation with their treatment members.

Data Collection

Participants engaged with group musical improvisation and verbal discussion in a pre-designed protocol of group music therapy. All sessions were audio/ video recorded, and the interview questions were implemented as questions for regular group processing. In addition to the questions listed, it should be noted that follow-up questions might emerge during the group processing. The following group session protocol were adhered to in this dissertation study:

Introduction – Greetings, Check-Ins, and Ground rules

In the beginning of the session, participants were first greeted by the researcher and the facilitator of the group music therapy session and asked about their understanding and awareness of single-session therapy, as well as their experience participating in or implementing single-session therapy. Participants' experiences pertaining to their work (in the case of therapists) or hospitalization (in the case of patients) were also explored in this check-in stage through interview questions.

Question 1. The focus of this study will be on single-session group music therapy improvisation to reflect today's music therapy practice in inpatient psychiatry; that is,

most patients might have experienced improvisational group music therapy one time due to rapid turnover, and the composition of group membership is different for each session. What or how much do you know about this modality of single-session therapy?

Question 2. Have you had any experience of participating in (for patients) or implementing (for therapists) single-session therapy?

Question 3. Do you have any former experience with improvisational group music therapy?

Question 4. What is your experience of working in adult inpatient psychiatric care in general (for therapists) or your experience of hospitalizations in an inpatient psychiatric unit (for patients)?

Warm-up Musical Improvisation

During this stage of the group, participants initiated the musical activity and played the musical instruments they chose without directives. Each individual participant chose to play a musical instrument as it best fit their needs and desires at that current moment. Participants then engaged in a discussion and gave feedback, reflecting on emotions, thoughts, and dynamics that were triggered by the initial interview. This refection can be interpreted as response art (Fish, 2012), through which participants resonated with and responded to the outcomes and process of the first interview through music playing.

Feedback and Discussion

Question 5. What did you notice?

Question 6. How did you feel in the music we just played?

Second Round of Musical Improvisation

In this stage, participants were asked to integrate what they have discussed and explore into their music playing. During the feedback and discussion period after this improvisation, participants focused on questions regarding how music playing related to their interactions with others or the development of coping mechanisms for daily life. Participants explored the dynamics and interactions of their music playing, connecting them to the interactions between colleagues and staff.

Second Round of Feedback and Discussion

Question 7. How does this experience of music making relate to your daily life and relationship with others?

Third Round of Musical Improvisation

Participants integrated what they learned from the previous discussion into the third musical improvisation. In the feedback and discussion after this piece of improvisational music playing, participants were asked to conclude their experience of music playing in this single-session group musical improvisation. Many focused on a significant moment, changes, or thoughts that stood out through the process of music playing. Participants also explored difficulties and challenges, which will be discussed in depth in a later section.

Feedback, Discussion and Conclusion

Question 8. What did you get and what thoughts stood out from this single-session experience of musical improvisation?

Question 9. What was difficult or challenging?

Question 10. What are significant musical moments/ events in this improvisational music therapy experience?

Question 11. Is there any change of emotion, bodily sensation, and thoughts after one session?

Question 12. Are there any other thoughts you would like to add?

This researcher sat outside of the circle to observe the group process in order to gain thorough perspectives for the therapist groups. The patient groups were conducted by this researcher because of the hospital policy and confidentiality; however, this researcher was also set to observe group process while leading. As the researcher was an active observer—a condition that is important for this research because the study of single-session groups is about catching events happening "at the moment" in person —it should be noted that the dynamics in these research groups might be affected. The researcher proceeded to minimize this influence by spending some time talking with participants before data collection in order for them to be accustomed to the researcher's presence.

Data Analysis

Participants' feedback and discussion were transcribed, including questions, and data were coded, and developed into themes using Moustakas's (1994) method of analysis. The meanings of the themes were further discussed also using Moustakas's (1994) method of analysis; his protocol is listed as: (a) listing and preliminary grouping, (b) reduction and elimination, (c) clustering and thematizing the invariant constituents, (d) final identification of the invariant constituents and themes, (e) using the relevant, validated invariant constituents and themes construct for each co-researcher (or participant) an individual textual description of the experience, (f) construct an individual structural description of the experience, and (g) construct an individual textural-structural description of the meanings and essence of the experience (p.120 –121).

Moustakas's (1994) method of analysis was also adapted for analysis of music. The themes (for example, dynamics of melody, rhythm and harmony) of participants' significant moments/ events in musical improvisation through audio/ video recorded in the session were described and compared with participant feedback and discussion.

Based on the above-mentioned protocols, the data analysis of narrative and music portions was processed in the following three stages.

Stage I (Narrative)

Participants' feedback and discussion were transcribed, including questions; data were coded by the researcher and another creative arts therapist (who has previously conducted qualitative research). These transcripts of interviews were initially coded using the review function of the Microsoft Word program. These words and short phrases were then listed and grouped (Moustakas, 1994), along with quotations that related to these words and short phrases. These listed and grouped words and short phrases were simplified, and redundancies were eliminated (Moustakas, 1994), then yielding the keywords.

Stage II (Music Improvisation)

During this analysis cycle of the musical improvisation session, the researcher and the board- certified music therapist who facilitated the group improvisations together listened to and watched audio/ video recordings of therapist participants' significant moments/ events in musical improvisation, while audio recordings of the patients' group improvisation were listened to solely by the researcher. This was done to get an overall sense of the music-making process and the music itself. After this listening, the rest of the stages were processed by the researcher; the meaning, changes, quality, and dynamics of the audio recording of these significant musical moments/ events were further described and coded with words and short phrases. These words

and phrases were simplified, and redundancies were eliminated (Moustakas, 1994), then yielding the keywords.

Stage III (Composite Review)

In this stage, the researcher conducted a composite review of keywords, significant quotations, and significant moments/ events in musical improvisation. Keywords related to significant quotations and significant musical moments/ events were comprehensively reviewed, reflected on, clustered, and thematized (Moustakas, 1994), then yielding the themes.

Subsequently, the results of the data analysis were presented using the relevant, validated and invariant themes that emerged from these three stages of analysis, incorporating keywords correlated with each theme. An individual textual description of the experience of each participant was thereby constructed, as well as a composite textual-structural description of the meanings and essence of this experience, integrating relevant themes (Moustakas, 1994).

Data Storage and Confidentiality

All data were stored in a password-protected database and will only be able to be accessed by this researcher.

Trustworthiness

Participation in this research posed minimal risk to participants. The probability and magnitude of harm or discomfort anticipated in the research were no greater in and of themselves than those ordinarily encountered in daily life. Participants was presented with a consent form and a verbal explanation of informed consent by the researcher to ensure participants understand they are completely free to choose not to participate in the research and are free to discontinue their participation in the research at any time. In addition, all clinical music therapy directives or interventions was conducted under the current professional standards of practice and codes of

ethics of the American Music Therapy Association. Member checking was conducted to ensure accuracy and resonance with participants' experiences, as member checking is typically used to validate and verify the accuracy of qualitative research (Doyle, 2007). Bracketing (Moustakas, 1994) was also processed in order to moderate this researcher's own perspectives. This research was reviewed by the Lesley University Institutional Review Board and was approved by dissertation committee. Accordingly, this researcher has been meeting regularly with the chair of dissertation committee for supervision to ensure the quality and trustworthiness of the research.

The Stance of the Researcher

This researcher experienced the realities and challenges in his twelve-year practice as a music therapist/licensed creative arts therapist in inpatient psychiatric care. These realities and challenges include shorter length of stay, rapid patient turnover, and focus of group work. Shorter length of stay leads to increased turnover of patients. Because of this rapid turnover and under aforementioned state regulations, therapists often work as group therapists in inpatient psychiatry. Individual work does happen, but in general therapists tend to focus on groups.

Through these years of work in this setting, this researcher learned that the power of improvisational group music therapy helps patients to create a space and a sense of safety within the therapist's immediate presence in the moment. In this safe space, patients and therapists explore the issues together, finding coping mechanism and addressing a broad range of therapeutic objectives and goals. Conversely, when it comes to addressing therapeutic objectives and goals through groups, this shorter length of stay and rapid turnover does affect groups implementing in this setting and made group therapy intervention different from other settings

Its's because of unpredictable combination of group members, which has made it difficult to set continuous group goals (Thomas, 2007; Yalom & Leszcz, 2005). Reviewing the literature, the concept of single-session therapy (Talmon, 1990) surfaced, as Yalom and Leszcz (2005) also indicated that the life of groups in inpatient psychiatry must be considered to be a single session.

Hence, this researcher first conducted a pilot study (Chen, 2019) to investigate the therapist's experience of implementing a single-session group improvisational music therapy in inpatient psychiatry, and this researcher continued to focus on this topic further; subsequently, this qualitative phenomenological research study was conducted to explore therapists' and patients' experiences and feedback in order to draw a more composite picture of single-session improvisational group music therapy as a reflection on music therapy practice in inpatient psychiatry.

CHAPTER 4

Results

Nineteen participants were recruited for this study. This number comprised nine patients who were hospitalized in inpatient psychiatric care at the time of data collection, as well as ten therapists from different modalities of creative arts/ activity therapies, who currently or used to work at inpatient psychiatric care. Participants' names and characteristics have been altered, using pseudonyms only to ensure confidentiality. Data were collected from six groups, three of which included creative arts therapists, and three included inpatients with a diagnosed mental illness. In the data analysis, keywords, significant statements, and significant moments that emerged from the interviews and musical improvisation session will be clustered into themes to portray participants' experiences. The results of the data analysis will be presented using the relevant, validated, and invariant themes that emerged from analysis, incorporating keywords that correlate with each theme

Participants and Overview of Group Process

This researcher led the patients' groups (D, E, and F), while the therapists' groups (A, B, and C) were led by a board-certified music therapist, Justin, who has experience working with patients with mental illness in a few different settings for two years in northeastern America. At the time of the research sessions, this researcher had been working for inpatient psychiatry for about 11 years. Participants in all the groups were allowed to spontaneously choose from the following instruments at any time: (a) djembe drum, (b) tubano drum, (c) two tambourines, (d) cabasa, (e) ocean drum, (f) gato drum, (g) singing bowl, (h) two shakers, and (i) the xylimba. (see Figure 1). Only the two group leaders used a guitar.

Figure 1

Instruments

For each group process, therapists' and participants' instruments arrangement and choice varied, depending on their decisions at the moment. In a way, although improvisation was used in all the study groups, the interventions both group leaders implemented were somewhat different throughout these six sessions. For example, Austin's (2008) two chord vocal holding was not used in a couple of groups, and the guitar was used by both group leaders for all the groups, while in some pieces of music playing, both group leaders instead chose to use

percussion instruments. This was to respond to the participants' needs at the moment, which mirror the reality of the clinical setting.

In Group A, participants Anna, Abe, and Acadia know one another and have worked together in the same hospital at different times in different contexts; however, this is the first time they worked with Justin and joined together in improvisational group music therapy. The participants in Group A all had previous experience participating in musical improvisation. The mood in Group A shifted from feeling frustrated, angry, and sad to eventually feeling more open, less tense, and realizing the need for restoration and self-care, which is also reflected in music playing. In group B, participants Barbara, Bella, and Brenda, similar to Group A, know one another, and work in the same hospital. This was their first time sitting together for improvisational group music therapy and working with Justin. All participants in Group B had previously taken part in musical improvisation. Group B started with a sense of reluctance and hesitation; as different musical dynamics were introduced by Justin, participants were led to vocalize their feelings by using explicit words to express their anger, anxiety, and frustration. In Group C, participants Candice, Cecilia, and Cora knew one another before joining this group. Caroline was the only participant who had not met any of the participants. This was the first time for Justin and the participants to work together with improvisational group music therapy. The participants shared that they all have previous experience participating in musical improvisation separately on other occasions; Caroline and Cecilia are music therapists, so they not only had experience of participating but also have served as facilitators for such groups. In Group C, there was initially a sense of anxiety and uncertainty, as the music was initiated in a disordered fashion. A variety of musical interventions were implemented, including the use of

voice. Towards the end, the group revealed their sense of connection and the change and release they had experienced.

For Group D, this was the first time this group combination of participants David, Debbie, and Dulce had worked together with this researcher in improvisational group music therapy. Participants were calmer and were somewhat reticent when it came to the interview. The mood of the music was generally calm and steady throughout the whole process. The participants' reactions to the group process included feeling like they were part of something, feeling connected, feeling able to make something, harmonizing, feeling peaceful and safe. For Group E, this was the first time for this group combination of the participants Eda, Edwin, and Elliot to work together with this researcher in improvisational group music therapy. In the initial phase of music playing, participants were unable to keep up with the rhythm as Eda's music playing was loud, disorganized and intrusive. Throughout the group process, participants focused on such topics as coping with hospitalization, life after discharge, and musical interaction. Nonetheless, at the end of the group session, participants all felt their mood had changed to be more relaxed, energetic, and less stressed. For group F, this was the first time for this group combination of the participants Fay, Fabian, and Felix to work together with this researcher in improvisational group music therapy. The mood of this group was calm as these participants shared that they actually felt comfortable and relaxed in inpatient psychiatric care. Towards the end of group, the participants appeared to be more motivated, and eventually found a way to be in the groove. Participants talked about compromise and cooperation during music making and finding a leader in the group. They added that they felt safe and felt like building up something.

The Process and Results of Data Analysis

The group interviews were first transcribed. These transcripts were initially coded using the review function of the Microsoft Word program. In the first cycle of interview analysis, a descriptive coding method (Saldana, 2013) was used to summarize in a word or short phrase the basic topic of a passage of qualitative data (p. 88). These words and short phrases were then listed and grouped (Moustakas, 1994), along with quotations that related to these words and short phrases. These listed and grouped words and short phrases were then simplified, and redundancies were eliminated (Moustakas, 1994), yielding three groups of keywords.

The first group of keywords is based on therapists' perspectives as follows: (a) adaption/ balance, (b) burnout/work overload, (c) chaos/instability, (d) rapid turnover of patients, and (e) uncertainty of role.

The second group of keywords is based on patients' perspectives as follows: (a) discharge (b) group programs (c) interaction with peers (d) isolation/constraint (e) medication management, and (f) treatment/care.

The third group of keywords is based on both therapists' and patients' perspectives as follows: (a) anger, (b) anxiety, (c) attention/focus, (d) bodily sensation, (e) calm, (f) catharsis, (g) change, (h) coping/restore/self-care, (i) culture/family value, (j) here and now/present, (k) musical interaction, (l) reflection, (m) relaxation, (n) resistance, (o) rhythm, (p) sadness, (q), tiredness/exhaustion, (r) uncertainty, and (t) validating.

During the first analysis cycle of the musical improvisation session, this researcher listened to the audio recordings with an open mind, observing the dynamics, changes, and meaning of the musical improvisation, and noting any personal subjective responses (Ferrara, 1984). To listen with an open mind, the researcher and Justin listened to the audio recordings of

the therapists' group musical improvisation, while audio recordings of the patients' group improvisation were listened to solely by the researcher. This was done to catch an overall sense of the music-making process. After this open listening, significant moments were selected and excerpted. These excerpts were described and coded with words and short phrases. Similar to the interview analysis process, the words and phrases were then simplified, and redundancies were eliminated (Moustakas, 1994), yielding the following keywords: (a) anger, (b) attention/focus, (c) cacophony, (d) musical interaction, (e) resistance, (f) rhythm, (g) safe place/space, (h) sense of belonging/togetherness, (i) use of guitar/chords, and (j) use of voice/vocalization.

In the second analysis cycle, the researcher conducted a composite review of keywords and significant quotations, as well as an audio recording of the musical improvisation session. Keywords related to significant quotations and music excerpts were comprehensively reviewed, reflected on, clustered, and thematized (Moustakas, 1994), yielding the following five themes: (a) the therapist's experience of work in inpatient psychiatric care, (b) the patient's experience of hospitalization in inpatient psychiatry, (c) participants' experiences of group musical improvisation in single session, (d) participants' challenges in single-session improvisation, and (e) therapeutic components in single-session group improvisational music therapy.

Subsequently, the results of the data analysis will be presented using the relevant, validated, and invariant themes that emerged from these two cycles of analysis, incorporating keywords correlated with each theme (see Table 2). An individual textual description of the experience of each participant will thereby be constructed, as well as a composite textual-structural description of the meanings and essence of this experience, integrating relevant themes (Moustakas, 1994).

Table 2
Themes and Keywords

Themes	Keywords (interviews)	Keywords (improvisation)
The therapist's experience of work in inpatient psychiatric care	Chaos/instability Uncertainty of role Rapid turnover of patients Burnout/work overload Adaption/balance Single session	
The patient's experience of hospitalization in inpatient psychiatry	Treatment/care Group programs Interaction with peers Stigma Isolation/constraint Medication management Discharge Single session	
Participants' Experiences of group musical improvisation in single session	Here and now/present Rhythm Musical interaction Reflection Culture/family value Anger Sadness Calm Bodily sensation	Rhythm Use of the guitar/chords Use of voices/vocalization Musical interaction Anger Sense of belonging/togetherness Safe place/space
Participants' Challenges in single-session improvisation	Anxiety Resistance Uncertainty Tiredness/exhaustion	Resistance Cacophony
Therapeutic components in single-session group improvisational music therapy	Change Catharsis Relaxation Validating Attention/focus Coping/restore/self-care	Attention/focus

Theme I: The Therapist's Experience of Work in Inpatient Psychiatric Care

This theme emerged from therapists' perspectives and their experiences of work in today's inpatient psychiatric care. In this theme, participants explained that their working

environment and situation were unpredictable and that the role they played in the inpatient psychiatric ward was uncertain. Given the reality of the rapid patient turnover in this setting, the therapists faced various challenges that led to burnout, and they had to adapt their ways of providing support and therapy to patients; thus, the model of the single session was also discussed.

Chaos/Instability

During the interviews before the first improvisation, participants were asked about their experience of working in inpatient psychiatry. They agreed that their work environment could be unpredictable due to rather unstable patients with acute symptoms and the rapid turnover. Most of the participants shared that in their fast-paced and unpredictable work environment, dynamics and situations could be chaotic and dangerous at times. Anna described this work environment in inpatient psychiatry with such words as:

> Chaos, unpredictability, lack of containment. Dangerous… trying to work in very difficult situations most of the time…

Another participant, Bella, said:

> It is definitely a hard balance working in inpatient, especially as everything is so up in the air, and unpredictable.

Participants shared that at times they did not feel safe working in this environment. One participant, Cecilia, was assaulted by a hostile patient. Participants expressed their concern about their work environment as they talked about the lack of safety and instability of this setting. Due to this dynamic, the effect of creative arts therapies on their work can be limited; patients might not be in an optimal condition to receive therapy. In this context, some participants expressed their frustration about their work not being able to provide the ideal

therapeutic environment for patients. They also expressed their uncertainty about their role as creative arts therapists.

Uncertainty of Role

All the participants briefly described their role in an inpatient psychiatric ward. They mostly run groups and occasionally individual sessions; they also work as members of a treatment team, and their work includes documentation. Participants use different modalities of creative arts to help patients cope with their issues, and develop insights into their problems. Participants also described their role as creative arts therapists/music therapists/drama therapists/ art therapists/ activity therapists. However, the participants expressed their uncertainty about their role in the treatment team. Cora reported:

> There is a lot for the therapist to attempt to accomplish, and quite often, you leave a group feeling like I'm not really sure what my role was.

Abe attributed this uncertainty to:

> Not being heard… not being seen… at times, very unsupportive [by administration].

Acadia added that this uncertainty of role also came from being misunderstood by, and conflicted with, other disciplines in the treatment team:

> Sometimes, there's some collaboration, and a lot of times there's miscommunication and conflict and not seeing each other… there's still a misunderstanding about what's being offered. The patients seem to get it in the moment, and I can see that they value it and express appreciation and gratitude for it. But our coworkers don't necessarily know how to comprehend what's going on, or how to best utilize and work with us.

In terms of uncertainty of role, one of the participants, Caroline, expressed her thought process of finding her role in this setting as follows:

> But, even just being in it a year, I've already been feeling those feelings, so ... Being trained similarly, finding out my role ... What is my role as a facilitator? Am I a teacher? What can I get out of this session? How can I really help them in these 45 minutes that I spend with them? … I have to remind myself of that every day.

In general, participants shared that they contribute to the treatment process for their patients and work with the treatment team. Nonetheless, they also shared their experiences of being misunderstood and not being heard and seen because, besides medication management, the focus of treatment in today's inpatient environment has become the patient's disposition, which, as the participants agreed, is being affected by the rapid turnover and the patients' shorter length of stay.

Rapid Turnover of Patients

In adult inpatient psychiatric care today, one of the most significant issues participants described is the rapid turnover of patients. Participants shared their overall experiences regarding this rapid turnover, which is a characteristic of inpatient psychiatric care. They shared the difficulties they experienced in establishing relationships with patients and the obstacles presented by such high turnover, which prevented the participants from reaching more therapeutic goals. One of the participants, Brenda, explained:

> That's true because our turnover's so fast. When patients are not ready, they don't come to groups. But, when they are ready to come, this is the moment they are discharged. So, we don't really have that much opportunity to continue therapeutic groups.

Barbara further described the scenes she encountered with this rapid turnover as follows:

> I was part of this system that just turns people over; the first thing that happened as soon as a person came in was that I was already looking at them as a number.

This statement reflects today's inpatient psychiatry in a hospital in a metropolitan area in the northeastern United States; that is, the number of discharges and each patient's length of stay are subjects that should be reviewed weekly in a length-of-stay meeting with all the treatment team members.

Burnout/Work Overload

As participants shared their experience of work in an environment of rapid patient turnover, they said the challenges and job requirements at their work could lead to burnout. In this work environment, due to the rapid patient turnover, therapist's end up dealing with an overload of paperwork, such as assessment forms, progress notes, and discharge summaries, instead of spending time providing direct patient care and therapy. Bella described the reality of this overload of paperwork as follows:

> One of the pieces you brought up was the dehumanization part, which is so hard because you have so many notes, assessments when you see people, so you try to do everything so quickly that you forget sometimes these people are people.

Related to this, Abe shared:

> I know definitely for me, and I've heard patients say, I'm not getting what I need. Nobody's listening to me.

One of the participants, Brenda, also stated that she tried not to let her passion for patients die in her heart. In spite of the overload of paperwork required for this job, most of the participants said they would still try to provide as much direct patient care as possible. Such care, which included establishing groups and one-on-one patient contact, could lead to burnout. However, participant Caroline indicated that although this work had been draining, it had also been "rewarding." In general, participants also focused on what they could do to cope with this

potential burnout and considered whether they could try to make some adaption that would enable them to fulfill their job requirements and find balance at work. The keywords adaption, balance, and single session reflect this discussion.

Adaption/Balance

To fulfill their job description in this fast-paced and unpredictable working environment where the rapid patient turnover and overload of paperwork imposes heavy burdens on the health care workers, some adaptation has to be made. The purpose of the adaptation, according to some participants, is for therapists to find a balance at work. Barbara indicated:

> I did the best I could do for myself. I tried to come up with a different framework.

In response to different frameworks, finding a balance was not only in the interests of addressing the therapists' workload, but also to better fulfill patients' needs, as Brenda indicated:

> I always say one sentence, "Just do one thing you really want to do, you're passionate about doing. Only one simple thing, maybe talk to a patient for five minutes, which can satisfy my need and the patient's." I feel that can help patients, though it's very challenging.

Related to this point, Anna further explained:

> So just being completely in the moment [is important] to make sure everyone's safe and everyone has the most beneficial experience.

In addition, Brenda stressed the importance of finding a balance between clinical work and work within the system of health care by saying the following:

> Only one thing, I believe: we have to find balance, to survive in this facility; this is something I believe; that is, it's not that they want to abuse us, but system wise, it's like

> that. No one can change it. We only can make adjustments to make a balance. It's not easy; it is challenging to everyone, including myself. It's one sentence, "not easy."

Single Session

In inpatient psychiatry, therapeutic goals for each patient have to be adapted and changed. In short-term group work, group or individual goals should be viewed through a different lens than one that embraces conventional long-term therapy. In response to this different way of viewing today's inpatient psychiatric care, single-session therapy was the focus of this research for group improvisational music therapy. Yalom (1983) indicated that a difficulty in this process is setting ongoing group goals because of the difficulty of predicting the combination of group members each time. When it comes to the question of implementing the single-session model in practice, Abe indicated that he had participated in single sessions, but whether or not they were therapeutic was a different story. Besides Abe, other participants also shared their experience of practicing this model of single-session therapy. Barbara addressed the subject of single sessions saying:

> I learned it on the unit I was on for about five years… so to speak, and I wrote an article about that.

Candice stated:

> I think that's what we do here, everybody knows it; this is what we're constantly doing.

Other participants also shared their experiences of implementing the single-session model at work. Acadia talked about her single-session work and the impact it had on the whole unit as follows:

> I have a 30-minute group, and that's pretty much my group for the day. It's very much a single session, and it's a brief single session. Oftentimes I'm amazed at how in such a short period of time it can really positively impact the vibe of the unit.

Other participants such as Anna had a similar point of view; that is, the formation of community through this single-session modality. Anna said:

> I think a lot about building community through those single sessions with whoever's there at that hour. I try to create some sense of a feeling of community, which doesn't often happen.

Cora depicted one single-session group and the dynamics of this group session as follows:

> What happens with patients is that the most dysregulated patient that does come in your group, it's like oh god, what's gonna happen, but they can sit there, and they can get something out of it and they maybe say something that is actually kind of profound and you see the faces of the other people that are surprised that this person would say that, but also how it might reflect their experience.

Although participants might have implemented this model of single-session therapy, they have not been taught about this idea, and this single-session therapy has not been their focus in their training to be a therapist. Cora explained that:

> Yes, we do [hear about a single session]. However, I'm curious because academically, I didn't study this as an area of focus, so this is actually quite interesting to me.

A couple of participants, such as Cecilia, who have worked in this field for a long time have witnessed the change from long-term therapy with patients to single-session in this setting, as Cecilia said:

> When I first started, I had patients that were actually staying a lot longer, so that's been more my experience. And I guess I wasn't also ... The education wasn't really in terms of single sessions, so it was more like long term or not necessarily really long term, but more than sessions.

Barbara felt the same way as Cecilia and said she wished there could have been a different system:

> Therein lies the system that they're in. It's shutting down on all of this more and more and more. You know one session can make a difference, so I wish we had a different system, because patients deserve more and we deserve support.

In lieu of this discussion and awareness of the single-session model, the need or longing for long-term and conventional therapy in this setting was also mentioned in this research, as Acadia indicated:

> Maybe disappointment ...Wanting to work more extensively with our patients. Hoping that we can have more than one session to develop whatever is coming up for them and explore that, but the reality is that in an inpatient unit you don't always get that.

Theme II: The Patient's Experience of Hospitalization in Inpatient Psychiatry

Patients' experience of hospitalization in inpatient psychiatry was mixed, while in this study almost all the therapists working in this setting described their work as challenging and chaotic. In general, most participants in groups D and F suggested the treatment was positive, while participants in group E were frustrated at the treatment. The participants also discussed their awareness and experiences of single-session therapy. Overall, most of these patient participants needed prompting when they expressed their thoughts on the interview questions or their reaction to group music improvisation. Most of participants' responses to the interview

questions tended to be brief and the participants needed to be encouraged to elaborate on the details. Nonetheless, this researcher allowed patient participants to make their own decisions in responding to the interview questions or sharing their experience of group music improvisation. Moreover, A few participants needed redirections: for example, participants Edwin and Fay were somewhat disorganized and tangential in their thoughts, and participant Eda was loud and talkative and resorted to pressured speech. Nevertheless, the participating patients still made meaningful contributions to this interview as they were relatively more stable in general, and all of them were compliant with their medication at the time of their participation in the research.

Treatment/Care

When it comes to the experience of hospitalization, most patient participants initially briefly described the treatment they received at the unit. Most of them gave a short statement, and at times, just a simple word such as, "good," or "okay." They then elaborated on their experiences when they were encouraged to give more details. As mentioned above, the participants in group D and F expressed that they had enjoyed positive experiences, while participants in group E said their experiences were relatively negative ones. The participants described their thoughts on the food, environment, medication management, and group activities in the unit. Participants Felix and Fay even said that they felt comfortable and relaxed on the unit. One particular element the participants focused on was people – the staff working with them. Fabian said that "It was actually a good experience. The staff are nice and caring." This statement reflects the positive perspectives of the participants in groups D and F. Furthermore, Debbie expressed the appreciation she received from her nursing practitioner:

> I'd like to thank my nurse practitioner. She is very caring, and she let me know what's good for me, and helped me with things that are good for me and got me the right medication.

Group Programs

Besides the general treatment they receive every day on the unit, the patient participants also shared their perspectives on group programs. They said the group programs helped them get through the day and showed them how to cope with stress. Felix said he believed groups in general helped people get through the day and taught them something. These aspects will be discussed in the next section. A group can also make patients feel "safe,", "supported," "better," "relaxed," and more "focused." Fay expressed her appreciation in this context by saying:

> I'm glad you guys came, that we're all in a group. It makes us feel better at the end of the day, I'm sure.

In addition, Eda described her experiences of participating in a group as "being able to be who I am and who I want to be" as she shared her resistance to medication treatment, her uncertainty regarding her discharge plan, and her concerns about her life after discharge, which will be discussed later in this section.

Interaction with Peers

After the participants shared some significant impressions and experiences concerning their treatment, groups, and the care they received in adult inpatient psychiatric care, others elaborated on the stress they are trying to cope with in the hospital. The participants attributed different reasons for their stress. Elliot said it was very difficult to cope with stress in the hospital because things were out of the patients' control.

One of participant's stressors in the hospital was their interaction with peers, especially when they encountered patients in crisis who were unstable, irritable, and even hostile. Edwin, referring to one emotionally distressed patient in the unit at that time said, "Some patients are just sick, which I have to deal with." Debbie also expressed her concern about an intrusive patient who persistently took her belongings and food away.

Stigma

Another stressor in the hospital or even in their daily life patients may encounter is stigma. Although staff have been trained to treat patients equally and respectfully in inpatient psychiatric care, a few participants in this research said they had been stigmatized on the unit. Edwin said the staff "see us like psychiatric people. They are not comfortable with us." This sentiment can be deemed as reflecting some paranoia in the practice, but these participants' experiences should still be significantly delineated. Although Debbie had expressed gratitude to her provider, she said she did experience a sense of stigma:

> They seem to look down upon you for some reason; they think that because you are sick you have to be under dressed…

Debbie shared that she likes to put on some make up and dress nicely while in the unit, but some staff members might not feel comfortable with that. Debbie shared that she actually took this experience in a positive way, "I am not thinking like that; I am trying to stay strong. That's what keeps me strong as well." Debbie said she had actually learned a lot through this process.

Isolation/Constraint

Due to the nature of the inpatient psychiatric unit as a locked unit, participants said they had experienced a sense of isolation and constraint. Patients in the inpatient psychiatric unit are not allowed to leave the unit unless they are discharged or granted permission or ordered by a

provider and escorted by staff to outdoor activities for a short period. This restriction made most of the patient participants experience a lack of freedom; participant Eda expressed her frustration by saying the staff were, "holding me from freedom outside." In this environment, patients are temporarily separated from their families, friends, and colleagues. Articulating this separation, Elliot said, "I just feel away from home, homesick." This restricted situation also prevented patients from getting access to the utility or daily routine they normally took for granted, such as TV or telephone. Eda described this situation as follows:

> I'm used to the outside, playing my own TV, going out and then getting ready. I have my own key. I'm free to go out, free to come back in… I miss my telephone, I miss my music, I miss the way I get up early in the morning to go outside and take an early morning walk.

Fabian also referred to the lack of TV and expressed his frustration accordingly, "What can I say? I cannot watch TV anytime I want." Interestingly, the other participant, Felix, a Hassidic male in the same group as Fabian responded to Fabian's comment on TV by saying he actually enjoyed watching TV in the unit because he does not own a TV at home, "[I watch TV] only when I'm in here." Similarly, a couple of participants expressed that the unit was not as constraining as they had expected; Fay said that she felt free in the unit, and Felix shared a similar view.

Medication Management

Medication is the central treatment in inpatient psychiatry and can be the main concern of patients and the treatment team. Most patients suffer some side effects from medication. On this subject Fabian said, "There are some somatic complaints still, and side effects from medication." In addition, compliance with medication and patients' insight into the need for

treatment can be limited. Although Eda had been accepting medication in the unit, she still had some resistance toward the medication because:

> All the doctors want to do is give us medication, when in reality, you don't need no medication, you just need somebody to talk to; like therapy.

Discharge

Other concerns the participants expressed related to when they would be discharged and their life's anxieties after discharge. Eda expressed her frustration at the uncertainty of her plan for discharge, as she had no idea when she would be allowed to leave, "I do not want to be here," she said. "I volunteered myself in here, now I have to fight to get myself out of here." In addition to the uncertainty of planning their discharge, participants also expressed concern about their life after discharge. Fabian addressed his concern on this issue:

> Now in the hospital, I feel fine, but I am more worried about life after discharge, which will be stressful for me.

Eda spoke angrily and at length about her frustration at certain societal predicaments some patients like her potentially face after discharge:

> We have a lot of problems, understand? I'm not speaking only for myself, or two people. I speak for everyone, because at the end of the day, we don't know where we going to go. We don't know if the city is gonna assign us somewhere we don't want to go. And, we have to be there for maybe a year, or even go to the courthouse and say that we have to do what the jury says.

Single Session

In terms of the question on awareness of single-session group therapy, the patient participants said they did not understand this modality. Even after this researcher explained the

rationale and concept of single-session therapy, only a few patient participants made sense of what they had experienced in this research as a single session. Each combination of research group members had never been formed before this study. Eda was one of the participants who understood, and she spoke about her experience and understanding of the single-session model:

> Yeah, just like... like a different art group. Like you only [have] this one art group next week or whatever, and then you give a lot a difference ... like us, a lot of different people… Just like, we switch up. Well, next time, around next week, me and you will still be here. Other two are not.

Like Eda described, in this research study, participants were assigned to a group, in which the combination of group members was new to them. Some patients might have been in the same groups before, but the members of other groups might never have worked with them in the same group. For example, Felix and Fabian were core members of a lot of groups before this study, but Fay was a stranger to them.

Theme III: Participants' Experiences of Group Musical Improvisation in a Single Session

After the participants shared their experiences of working and being hospitalized in inpatient psychiatric care, they picked up the instruments and started to play improvised music as a group. This music playing leads to this theme on participants' experience of single-session group musical improvisation. This was a here-and-now experience as the participants formed a structure at the present moment. The participants' reflections on music and their interaction within music will also be depicted. By playing music, the participants were motivated and inclined to respond emotionally to the thoughts they had experienced beforehand. Participants also talked about their experience of this single-session music-making process afterwards;

emotions, feelings, thoughts, bodily sensations, and other phenomena emerged through the improvisation. This section will elaborate on them.

Here and Now/Present

The participants shared their thoughts on the experience of single-session music making in which the idea of "here and now" and "in the moment" as it related to community building and dynamics emerged throughout the session, especially after music improvisation in the research group. There was also a discussion on what participants might take away from this one group. One of the participants, Cora, commented on this by asking, "What can I get out of this session?" Another participant, Felix, pointed out, "You may need to be present here and now," as he talked about what he had learned from this single-session group.

Anna referred to this improvisation process as being in the moment, in the here now. As she said:

> For me, [single-session] is really about being here and now, in the moment. Whatever happens, let's go with it, and shape it from there.

When it comes to this single-session experience, Brenda expressed that this was the moment she needed, and she was putting herself in it; "I get that it's very beneficial for me." Commenting on the single-session experience, Dulce said she was so focused in the moment. "We are not rushing," she said. In response to Dulce's statement, David indicated that the participants in group D seemed to "just focus on the here and now when they tried to find a direction and make music together."

Rhythm

Through the musical improvisation in this study, it appeared to participants that rhythm served as a fundamental element to establish a short-term community (Chen, 2019) and to

maintain the structure. From the improvisational session of this study, it was found that an immediate structure was formed by rhythm, and that this structure was sustained as long as the rhythm continued. When the rhythm ended, the structure dissipated. Rhythm also created a sense of comfort in this structure, as testified by Caroline, who said she enjoyed the tones "that definitely [provide] comfort in rhythm." Eda said this structure was as if the participants were communicating in rhythm. She said, "It was more like communication."

Furthermore, participants in group D talked about their experience of playing together for the first time, but the music sounded good because they were able to play to the same beats. Dulce commented on this experience by saying "I think it was cool we never played together, but we can play to the same beat… It also sounded good because I was making beats. It sounds like strength to me." The following excerpt will depict the structure rhythm may create in the music from the ninth to the tenth minute in group D (see Excerpt A https://youtu.be/dzZcGt5mEBg):

> In this excerpt, David played the tubano drum, Debbie played the tambourine, and Dulce played the djembe. This excerpt took place at the beginning of the first piece of music playing, when participants tapped their choice of instrument without any clear direction; meanwhile, this researcher held the guitar without playing it initially, until he found a down beat from the tambourine playing. This researcher strummed a chord, and then David seemed to have also gotten into this beat. At this point, a steady rhythm was formed, and a structure of music was established.

In group F, two participants were aware of rhythm while making music as a group. Fabian said that making a beat was like making an announcement, and that the group's members would follow the person who made the beat. Fabian added that the music seemed to build up

little by little within this rhythm. In response to Fabian's statement, Fay shared that this process made her feel motivated with:

> Just particular concentration, and in the way, it's going around make sure it has some kind of musical rhythm to it.

Use of the Guitar/Chords

In all the group improvisations during this study, two group leaders played the guitar as one of the interventions, reflecting the fact music therapists use the guitar as one of the primary instruments for music therapy. The guitar was being played in all the groups to motivate and guide the participants. The guitar provided an immediate structure and direction for participants to follow and further form music, which is exhibited in the following, except for one significant moment in group D (between the 36th and the 37th minute; see Excerpt B https://youtu.be/K56h-_dj60s):

> This excerpt was taken from the first minute of the third piece of music and was considered a significant moment by all the participants. At this point, Debbie played the shaker and at the same time she played the gato drum. Dulce played the ocean drum, tilting it gently back and forth. Debbie was hitting the singing bowl gently. In the first 15 seconds, participants explored the sounds of the instruments; soon after that, this researcher gently played a two-chord (CM7 and G) progression. As soon as the guitar came in, the participants seemed to have found their rhythm. As the music went on, Debbie switched to play the xylimba; subsequently, Dulce initiated vocalizing the "Ah" sound, and the researcher then joined in her vocalization.

In this excerpt, the guitar provided a two-chord progression, which was predictable enough for the participants to join in, and for one participant to initiate vocalizing. As a musical

structure was established by the guitar, group members would take over the leading role, as shown in the following excerpt taken from group E between the 32nd and 33rd minute (See Excerpt C https://youtu.be/Ql1A6cUj8WM):

> The researcher played the two-chord (C-G) progression initially to lead the music playing. Eda played the singing bowl and tambourine at the same time as she placed the singing bowl on the chair. Edwin played the tubano, and Elliot played the xylimba in a steady and consistent melodic pattern. At one point, Elliot's melodic xylimba playing started to lead the way of the music; Elliot and Eda's music playing further reinforced and strengthened this dynamic. The researcher's guitar playing, meanwhile, started to fade away, serving a rather accessorial and supporting role in this music-making process.

It is clear from this excerpt that the musical structure was formed as the group leader played the guitar and then the other participants took over. Besides the chord progression, the researcher also tapped the guitar as a percussive instrument at some points; Justin slid, plucked and scratched the strings to make "ugly" sounds to motivate the music playing in group B.

Use of Voices/Vocalization

There were different moments when participants used their voices while making music. Vocalizing can be a way of making music, initiating the beat and further form a rhythm for other instruments to follow. The following excerpt of music taken from group A between the 24th and the 25th minute serves as an example of such vocalization: (see Excerpt I https://youtu.be/StHUeAU7bUA; the participants' voices were altered for confidentiality.)

> A sense of uncertainty developed at this point, and participants were not sure which direction to follow musically although there sounded a rhythm in the music; shortly after, Anna started making some sounds vocally and rhythmically as if initiating another beat

and calling other participants to vocalize with her. Anna was playing the gato drum, Justin was playing the shakers, Abe was playing the tambourine, and Acadia was playing the xylimba. When Anna initiated this vocalizing, other participants appeared to form a rhythm with their instruments playing and seemed to have found a direction to go along with; meanwhile, the participants started making a variety of vocal sounds in a conversational manner with different dynamics.

Furthermore, participants in group B explored ways to use their voices by improvising in a rather different way, with profanity, as shown in the following description of the music taken between the 17th and 19th minute:

In the initial part of this excerpt, participants came to a point at which they were reluctant to go on. Justin tried to promote participants by making different sounds with the guitar; he scratched the strings and plucked different notes to engage any sounds made by the other participants. At that time, Barbara played the singing bowl, Bella played the cabasa, and Brenda played the ocean drum. Participants did eventually establish a short rhythmic musical rendition but dispersed very quickly. When the music quieted down, Brenda continued to tilt the ocean drum back and forth, with pellets rolling around inside the drum making ocean sounds. Justin and Barbara then started to converse in a soft speech; subsequently, Barbara burst out with a couple of curses, and went on to talk about the system she works in. At one point, Brenda uttered the four letters of the F word one by one, which instantly led to the group playing their music in a rhythmic and cohesive fashion; furthermore, Barbara rapped with profanity and the other participants intermittently screamed using swear words.

This part of group B also led to a discussion on culture and family values, which will be delineated later; furthermore, through this behavior, Barbara and Bella saw another side of Brenda they had never seen before (they knew one another before this study).

In addition to the two forms of vocalization discussed above, Cecilia and Caroline were singing the "Ah" sound in a style of bel canto. Cecilia found that while they did this they were mirroring each other's voices, as shown in the following excerpt of music between the 18th and 20th minute. (See Excerpt J: https://youtu.be/SMEho_bLt8U; the participants' voices were altered for confidentiality.)

> Justin initially played the guitar with a I-V chord progression, while Candice played the xylimba, Caroline played the tubano drum, Cecilia played the singing bowl, and Cora played the djembe drum. At one point, Caroline and Cecilia sighed as the music went on; then, Cecilia and Caroline started vocalizing the "Ah" sound with melodies in a conversational manner, and Justin joined in later. They seemed to mirror one another; soon after this vocalizing was initiated, Justin added an IV chord, and Caroline and Cecilia's melody shifted and escalated, which led Justin to shift into different chords. In this excerpt, Candice and Cora seemed reluctant and distant from the process, contributing intermittently to this music making.

Besides the therapists' groups, vocalization was used in one patient's group (group D), as this researcher used a two-chord progression of vocal holding and initiated vocalizing; Debbie was the only participant who joined in. Nonetheless, voices can be provided with a variety of dynamics, directions, and possibilities while making music. It has been shown that voices can initiate music, promoting cohesive playing of instruments and musical interaction.

Musical Interaction

Music making is a process of interaction. This was indicated by Fabian's admission that he tried to listen to other people's playing to understand them in the music. Felix regarded this process as "teamwork." Fabian further pointed out, "I think in the music someone has to lead and motivate us to create a good atmosphere." The following excerpt portrays this experience taking place between the tenth and eleventh minute in group F (See Excerpt D https://youtu.be/J9HUvkcADOQ):

> In this excerpt, Fay played the gato drum, Fabian initially played the shaker and then turned to the cabasa, Felix played the xylimba. The researcher played the tubano drum to lead the group, providing a steady rhythm for the participants to join in. Fay beat the gato drum in response to the tubano's beats, while Felix played the intervals to fit into this rhythmic pattern. Fay and Felix simultaneously seemed to be trying to coordinate their playing rhythmically and melodically. Fabian seemed to be exploring two smaller instruments, and his playing sounded lagged as he looked for direction to follow.

On musical interaction, Cecilia shared her observation and said she paid attention to other participants playing different instruments and the way they played them. Candice said each person played a different role and that "Everybody was representing themselves in music." With the presence of different sounds or people performing different roles in playing music, Edwin depicted the musical interaction as follows:

> If you go your own beat, we switch to that beat, too. I hear myself and others. In music, sometimes I play the drum; I can be leader and a follower. I lead, and I follow… you lead as you play the guitar… you lead, and you also follow… we listen and help each other.

Reflection

When some of the participants shared their single-session music-making experience, they reflected on their daily life or on other issues and concerns. Acadia shared:

It just reminded me of some really difficult stages of life, but very creative times too.

Brenda related this music-playing process to the relationship between colleagues and staff, as she finds that this relationship sometimes doesn't work out all the time. In trying to make music as a group, Brenda observed:

> [This music playing] relates to daily life, and I thought about the entire relationship between colleagues and staff… sometimes you think it works out, but sometimes it does not. We try our best.

David said that while he was playing music, at one point he thought about what to do when he left the hospital. He said:

> So, I was trying to focus on playing the music, but then good ideas just kept coming to me about what I should be doing to get my life together.

Debbie also shared that while playing music she thought about her life after discharge; in particular, she thought about staying away from all temptations. After playing the ocean drum, Eda was reminded of the sounds of a train, which led her to talk about the insecure life routine she might encounter, especially after discharge. She said:

> Well, this [sound] has been like rushing, trying to get home, get to your kids, or at least go to work, or whatever it may be; going up and down the staircase and sitting next to a stranger. You don't know what's going to happen to you at the end of the day.

Culture/Family Value

One of the topics that came up in the discussion after playing music was culture. In group B, there was a time when the participants used explicit and profane language while playing the instruments. While they felt a release, there was a discourse about one of the participant's reservations and inner conflict about using those words. Brenda said that using these words was not part of her family's culture. As the participants in group B talked about this phenomenon, they realized how important culture and family values are in the creative process. They also found that music can create a safe place in which the participants can express themselves by using these words.

Furthermore, two participants in group E talked about culture being a factor in music. Edwin shared that music is like different kinds of beats from different cultures, "like Trinidad too, all mixed up. There are black, Spanish, Chinese, all mixed up." In response to these comments on the mixture, Eda articulated how music can represent a person or what is in a person. She said that:

> Hearing different types of culture or people that sing African or Nigerian songs, or those who have a different type of instrument ... makes you feel comfortable with what's in yourself. Just like you tell someone you like jazz, or [pointing to Eda] he said he likes rock music…

Anger

In this study, participants shared their experiences of playing music to reflect or response to their emotions. Abe said, "I was expressing all my emotions throughout the music." Several participants, especially in groups A, B, and E related to the emotion of anger, especially those

participants who reacted strongly to the interview questions about their work and experience of hospitalization.

Abe said the drum served as a means to express his anger at some issues working in inpatient psychiatry:

> I know I started off very, very angrily. [There was] a lot of anger towards this institution, and the way it's run, and patients coming last, and our well-being coming last, and I was very, very resentful, I guess… I was able to non-verbally express all of my rage on that drum.

This rage and anger were shown in the following excerpt taken from group A between the 15th and 17th minutes (See Excerpt E https://youtu.be/itCks1wRVd0):

> There was the singing bowl played by Acadia, the tubano drum played by Abe, and the djembe drum played by Anna. Justin played the guitar. Initially, participants were tapping or gently hitting their instruments as if they were finding a direction to follow. Justin strummed a minor chord steadily and strongly as if providing an invitation for the participants to join in. Shortly afterwards, Anna started beating the djembe drum, which matched Justin's guitar playing. Meanwhile, Abe started scratching the tubano drum, leading to an escalation of the music as Acadia joined in, making louder sounds, and Abe started banging the tubano drum. The music was becoming faster and the tension of the music was being rapidly increased and sustained for a short while, as if there was so much emotion that needed to be let out. At one point, the music gradually deescalated and became more rhythmic and calming as participants seemed to have found a steady beat. It was as if they had released some emotion or anger that emerged from the interview before this music playing.

In group B, Barbara described her experience of playing the ocean drum as a way to contain her anger after the initial interview. She said:

> The experience of playing was a powerful and beautiful way to be angry and, within it, [hear] the thunderstorm and the ocean.

Besides the therapists, the patient participants also shared their experience of expressing anger in the music. Eda said she let distress and anger out through the music without saying swear words as she was "distressed and angry, and what we were holding in, we finally let out, but it wasn't in no cuss word, but we let it out in a nice way." Similarly, although she was calm throughout the session, Dulce was aware of and revisited her anger towards her own personal issues in life while playing music, and shared that the anger was right here, and she was able to "throw anger out" through the music. She added, "I do it not by punching people but by playing the drum."

Sadness

Besides the anger described above, one other strong emotion that emerged during the music playing was sadness. This sadness, which also emerged on a few occasions with anger, happened especially in group A. After musical improvisation, Anna realized through music that underneath all that rage is a lot of sadness, and she continued to indicate that "a lot of sadness just for the stories we hear, and the patients." Abe responded to this by saying he was "messing with sadness" while playing music in the group, and he described the sadness he experienced in this music improvisation as follows:

> I just had to sit with it for a long period of time, and then eventually I started making the music... I've been watching a lot of YouTube videos with orcas and cubs ... Lionesses

> calling for their cubs … woo ... and it's just like sadness… that was a lot of my sadness that needed to come out, and I got a little choked up at the end.

Acadia also shared that while playing music after the interview, she thought her patients in the unit were stuck in the same place, which made her sad. Acadia indicated:

> Yeah, and I felt the sadness too… it's sad when it ends because then our patients have to go back to just being in the milieu, and the reality is kind of sad, but thank goodness it [this research group improvisation session] happened; thank goodness this is an opportunity for something.

Similarly, Barbara also shared that she experienced this sadness/grief while playing music after the interview on her work experience, and this sadness also surfaced with anger. She described this experience as follows:

> I just felt such grief, and then when Brenda started playing, I felt that there was this anger, but that was underneath my grief. I connected with that, and it's easier for me to detect the grief part of me that connects with my anger. It's harder for me to reconnect with the anger.

Calm

After the group improvisation when the group members had elaborated on their "catharsis," which will be discussed in the other theme, all the participants in group A indicated they felt calmer at the end of the session, in contrast to their mood of anger, frustration, and sadness they had felt after the initial interview. Anna described the experience as, "I feel more open, less tense, a little bit more fluid. I feel calmer after all." Other participants in other groups spoke of similar experiences. Afterwards, Acadia also pointed out a sense of calmness she felt she had gained. Brenda indicated that the experience of group improvisation felt like they were

going all out, and after that, it felt peaceful. Brenda also recalled the musical moment when she strummed the guitar softly and calmly after the initial phase of the improvisation session, which was characterized as being loud and tense. Brenda described:

> It feels like after it's out and I feel like some peaceful starting especially when I play the guitar enjoy with me it's like just comes and goes comes and goes.

Eda described this sense of calmness as finding peace of mind after letting off steam through music after sharing her frustration at her hospitalization and life after her discharge. She said:

> Music eases the soul. Music, to me, makes me feel free. [I] came out of this group to find peace of mind and was doing what we want to do."

Besides the calmness that emerged from group improvisation and the process of catharsis, the participants in group D and group F described the sense of calmness they experienced during the music playing. They said it gave them comfort, space, and time; Dulce said this activity helped calm her down.

Bodily Sensation

Cecilia said playing music enabled her to lessen her body pain and relax her. Caroline related to this experience, and a keyword, bodily sensation, emerged. In the discussion following the musical improvisation, Caroline noted that she got more sensory feedback than emotional feedback, which also related to transference to the patient's experience. Caroline described this phenomenon as follows:

> I think for me it was maybe less about feelings for me, and more like sensations. I was really drawn to instruments that were going to give me sensory feedback. The drum and the cabasa were like, "Aw, this is what my patients feel." I have that physicality.

Other participants shared their experiences related to bodily sensation. Fabian referred to the music playing as "an exercise." Anna shared that when she played the music, she literally felt like "a vibration in my own body." Bella also related to her experience of playing the cabasa, saying that she too experienced a vibration. "I enjoyed the vibrations on my arms," she said:

> Using [music] like this takes you back to your child self. Just like hitting it, feeling it up your arms, getting a little bit of a massage there.

In addition to the effects of the instruments, one participant said using her voice to make sounds raised her awareness of her throat and hand. Acadia articulated this experience as follows:

> I feet aware of my throat. I think [that awareness comes] from the sounds I was making, the really gnarly growls that came out earlier. I think that scratched my throat and now I feel aware of my voice. I feel aware of my hands, and I feel like I've made something today… I feel aware.

Sense of Belonging/Togetherness

When the participants improvised music as a group, there was sense of belonging and togetherness coming up through the process in one session. This emerged especially in the patients' groups. In response to this phenomenon, David said:

> This is making me feel like I am part of something, and other people are part of it, too.

Debbie added:

> We were all connecting with each other; we were trying to balance each other out.

Debbie also referred to this group process as “oneness,” and “everybody's feeling peace... peace, love, all in one thing.” Related to rhythm, Dulce further described this sense of belonging as “on the same page.” She said:

> We were all on the same page. We all played different instruments, but we kept similar beats, so it felt like we were on the same vibe. This way, we all could hear each other. No one was trying to sound louder than the others. So, we were all on the same page.

Participants in group E also brought up this sense of togetherness. Edwin described her experience:

> We stopped doing different things, and then seemed to be together for the last five minutes or so. We were together.

Elliot further articulated this sense of togetherness as he said:

> Now it's like we saw a different personality in the person. I felt people with a different personality or different people bound together in the music. We tried to help each other, to connect and listen to each other. It’s like we tried to lift the others and build up something, and to stay positive in our day-to-day life, so we can be better.

The following excerpt, which was taken from the 8th to the 10th minute in group E further highlighted this experience (See Excerpt F https://youtu.be/lv-SbCKuRaU):

> In this excerpt, Eda was playing the singing bowl, Edwin was playing the tubano drum, and Elliot was playing the djembe drum. The researcher was playing a two-chord progression in 4/4 meter. Eda was hitting the rim of the singing bowl in response to this chord progression, while Edwin found his way to fit into this playing. Elliot initially was only tapping the djembe and seemed unable to make his djembe play audibly. At one point, Elliot was gradually making his music playing heard and he eventually found a

musical direction to fit into the music playing with the rest of the group members. The music went on in a steady and strong fashion. The participants shared that they felt they had worked together on something with a sense of belonging.

In group F, participants elaborated on their experience that led to this sense of belonging and togetherness. Fay said, "Yeah, we are. We did create something together," and she further commented that:

> I guess it's going to be there for me for a period of time, and then it leaves. I am still part of it. No matter what the reason is, it is still left with us, I think.

Related to Fay, Felix articulated:

> I think we have ups and downs and were trying to look for a direction to play music together.

Fabian then added and related this experience to his daily life:

> I feel I am part of it. And I think that making music is also about cooperation, like in our daily life. This way, we can make things better, make music sound better.

On this topic, four therapists shared their thoughts. Anna said the participants were in the rhythm and making music together. Related to her experience of work and this musical improvisation, Acadia said:

> It just made me think of how connected our disciplines are too, that naturally I wanted to move and sing and use my voice. They all feel so part of each other.

After group music playing, Caroline responded to her experience, saying:

> It felt like there was a working through of something… we were playing all together.

Cora then added:

> It's like we're all in this boat together.

Safe Place/Space

As the participants found their rhythm together in the musical improvisation, releasing their emotions and reflecting their thoughts, culture, and life experiences, their music created a virtual space and a safe place. Brenda said he found a balance and a safe place to release his emotions. In group B, although being reluctant to make music, participants found that at one point in the musical improvisation they were getting to a comfortable place where they, especially Brenda, allowed themselves to use explicit language to express their anger, frustration, and anxiety. Brenda, who had expressed her experience about profanity in the context of her culture, said:

> I said this [profanity] because two of you were doing this ... well it's good to say f-u-c-k; it's like sometimes we need to be allowed to say it or sometimes just... allow yourself to do it and then say anything if it is helpful… So I feel so released after this group process, and I just feel peaceful because I have a lot to look forward to after this.

As mentioned above, rhythm created a structure and it also helped participants feel safe. In response to Cora's xylimba playing, Caroline said:

> You were playing something on the marimba, and it was just kind of this lullaby, like a metronome. I felt safe in that, that safety in you playing… I felt the safety in your rhythm.

This was depicted in the following excerpt between the 27th to the 29th minute in group C; music clip is not included for this excerpt because participants may be identified:

> In this excerpt, Justin played the tambourine, Candice played the cabasa, Caroline played the ocean drum (tilting it back and forth), Cecilia played the gato drum, and Cora played the xylimba. At this point, Cora played a certain musical pattern and rhythm on the

> xylimba; throughout this excerpt, she kept this musical pattern and rhythm, creating a structure like a lullaby as Caroline described afterward. Other participants fitted into this structure and pattern; Caroline and Cecilia vocalized on this musical pattern, with a melody and the dynamics of a rocking feeling.

In group A, a couple of participants related to this topic. Anna described an image coming up as she played music, and said,

> Then I got into like a rhythm with that thing, and it just felt I had this image of being like in the rain forest and like happy times. Like we can be happy even though we're here, like we have bananas and we have the sunshine, and we're just like making music together and things are good, joyful, and happy.

Abe spoke of the trust that helped him through this process:

> So, that was a lot of my sadness that needed to come out, and I got a little choked up at the end, which takes a lot of trust because I don't choke up in front of anybody."

Dulce described her experience as similar to being in a safety bubble:

> It is just like a safety bubble. You forget about things going on outside and calm down… It's just I was safer in here than out there.

In group F, a couple of participants mentioned that they particularly wanted to stay in the group longer as it felt safe and helped them forget about stress outside at the moment. Fay said:

> I guess after that feeling of release most of us wanted to stay in the group. We didn't want to be on the other side worrying about other things going on … I feel we were creating something in this space, not caring about what's happening outside of this room. Feeling safe here.

Fabian added:

> Yes, I feel safe; I really focus on the process. I get a sense of safety and forget about stress outside at the moment. It's good for everyone here.

Theme IV: Participants' Challenges in Single-session Improvisation

In these study sessions of single-session improvisational group music therapy, participants experienced different challenges in their process of improvising music. These challenges included anxiety, uncertainty, resistance, tiredness, and cacophony, which emerged in the interview and were observed in the music playing.

Anxiety

Two participants experienced anxiety at different points of the group sessions. Cora shared that she was anxious when she arrived for the session because she felt she was obliged to attend this research group. Barbara shared that she had become more anxious towards the end of the session as she was not sure whether she would be able to work well within the groups she was going to join. She articulated this anxiety, saying:

> I'm starting to get anxious because I'm like ... I have to... I have a very specific warm-up protocol that I have to do to be ready for whatever is coming up, like a real, literal, physical thing.

Barbara continued, saying that she tried not to feel anxious, and thought she did do well. She said:

> I wanted to participate in this…I didn't really think about how this was going to affect the actual group.

This sharing led to the discussion of self-care and coping, which will be covered in the next theme.

Resistance

This keyword was brought up in group A by Acadia as she shared:

> It's a subtle thing because I signed up. I wanted to be here. I showed up, but I think every time at the beginning, even with my own modality, there's always a little bit of resistance.

Acadia further explained that this experience of making music made her think of some multi-model gatherings that had been held in the same room as this study session. Related to this, Acadia said:

> I always feel resistant to starting it because I know it's going to open up something. And then, once I'm in it, I'm like "oh my god I need this everyday with this group, you know?" And, as we were creating music and making sounds just now it reminded me of that, and how much I feel like we were here as a way to... How much I need it, even with all that resistance.

This resistance was also described by Bella, who voiced her displeasure at this music playing because she thought she was not very musically inclined although she still tried different instruments throughout the session. She was also preoccupied with a personal matter at the time of this research group, which contributed to her sense of resistance. Barbara also articulated this sense of resistance after group music playing, saying that she loves music but does not like to create music; "it's not my thing," she said.

This resistance was depicted in this excerpt taken from group B between the 39th to the 40th minute, the initial minute of the second piece of music playing (See Excerpt G https://youtu.be/Mr_uAiQRMVs):

> Justin stood up holding the xylimba on his shoulder and played at intervals with two mallets; Bella was sitting and tapping the tubano drum softly; and Brenda stood up,

> shaking two of the tambourines, and at one point, Brenda shook these two tambourines towards Bella as if trying to motivate Bella. Barbara also stood up, initially playing two shakers, and shortly afterwards, she put those two shakers away, only making gentle movement to GL1's xylimba playing. It appeared that Barbara and Bella were not willing to try to make further music together; they seemed to play the musical instruments they picked at that moment and were not motivated or actively engaged in the process. Two minutes later, the music dispersed and eventually stopped.

While this sense of resistance was mentioned in groups A and B, some participants were observed to be rather uncertain about what they were able to contribute in this group process of music making, which will be discussed under the following keyword.

Uncertainty

Three participants specifically raised their concern about not being able to play an instrument and were uncertain how this music-making process works. Anna described music making as a "journey," and she added that starting the journey was the hardest part for her. Anna said she is not a musical person and described her feelings about playing a musical instrument:

> Sometimes I got frustrated having an instrument and not knowing how to play it or not being able to keep a steady rhythm or just managing the coordination of holding a mallet and not knowing how sounds go together and wanting it to sound right.

Abe said he felt vulnerable playing in front of other people and did not feel comfortable when the subject of sadness came up in the group discussion. David also expressed this uncertainty of playing instruments with others in the group:

> Because I have never played these instruments before, so I didn't know how they would sound if I hit them a certain way. So, that was kind of difficult. I don't want to make a noise that's not music, but I felt like no matter what I did, there was no wrong answer.

On this topic, Acadia spoke about her uncertainty in playing music by asking the following questions:

> Oh, am I playing this drum right? Should I be doing this better? Even though I'm very aware it's not about any technique. So, it just still pops up anyway. Also am I being too loud? Was I making too much noise? Was I taking up too much space? Even though I know we're allowed to do whatever, those little questions come up. Am I playing too long? Are people ready to end? Should I stop?

Tiredness/ Exhaustion

The other challenge participant brought up was physical tiredness. Barbara shared her feelings on this subject after playing music:

> My arms are literally too tired. My fingers are at muscle failure. I can't. Then I started feeling, what a drag it is that you have to lead with an instrument."

Related to Barbara, Bella also expressed her exhaustion, saying:

> Like towards the end when I was just like I can't I'm just really tired ...

In group A, Abe shared that he had this sense of tiredness, especially after the last round of music playing, so did Anna as she articulated at the same point of the study group that she was so tired she did not want to do any more music. In group F, Fabian and Felix also shared that their hands and arms were tired as they played the instruments so hard and for such a long time.

Cacophony

Participant Anna brought up this challenge, saying:

> I felt there was some cacophony, which was a little bit challenging. It felt darker in the beginning.

When the participants tried to find a way to play together, the result was a cacophony of sounds, as depicted in the following excerpts from Group A (the 19th to the 20th minute); music clip is not included here because participants may be identified:

> At this point, participants seemed to have found a rhythmic direction to be synced with; Justin played the guitar, Anna played the gato drum, Abe played the singing bowl and tubano drum like a drum set, and Acadia played the xylimba. In the initial part of this excerpt, Justin's chord progression matched the xylimba's notes; however, there was a sense of uncertainty as they were adjusting their own rhythmic patterns to sync with others. Soon afterwards, the music started to turn darker as Anna started issuing unpleasant screams. Justin was then moving his chord progression that sounded dissonant with the xylimba's notes. Meanwhile, participants started making an "Ah" sound with Atonal scale, escalating to a point where all the participants screamed at one another.
>
> After this excerpt, the participants in group A eventually found a way to "play together." They felt the music shifted and sounded better; it made them feel better. This cacophony also took place in groups B and F; afterwards, participants in these two groups addressed the change of music and mood. This sense of change will be discussed in the next theme.

Theme V: Therapeutic Components in Single-session Group Improvisational Music Therapy

As the participants shared their experience of playing music and the challenges they faced, this study observed the therapeutic factors at play. The following discussion will focus on the therapeutic aspects of single-session group improvisational therapy.

Change

One of the processes in therapy is to promote change (Yalom & Leszcz, 2005). This goal of making changes in a single session ought to be reviewed through a different lens than conventional long-term therapy. In this study, a discussion on change surfaced during one session when Anna indicated she "felt very much like there was this transformation occurring" in single-session improvisational music therapy group. She referred particularly to the cacophony taking place when the participants started playing music. Anna said she felt restored at the end. Acadia related to this statement, and commented at the end of the session:

> I feel privileged and I'm kind of in a different place now because it shifted.

In the discussion on change, Bella shared her experience after the music improvisation by saying:

> I think in the beginning I felt pretty raw, but now I'm pretty calm. I'm ready to move on to whatever's next."

Similarly, and related to the catharsis after playing music, Brenda shared that she felt so happy and looked forward to what she would do next after this session at work. She said she would allow herself to release everything before she left. Barbara also referred to the changes in the patients' efforts and progress:

> It gives you more appreciation of the efforts the patients put in and what motivates them.
>
> I want to be more aware of any changes in the patients.

In group C, in the discussion on change, Cora said that she was initially anxious in joining her group, but at the end she felt released and realized she had carried a "coil of energy," and tried not to be stuck in negativity. Cecilia simply shared that she felt happier, and Caroline shared that this music playing made her more energized.

Patient participants in group D viewed the changes in a manner that was similar to group C, and said they felt more energized. David said he felt like reaching out, and Debbie said that playing the music made her want more change and to learn more about how to harmonize herself. Dulce commented that this musical gathering had made her feel safer. Change was also experienced in group E, where the participants used the music to express their frustration and anger towards their hospitalization and life after discharge. This change included feeling more energetic. Eda indicated to this researcher that, "You see me. Listen. You see me smiling, right?" Edwin reported that he felt more relaxed and less stressed, and Elliot referred to this experience of getting better as "uplifting." He said:

> It's like we try to lift others and build up something, stay positive in our day-to-day life so we can be better.

Interestingly, in group F, Fabian and Felix said they did not experience change in different aspects within one session. Felix said there had been no change, and that he had just enjoyed playing music. Fabian simply commented that she was in a good group; however, Fay added that playing music together did help her feel better:

> I'm glad you guys came, that we're all in a group. It makes us feel better at the end of the day, I'm sure.

Catharsis

As the participants played the music to respond to the discussion and emotion triggered through the interview, they got rid of strong feelings or energy through the music; they let off steam as they played the music, letting sadness come out, or they contained strong emotions. Cora indicated that the whole experience of group music improvisation was a "release and a

relief." Cecilia described this experience as "the awesomeness of getting out those emotions and feeling them." Acadia regarded this process as cathartic. Acadia related by that by saying:

> [I] became aware of how powerful the groups are, and that they allow for all of this catharsis.

Anna further described this experience as a release, adding that all the sounds were really releasing for her:

> I started to literally feel like a vibration in my own body get released.

After the first group improvisation, Brenda described the feeling of release: "It's very powerful and very helpful, so when I did it, I just felt a whole release." Commenting further on this experienced she added:

> Like the first task [group improvisation]. It's very significant. You really led me in right away…And in ten, fifteen minutes, I just felt totally like refreshed, and all the anxiety, anger, or whatever just got washed away, leaving me fresh and ready to move on.

Related to this process, one of the patient participants, Elliot, described this sense of release and catharsis as, "I just got some energy… It's like getting energy out of me."

Furthermore, most of the participants in the first improvisation indicated that they had experienced this sense of catharsis, which is also significantly true for all the therapists' groups and the patients' group E. The first improvisation in these groups tended to be longer than the following two group improvisations; it seems the participants in these groups had already released their energy and emotions there.

Relaxation

In therapy, relaxation techniques were often considered as an intervention. In this study, music helped provide relaxation as an intervention. In response to his experience of playing the ocean drum and rain stick, Abe said:

> I think rain really relaxes me, and the ocean really relaxes me. It relates because I'm taking more care of myself.

Bella indicated her feeling about her experience saying:

> It felt good, and I feel a little more relaxed right now than before.

Caroline also described her experience of playing music as not only feeling more energized but also more relaxed. Debbie added that the musical experience just made her feel like more alone… "just relaxed, taking time to myself."

Edwin described playing this music as relaxing, making him less stressed. Felix and Fabian talked about their experience of hospitalization as relaxing and said that their music improvisation was also relaxing. Felix said:

> I feel relaxed while playing the music.

This relaxation was also brought up in a somatic sense. Cecilia reported that this sense of relaxation helped her lessen her body pain as she said:

> Yeah. Some lessening of my body pain. I just feel super happy. And, this is just fabulous, yeah… I am able to relax, breathe, and more.

Validating

Through this single-session improvisational music playing, there was a feeling of being validated in a different way; this sense of validation was about being accepted, recognized, and

acknowledged emotionally and professionally as well as in any relationship. Abe described this music playing experience as "validating," as being seen. He added:

> I never make a really big deal of being seen but it felt good being seen by everybody here. Just being seen and feeling validated. I feel it's been good."

On validation, Anna stated:

> I feel like I started with a lot of just wanting loud sounds like pounding and deep resonance to express myself. That felt validating.

For the therapists, this sense of validation through playing music was also connected to their experience of their work with patients. Barbara reflected this sense of validation by saying:

> So, on the one hand, it reinforces my belief in the importance of patients having access to creative arts therapies.

Cecilia shared a story that she was reminded of while playing music as follows:

> Reminding me of that because I remember there were certain moments and there was a patient years and years ago with whom I was doing a creative expression with music, and she wrote... they were drawing and stuff ... And she wrote, "I was alone, so very alone. And you ... And something like you brightened my day with music. Something like that. It was like something that I'll never forget"

For patients, this sense of validation came from their realization of being able to make music extemporaneously as Dulce shared;

> I never knew I could make music, so that was pretty cool.

David added:

> Anybody can make music; you just have to be really willing to make music with other people.

Participants in group E all agreed that they made good music, and similarly, participants in group F shared that they had made an effort as a group with a group leader to make good music together. In terms of these group efforts, the other keyword, sense of belonging and togetherness surfaced, which has been delineated above.

Attention/Focus

On the therapeutic effect of music, the ideas and reactions pertaining to focus and attention were raised through the discussion after playing. Describing her experience of this single-session musical improvisation, Acadia said:

> I think what came up for me was this sense of timelessness. I could just continue doing this forever.

In group C, Cora related:

> I really like this attention. And I have it in the back of my mind; it always kind of led me.

Edwin elaborated his experience on the concept of flow, and said:

> Music playing helps me focus. I am so focused on playing music at the moment that I forget my problems. Every time I participate in this kind of group, I feel the same way.

Debbie referred to this experience as a positive vibe, saying:

> Nobody not thinking about nothing else, no troubles, no nothing, just right now, in the moment… I am thinking, just a positive vibe. Everybody's just making music. Forget about everything… just making music."

Similarly, Fabian articulated his attention to playing the music:

> I don't know. I didn't really think about anything when I played.

The following excerpt taken from the 17th to the 19th minute in group F illustrates this experience (See Excerpt H https://youtu.be/p8WmzO4nBH4):

> This excerpt started after a short quiet down time, as Fabian was exploring the ocean drum, tilting it back and forth slowly. Then, Felix started playing the xylimba with no clear pattern; shortly afterwards, the researcher started to play the tubano drum, providing a strong beat with a steady rhythmic pattern, and Felix's xylimba fitted into this pattern right away; meanwhile Fabian played the tambourine loudly, matching up with the tubano's playing. Felix continued to move the ocean drum around as a background, though he was being attentive to the others' music. This strong, loud, and relatively faster music went on with this same dynamic.

These participants shared their experience of music playing as being a "focus," "attention," and "forget about time and everything" to respond to, and cope with, challenges they are experiencing in their lives, such as hospitalization, anxiety, and other stress.

Coping/Restore/Self-care

As the effects of playing music were discussed, reference was made to self-care and coping, especially for therapists; coping in this context is when therapists provide therapy to patients. This talk of self-care also related to its restorative effect in music. For example, Abe indicated:

> There's a calmness, whereas the last piece was angry then sad, and stayed sad. This was more of a restorative piece for me I think.

Anna said she felt that given that space and time in music she could do things to take care of herself and needed to do more after this group to feel better and restored.

In group B, self-care was also explored in the discussion after the improvisation, and the group talked about finding a balance at work. For instance, Brenda said it was important to take care of oneself in order to take care of the patients, and to find balance. Bella, referring to the importance of self-care, said as a therapist it was important to know "how much I can give myself." Brenda related to this and addressed the importance of routines such as meal times, as her work would not be affected.

Participants in group C also brought up the significance of self-care as they related to the experience of single-session music playing. Caroline said:

> I felt like we're giving so much of ourselves and it's hard to remember to keep something for ourselves.

Participants agreed that this session they were in was so helpful in terms of self-care; as this music therapy session or other creative arts therapy sessions were provided to patients daily, participants in group C indicated that these creative arts therapy groups should also be done for therapists' self-care. Cora related to this and said:

> As a therapist, caregiver or whatever, we're often providing this for our patients and the clients. But having it also for ourselves is important. Something that I want, in the end.

As for the patients, a discussion on this topic only emerged in group D. Through playing music, participants in group D raised their awareness of "not rushing" in coping with the stresses of daily life. David addressed this awareness by saying:

> Taking our time and just to be once in something else. In that, we don't need to rush or anything.

In response to this discussion, Debbie shared that in playing the music, she was learning how to harmonize herself out in the world, and she further allowed her desire to change and spoke about how she had found change through music.

Summary

All in all, these five themes emerging from the interviews and group musical improvisation mirror the current reality of group improvisational music therapy in inpatient psychiatric care. The first theme revealed therapists' experiences of working in inpatient psychiatry. Various issues were brought up in the interviews, such as facing an unpredictable working environment, patients' rapid turnover, uncertainty about their role, and the application of single-session therapy. Topics of adaption and finding balance emerged in the discussions; it appears clear that a therapist must adapt her or his interventions to this setting in order to cope with this rapid turnover and further reach a balance within overloaded work as a clinician working for inpatient psychiatry.

The second theme revealed patients' experience of hospitalization in inpatient psychiatry. Most of the participants acknowledged that they had received treatment and care from their providers, and were comfortable with it; however, they also mentioned different issues experienced during their stay, such as interaction with peers, stigma, isolation, and medication management. Some patients voiced their concerns about life after discharge. They also talked about their experience and knowledge of single-session therapy; most of them were not aware of this concept.

The third theme revealed both therapists' and patients' experience of group musical improvisation in a single session. When it comes to making music in a single-session model, the subject of the "here and now" was raised and other factors such as culture, emotions, and somatic

reactions were discussed. The significance of using music to respond to emotions or thoughts emerged from the interview. This result also revealed that playing music, using the guitar, voices, rhythm, and musical interaction within a single session was a way of expressing emotions.

The fourth theme revealed the challenges in single-session improvisation. Some participants talked about anxiety, uncertainty, and feeling tired; some also showed resistance to playing music. It was also noted that producing a cacophony was mentioned, as a cacophony can also initiate and motivate the music-making process.

The fifth theme revealed therapeutic components in single-session group improvisational music therapy. Therapy is about change, and in this study, musical improvisation helped participants reach a catharsis, find relaxation, and feel validated. The process of music making helped the participants to focus on the present and forget about stresses outside the room or hospital. Some also found music making could be restorative and used as a coping mechanism for self-care.

Finally, in the following section, the results of the data analysis will be further discussed and contextually compared in order to better understand the findings and phenomena that surfaced from these six study groups.

CHAPTER 5

Discussion

According to Creswell (2013), a phenomenological study describes the common meaning of multiple individuals' lived experiences of a concept or phenomena. The core purpose of phenomenology is to process individual experiences with a phenomenon into the universal essence (p.76). The present study is a qualitative, phenomenological study designed to elicit the multifaceted experience of therapists and patients in an inpatient psychiatric setting with single-session improvisational group music therapy. Through six separate group sessions of music playing and interviews, participants revealed their thoughts and individual lived experiences on being hospitalized or working in an inpatient psychiatric setting, as well as their immediate reaction towards and experience of group improvisational music playing in single-session therapy, a common technique in today's inpatient psychiatry.

In this study, therapist participants' professional experiences and patient participants' experiences of being hospitalized were explored. The therapist participants reflected on their experience of work and their role in the treatment team, as well as their experience with single-session therapy. The findings indicated that in today's inpatient psychiatry, the working environment of creative arts therapists can be unpredictable and chaotic. To fulfill their job description in this unpredictable working environment, therapists reported that they had to adapt and find balance to cope with potential burnout, and with being overloaded with paperwork due to rapid patient turnover. In terms of patients' experiences of hospitalization, patient participants shared their experiences of the treatment and care that they received from providers. They also shared concerns about life after discharge, stigma, and interaction with peers on the unit.

During the improvisational group music therapy phase of this study, therapists' and patients' experiences was explored. Several findings emerged in this process of music making, including the idea of the "here and now," culture, and emotive and somatic effects. The use of music was explored with regard to guitar playing, voices, rhythm, and musical interaction in a single session. Challenges to single-session improvisational music making included anxiety, uncertainty, cacophony, resistance, and fatigue. There were also reported therapeutic benefits of single-session improvisational group music therapy, as the process of music making enhanced catharsis, relaxation, a sense of validation, a focus on the present moment, and coping mechanisms.

The meaning and significance of these findings in relation to the existing literature and theory will be discussed in the following sections: (a) The significance of single-session therapy, (b) Therapists' professional experiences versus patients' experiences of hospitalization, (c) Structure of musical improvisation, (d) Musical response in single-session group music therapy, (e) Therapeutic components, and (f) Integral ways of thinking.

The Significance of Single-Session Therapy

From the data uncovered in the literature review, the average length of a patient's hospital stays in the United States today ranges from seven days to two weeks (CDC, 2015; Ithman et al, 2014; Lee, Rothbard, & Noll, 2012; Thomas, 2007). This shorter length of stay naturally leads to an increased turnover in patients (Kalseth et al., 2016; Park et al., 2015; Silverman, 2009). Shorter stays are partially attributable to improvements and advancement in medication, as well as more limited insurance coverage. This shorter length of stay and rapid turnover affects group dynamics, making group therapy interventions different from those offered in partial hospital and outpatient settings, as the constantly changing and unpredictable

combination of group members makes it difficult to set continuous group goals (Thomas, 2007; Yalom & Leszcz, 2005). However, this should not be taken to mean that group work is not possible. Yalom & Leszcz, (2005) write that therapists must consider the life of groups in an inpatient psychiatric ward as being only a single session. The idea of single-session therapy was coined by Moshe Talmon (1990), who argued—contrary to popular wisdom at the time—that clients might meet their needs within a single session.

In the present study, most therapists agreed that they were aware, at least to some extent, of this single-session model, and of how it may be a helpful response to higher turnover and shorter inpatient stays. However, therapists had different opinions towards this model of single-session therapy. Two participants talked about how they were able to build community within a single session, and how this sense of community continued and had an impact on the dynamics of the unit. One therapist participant described the dynamics and change from a single session, in which dysregulated patients were able to focus on group tasks and share in the group process. Therapist participants shared that they had learned to adopt a frame of single-session clinical work.

Conversely, one therapist participant raised doubts about how effective single-session therapy could be. Although acknowledging the reality of the current psychiatric care model and the practical need for implementing a single-session therapy model, two of the participants reported a lack of knowledge or training in this model, with the single-session model outside of their academic area of focus. One participant indicated that she was a novice to this single-session approach, as her past experience had been exclusively working in a long-term therapeutic setting, and she never studied the single-session model. One participant expressed her longing to

engage in long-term therapy and shared her disappointment with not being able to work with patients over a longer period of time.

In addition to therapists' experiences, patient participants also shared their understanding of single-session therapy. Most patients had never heard of the concept of single-session therapy, and even after this researcher explained this concept, few patients reported that the idea of single-session therapy made sense. One participant described how group members changed over the course of several weeks, reflecting the reality of constantly changing group members. This constant change was reflected in the recruitment of both therapists and patients in the present study, with continually changing combinations of participants within these groups.

In his book *Single-session therapy: Maximizing the effect of the first (and often only) therapeutic encounter*, Talmon (1990) found, after analyzing data from outpatient clinics in the 1980s, that the most frequent length of therapy reported by every one of the therapists surveyed was a single session, and that thirty percent of all patients attended only a single session over the course of a year (p. 7). In light of this finding, Talmon subsequently delineated step-by-step guidelines for therapists to follow to maximize the therapeutic potential within these constraints:

(a) Getting started: Getting ready to induce and prepare for change,

(b) Fostering readiness to change: Creating readiness for action and change is crucial,

(c) Alternate opening: The possibility of change is introduced right from the start,

(d) Focusing on pivot chords: Listening attentively to the patients to find the focus,

(e) Looking for patients' strengths: When patients are allowed to be explorers, with minimal therapist intervention, this creates the possibility for true change,

(f) Practicing solutions in the session: A here-and-now experience in which the patient thinks, feels, and acts differently can make real and immediate desired changes,

(g) Allowing for last-minute issues: Questions are raised at the conclusion of the session to air last-minute issues and to offer reassurance, and

(h) Giving final feedback: The four elements of final feedback usually include acknowledgement, compliments, diagnosis (or assessment), and prescription (or task).

In the current study, the collection of data was designed to explore participants' lived experiences involving inpatient psychiatry and their experiences of participating in single-session improvisational group music therapy, which was set to mirror the current practice of music therapy group in inpatient psychiatry. This process of data collection can be regarded as a plan or protocol of a single-session improvisational music therapy group and can reflect Talmon's step-by-step guidelines. The data collection process includes (a) Introduction: Greetings, check-ins, and ground rules. (b) Warm-up musical improvisation. (c) Second round of musical improvisation. (d) Third round of musical improvisation.

In this study, the process of data collection or respectively a protocol of an improvisational music therapy group were set to be implemented in all six research groups accordingly. Nonetheless, the results of this set group process vary. Participants' reaction, group process, choice of musical instruments, and dynamics of music are different throughout these six groups with participants who are therapists with different backgrounds and patients with an extensive range of psychopathology. This difference of group results resonates with the reality of groups in inpatient psychiatry; that is, the life of groups in inpatient psychiatry must be considered to be a single session (Yalom & Leszcz, 2005) and therefore will tend to bring their own unique dynamic each time.

From these six groups, moving through the stages of data collection, a single session of improvisational group music therapy offered participants an opportunity to bring up issues, emotions, and thoughts. Through this single session, participants were able to process issues, emotions, and thoughts by responding through both music playing and verbal discussion. However, while there were benefits, difficulties and challenges also emerged. In the following section this single-session process is further explored, including participants' experiences, their musical responses, integral ways of thinking about music therapy, the structure of music, and therapeutic elements.

Therapists' Professional Experiences and Patients' Experiences of Hospitalization

Throughout the first stage of data collection, therapist participants revealed that their work environment can be chaotic, dangerous, unstable, and unpredictable. Patients are admitted when they are acutely ill with diverse diagnoses and symptoms (Cook et al., 2014; Yalom & Leszcz, 2005); while some patients enter the hospital when already relatively stable, or quickly improve their mental status and behavior, others are disorganized, psychotic, and isolated, especially in the acute stage of their illness. The shorter average patient length of stay means that more patients are in this acute stage, making this workplace unsafe and unpredictable. There has been much discussion of issues of patient and employee safety (Slemon et al., 2017), especially in light of the frequent aggression and violence that occur in many inpatient settings (Hallett, Huber, and Dickens, 2014; Kelly et al., 2016).

Therapist participants raised concerns about role uncertainty, as they were often misunderstood and struggled to find their roles in the treatment team. Participants reported that the central focus of inpatient psychiatry is on what medication has been prescribed, and its effects on patient mood and behavior. Therapists also reported being overloaded with

paperwork, which is required for the initial assessment, progress notes, and discharge summary; with increasing patient turnover, therapists' paperwork has increased accordingly. Burnout also emerged as a major issue, with an unpredictable and unsafe work environment, extensive paperwork, and less time spent providing direct patient care and therapy.

Burnout is well-documented in mental health professionals (O'Connor, Neff, and Pitman, 2018), with factors such as excessive workload, role ambiguity, and stressful professional relationships being key determinants for burnout. However, therapist participants in the present study also reported successful strategies to find balance and mitigate stressors. One success strategy was to adopt a new framework of clinical practice, such as "do one thing at a time" or "be in the moment [and] make sure everyone's safe and everyone has the most beneficial experience" (Anna). Protective factors against burnout and stress include good supervision, role clarity, the cultivation of a safe work and therapy environment, a sense of being fairly treated, and work conditions that support empowerment (Delaney & Johnson, 2014; O'Connor, Neff, & Pitman, 2018)

In terms of patients' experience of hospitalization, patient participants in groups D and F generally reported having positive experiences, despite the stressors of hospitalization; in contrast, participants in group E generally found the hospitalization experience frustrating. Most patients, especially ones in groups D and F, reported that staff were caring, and participants Felix and Fabian even regarded the hospitalization experience to be comfortable and relaxing. Participants discussed their experiences of taking part in group programs on the unit. Group programs helped them get through the day and also helped them develop more positive coping skills. Eda described her experiences of participating in a group, where she felt that she was free to be who she wanted to be, despite her disagreements regarding prescribed medication. The

experiences shared reflect the need for support and structure in acute inpatient psychiatric care, the importance of program clarity, and the significance of positive relationships between caregivers and patients, as supported in the literature (Bola & Mosher, 2003; Johansson & Eklund, 2004; Thineault et al., 2010). Patients' reflections on their positive experiences of hospitalization also echo the literature indicating that patients may also feel safe, supported and cared for; may experience healing as a result of treatment; may regain a sense of control, and learn to manage mental health (Johansson & Lundman, 2002; Jones & Mason, 2002; Katsakou & Priebe, 2007; McGuiness et al., 2018; Seed, Fox & Berry, 2016; Thineault et al., 2010).

Stressors of staying in the hospital included a feeling of stigma. Examples of this included Debbie's story on make-up and dressing nicely, and Edwin's feeling that staff "see us like psychiatric people" and are not comfortable with patients. Other patient participants felt constrained (Eda and Fabian complained about not being able to watch TV freely), had difficulties around peer interaction, or reported a sense of isolation (Elliot shared feeling homesick). Medication management was also a significant stressor of hospitalization. Fabian brought up the side effects of medication, and Eda discussed her disagreements with her care providers regarding medication. Participants also brought up concerns of uncertainty around when they would be ready for discharge, discharge planning, and life after discharge. Patients' reflections on their unpleasant experiences of hospitalization echo the literature indicating that patients may experience feelings of confinement and restraint; not being cared for; loss of control, autonomy, and normality; or a sense of fear, stigma, isolation, and rejection (Johansson & Lundman, 2002; Jones & Mason, 2002; Katsakou & Priebe, 2007; McGuiness et al., 2018; Seed, Fox & Berry, 2016; Thineault et al., 2010).

In comparing the experiences of therapists and patients around inpatient psychiatry, the present study found that therapists and patients had different views on their experiences while working or being hospitalized in this setting. Most therapist participants made overall disparaging and unfavorable remarks about their work environment and conditions, citing stress, role uncertainty, safety issues, and rapid patient turnover, which in turn led to an overload of paperwork, burnout, and a sense of unpredictability. In contrast, while a few of the patient participants reported stressors of hospitalization such as medication management, interaction with peers, discharge uncertainly, stigma, and a sense of isolation and constraint, most of the patient participants reported an overall positive experience of hospitalization, which most of them regarded as calm and relaxing. A couple of patient participants expressed their gratitude towards their providers and for the treatment and care they received during their hospitalization.

Reviewing these different perspectives on inpatient psychiatry from therapists and patients, it should be noted that the patient participants were all in the later phases of their hospitalization (i.e., no new admissions were interviewed); most were medication compliant, their moods were stabilized, and psychotic symptoms and challenging behaviors were under better control. It might therefore be reasonable to expect that this population of inpatient participants might be more likely to focus on the benefits and positive aspects of inpatient psychiatric treatment when reviewing their experiences of hospitalization, when compared to how new or less stabilized patients might respond (although patients still brought up stressors and complaints). Patients in this stage of hospitalization were also concerned about life after discharge, which new arrivals might be less concerned about.

Unlike these patients, however, the therapists interviewed constantly had to interact with patients in the acute stage of their illness, which led to stressors around unpredictability, safety,

burnout, and an overload of paperwork due to patient turnover. However, it should be noted that, although this shorter length of stay may increase the stress that therapists experience, shorter inpatient psychiatric treatment can be potentially beneficial for patients as they can return to the community sooner; as Bromley et al. (2013) indicated, community involvement and support is a crucial component of recovery for the patients with several mental illness, especially when inpatients with diagnosed mental illness begin to focus on life after discharge in the later part of hospitalization. With these short stays, the focus needs to be not only to help patients to recover from their acute stage of illness, but also for the treatment team to create a safe and therapeutic milieu in which patients can develop and refine coping mechanisms through groupwork (Doyle, 2015; Silverman, 2009; Silverman, 2011). These mechanisms will then be essential for patients to sustain their recovery after discharge. In terms of groupwork, musical improvisation in music therapy is one of the essential group protocols in inpatient psychiatry, providing the "quickening" quality of music (Ansdell, 1995, p.81) as an important factor in therapy. Ansdell (1995) defined "quickening" as "to give life to" and "to impart energy" (p.81), suggesting that music therapy is a way of finding access to life in music, "an experience at once purely musical but also irreducibly part of the flow of our bodies, thoughts and feelings: of the inner flow of our lives as a whole" (p.87). Hence, the process, structure, and dynamics of musical improvisation in group music therapy will be discussed next.

Structure of Musical Improvisation

After sharing their experiences of work and hospitalization, participants were given the choice to pick up a musical instrument and play music as a group. The present study found that a structure of musical improvisation could be created through rhythm, the use of guitar, chords, vocalization, and the musical interaction between these elements. In light of forming structure of

improvisational music playing in one session, several participants such as Anna and Felix shared that they focused on the dynamics of music in the moment while playing music, interacted musically with other participants, and put themselves in a "here and now" music-making process, which further created an immediate structure of music in the moment, as music therapy improvisation being a process of experiencing elements of music (Bruscia, 2012; Carroll & Lefebvre, 2013).

In this study, it appeared that rhythm provided a structure and space, with participants interacting, feeling comfortable in the music playing, and enjoying the sound of the music, all while finding the same beats, which echoes Kossak's study (2008) on attunement, reflecting the need of space, connection, and safety being formed through free structured sound and rhythmic improvisation. Caroline shared that she enjoyed the tones providing comfort in rhythm, and in group D, participants also shared that the music sounded good because they were able to play in the same beat. Within a single session, music was built up little by little within the rhythm over a very short period of time as Fabian shared after music playing; this dynamics has also shown in the music from the ninth to the tenth minute in group D (See Excerpt A https://youtu.be/dzZcGt5mEBg). During this gradual process of finding and building up the rhythm, participants in group F reported feeling motivated and driven by the music to concentrate; and in group D, participants shared that they further explored the strength through this process and reflected on their feeling of belonging in this single-session group.

In single-session music improvisation, the structure was sustained as long as the rhythm continued, but as soon as the rhythm ended, the structure dissipated, echoing Spring & Hutcheson's (2013) argument on rhythm: that is "rhythm operates on several levels to move music through time and to generate musical form" (p. 5). Rhythm moves different tones to form

intervals and harmony; when musicians create successions of these intervals, this becomes a scale of melodies (Zuckerkandl, 1959; Zuckerkandl, 1969). Melody, harmony, and rhythm are considered to be the three basic elements of music, in connection with Ansdell's (1995) account, that is, music becomes meaningful as "one or more people build a structure of rhythms, melodies and harmonies within an overall form" (p,26). In this sense, in single-session improvisational group music therapy, these three basic elements are structured in the moment to extemporize melodies and harmonies within the rhythm. Melody (i.e., the succession of tones) will not occur without rhythm, and harmony (i.e., the combination of tones) will not be formed, either, as Thaut (2013) argued that rhythm is the core element binding "simultaneity and sequentiality of sound patterns into structural organizational forms" (p, 4). Hence, within rhythm, tones can follow each other, becoming melody, or coincide, shaping harmony.

The present study shows that another way to form structure in music is through the use of the guitar, which can provide chord progressions with rhythm. In this study the introduction of the guitar seemed to create a clear and immediate path for participants to follow and to contribute musically to, establishing a unique musical structure in that moment. The chords used in this study were basic I-VI-V, used in most folk and blues songs as well as two-chord progressions, or other combinations and styles. The findings of the present study suggest that, when it comes to the use of chord progressions, simpler and more predictable chord progressions can help participants to feel more motivated and comfortable joining in with the musical improvisation. In the present study, when participants struggled to find ways to make music, a musical structure formed as soon as the guitar came in. In group E, group members even took over the leading role once a musical structure was established by the guitar.

The guitar is widely used by music therapists, in part because it has so much versatility. In addition to providing chords progressions, the guitar itself can be used as a percussive instrument, either by strumming rhythmically, or, as took place in the present study, by simply tapping on the guitar (as the researcher did). Justin also made some "ugly" sounds as he explored different ways to make the guitar sound as he was trying to engage participants in group B and to encourage them to play music.

In the present study, two-chord progressions were intentionally implemented. This choice to use a simple progression was utilized because it felt like it would create a musical environment that was predictable and inviting, encouraging participants to contribute tones and sounds. This was similar to Austin's (2008) proposed reflecting vocal holding techniques, whereby the intentional use of two chords, along with the therapist's voice, creates a stable music environment that "facilitates improvised singing within the therapist-client relationship" (p. 146). This two-chord progression appeared to also provide a container to enhance the relationship or to build immediate rapport between therapists and patients in this single session, as shown in group D when the guitar provided a two-chord progression, being predictable enough for the participants to join in, and for one participant to initiate vocalizing.

Furthermore, voice and vocalization offered another way to form a musical structure within the present study. There were several moments when participants initiated and explored vocalizing, improvising singing within the two chords. In group D, the researcher initiated improvised singing with two chords, although participant Debbie was the only one to join in with the singing. Besides improvised singing initiated by two chords, vocalization can also provide beats to form a rhythm, which further facilitates the musical structure; in group A between the 24^{th} and the 25^{th} minute, Anna made some sounds vocally and rhythmically as if initiating a beat

and calling other participants to vocalize with her. Voices can also be used differently from improvised singing or vocalization; for example, in group A, participants screamed, yelled, and made dissonant sounds to reflect their emotions.

The present study also noted that this musical structure was based on participants' participation, as well as on the interaction between participants. Even with rhythm and chords being provided, musical structure would not be established without participants paying attention to the music-making process. To form this musical structure, participants closely listened to others and responded to the rhythm and chords or to other participants' music playing, coordinating in that moment; for examples, Fabian allowed that he listened to other people's playing to understand them in the music, further looking for the direction to follow as Fay and Felix simultaneously coordinating their playing rhythmically and melodically, as shown in Excerpt D https://youtu.be/J9HUvkcADOQ In this process of music making and in finding and forming a musical structure, all of the participants played particular roles in how they presented themselves in the music – "I can be a leader and a follower" (Edwin).

The Response through Music in Single-Session Group Improvisational Music Therapy

In this study, most participants appeared motivated and driven by the music that they created. Forming a musical structure, they seemed engaged together within the moment to respond musically to the lived experiences that they shared in each round of the interview, or to the lived experience of music playing in the prior round. This process of response and reflection through music mirrors the idea of response art, as proposed by Fish (2012). In response art, therapists respond to material that comes up in their clinical work by creating artwork privately, with clients, or as part of supervision and training. This artwork may be used for self-care, support empathic engagement with clients, or may illuminate countertransference (Fish, 2012).

This here-and-now improvisational music therapy allowed participants to reflect and contain their emotions, thoughts, and other aspects of psychic work through music playing. Through music playing, in the present study, participants gained awareness of their bodies, as Caroline described the experience of group improvisation bringing her sensory feedback of body. personal dynamics in their lives around issues such as cultural impact, socialization, and the roles of place and space. All of these phenomena will be further delineated with examples and tied with literature in more details in the following discussion.

The present study revealed that music playing can be used to respond to the emotions, thoughts, or feelings surrounding life events or experiences. By responding musically to the emotions that emerged from the first round of check ins regarding their work, or hospitalization, participants shared and expressed their emotions through music. Anger was one emotion that emerged through the interviews, and that was clearly expressed during music playing. Abe indicated that he expressed all of his emotions through music, and anger was clearly one of them, which he expressed by playing a drum loudly and intensely to nonverbally express his anger towards the issues of working in inpatient psychiatry. Other participants also shared anger through music playing, such as Barbara, Eda, and Dulce. Barbara played the ocean drum to contain her anger, and Eda was able to express her anger without using swear words. Dulce gained awareness of their anger through music and was able to "throw anger out." Participants also exhibited sadness and calmness through their music. Abe described a moment of playing music as "messing with sadness." Anna shared that underneath their rage was a lot of sadness, and on a few occasions, sadness emerged alongside anger; Barbara also experienced sadness along with her anger, saying that "I felt that there was this anger, but that was underneath my grief. I connected with that."

A sense of calmness often emerged after music playing as participants elaborated on their experience of "catharsis." Participants shared that music can help them to release their sense of anger and sadness; Eda described this calmness as finding peace of mind after "letting off steam," and feeling free. This peacefulness often emerged after an initial phase of music playing: After the first round of music playing Dulce shared that playing music can calm her down, and Anna described feeling more open, less intense, and calmer after playing music. Participants also noticed sensory feedback and bodily sensations during improvisational music playing, with Cecilia sharing that playing music helped her relax and decreased her physical pain. Other bodily sensations were also mentioned, including music playing being an exercise, a way to physically embody patients' experiences (therapist's response), and a vibration felt when participants played music in the groups, as Anna shared that she literally felt a vibration in her own body while playing music, which brought her a sense of relief. This dynamic of vibration occurs in group improvisational music playing, as if resonating among two or more identical tuning forks, further symbolizing interpersonal communication, mirroring, or attunement (Farber, 2017; Kossak, 2015).

The present study demonstrated how the experience of music playing encourages participants to discuss culture. In group B, after participants used explicit language while playing music, Brenda brought up the countertransference that came up for her, connecting this with her family values and culture. Participants in group E commented on how music could represent different cultures or types of people, "making you feel comfortable with what is in yourself." (Eda)

Improvisational music playing can also create a sense of belonging and togetherness. This sense of belonging or togetherness was described as being "on the same page" (Dulce), as

"we stopped doing different things" (Edwin), as we "help[ed] each other, to connect and listen to each other" (Edwin), and as feeling part of something (David and Fabian). When a sense of belonging or togetherness was established, this created a safe space in which participants reported feeling comfortable, safe, and trusted.

Nonetheless, like any treatment modality, improvisational music making also posed unfavorable experiences or challenges, including anxiety, uncertainty, resistance, fatigue, and cacophony. Anxiety emerged as one participant (Cora) shared that she felt obligated to participate in this research study, while one other participant (Barbara) shared that she did not feel ready for group music making. This sense of anxiety might have originated from a sense of uncertainty before joining an improvisational music therapy research group. One participant, Anna, described this process of music making as a journey, with starting the journey being the hardest part. Music making carried a sense of uncertainty, with participants unsure of how the music and instruments would sound, as well as whether they would feel comfortable sharing the emotions that might be triggered in the interview and music making in front of other people. Participants might also have felt vulnerable even playing instruments in front of other people, especially if they did not have experience with group music making or instrument playing.

Participants reported resistance towards music making, stemming from a sense of uncertainty, being distracted by personal issues, or preferring to express themselves through other creative arts or media. Participants such as Barbra and Bella expressed discomfort or displeasure of creating music; Barbara said that "it's not my thing" and Bella said that she is not musically inclined. Participants resisted starting due to uncertainty around the process, and how it "might open up something" (Acadia). Participants also expressed this resistance by playing music, but not responding to or engaging with the group. In group B, for example, one

participant played softly and did not interact musically with others, despite constant encouragement by the group leader and other participants; as a result, the entire group's music fell apart and stopped after a short period of time.

The present study demonstrated how playing music can lead to physical fatigue and a sense of exhaustion as participants played the instruments in a way that was both physically and emotionally intense. This fatigue may have been one of the reasons that both groups A and B had shorter second rounds after they had longer first rounds of music playing. Some participants shared how tired they felt, and "did not want to do any more music" (Anna).

The last challenge, cacophony, can be a turning point for a group to become more connected. When cacophony occurs, participants may not feel comfortable, and unpleasant, dissonant sounds may contribute to feelings of anxiety, uncertainty, and resistance. Nevertheless, this experience of stressful dissonance within improvisational music therapy can offer a space in which participants become aware of solutions and implement them to make changes, which echoes the theory of misattunement, as Kossak (2009) suggested that "misattunement may be an important and necessary stage of psychological development…where a re-experiencing of mistuned moments allows for new awareness, a shift in consciousness, and where new actions and reactions can be integrated" (p.16). In this study, participants reported findings ways to work through cacophony to "play together" and make music "sound better." In therapy, care and a sense of safety and support may have to be given by the therapists and established with clients; however, it is also important that confrontation and challenges are involved in therapy so that changes can be made and a stable structure can be established; in the context of improvisational music therapy, these may involve a sense of resistance, uncertainty, exhaustion, stressful dissonance, or cacophony (Johnson, 2018; Kossak, 2015).

Therapeutic Elements

When participants can "[make] music sound better" from cacophony and play together, there can be a powerful feeling of change, the ultimate goal of therapy (Yalom & Leszcz, 2005). The present study demonstrated how, within a single session of music therapy, music may provide various ways for participants to reflect, contain, and respond to their emotions and thoughts (here, specifically, regarding their personal experiences pertaining to adult inpatient psychiatry). This single session of improvisational music therapy had different effects on participants with different concerns or different experiences with adult inpatient psychiatry, such as patients with different symptoms and clinical presentations, or therapists who felt angry about working in this setting. As per the interview and significant musical moment in the present study, music can help participants release their emotions and gain a sense of relaxation; playing in a group, specifically, can also give participants a sense of validation and acceptance. Music can motivate participants, help participants find structure and organization, and help participants to get in touch with and relate to issues in their daily life. In music, participants focus on the process of music making and on the present moment, instead of on the stress and challenges of work, hospitalization, or other difficulties. This focus on the present moment offers not only temporary relief, but also an arena within which to develop coping mechanisms for these challenges. In the present study, improvisational group music therapy appeared to help both therapist and patient participants to achieve all of these positive effects within a single session. All of these phenomena will be further delineated with examples and connected with literature in more details in the following discussion.

Before participating, some participants reported feeling on edge or anxious because of uncertainty or because of personal matters in their lives; however, after this single session of

music making, they shared that they felt much better, calmer and more energetic. For example, Bella was preoccupied with her personal matters in the time of group, but in the end, she shared that she felt much better. Anger, sadness, frustration, and other emotions were sometimes reported to be released not only through a single session of improvisational music playing, but sometimes even within a single section of music played within a session. For example, Dulce shared that she was able to throw her anger "not by punching people but by playing the drum." (Dulce)

Catharsis surfaced as a therapeutic element, as participants shared that they let off steam through music playing and the "awesomeness of getting out those emotions" (Cecilia). This catharsis was enabled through the power of the process of group music making. The sound and vibration of music also helped bring about this release and relief, with participants reporting feeling refreshed, releasing negative energy while feeling more energized, being contained, and eventually moving on.

The sense of relaxation that participants reported connected the experience of group music making with other relaxation techniques. Several patients played the ocean drum and the rain stick, instruments that produce exceptionally soothing sounds. Music also led one participant, Debbie, to a place where she felt alone in a positive way, "just relaxed, taking time to myself" (Debbie). Participants not only reported feeling emotionally relaxed, but some reported that music playing reduced somatic pain as well, as Cecilia reported lessening of body pain through music playing.

One of the stated therapeutic elements, a sense of validation, stood out especially strongly in the therapists' groups, as they expressed the experience of not being heard at work, and in the study group, where working through music offered a safe and supportive process. Therapist

participants felt heard and being able to express themselves reinforced their belief in the importance of helping patients and clients to access the creative arts. The patient participants also recognized a sense of achievement as they realized that they could make "good music" together, fostering a sense of belonging.

In the process of making music, participants were able to practice focusing, paying attention to the here-and-now and forgetting about time and their problems. This experience echoes Csikszentmihalyi's (2008) concept of *flow*, an experience described as the optimal state of inner experience, in which there is order. In this music making process, participants were guided to attain flow; by cultivating their focus and attention, participants found structure and order, allowing them to overcome difficulties and challenges (Chen, 2019).

In terms of overcoming difficulties and challenges, the present study found that a single session of improvisational music playing allowed participants to explore and develop coping mechanisms, practice self-care, and find restoration. Within the time and space cultivated in music playing, participants could take care of themselves, as one participant reported "feeling better and restored" (Anna). Within the process of music making, participants created a healing space through the structure of music; within this moment there was awareness of "not rushing" and finding harmony. Routine and balance were also increased, making participants better able to cope with stresses in their daily lives.

Reflecting on these results and on the discussion of the therapeutic elements, while single-session improvisational group music therapy did not lead group members into an in-depth exploration of psychodynamics, it was able to help patients to release emotions and develop problem-solving strategies, which they could then apply to coping with issues and changing behaviors. These findings confirm the results of multiple similar prior studies (Basoglu,

Salcioglu, & Livanou, 2007; Diskin & Hodgins 2009; Doyle, 2015; Jones, 2005; McCambridge & Strang, 2004; Silverman 2009; Silverman 2011). In the present study, the main areas of focus for creating change during improvisational music making were catharsis, releasing and containing emotions, and the development of coping skills. Considering the reality of shorter stays and increasingly rapid patient turnover in inpatient psychiatry, the long period of time and consistent group makeup that patients may need to cultivate the rapport and trust needed to undergo and process deeper psychological exploration in traditional group work may not be realistic for many patients. This makes the positive outcomes of this single-session therapy all the more impressive and appealing.

However, for single-session improvisational group music therapy to achieve these successful outcomes, therapists need to adapt their goals and techniques, which may be different from those of conventional therapeutic interventions. The biggest change may be an emphasis on responding to patients' reactions and feelings right in the moment, instead of allowing patterns or patient revelations to emerge more slowly over time as pointed out by Anna as she stated, "For me, [single-session] is really about being here and now, in the moment. Whatever happens, let's go with it, and shape it from there." In single-session group music making, patients' work with their therapist creating a very short-term community, in which members pay attention to the here-and-now process of creation in that moment (Yalom, 1983). Responding musically to the issues or feelings that arise, groups members can give and receive support; experience catharsis, a sense of validation, and relaxation; practice self-care; and strengthen coping mechanisms.

Integral Thinking in Music Therapy

As discussed in the preceding section, the present study has shown that a single session of improvisational group music therapy can help participants to reach their therapeutic goals, provided that the therapist adapts his or her technique from conventional ones, which tend to assume a longer period of time for treatment, and with a more stable group composition. This study also noted the difficulties and challenges that participants experienced with this treatment modality, some of which prevented participants from being able to fully take part in the process of creating music, or which made it difficult for other group members to engage fully. To address these unfavorable experiences of or reactions to improvisational group music therapy, therapists need to be trained in a variety of interventions and methods, allowing them to address the diverse therapeutic goals of patients with different diagnoses, needs, and backgrounds. In this respect, the importance of familiarity with different therapeutic methods parallels the integral thinking that is so central to music therapy. Bruscia (2011) described *integral thinking* as a comprehensive approach to addressing the clinical needs of the client, and as a way of thinking, which embraces all existing models and theories (as cited in Lee, 2015).

In accordance with integral thinking in music therapy, and in light of the challenges reported in improvisational music therapy, one approach therapists should consider is imposing more immediate structure in the group session. Although musical structure can be formed in improvisational group music therapy in multiple ways, song was one way to establish immediate structure in this researcher's pilot study (Chen, 2019); the use of song seems especially effective when the improvisation feels too open to group members, leaving them feeling vulnerable, unsure of how to connect, or too formless. In this same pilot study (Chen, 2019), it was also noted that song and improvisation can take place simultaneously within the same musical

structure, with patients improvising on musical instruments to previously composed songs or creating a new sound (Solli, 2008). The therapist may also use a previously composed song as a structure for clients to improvise lyrics to, or to simply vocalize along with. Singing along can also be an effective intervention for many patients.

In addition to making music and singing, other techniques not utilized in this study such as receptive music therapy, music listening, and the discussion of lyrics can also all be implemented in single-session music therapy. Listening to music is extremely common (Grocke, 2016), and most people access music daily from a radio or other electronic device. Because this experience is so common and passive, patients may be less anxious about engaging with this specific form of music therapy. Bruscia (1998) indicated that, in receptive experiences of music therapy, clients can listen to music, responding to this listening experience silently, verbally, or with other art forms (e.g., fine art, dance, or creative writing). In receptive music therapy, patients are able to use a familiar way of engaging with music to address clinical needs emotionally, somatically, and verbally through active interaction with either music itself or other art forms. They can also process these experiences with their therapist to achieve therapeutic goals and objectives.

Different art forms can be used not only in receptive music therapy, but also in improvisational music therapy. Patients may improvise musically with the instruments, responding to the drawing, painting, or murals they created together with their therapist. Creative writing may lead to song composition. Movement and postures can be translated into paintings or drawings, as well as into improvised music or pre-composed songs. Stories can also be created, reflecting the art and music created in the group space. This integral thinking in music therapy also works well with the reality that, in most adult inpatient psychiatric care

facilities in New York City and New York State, a number of different therapy groups are provided daily (New York State Office of Mental Health Psychiatric Centers, 2012; Operation of Psychiatric Inpatient Unit of General Hospitals, n.d.). These activities are offered by activity therapists or creative arts therapists of different modalities, including music therapy, art therapy, dance/movement therapy, drama therapy, and recreational therapy. These activity therapy groups may offer creative art therapies, discussions around coping skills, or simply open social experiences. A creative arts therapist might therefore be called upon not only to provide creative art therapy groups, but also verbal discussion groups on topics such as coping skills development and psychoeducation, as well as unstructured games and leisure time. All of these groups must to cater to patients with different functioning levels, entailing different levels of support and structure.

A range of techniques can be incorporated as creative arts or music therapists seek to best address patients' clinical needs through these diverse forms of therapy. To determine the most appropriate approach for patients to grow and address their issues, it would seem that therapists would need to examine each patient's aesthetic experience. Dewey (1934) described experience as the result of an organism and the environment influencing each other. The outline of the common pattern according to Dewey is set by the fact that every experience is the result of an interaction between a living creature and some aspect of the world in which he or she lives. Along these lines of thinking each patient's aesthetic experience comes from his or her daily life experiences, with the two being inextricably connected. Aesthetic experience cannot be separated from a person's daily life experiences and the here-and-now experience of creation in creative arts therapy. Thus, as indicated in this study, a therapist facilitating a creative arts therapy group in an inpatient psychiatric setting, and applying a single-session modality, would

need to establish immediate rapport to understand each patient's clinical needs, aesthetic experience, and experiences of daily life. It is only when they are aware of these multiple levels and how they interact and affect each other that therapists can effectively connect with patients and find ways to build coping mechanisms to create lasting positive changes, which echoes the idea that "attunement" and "empathy" result in a state of oneness and wholeness (Jerak, Vidrih, & Žvelc, 2018). This can be seen in Debbie's reflection that in the group process she experienced a sense of "oneness" and "everybody's feeling peace... peace, love, all in one thing."

Limitations

A few limitations to this study need to be addressed. First, participants were all recruited from a metropolitan area of the Northeast United States, and the literature cited is mostly from the United States Findings may thus only reflect the reality of group improvisational music therapy in inpatient psychiatry in this particular area of the United States and to these specific participants. A second limitation was that, while two additional music therapists initially agreed to participate in study groups A and B respectively, they eventually declined to participate. Considering the small group size and the richness that would have been added by having two additional trained music therapists involved, the loss of these two participants may have influenced the dynamics of these two groups, and by extension the resulting outcomes.

Another limitation centered on the researcher's role in study groups, as this researcher was also a group facilitator employed in this setting. This researcher therefore had already interacted with and built rapport with many of these therapists and patients prior to the research intervention, which would have certainly led to different group dynamics than if the therapist was unknown to the participants. The participants who were recruited also tended to be those who were medication compliant, and therefore who had better control over their behavior, were

more mentally stable, and were overall higher functioning. The study groups therefore may not have captured what this intervention would have been like for inpatients who were medication non-compliant, and who were often floridly psychotic and disorganized.

Conclusion

Through sharing the experience and findings of the present study, this researcher aimed to depict creative arts therapists' and patients' experiences of working and being hospitalized in an adult inpatient psychiatric setting, as well as their experiences participating in single-session group improvisational music therapy. With a reality of short stays and rapid turnover in this setting, modalities like this are especially important to understand: Unplanned single-session groups occur, and the single-session model has gradually become the norm in inpatient psychiatric care, meaning that music therapists in this setting must adapt treatment goals and interventions to this single-session reality. This study demonstrated how, through this single-session group musical improvisation, patients in this setting were able to find the sense of safety and structure they needed to amplify their emotions, thoughts, and issues. Through this unique group process, learning and change were able to take place in the present moment, or seeds were planted that might manifest positive changes in the future. This study also shared insights into the difficulties and challenges that patients in this clinical setting may have in engaging with improvisational group music therapy, which may understandably be uncomfortable and anxiety producing. This modality is clearly not always appropriate for every patient at every stage of their journey towards healing and wellness, and therapists must integrally and comprehensively consider a range of creative arts therapies or conventional verbal interventions to meet each patient's needs.

Finally, this study focused on the modality of music therapy implemented in a single session, which many participants found stressful or uncomfortable. This reported participant discomfort underlined the importance of being able to offer different modalities of creative arts therapy or other verbal interventions, depending on patient need. Thus, future studies should compare inpatient psychiatric participants' experiences with different modalities to gain more insights into the most effective implementation of different creative arts therapies, as well as other verbal therapeutic interventions, in this setting.

APPENDIX A

MUSIC EXCEPTS OF SIGNIFICANT MOMENTS

The following are the links of excerpts:

Excerpt A: https://youtu.be/dzZcGt5mEBg

Excerpt B: https://youtu.be/K56h-_dj60s

Excerpt C: https://youtu.be/Ql1A6cUj8WM

Excerpt D: https://youtu.be/J9HUvkcADOQ

Excerpt E: https://youtu.be/itCks1wRVd0

Excerpt F: https://youtu.be/lv-SbCKuRaU

Excerpt G: https://youtu.be/Mr_uAiQRMVs

Excerpt H: https://youtu.be/p8WmzO4nBH4

Excerpt I: https://youtu.be/StHUeAU7bUA

Excerpt J: https://youtu.be/SMEho_bLt8U

APPENDIX B

RESEARCH INFORMED CONSENT

Research Informed Consent

You are invited to participate in the research project titled "The Experiences of Single-Session Improvisational Group Music Therapy: A Therapist's and Patient's Reflection on Music Therapy Practice in Inpatient Psychiatry." The intent of this research study is to explore participant's experience while participating in improvisation group music therapy within one session to reflect music therapy practice in adult inpatient psychiatric care.

The results of this study will help therapists learn more about the experiences of patients in inpatients psychiatric care with different perspectives and backgrounds, and enable therapists to adapt goals and treatment plans of improvisational group music therapy accordingly when applying this method in one session in the setting of adult inpatient psychiatric care. Participants will engage with group musical improvisation and verbal discussion in a pre-designed protocol of group music therapy. All sessions will be audio and video recorded, and the interview questions will be implemented as questions for regular group processing.

In addition:

- Former knowledge about musical instruments playing is not necessary.
- You are free to choose not to participate in the research and to discontinue your participation in the research at any time.
- Identifying details will be kept confidential by the researcher. Data collected will be coded with a pseudonym, the participant's identity will never be revealed by the researcher, and only the researcher will have access to the data collected.
- Any and all of your questions will be answered at any time and you are free to consult with anyone (i.e., friend, family) about your decision to participate in the research and/or to discontinue your participation.
- Participation in this research poses minimal risk to the participants. The probability and magnitude of harm or discomfort anticipated in the research are no greater in and of themselves than those ordinarily encountered in daily life. Data will be collected using standard-of-care procedures to ensure minimal risk to the participants.
- Discomfort may arise due to certain themes potentially emerging from music improvisation and verbal processing. Debriefing will be conducted after each group to affirm participants' understanding of the purpose of the study and ensure whether participants experience any discomfort. All outpatient participants need to be under the regular care of a doctor/therapist who will serve as a key resource if you experience any discomfort. For creative art therapist participants, there will be peer supervision after debriefing if you experience any discomfort.
- Participation in this study and engaging with improvisational group music therapy (and all it has to offer) might bring benefits such as enhancing self-awareness and overall enjoyment; creative arts therapists may learn more about their colleagues' experiences, and enhance knowledge of adapting goals and treatment plans when applying different methods of creative arts therapies in one session in the setting of adult inpatient psychiatric care.
- If any problem in connection to the research arises, you can contact the researcher Yu-Ying Chen at (212) 562-3630 and by email at yu-ying.chen@bellevue.nychhc.org or the dissertation faculty Mitchell Kossak PhD, at 617-349-8167 and by email mkossak@lesley.edu.

- The researcher may present the outcomes of this study for academic purposes and may include audio and video clips (i.e., articles, teaching, conference presentations, supervision, etc.) in such presentations. In the case of presenting video clips as examples, the identity of the participants will be protected (e.g., the participants' faces will be blurred).

My agreement to participate has been given of my own free will and that I understand all of the stated above. In addition, I will receive a copy of this consent form.

_____	_____	_____	_____
Participant's signature	Date	Researcher's signature	Date

There is a Standing Committee for Human Subjects in Research at Lesley University to which complaints or problems concerning any research project may, and should, be reported if they arise. Contact the Committee Chairperson at Lesley University, 29 Everett Street, Cambridge Massachusetts (irb@lesley.edu)

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