Chapter 10

SUPERVISION IN THE FIELD

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Introduction

The focus of this chapter is supervision provided in the field for undergraduate student music therapists (SMTs) moving through five developmentally sequenced levels of practicum. Accordingly, each level of practicum poses new challenges, but also provides opportunities for SMTs to hone already evolving competencies. Supervising in the field means being keenly present in the unfolding moments as SMTs engage with clients and learn from each encounter about themselves, their clients, treatment processes, and the potential impacts of music and music experiences in therapy. Field supervision is, therefore, exciting and often spontaneous work, but it is also a delicate business. SMTs, it is assumed, are doing the best they can in the clinical moment to relate to their clients and address their clinical needs, yet to do so they draw from what is at first a rather shallow pool of knowledge, skills, and experiences. This is a pool that will take considerable time and effort on both SMTs' and supervisors' parts to adequately fill prior to internship and entrance into professional life. Along the way, supervisors must provide careful guidance toward helping the SMT develop facilitation skills, while at the same time attending to the needs of volunteer clients and seeing that their clinical needs are adequately addressed[1]. SMTs and their clients are both in vulnerable positions in these somewhat contrived therapeutic situations—contrived in the sense that practica are, by necessity, relationships of convenience created between a healthcare facility or school and a university training program and undertaken between vulnerable clients and novice music therapists. Thus, an essential role of a supervisor in the field is seeing that both SMTs and clients have mutually beneficial experiences during the times that they share, and that each comes away having gained in some fashion—not just the SMT in training. Following sessions, SMTs will have the benefit of ongoing supervisory interactions during practicum labs and one-on-one supervision meetings whereas volunteer clients continue on into their daily milieu, hopefully carrying over any benefits gained from music therapy. It is thus important that field supervisors are alert to the nature of the unfolding interactions, particularly during early practicum experiences, in order to offer relevant support so that clinically beneficial and satisfactory experiences are had.

Developmental Issues in Field Supervision

The five levels of practicum in the program with which I am involved are developmentally sequenced such that competencies developed in earlier experiences support the work of

[1] Clients that our SMTs work with in most practicum sites outside of the on-campus clinic have not sought music therapy services on their own and are, in essence, volunteered *by* the facilities in which they are clientele, residents, students, or program participants. It is in this sense that I use the term *volunteer clients*. This is also why, from an ethical standpoint, a supervisor's efforts must include attending carefully to these clients' welfare during music therapy practica.

latter practica. Naturally, the SMT also continues to face new challenges with each subsequent clinical group, and these challenges must be assimilated within the SMT's level of development both as a therapist and as a person. Undergraduate SMTs are generally identified as being in the developmental stage of *self-definition* or that which Kegan (1982) refers to as the *institutional self* (pp. 221–254). This is a time when an individual "determines one's own identity, formulates one's life goals, invests in the future, and sacrifices various things to achieve one's own personal dreams" (Bruscia, 1991, p. 8). Through eventual navigation of the challenges in this developmental stage, an individual comes to express their sense of self as structurally organized and balanced and they are able to hold fast to opinions and beliefs regarding their roles within organizations and in relationships. The path to becoming a therapist clearly mirrors the challenges of this developmental period. Also during this stage, an individual is said to develop their "musical personality" as they come to understand and embrace their distinctive relationship with music and how they use music to meet their own personal/psychological needs (p. 9). Hence, one can conceive of SMTs as traveling parallel paths of personal and professional development, awareness of which is helpful to supervisors as they consider ways of intervening, guiding, and supporting supervisees. For instance, supervisors might encourage SMTs to go to their preferred music as support and accompaniment to difficult growth processes and to practice careful reflection about their experiences of and relationship with music. Such reflection is not only beneficial to an SMT but may also inform their clinical decisions about music's potential for clients' therapy processes.

Each SMTs maturity, consequently, is taken into account in the process of determining practicum placements, but also when providing supervision in the field. Each SMT's level and path of development is unique across the knowledge and skills areas relevant to music therapy. Some SMTs possess a surprisingly high level of personal, interpersonal, and musical maturity, some seem to be only at the beginning stages of forming and embracing a stable sense of musical and personal identity, and still others fall somewhere in between. Due to the challenges placed on SMTs at this particular stage of human development and the practical necessities and demands of undergraduate music therapy education and training, carefully sequenced exposure to informational materials, therapy processes, theoretical concepts, and clinical responsibilities in practica (and in the classroom, for that matter) is essential. Supervision in the field and in practicum labs serves to help SMTs integrate learning from these various avenues into a cohesive understanding of themselves, of the potentials of music therapy as a treatment modality, and of their own evolving role in it.

Decisions regarding the clinical placement sequence for each SMT is complex, and is accomplished through consultation between music therapy faculty and field supervisors. Multiple layers of considerations are taken into account throughout the five level sequence relative to each SMT's personal development, musical and interpersonal readiness, demands of the clientele in various clinical sites, and available supervisors. In our program, undergraduate SMTs become eligible to begin practicum following three semesters of course work that includes passing courses or competency examinations in introductory music therapy and music therapy treatment processes, music theory and aural skills, guitar and keyboard skills, and developing song repertoire that is relevant across clinical groups along with requisite vocal skills to re-create that material. These preparatory semesters allow music therapy faculty to gain a sense of each SMT's personality, music and interpersonal skills, and work ethic as well as already present

foundational competencies and the relative rate at which each SMT develops new competencies.

The first level of practicum in our program always involves work with nursing facility residents with Alzheimer's disease and related dementias (ADRD) and other complications of aging. This decision in no way reflects a perception that these individuals' needs are less significant than, say, individuals in a psychiatric setting, or that the work is in some way easier or potentially less intense. Rather, this decision is based largely on the complementary nature of the needs of older adults with ADRD and the early training needs of SMTs. Hence, three pre-established, overarching aims for the work during this first practicum are for the SMT to (1) provide music and music experiences that residents can engage in as deeply as possible given their challenged resources, (2) create opportunities within music experiences for inter-musical responding between residents and the SMT and/or other residents, and (3) forge an interpersonal connection with each resident. These aims touch simultaneously on a broad range of competencies related to music, clinical, and music therapy foundations (AMTA, 2013). Yet just as important is the point that, addressing these three aims helps to focus SMTs' in-session efforts primarily on musicing and relating, rather than on extra-musical endeavors such as observing and accounting for specific predetermined resident responses/actions. The emphasis here is for the SMT to develop skills for entering into and staying as fully as possible in the music with and for the residents. For residents, whose expectations while attending a "music group" is to somehow be involved musically, they can experience the satisfactions and benefits of engaging with the music and with others (Aigen, 2005).

The second and third practicum placements vary according to the areas of competence that each SMT demonstrates during the first level as well as programmatic needs, availability of training sites, and availability of supervisors during a given semester. Competency issues surrounding musical and interpersonal skill development are primary considerations, along with an SMT's evolving facilitation style. Facilitation style at this level has to do with an SMT's evolving ability to act fluidly in both directive and non-directive ways as warranted and to consciously "…use oneself effectively in the therapist role…" toward forging and deepening a therapeutic relationship (AMTA Competency 9.3). SMTs invariably demonstrate different levels of competence in these areas and are therefore positioned to benefit from the second level of practicum in different ways. Given supervisors' evaluations of the pool of SMTs moving to the second level, each will be placed in a school situation where they will work with students in an early intervention, elementary, or middle school classroom, in the on-campus clinic with a child, or in an adult psychiatric facility. The third level of practicum entails redistributing these same SMTs among the sites just described. With regard to placement in adult psychiatric settings for SMTs who might not have been ready the previous semester, it is assumed that, for most students, their potential success is enhanced due to ongoing development during the previous two terms. In rare cases, an SMT may be redirected away from psychiatric work until a later semester due to ongoing personal and academic developmental concerns.

SMTs in the final two levels of practicum are placed in the on-campus clinic, a children's hospital, a short-term adolescent treatment facility, a high school classroom, or a hospice setting. These decisions are made with SMTs' expressed preferences in mind as well as supervisors' input, with the caveat that an SMT's preference is not necessarily the top priority, depending on the student's overall competence to date. An additional consideration for practicum placement is brought to bear at this point in training having

to do with theoretically striving to help *round* an SMT's experience and skills sets, regardless of the nature of prior placements. For instance, an SMT who demonstrates inadequately developed verbal skills may be placed in a setting where they are challenged to use their verbal techniques to a significant degree. Or a student whose abilities with regard to re-creating live song material with guitar or keyboard will be placed where those skills are consistently in demand, or more practically, an SMT who has yet to work one-on-one with a client will be placed in this type of situation. All told, determination of practicum placements requires careful consideration of many variables that are influenced by each SMT's ongoing developmental processes.

Competencies, Programmatic, and Practicum Structures

Given the nature of music therapy education and training as competency driven, evaluation of an SMT's growth relative to the AMTA Professional Competencies (2013) occurs at every level of practicum. Competencies relative to actual facilitation of therapeutic encounters are of particular focus for undergraduate supervision in the field as SMTs are in the process of shaping their conceptualizations of the practice of music therapy with varied clinical groups. As articulated, the somewhat vague nature of many of the AMTA Professional Competencies poses a challenge for supervisors in that they require careful interpretation. Yet interpretations must also be malleable in that they may need to be adapted according to the precise level and focus of the clinical work at hand. For example, interpretation of competencies relative to the nature of therapeutic relationships (e.g., competencies 8.1 and 9.1) and use of one's self (e.g., competency 9.3) will vary between the contexts of music psychotherapy and neurological rehabilitation or activity level therapy (Wheeler, 1983).

Student enrollment in our program is typically approximately 90% Caucasian and 90% female, which is not atypical for undergraduate programs in the Midwestern United States. We have had students with African American, Chinese, Indonesian, Korean, Latina, and Nigerian racial and ethnic identities in our program. While present in our practica, there is currently not a great amount of identified racial and ethnic diversity among the clients we typically serve. As a program, we continually strive to expand the range of persons that our SMTs work with (and thereby learn from) including individuals with varied ethnic, religious, gender, social, and generational identities and so forth, as well as those who are racially different from the predominantly white population of our geographic area and our university. Admittedly, we as a program are in the early stages of incorporating across our curriculum and supervision concepts related to culture as significant factors in therapeutic processes. Topics related to cultural differences were only minimally an aspect of music therapy training during the 1980s, 1990s, and even in the early 2000s when the two longest term instructors completed their degrees. Historically, therefore, concerns related to culture have only periodically been a part of our undergraduate supervision processes. As a program, we are really just entering the territory where faculty and supervisors possess useful language and modern conceptualizations of culture in order to be/feel qualified to meaningfully and knowledgably address culture-related issues with students. Interestingly, I personally believe that many of the current generation of our students have, in a general and perhaps unconscious way, already gained considerable exposure to contemporary language and concepts relative to the significance of culture and cultural identities. But

now with a strong emphasis on cultural awareness in the mass media and regular training opportunities available on and off campus, faculty have initiated a fundamental shift to bring issues of culture to all aspects of the program. Looking to the AMTA Competencies, we recognize the following specific competencies related to culture that serve as a basic grounding for supervision around issues of culture in music therapy:

1.2 Identify the elemental, structural, and stylistic characteristics of music from various periods and cultures.

11.1 Select and implement effective culturally-based methods for assessing the client's strengths, needs, musical preferences, level of musical functioning, and development.

13.12 Develop and maintain a repertoire of music for age, culture, and stylistic differences.

17.9 Demonstrate knowledge of and respect for diverse cultural backgrounds.

17.11 Demonstrate skill in working with culturally diverse populations.

With these competencies in mind, supervisors endeavor to include foci on cultural diversity and understanding of the concept of *cultural humility* (Hook, 2017) into their supervisory repertoire, and to increase their sensitivity to the challenges encountered by SMTs as they learn to recognize and address various aspects of culture that might impact treatment.

Supervision in our program is currently provided by one of three fulltime instructional/supervision faculty (two doctoral and one masters level MT-BCs) and we also draw on the expertise of seven MT-BCs who work in varied facilities or private practices throughout our community (four are master's level, two are in graduate programs, and one is in a PhD program). Supervisors are paid employees of our university (i.e., adjunct faculty) during the semesters that they provide supervision. While we seek to diversify our supervisors, all current supervisors are Caucasian and all but one are women. Three of our current practicum sites have an MT-BC on staff who provides supervision; these individuals are included among the adjunct faculty just mentioned. For the remaining sites, supervisors must travel to and from sessions. The range in years of clinical experience among all available supervisors is from 3 to 25+ years. Areas of clinical expertise among the supervisors include child, adolescent, adult, and geriatric psychiatry, addictions, ID/DD (early intervention through mid-life adults), geriatric, hospice, medical, and neurological disorders. We strive to capitalize on the strengths and experiences of each supervisor as assignments are considered, but at times programmatic needs take precedence as schedules are coordinated between supervisors and SMTs. Supervisory assignments are primarily made through initial consultations among the fulltime faculty followed by further coordination with available supervisors. One fulltime faculty member serves as Clinical Coordinator. This person manages many aspects of practica each semester including, for example, the process of assigning supervision responsibilities, tracking document processes related to background checks, confidentiality, video or audio releases, and other requisite documentation required of the various clinical sites.

The first level of practicum is supervised by at least one of the fulltime faculty who know the entering students from at least one academic course. This faculty member

also facilitates the first level supervision lab, thereby providing initial consistency between feedback and guidance provided in the field and during labs. We believe that this arrangement helps new SMTs to develop a sense of security in the supervisory relationship and in laying a strong foundation within the culture of our program. Responsibilities for subsequent practica and lab supervision are distributed among available fulltime and adjunct faculty.

In our program, each level of practicum has its own competency evaluation form populated with AMTA Professional Competencies that faculty supervisors have determined are the most relevant to account for, given the characteristics of the specific client or group with whom an SMT is assigned. Given the obvious developmental nature of any competency attainment process, SMTs are evaluated on the ongoing progression of growth that they demonstrate and not on total achievement or mastery of competencies—as there is always room for growth and nuanced development, even among seasoned professionals. Hence, supervisors and SMTs at every level of practicum are aware of the specific competencies for which evaluation will occur during any semester. This knowledge helps SMTs to understand the types of demands that they will face during their practicum. Isolating the most relevant competencies per practicum placement also helps to focus the field supervisor's attention toward the most important clinical actions and interactions believed applicable in each setting. A supervisor's efforts can therefore be maximized toward helping SMTs advance toward competence at their developmentally appropriate level.

The organization of our five levels of practicum has evolved over the past twenty or so years and is now fairly stable in its structure. Practica typically occur two days per week, for 45 minutes of hands-on client engagement each day. Each level of practicum has an associated weekly group supervision lab facilitated by a fulltime or adjunct MT-BC faculty member. During the first three levels of practicum (which I refer to here as *early levels*), SMTs typically co-lead in teams of two, the work is conducted with client groups in varied facilities (typically from 2 to 15 participants per group), and an assigned supervisor is present at each and every session throughout the semester. Also during the early levels of practicum, at least 10 to 15 minutes of debriefing time occurs directly following each session, giving SMTs and supervisors the opportunity to bring immediate concerns to light or to celebrate successes. Debriefing time is, therefore, precious time. It is sometimes the case that supervisors and SMTs ride together to and from practicum sites, and these times are also often used for aspects of supervision. Examples of topics addressed in transit might include revisiting salient events from the previous session, discussing specific clients and their needs and strengths, and talking through session plans and roles to be taken during the day's session by SMTs and the supervisor. Procedural issues for discrete music experiences are also sometimes reviewed, such as speaking out loud any verbal instructions that one of the SMTs will be required to offer toward facilitating certain music experiences. We have also often engaged in singing through song material that is planned for the session. While perhaps considered informal supervision, this time can be essential for troubleshooting a session plan by identifying uncertainties on an SMT's part and thereby enhancing their potential for successful engagement with clients. The ride back to campus is often used for further debriefing following sessions and considering potential aims for the next session.

An on-campus music therapy clinic is also available for practica. Assignments for the clinic are typically made for senior level SMTs, but earlier level students may work in the clinic as well. A supervisor is present at all sessions regardless of the level of SMT due

to legal implications related to running an on-campus clinic. Structurally, supervision of SMTs in the clinic differs in a variety of ways from how it is carried out in the field. Sessions are most typically conducted with individual clients. These might include, for example, persons with organic neurologic disorders such as children on the Autism spectrum, children with down syndrome or another form of intellectual disability, or an adult who has experienced a stroke. The supervisor observes sessions from an adjacent observation room through a one-way mirror. The supervisor's presence, therefore, is less visually obvious during sessions, yet they can speak into a microphone to offer suggestions that are audible to the SMT in the clinic space. A microphone in the clinic space ceiling continuously picks up the sounds of each session which are audible to the supervisor in the observation room. This technology allows for immediate interactions to occur between the SMT and the supervisor in the clinical moment. Guidance regarding the music, instruments, procedures, facilitation techniques, or how the SMT might use the space differently can be made with little to no distraction to the client's experience. Sessions in the clinic are videotaped, which provides yet another extremely useful tool for supervision following sessions. With the convenience of being on campus, supervisor and SMT engage in debriefing time immediately following all sessions.

It should be noted that our program does not include a semester of student observation in the field. This is based on a belief that, regardless of the amount of prior observation, actually engaging and interacting with clients musically is a truly unique experience that each SMT must undergo in order to begin to understand the processes and challenges involved in providing music therapy. We therefore believe that SMTs benefit more from a practicum schedule that maximizes hands-on clinical work rather than observation. It can be argued, however, that an adequate amount of observation experiences do, in fact, take place within this model, but these occur within the context of seeing a supervisor facilitate or co-facilitate as well as when sharing leadership responsibilities with peer SMTs.

During the latter two levels (i.e., *senior level* practica), SMTs might be on their own as facilitators or may still work with a partner. During senior levels of practicum, a supervisor will accompany the SMT to the clinical site, provide at least 2 sessions of modelling or co-facilitating, then withdraw for a few weeks while the SMT, who now has a considerably deeper pool of knowledge, skills, and experiences from which to draw, works independently. (Our policy for psychiatric and hospice work, however, is that a supervisor must be present at all sessions, regardless of practicum level[2]). The supervisor then returns to observe the SMT typically from three to five more times during the semester. As a consistent touch point, upper level SMTs provide a required "phone update" to the supervisor within two hours of completing each session. During phone

[2] Our policy insisting that a supervisor be present at all sessions when an undergraduate SMT works with hospice patients is based on our belief that the end of life is a potentially deeply transformative time for each patient (and often as well for the patient's family), and that therapeutic encounters must therefore reflect that potential depth of experience. Hospice is not an appropriate time for activity level of therapy. Therefore, only SMTs who demonstrate strong musical and verbal skills, suitable clinical intuition, and adequate psycho-emotional maturity are permitted to work in hospice—with constant supervision. This policy not only protects patients and families by ensuring that therapeutic encounters are need-based and meaningful, but also protects SMTs from emotional harm as they provide treatment and comfort to a dying patient. Both of these intentions align with ethical code 3.11 of the AMTA Code of Ethics: "In those emerging areas of practice for which generally recognized standards are not yet defined, the MT will nevertheless utilize cautious judgment and will take reasonable steps to ensure the competence of his/her work, as well as to protect clients, students, and research subjects from harm" (AMTA, 2014)

updates, SMTs report on which clients were in attendance, session aims, salient musical and non-musical events that occurred during the session, and statements regarding what the SMT learned from the day's experiences. All SMTs across levels submit a session plan for every outing, a session evaluation afterward, and a reflexive journal for each session. These documents are evaluated and commented upon by assigned supervisors who may address a wide range of topics from writing style and use of clinical terminology and nomenclature to exploring SMTs' awareness of countertransference issues as they manifest in various ways. Thus, exchanges that occur between SMT's and supervisors via clinical documentation play a critical role in the overall supervision process. All told, the amount and variety of interactions between SMTs and supervisors on a weekly basis across all practicum levels is extensive. But whereas the demands placed on supervisors in our program is great, we also have long enjoyed a 100% success rate for SMTs securing excellent internships, passing the Board Certification examination the first time taking it, and obtaining satisfactory employment.

Clinical Orientation Issues and Integral Thinking

Our program has fully embraced the notion of *Integral Thinking* articulated by Bruscia in his William Sears Distinguished Lecture at the AMTA Annual Conference in Atlanta, Georgia (2011), expounded in *Defining Music Therapy, 3rd Edition* (2014) and also described by Lee in the Journal of Music and Human Behavior (2015). Since the Sears lecture, these concepts have become foundational to the way that I personally provide supervision. Briefly, integral thinking advocates for a therapist to understand and be as fluent as possible in a variety of theoretical orientations that support music therapy and to access and apply a particular theoretical stance based on clients' needs, rather than practicing from a predetermined orientation. The basic rationale is that different clients and their changing needs often call for a different approach to therapy than that used earlier in treatment or even earlier in a session. Therapists, therefore, are called upon to flexibly shift their perspective along with their application of music therapy methods and techniques to accommodate a client's emerging needs. In clarifying concepts related to integral thinking, Bruscia also described three ways of thinking that undergird music therapy practice and between which a therapist may think and act integrally: outcome-oriented, experience-oriented, and context-oriented thinking (2011). Each way of thinking is a viable and important way to approach and individualize treatment for clients and their clinical concerns. Working knowledge of the attributes of these ways of thinking is therefore important within the various forms of supervision that SMTs receive.

In an outcome-orientation, clinical outcomes (i.e., client responses) are predetermined and music experiences are used in various ways to elicit these responses. Outcome-oriented thinking is beneficial when therapeutically beneficial client responses that are observable and/or measurable have been clearly identified. Examples include particular movement schemes for physical or neurological habilitation or rehabilitation or when pain management or alteration of physiological functions (e.g., heart or respiration rate) is called for in a medical setting. In an experience-orientation, on the other hand, broad clinical aims are kept firmly in a therapist's mind going into treatment, but specific client responses toward those aims are not predetermined. Rather, music experiences are brought to bear in order to identify and work with clients' specific needs as they emerge in the moment. Here, a client's agency in determining and enacting relevant sorts

of therapeutic responses is encouraged and supported. Experience-oriented thinking is beneficial when specific responses toward addressing clinical change are not clearly identified or identifiable, for instance when working psychotherapeutically with adult clients with issues related to depression or addiction. Finally, a context-orientation, simply considered, has to do with treating the contexts in which our clients live and interact (rather than just the client them self), and might include, for example, a client's familial or social contexts or the broader community in which they live. A fundamental rationale for context-oriented work is that we are products of the different contexts in which we develop and live. Health and non-health, therefore, are related and potentially reflected in those contexts as well as in the client. It therefore makes sense to work to enhance the health of both the client and their particular context or community. Music therapy for context-oriented aims is, for our program, not a focus at the undergraduate level, and therefore is not further addressed in this chapter.

The needs of the volunteer clients with whom our SMTs work are amenable to both outcome and experience-oriented approaches. SMTs learn through course work and supervision in clinical settings and labs when each orientation might be indicated for a client or group, as well as how to adopt each orientation during session planning, designing, facilitating, and evaluating processes. Whereas SMTs in the early levels of practicum are not yet versed in a range of theoretical positions from which to enact decisions related to these orientations, the supervisor will use their expertise and judgment to provide relevant guidance appropriate to the clients and clinical setting. Therefore, when working from an outcome-orientation, clinical practice concepts such as those from medical, behavioral, or cognitive-behavioral approaches are encouraged and supported by the field supervisor. In contrast, when working from an experience-orientation, concepts from humanistic, psychodynamic, existential, gestalt, or music-centered approaches are encouraged and supported. A similar supervisory approach is also used for senior levels of practicum. Here, however, senior level SMTs will have a stronger understanding of the various theoretical perspectives available from course work and prior clinical experiences and supervision. These SMTs may therefore begin making their own decisions regarding the most relevant or useful perspective to assume and related techniques to enact in a certain instance for a client's benefit.

Supervisor Roles

While supervising in the field, each session poses different types and levels of challenges for SMTs, and supervisors may, therefore, position themselves differentially in order to provide the most useful guidance and support. Particularly during the early levels of practicum, a field supervisor may choose from a variety of roles as they observe and provide requisite supervisory assistance, including as a model, a co-facilitator (aka, co-leader or co-therapist), a group member, or an observer. Each role offers potentially different "positions" from which to experience, observe, comprehend, and respond to the nature of an SMT's clinical facilitation. The decision regarding which role might be most beneficial for any given session is based on a host of factors that may include, for example, the SMT's a) level of readiness for independent leadership, b) musical and conceptual preparedness relative to the types of experiences that are planned and designed for the session, c) ability to effectively use musical or verbal techniques, d) emotional and interpersonal maturity, and e) ability to handle the intensity of

psychological demands that one might experience given the acute nature of a particular clinical group. For example, there are clearly different psychological/emotional demands placed on an SMT when providing habilitative services for children with IDD in a school setting versus when providing rehabilitative services for adult males in a substance use disorders treatment program. During senior level practica in our program, a supervisor typically takes a co-facilitator role for a few sessions at the start of each semester and an observer role later in the term. Yet, such decisions are flexibly made in accordance with the needs of the clinical group and the particular competency development needs of the SMT. Explanations of the various supervisory roles follows.

In taking the role of *model*, the supervisor is directly involved with clients, demonstrating for SMTs one way of working with the particular client group, while the SMTs place themselves among the clients and participate as the clients do. SMTs in the group are also available to assist client's as they see the need arise or as suggested by the supervisor. In the modelling role, a good deal of teaching may take place as the supervisor explains their actions to the SMTs before, during, and/or after the session. Supervisors also share their perspectives regarding client responses, actions, and interactions that are witnessed. In my approach, prior to a session, I share with my supervisees my session plan and the decision processes that I underwent to create the plan, design the specific music experiences, and select the relevant musical resources to be used. I may also share my speculations about adaptations that may need to occur as the session unfolds depending on client responses. SMTs may have witnessed their supervisor's approach to facilitating music experiences via classroom demonstrations, as mine have, but in the actual context of work with clients, the type of modeling described here takes on new meaning due to the authenticity of the client–therapist–music interactions. The goal from this role is not to present "the way" to facilitate music therapy, but rather "one way" that SMTs might draw ideas and inspiration from as they prepare to facilitate their own sessions. Gradually, SMTs will take supervisors' modeling and their own experiences to re-conceptualize and form their own approach to engaging clients based on their own strengths, proclivities, and personality. In my work during the first three practicum levels, I model 2-3 sessions then co-facilitate at least one time with each SMT prior to the teams' beginning to co-facilitate together. In latter levels of practicum, I provide modelling within the context of co-facilitation. I share session leadership during at least two sessions at the start of a semester, thereby providing support and modeling toward helping the SMT to establish themselves in the setting and in relationship with the clients that they will serve.

As *co-facilitator*, a supervisor shares with an SMT the responsibilities of planning a session, designing the music experiences to be carried out, engaging clients through musicing, and processing clients' experiences. Supervisor co-facilitation, in this conceptualization, is part teaching, part modeling, and part supporting. In that responsibilities for the session events are shared, the co-facilitating SMT can take as strong a leadership stance as they are able with the knowledge that full and immediate assistance is at the ready. Co-facilitation in the field can be structured in a variety of ways. For example, in early levels of practicum, supervisor and SMT might take turns engaging clients in discrete music experiences throughout the session. Here, the SMT shifts from leadership to observation and back, learning from each position. For the insecure SMT, this format provides brief episodes of breathing room as they prepare to facilitate the next music encounter. Alternately during early practica, supervisor and SMT might split a session into first and second halves, with each taking responsibility for one or the other. In this situation, the SMT experiences sustained but time-limited engagement with clients

with the challenges of creating a cohesive flow of interactions while also observing the supervisor's approach during a sustained period. Another co-facilitation variation is for the SMT to take the leading role as facilitator of the entire session while the supervisor acts as assistant. In this case the supervisor may take responsibility for structural aspects of the session such as arranging the space and instrumentarium required for different music experiences and setting up, testing, and monitoring technology/sound equipment. The SMT, thereby, maintains their focus and efforts on interacting with clients musically and interpersonally or preparing them for subsequent music encounters. Throughout the co-facilitation process, the supervisor can offer the SMT in-the-moment instructions, suggestions, and/or affirmations as the work unfolds. Care is taken to not overwhelm the SMT with facilitation guidance, but to offer a level of support that can be quickly processed and acted upon by the SMT as necessary for the client/group to have a clinically beneficial experience. As in the role of modeling, the point is never to dictate a way to work but to provide nuanced guidance that may help the SMT's individualized efforts to unfold in a successful way for both the SMT and their clients.

When a supervisor takes the role of *group member*, they have the opportunity to experience the SMT's techniques of engagement from the same perspective as that of the volunteer clients[3]. From this position, one can engage in the various musical and non-musical encounters that occur along with the actual group members, while also being ready to offer suggestions to the SMT as needed. One can choose to simply be a group member and respond authentically, while at the same time meta-processing regarding salient techniques and related client responses that will be important to address following the session. The perspective of group member can be quite informative in considering both interpersonal and inter-musical interactions that occur between the SMT and the client(s). With regard to interpersonal interactions, the supervisor may attend to the relative effectiveness of the SMT's use of physical space (i.e., proximity), touch, gestures, affect, and verbalizations as they attempt to forge trusting relationships with individuals or the group. Concerning inter-musical interactions, particularly when considering experiences wherein clients improvise or re-create musical sounds, the supervisor can experience firsthand the nature of the group's musicing and how its processes unfold as well as the aesthetic appeal of the music for the group and as this may relate to the SMT's facilitation techniques. Here the supervisor may attend to the SMT's effective modeling and facilitating of the music, such as vocally demonstrating an accurate melody and lyrics for a song re-creation, playing a clearly recognizable rhythm pattern to be imitated or for which clients are to synchronize instrumentally, offering strong rhythmic and/or harmonic grounding, conducting dynamic shifts, and so on, along with use of verbal and gestural guidance as needed. Participating as a group member during musicing also allows for the supervisor to subtly bring their own musical techniques to bear, if warranted, to help support the group's musical efforts.

Lastly, a supervisor may take the role of *observer*, witnessing events of the session from outside of the group. As an observer, the supervisor can assume a wider and

[3] To be clear, we subscribe to Bruscia's (2014) definitions of *technique*, *procedure*, and *method* toward carefully discerning and communicating about an SMT's actions within a session. "A technique is a single operation or interaction that a therapist uses to elicit an immediate reaction from a client or to shape the ongoing, immediate experience of the client" (pp. 128–129). Techniques can be musical, verbal, or gestural. Procedures are "the organized sequence of operations and interactions that a therapist uses in taking the client through an entire music experience" (p. 128), and a method is "a particular type of music experience used for assessment, treatment, and/or evaluation" (p. 128) and includes improvisation, re-creation, composition, and receptive or listening experiences and their myriad variations.

potentially more objective perspective on the session processes, observing the SMT's and group members' actions and interactions free from the supervisor's own direct influence. As observer, the supervisor may choose to remain entirely removed from the session events and withhold all opinions and suggestions until after the session. Or they may verbally or gesturally interpose these as they see a necessity in the clinical moment.

Different supervisory roles allow the supervisor to experience different phenomena related to the SMT's efforts and the clients' processes. These varied forms of information become useful during debriefing times that follow sessions.

Processing Clinical Experiences

Debriefing between SMTs and the supervisor that occurs immediately following each session during the early levels of practicum is an important opportunity for SMTs to bring to light the clinically salient events and interactions that they experienced. Processing the myriad events and interactions that happen within a music therapy session is often daunting due to the complexity of accounting for nearly an hour's worth of musical and non-musical engagement with 2 to 15 volunteer clients, but is nonetheless an essential aspect of field supervision. Having a structure within which SMTs can organize their recollections and immediate reflections about a session is also essential to ascertaining that significant musical and interpersonal events and interactions receive attention. An effective model for observation and processing of experiences from practica is one developed by Gardstrom (2002) which focuses on three aspects relevant in all music therapy sessions regardless of model practiced or approach taken; these are structural, musical, and relational aspects. Addressing one of these aspects at a time helps to narrow the focus during debriefing, making for an efficient use of precious processing time. Issues brought forth during debriefing are often subsequently given attention in the SMT's clinical journals, in one-on-one supervision meetings, and in the weekly supervision lab.

Structural aspects are those having to do with the environment as well as the organization and sequencing of an SMT's facilitation procedures as they were enacted throughout a session. Environmental aspects have to do with the clinical space and how its use benefits or detracts from session events. The most basic example of an environmental aspect is consideration of the arrangement of the contents in the room, or of the group itself, for maximum engagement and interaction. Other examples include placement of instruments in the space so that their distribution to group members can be accomplished quickly and efficiently or placement of instruments relative to each client's physical capabilities or challenges (i.e., proximity and positioning) toward maximizing the potential for successful music engagement and expression. The environment can function to enhance or inhibit inter-musical and interpersonal interactions. In my experience, however, once environmental concerns are recognized by an SMT and examined relative to their beneficial or deleterious impact on session events, they infrequently reappear in subsequent sessions. This is because solutions for environmental issues are often concrete and easily managed.

Facilitation procedures, on the other hand, are structural aspects of sessions that are more challenging to address because they are situation dependent. This is in part because there exist no inviolate protocols for how any given music experience *should* be facilitated with any particular client or group. But it is also the case that facilitation procedures are gradually shaped by each SMT's particular personality and interaction

style, the process of which should be critically considered but also nurtured as appropriate by the supervisor (Summer, 2001). And whereas there may be a few fundamental steps that any therapist must enact to engage clients in a given type of music experience, procedures must be flexibly brought to bear during a session depending on the nature of clients' cognitive, physical, and psychological functioning and readiness. Procedures and their facilitation, therefore, are often idiocentric in character (i.e., uniquely carried out by each SMT) as they are performed in response to particular clients' functioning and proclivities, which are interpreted by the SMT in the moment. For example, the way that verbal instructions are articulated toward engaging a group in a referential or non-referential improvisation must account for the clients' cognitive and receptive language skills, past experiences that they may or may not have had with improvising, and the groups' current level of receptiveness or resistance.

I recall a female SMT who was working with men with substance use disorders and who sought to introduce referential improvisation. The choice of method was intended as an opportunity for the group to explore feelings surrounding establishing and maintaining healthy boundaries relative to friends and family members, some of whom are themselves substance users and others who are inimical or "toxic" in other ways. We had learned that many in the group came from economically depressed parts of Appalachia where education was not necessarily emphasized or encouraged in families nor within the coal mining communities in which they lived. The typical vocabulary used among most of the men seemed to evidence this particular cultural characteristic. The SMT eagerly began the introduction using terms that she had learned in the classroom relative to clinical improvisation methods such as "referential," "programmatic," "extemporaneous," and "interpretation." These words, however, did not fit into the group members' vocabularies and seemed to elicit confusion and resistance to the intended process, and potentially evoked an unintentional sense of elitism aimed at the SMT by the group members. Intervening following a question from a group member about the term "referential," as well as reading the look of confusion on some of the men's faces, I quickly provided an alternate description of the intended process of "playing an instrument with a specific feeling in mind" and "play with the energy of that feeling," the group was able to engage meaningfully in the process. The SMT learned the importance of considering language as a cultural attribute and meeting the group at a linguistically functional and helpful level in order to communicate successfully. A manualized way of describing the experience and inviting clients into it, therefore, would not be able to account for the different abilities and attitudes that often exist in client groups. Therefore, it is the SMT's challenge to match their procedures and how they are carried out to the needs of the client or group. In my experience, next to meaningful client musical or verbal responses during a session, facilitation procedures are often the first aspects that SMTs wish to discuss during debriefing as they reflect on what felt to them to be successful interactions or missteps in the process. Evaluating each SMT's progress in developing various facilitation competencies, therefore, means that supervisors must be careful to not impose their own preferences on the SMT's facilitation style/approach but rather to support them in critically discerning the most useful options for shaping their own repertoire of procedural actions.

Musical aspects are those related to the specific music experiences (i.e., method variations) selected and designed toward particular clinical aims and the musical materials selected and/or sounded during the session. Musical materials might include, for example, live or recorded renderings of songs or pieces used within discrete music

experiences, salient music elements performed, improvised, composed, or heard, inter-musical events that occur between clients or between clients and the SMT (i.e., interactions during musicing episodes), and instruments or playback devices. With the supervisor's understanding of each SMT's maturity and musical and clinical acumen at a given point in time, reflection on musical aspects of the session is encouraged at varying levels. For instance, on a practical level, the SMT might reflect first on whether the music experiences and related musical materials were at all beneficial to the therapy process; that is, met the clients' needs during that particular session. Another practical musical concern might be evaluation of the key, tempo, and dynamics of a live rendering of a song and how these features functioned toward the session aims and helped or hindered clients' engagement. In this regard, I recall supervising an SMT while working with a group of older adults on a dementia unit in a religiously affiliated facility where the clear majority of residents were Caucasian women. These group members, whose ages ranged from their 70s into their 90s, had lived most of their lives in the immediate area where we were located in the northern Midwest of the United States. As part of the session plan, the SMT had prepared to engage the residents in singing together Over the Rainbow (by Harold Arlen and E. Y. Harburg)—typically an excellent song choice for this particular group to stimulate reminiscences to be shared verbally. With this song, the SMT surmised that the residents would more than likely recall many of the musical features as well as the lyrics, the film from which the song gained its popularity, and perhaps the film's starring actors as well. However, the live rendition that the student provided was not based on the original arrangement sung by Judy Garland in The Wizard of Oz. Rather the SMT chose a version that was, at the time, receiving considerable airplay on radio stations geared toward youth and young adults and used in advertising. This version was recorded by a male Hawiian artist named Israel Kaʻanoʻi Kamakawiwoʻole and featured a male singer, ukulele played in a quazi-Reggae rhythmic style, and with altered melody and lyrics sung in a sequence of lines that deviated from the Garland performance. While pleasant to listen to, the residents were largely non-responsive to the song due to their lack of familiarity with most of the musical features of the SMT's rendition. The experience seemed to leave the residents somewhat perplexed and the energy in the room, which had been rather lively and ebullient prior to this song, had dissipated by the time the song had concluded. Not aware of why the mood had changed and the residents struggled to remark in accordance with the SMT's probes about the song and the film, the SMT eventually moved forward by introducing another Tin Pan Alley song in its original and over-learned style and arrangement, thereby re-grounded the group in the music therapy session and helping the SMT follow through with the aim of evoking reminiscences among the residents. In subsequent processing during supervision, the SMT was asked to recount the thought processes that had led to her decision to learn and use the alternate arrangement of Over the Rainbow. The SMT recognized that it was her own enjoyment of and enthusiasm over the newer rendition that guided her decision to use it rather than a careful accounting of the residents' cultural contexts and experiences. She was able to connect the residents' lack of responsiveness to the musical mismatching that occurred between the residents' expectancies regarding the *definitive* recording they had grown accustomed to hearing and the newer version.

Concerns more peripheral to the sounded music might include the SMT's use of proximity, affect, and musical, verbal, and/or gestural cues/guidance during musicing episodes. A concern more immediately related to an SMT's specific musical

competencies is reflecting on how and when various musical techniques were initiated and what their impact was on clients' musicing experiences. Lastly, an example of a theoretical concern relative to clients' musicing might be the SMT's ability to construct in-the-moment interpretations of a client's musical contributions (i.e., meanings that the SMT might ascribe to the client's music) and discerning how an interpretation may have influenced the SMT's decision making as the music or the session unfolded.

Finally, *relational* aspects have to do with interpersonal and inter-musical relating between clients and between clients and the SMT, and how those experiences inhibit or help to facilitate and perhaps deepen the therapy process. Reflecting on how clients relate to each other involves the SMT interpreting observations of group members' interactions during and between discrete music experiences. On the other hand, the SMT has direct access to their own experiences regarding the nature of interactions with clients, how these felt at the time, and whether and how an experience influenced further decision making or the client's experience. With regard to both beneficial or detrimental episodes of relating, the SMT might be encouraged to reflect on the precise nature of a salient interaction, noting who initiated the contact and through which modality (e.g., gesture, words, or music), precise words used, affect/feelings evoked, how long the interaction occurred and how it ended, and how the interaction may compare to previous ones. Reflection on relational aspects are informative on many levels, as an SMT learns about their developing use of self in the treatment process as well as how music and music experiences have great potential to elicit and deepen connections in therapy.

An episode was shared with me regarding an SMT's work on the psychiatric unit of a local hospital where she encountered a Caucasian adolescent female who had been admitted following a suicide attempt two days previously. The young woman suggested listening to a rap song together, but warned that the lyrics were rather explicit and included liberal use of the n-word among other potentially offensive words/phrases. The SMT, who identified as Asian American, considered her options to honor the patient's choice of song, find a "clean version" of the song, or suggest an alternate song. The SMT decided to honor the patient's choice and while listening, consciously focused her attention on the underlying massages of the song lyrics, then chose to not bring further attention to the potentially offensive words. The SMT reported that there was some palpable tension between the SMT and the patient while listening to the song. Yet the session continued in a positive way and the therapeutic relationship seemed to the SMT to have been strong and beneficial to the patient as she freely discussed aspects of her life experiences. However, the SMT also described wondering in the clinical moment as she made what she considered to be a crucial decision (as well as later in her reflective journal) how the session events might have been different had she been either black or white. The SMT and the patient did not share the same racial characteristics. Might the patient's song choice have been different had the SMT been white? Was the patient's warning about offensive language offered as a common courtesy or would the warning itself have been different or perhaps not issued at all had the SMT been black? This SMT believed that issues related to race were clearly influential during the session and were related to the choice of music and how the music was shared. The SMT went on to explore how the sharing of music has potential for impacting the development of a therapeutic relationship between persons with disparate cultural characteristics and histories.

As indicated, field supervision during senior level practica occurs less frequently than at earlier levels. Most SMTs at this point have presumably developed suitable functionality with regard to competencies relevant for more independent clinical work.

At the senior level, SMTs have accumulated three semester's worth of experiences facilitating music therapy with different clinical groups (some wherein clients and SMTs do not share the same cultural backgrounds), are generally more advanced in their musicianship and understandings regarding music in therapy processes, and have continued to grow in their personal maturity. At this level, then, SMTs are encouraged to reflect more critically about the nature of structural, musical, and relational aspects of music therapy sessions and discrete music experiences, and to begin couching their reflections within theoretical perspectives and concepts. Commensurate with these levels of practicum in our program, students' course work includes focus on myriad theories that support music therapy, concepts relative to music psychotherapy, and also engage in authentic, process oriented group work with peers in a closely monitored, student led Learning/Support music therapy group. Thus, as noted in the introduction to this chapter, a key focus of supervision at this level is on helping students to integrate these diverse streams of knowledge and experiences into a firm conceptualization of music therapy and the SMT's potential roles in it.

An additional point is made here regarding supervisors' experiences related to processing therapeutic encounters particularly when the supervisor is in the role of co-facilitator as described previously and as occurs in some work at the senior level. I noted that supervisor co-facilitation is part teaching, part modeling, and part supporting. In the following vignette, we see that in the role of co-facilitator, the supervisor must also exercise a high level of reflexivity and internal metaprocessing as they consider not only how to most usefully respond to clients but also how their supervisee might perceive their processing techniques. An example of group work, created from an aggregate of supervisory encounters, is the following having to do with practicum at a substance abuse treatment facility. During her first session, the only African-American person in a women's group began the session with arms folded, legs crossed, and a flat affect which we interpreted as displaying a closed body posture and indifference to the process. Later in the session, while listening to a peer's song choice, she seemed to be deeply moved, she smiled and began to interact with the group and shared her story and insights. This event was recognized and discussed in debriefing by the supervisor and the white female SMT co-facilitator as important for the woman and for the group. In subsequent sessions, and from our cultural perspective, we began to perceive this woman as dominating, to the potential detriment of the group therapy process and to relationships with her peers. The supervisor (also white) struggled during a later session with how to intervene in order to bring more balanced attention and focus on all of the group members. The supervisor's typical response would be to act in a fairly direct manner to work with the woman's actions and bring awareness of the need for equal time for all members, but she hesitated due to concern that her limiting of the woman's verbal contributions might be perceived either by the woman or by the SMT as diminishing of the woman's voice and agency on racial grounds. The conflict was perceived by the supervisor in the moment as protecting the group as a whole without being perceived as thwarting the woman's agency.

In a subsequent debriefing, it came to light that the SMT co-facilitator had reservations similar to the supervisor's. She wondered about the implications of drawing too firm a line when it comes to what we assess from our perspective as overactive client participation, especially when the client might already feel somewhat isolated due to racial differences among the group members. The supervision discussion brought to awareness the challenges of balancing group members' voices while carefully considering the contexts within which those voices have developed and been used effectively or

ineffectively to communicate one's self and one's needs in life. The supervisor's self-disclosure of her own reflexive processes and struggle with this client in the moment and afterward provided a thoughtful model for the student to witness and perhaps emulate in their own way in future encounters.

Conclusion

Described above are what I hope is a helpful variety of concepts relative to supervision in the field with undergraduate student music therapists (SMTs). The concepts presented stem from field supervision provided for SMTs in five levels of practica through a university program in the Midwestern Unites States, and have evolved over an approximately twenty-year period. Premises that undergird the approaches described were provided with an emphasis on the perception of students as actively developing both as persons and as music therapists. It was noted that one of the unique concerns of a field supervisor is to carefully attend to and balance the needs of both SMTs and their volunteer clients in the moments of clinical-musical interaction. SMTs consistently progress in developing the many requisite facilitation competencies articulated by AMTA (2013) through varied practicum experiences, and the developmental structure of the program's practicum sequence and the various types of supervision experiences provided assist in this process. SMTs and supervisors begin each term with awareness of the relevant competencies to be practiced and evaluated, thereby focusing the work of each. A brief description of the program's reliance on concepts related to integral thinking (Bruscia, 2011, 2014), including the utility of outcome and experience-oriented perspectives with their relevance for training and supervision was provided. Four useful roles that a field supervisor may take within any given music therapy session were described and include the roles of model, co-facilitator, group member, and observer. These roles provide a supervisor with different sorts of opportunities to teach, model, guide, and support SMTs as they in turn learn from their facilitation experiences. The significance of engaging in debriefing immediately following sessions to process SMT's experiences was stressed. Lastly, a model that focuses SMT's and a supervisor's attention during debriefing on structural, musical, and relational aspects of therapy sessions was presented along with explanations of potential benefits associated with use of this observation model for both SMTs and supervisors.

Just as supervision processes are not intended to impose an approach on a supervisee as "the way" to practice, the concepts presented above are intended to show just "one way" that field supervision may be conceptualized and conducted for undergraduate trainees. In fact, looking back at this chapter, I realize that there remains a wide range of important concepts at work across our various practica that were not even mentioned here, let alone explained. Given careful reflection on all that was articulated above, however, I realize also that supervision at the undergraduate level is, to a large degree, similar to a music improvisation process. It draws on myriad nuances of observation, listening, and action. And due to the multiplicity of constituent facets that interact during the practicum process such as the personalities of clients, SMTs, and the supervisor, the time of day, the weather, the broken guitar string, the emotionally moving song, and so on, supervision in the field is, in its inspiring way, never the same way twice.

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