

**IMPROVISATIONAL MODELS
OF
MUSIC THERAPY**

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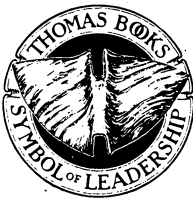
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To the loving memory of my mother
LENA BARCELONA BRUSCIA

And to my beloved father
NICK BRUSCIA

PREFACE

THE PURPOSE of this book is to provide a comprehensive source of reference on the use of musical improvisation in therapy. The book contains an introduction to the fundamentals of improvisational music therapy (Unit One), a detailed synopsis of over twenty-five models of therapy that have been developed over the last thirty years (Units Two through Nine), and a synthesis of the various models into basic principles of clinical practice (Unit Ten).

The models were identified through an exhaustive search of the music therapy literature, including journals, books, and conference programs. The intent was to include all music therapists who have used improvisation as a primary method of clinical intervention.

Unfortunately, the literature on improvisational music therapy is somewhat scattered and fragmentary. Many journal articles appear outside of the music therapy literature, and several books are out of print. In addition, many music therapists who use improvisation extensively have not written or published anything about their work. In these cases, information had to be obtained through questionnaires, personal interviews, tape recordings, and/or notes.

All available writings, publications, and materials pertaining to each model were used as sources of information. In many cases, this represents the first attempt to bring together and synthesize all of the existing literature on a particular model, and to synthesize the ideas of the originator at various stages in the formulation of the model.

Each model has been described according to the same basic outline. The outline was developed by the author to provide a uniform way of collecting and organizing information about each model, while also providing a framework for synthesizing different models according to common topics or variables. The main topics are: background, salient features, clinical uses, client prerequisites, therapist qualifications, goals, media and roles, session format, theoretical orientations, assessment and evaluation, preparation for a session, organization of a session, procedures, techniques, client-music dynamics, intrapersonal dynamics, client-therapist dynamics, group dynamics, and process (or stages of therapy).

When an entire unit is devoted to a single model, these topics are grouped together into four main chapters, followed by a Unit Summary and References. The chapters are entitled: Introduction, Assessment and Evaluation, Treatment Procedures, Dynamics and Process. When a single chapter is devoted to a model, the topics of the outline are used as subheadings within the chapter itself.

The chapters and sections within each unit have been sequenced to accommodate the informational needs of the reader, which vary considerably according to the model being described. Consequently, the topics do not always occur in the same order in every chapter and unit.

Summaries are provided for those models that take an entire unit to describe. They are not given for those models that are described within a chapter.

The reference section always appears at the end of the unit, even when chapters within the unit deal with different models. All citations within the text refer to the number assigned to the bibliographical source in the reference list. That is, any number appearing in parenthesis within the text refers to the corresponding bibliographical source in the reference list. The bibliographical sources have been numbered using alphabetical and chronological ordering, rather than according to their order of appearance in the text.

Because topics in the basic outline overlap somewhat, sections within the same unit or chapter may cover the same information, but from a different perspective or with a different emphasis. Some of these overlaps are inherent in the model itself. In fact, it is interesting to find that each model can be characterized according to its own unique overlaps. For example, in one model the sections on goals and musical dynamics may overlap because they are interdependent; whereas in another model, goals and assessment are closely linked together and therefore have sections that overlap in content.

Besides showing which aspects of the model are methodologically linked together, these overlaps between sections can also reveal how integrative and logically consistent the model is.

Needless to say, the amount of information available on each topic determines the length of each section. Thus, the length of sections may vary considerably from one model to the next. While the obvious reason for a short section is that the originator has simply not written or dealt with the topic, the less obvious reason might be that the topic is not particularly relevant to the model. Sometimes the originator has not addressed the topic because it is not essential to an understanding of his/her clinical approach. Here again, completeness of the information on these topics can provide considerable insight into the basic premises underlying the model.

Case material and clinical examples have not been included in the book. Aside from not having sufficient space in the book to do them justice, their inclusion goes beyond the purpose of the book. It is hoped that the reader will return to the original source for more detailed clinical information on each model.

Since it is rare for one music therapist to write about the work of another, a major concern throughout the writing of this book has been accuracy. For this reason, the originators of every major model were asked to review the author's manuscript and to make any revisions that were deemed necessary. All of their recommendations for revision were incorporated. Hence, every unit or chapter of the book devoted to a particular model has been scrutinized and approved by its originator(s) and where appropriate by other therapists who have used the model.

In addition, to insure organizational clarity and to enhance readability, every section of the book has been critically reviewed by other music therapists and creative arts therapists.

Notwithstanding the author's efforts to provide a complete and accurate report of his own work and the work of his colleagues, the experience of writing this book has pointed out that, as powerful and valuable as they are, words are only words. Even the most accurate, eloquent description of a model cannot do justice to the process of improvisational music therapy itself. Most therapists spend their entire careers trying to find the words to describe their clinical work, just as musicians spend their entire lives trying to capture the essence of musical experience. Therapy and music are both indescribable in their own right, and the art of music therapy is even more elusive to the pen.

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**IMPROVISATIONAL MODELS
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MUSIC THERAPY**

UNIT ONE

**THE FUNDAMENTALS OF
IMPROVISATIONAL MUSIC THERAPY**

DEFINITIONS

MUSIC THERAPY is a goal-directed process in which the therapist helps the client to improve, maintain, or restore a state of well-being, using musical experiences and the relationships that develop through them as dynamic forces of change. The therapist helps the client through assessment, treatment, and evaluation procedures. Aspects of the client's well-being that can be addressed through music therapy include a wide variety of mental, physical, emotional, and social problems or needs. In some instances, these problems or needs are approached directly through music; in others, they are addressed through the interpersonal relationships that develop between client, therapist, and/or group.

Music therapy may involve the client and therapist in a broad range of musical experiences. The main ones are improvising, performing, composing, notating, verbalizing, and listening to music. Methods which employ improvising as a primary therapeutic experience are referred to as "improvisational music therapy."

Improvisation is a creative activity which commonly occurs in everyday life, in the performing arts (music, dance, and drama), and in the respective arts therapies. Accordingly, the term "improvise" has many different definitions.

In everyday language, "improvising" means to make something up as one goes along or as Webster put it "to make, invent, or arrange offhand." In certain situations, it can also mean to create or fabricate something from whatever resources are available. In music, "improvising" is defined as "the art of spontaneously creating music (ex tempore) while playing, rather than performing a composition already written" (1:140).

In a music therapy context, improvising encompasses elements of all these definitions. It is inventive, spontaneous, extemporaneous, resourceful, and it involves creating and playing simultaneously. It is not always an "art" however, and it does not always result in "music" per se. Sometimes it is a "process" which results in very simple "sound forms." Music therapists strive to improvise music of the highest artistic quality and beauty, however, they always accept

the client's improvising at whatever level it is offered, whether consisting of musical or sound forms, and regardless of its artistic or aesthetic merit.

CLINICAL USES

Improvisational music therapy has been practiced in diverse clinical settings, including psychiatric hospitals, residential institutions, medical hospitals, prisons, out-patient programs, clinics, regular or special schools, community programs, therapy institutes, training centers, and private practices. It has also been used with numerous client populations including individuals with mental retardation, learning disabilities, psychiatric disorders, social and behavioral adjustment problems, sensory impairments, physical and orthopedic handicaps, neurological impairments, bodily injury and pain, medical illness, emotional deprivation, social disadvantage, substance addiction, and the infirmities of aging. In addition, improvisational music therapy has been used to promote psychological growth in normal children, adults, and senior citizens, to improve marital and love relationships, to assist families in conflict, to assist in relaxation and pain reduction, to treat musical problems, and to train and supervise therapy students and professionals.

Models of therapy are usually designed for a specific clinical setting, to meet the needs of a particular client population or group. It is therefore important to know which models are more appropriate for which population, and what kinds of clients benefit the most from each model.

Many of the differences found between models of improvisational therapy are due to differences in the clinical setting and population for which they were designed. For example, some models are for children, others are for adults. Some are designed for intellectually normal individuals, others are for intellectually impaired individuals. Such differences in clinical application have profound effects on the design of a model, including its goals, assessment and treatment procedures, and prerequisites for client participation. Consequently, most models have to be expanded or adapted before using them in a different clinical situation. Fortunately, because most improvisational models emphasize spontaneity and flexibility, they are relatively easy to adapt or expand.

Improvisational music therapy can be used with individuals on various levels of development and functioning, however, there are some basic prerequisites that must be considered in screening clients. Each model has its own prerequisites for participation, depending upon the clinical setting and the population for which it was designed. The prerequisites for a model are determined by what the client will be asked to do. If the model involves singing or playing an instrument, then the client has to have the physical capabilities required. If the model involves discussing the improvisation, then the client has to have the necessary language skills. Thus, an essential consideration in adapting a model for use with another population is its prerequisites for client participation.

A final consideration in applying a model of therapy is what contraindications there may be. Certain clients have adverse reactions or abreactions to certain kinds of sensory stimulation, motor activity, or psychological experience. Thus, each model should be analyzed to determine whether it engages the client in anything that might cause discomfort or harm to him/her. Obviously, the therapist must have also collected the necessary client information before considering any model.

GOALS

Every model of improvisational music therapy has its own goals for helping a client to achieve a state of well-being. A goal describes the overall direction of the therapist's efforts and the desired outcome of those efforts with respect to the client. The direction of the therapist's efforts may be to increase, decrease, improve, maintain, or restore some aspect of the client's being. The outcome may be a specific feeling, attitude, trait, habit, behavior, relation, or state of being.

Three levels of goals can be identified. "General" goals are those which reflect the overall therapeutic aims of the model itself. They usually indicate the broad kinds of therapeutic problems and needs that the approach was designed to address.

"Population-specific" goals are general goals that have been adapted to address the specific needs of a particular client population or diagnostic group. For example, if self-awareness is a general goal of the model, the population-specific goal may be *body* awareness with one population and *emotional* awareness with another.

"Individual" goals are those that focus on the specific problems and symptoms that a client presents, while also considering the unique strengths and resources that the client can bring to bear in resolving them. As such, individual goals address those needs which are most relevant to the client's well-being, be they broad and pervasive, or limited and focused. Most often, individual needs are identified and prioritized through assessment procedures.

Models vary considerably with regard to the process of formulating goals. Goals may be established at the very beginning of therapy, or they emerge as therapy progresses. In some models the client sets his/her own goals, with varying degrees of guidance from the therapist; in others, the client does not participate in the formulation of goals. Goals may be established by the therapist independently, in consultation with parents, guardians, or other professionals, or as the result of a team process.

Improvisational music therapy generally addresses the following goal areas:

- . . . Awareness of self, physically, emotionally, intellectually, and socially;
- . . . Awareness of physical environment;

- . . . Awareness of others, including significant persons in the family, peers, and groups;
- . . . Attention to self, others, and physical environment;
- . . . Perception and discrimination in sensorimotor areas;
- . . . Insight about self, others, and the environment;
- . . . Self-expression;
- . . . Interpersonal communication;
- . . . Integration of self (sensorimotor experiences, levels of consciousness, parts of self, time, roles, etc.);
- . . . Interpersonal relationships with significant others, peers, and groups;
- . . . Personal and interpersonal freedom.

SALIENT FEATURES

Each model of improvisational therapy has certain features which make it unique and different from other models. Often, these features are implied in its name. For instance, "Experimental Improvisation Therapy" was given its name because of its resemblance to an experiment, and because it uses only improvisation. "Creative Music Therapy" was given its name to suggest the importance of creativity, and to indicate that it includes musical experiences in addition to improvisation.

The salient features of a model can also be gleaned from its specific focus or emphasis in the clinical situation. For example, a model may be characterized by its clinical uses and goals, its use of individual or group settings, its theoretical orientation, or its procedures and techniques for assessment and treatment.

Besides name and clinical emphasis, perhaps the most revealing information about a model of therapy is the originator's basic ideas on the role of musical improvisation in therapy. In fact, the reader will discover that the "salient features" of a model most often refer to the originator's purpose and rationale for using music, and the ways that s/he uses improvisation in particular.

Because improvisation is used in a variety of clinical settings, the first issue that arises is whether the model has goals which are educational, recreational, or therapeutic in nature. Educational goals are concerned with helping the client acquire knowledge or skills in music or another related discipline. Recreational goals are concerned with improving the client's use of leisure time. Therapeutic goals are concerned with helping the client gain insight about him/herself, work through feelings, problems, and symptoms, make basic changes in his/her personality, and develop more effective methods of adaptation. Of course, these goal areas overlap frequently.

Even when all of the goals are therapeutic in nature, models of music therapy may still have basic philosophical differences. A core issue at the root of these differences is whether music is used *as* therapy or *in* therapy.