IMPROVISATIONAL MODELS OF MUSIC THERAPY

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This comprehensive guide introduces the fundamentals of improvisational music therapy, surveys over 25 models of therapy, and synthesizes the various models into basic principles of clinical practice. Specific models described include creative music therapy, free improvisation therapy, analytical music therapy, experimental improvisation therapy, Orff improvisation models, paraverbal therapy, and other miscellaneous models. Each model is described in a uniform manner—background, clinical uses, goals, session format, assessment and evaluation, preparation for a session, client-therapist dynamics, stages of therapy, and others—to provide a solid framework for accurately comparing the different models.

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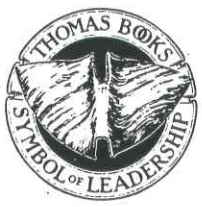

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UNIT ONE

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.

When used *as* therapy, music serves as the primary stimulus or response medium for the client's therapeutic change. In such approaches, music is used to influence the client's body, senses, feelings, thoughts, or behaviors directly. Or, music is used as a context for the client to identify, explore, and/or learn the therapeutic options available to him/her. (The former is often called "Music as Stimulus," and the latter is called "Music as Response"). In music *as* therapy, emphasis is given to the client relating directly to the music, with the therapist aiding the process or relationship when necessary. Hence, the therapist becomes a guide, facilitator, or bridge leading the client into therapeutic contact with the music. Intermusical and interpersonal relationships that develop between the therapist and the client serve to stimulate and support intramusical and intrapersonal relationships that develop within the client.

When used *in* therapy, music is not the primary or sole therapeutic agent but rather is used to facilitate therapeutic change through an interpersonal relationship, or within another treatment modality. When the interpersonal relationship is the primary stimulus or medium for therapeutic change, emphasis is given to the client relating to the therapist, partner, or group, with music aiding the process or relationship(s) as necessary. When more than one modality is used to stimulate therapeutic change, emphasis is given to the client working through his/her problem within the modality that is best-suited at the time, be it music, art, dance, drama, or verbal discussion. Thus, in music *in* therapy, music is used as the guide, facilitator, or bridge leading the client into therapeutic contact with a person, a modality, or the client him/herself. In these instances, relationships that develop between the client and music serve to stimulate and support intermusical and interpersonal relationships that develop with others.

The quality and degree of musical participation by the therapist differs in those models using music *as* therapy versus *in* therapy. When used *as* therapy, the therapist is likely to take a more active improvisatory role, whereas when used *in* therapy, the musical role of the therapist may vary considerably.

The extent to which music is used *as* or *in* therapy affects other basic issues. Improvisational music therapy may be used as a primary treatment modality, as an adjunct to another modality, or as part of a multidisciplinary approach. When used as a primary treatment modality, the improvisational therapist takes overall responsibility for identifying and meeting the main therapeutic needs of the client. When used as an adjunctive modality, the therapist works towards the accomplishment of goals established by the primary therapist, and employs consistent methods and procedures. In a multidisciplinary approach, the therapist contributes to a team process of assessment, treatment, and evaluation, and takes whatever role is decided jointly with the team. Thus, the improvisational therapist may work independently, with a cotherapist, under the supervision of another therapist, or as an equal member of a multidisciplinary team.

Another basic issue in defining a model is the specific role given to improvisation in the therapeutic process. Improvisation can be used as a means of assessment, treatment, and evaluation. In some models, improvisation is used exclusively, as the main procedure in all three areas. In others, it is used in only one area, or as one of many procedures that may be employed. Hence, improvisation may be used as a method in itself, or as a technique within a broader method.

When not used exclusively, improvisation may be used in conjunction with a variety of other activities and modalities. When part of a comprehensive approach to music therapy, it is used in conjunction with activities such as listening, performing, composing, notating, and verbalizing about music. When used within a creative arts therapies approach, it can be combined with movement, dance, mime, drama, story-telling, play, poetry, and art. When used as a form of psychotherapy, it may be combined with any of the foregoing arts modalities plus verbal strategies, and various action methods. The amount of verbalizing that takes place within improvisational music therapy is often a major issue in distinguishing between different models and philosophies.

Models of therapy can also be distinguished by the type of musical improvisation used. An improvisation may represent or refer to something outside of itself for meaning, or it may represent or refer only to itself. When the music is organized in reference to something other than itself, it is called a "referential" or "programmatic" improvisation. Examples include improvising to a verbal statement, feeling, idea, event, situation, person, image, memory, title, story, drama, or artwork. When the music is created and organized according to strictly musical considerations, without representing or referring to something outside of itself, it is called a "nonreferential" improvisation. Examples include any instrumental or vocal improvisation that does not rely on a program for its musical organization and meaning.

Improvisational procedures can also be distinguished according to whether they are active and/or receptive. When the improvisation is active, the client improvises (with or without another person), and listens to his/her own improvising as it unfolds. When it is receptive, the client does not improvise but rather listens to another person improvise.

A final distinction that can be found between models is musical medium. A model may emphasize vocal, instrumental, body-sound, or movement improvisations, or any combination thereof.

THEORETICAL ORIENTATIONS

Aside from having a fundamental philosophy regarding the nature of music therapy and the role of improvisation, each model of improvisational therapy is rooted in one or more treatment theories. Treatment theories used in music

therapy can come from many different disciplines, including psychotherapy, speech therapy, occupational therapy, physical therapy, music education, or other arts therapies, to name a few. The theories may deal with personality, emotional development, communication, motor action, music, or any other area of human functioning.

In improvisational music therapy, theories of psychotherapy are most often cited as the basis for treatment. The most frequently cited theories are those of the psychodynamic, existential/humanistic, and gestalt schools of psychotherapy. Theorists associated with psychodynamic thinking include Sigmund Freud, Anna Freud, Melanie Klein, Margaret Mahler, Carl Jung, Wilhelm Reich, Alexander Lowen, Eric Erikson, and Karen Horney. Theorists associated with existential and humanistic schools include Ludwig Binswanger, Abraham Maslow, Carl Rogers, Virginia Axline, and Clarke Moustakas. Theorists associated with the Gestalt school are Fritz Perls and Joseph Zinker. Other theories that have been used are behaviorism, Transactional Analysis, cognitive developmentalism, Neurolinguistic Programming, Tavistock, and T-Group models. Some models of improvisational therapy lean heavily on one theory, other are more eclectic and rely upon constructs from different theories. When constructs from different theories are used together, they must be compatible. Not all theories and constructs fit together to make for a consistent model of therapy.

The "theoretical orientations" of a model have profound effects on goals, procedures for assessment and evaluation, the dynamics of intervention, and the process or course of treatment. They also determine how improvisation is used and the rationale for emphasizing certain aspects of improvising over others. Thus, theoretical orientations are responsible for many of the differences that can be found between improvisational models of music therapy.

THERAPIST QUALIFICATIONS

An important factor in effective therapy is how qualified the therapist is to use the procedures and techniques involved in a particular clinical model. With regard to improvisational music therapy, the qualification requirements fall into three main areas: musicianship, clinical expertise, and personal qualities.

Improvisational models differ according to which area is emphasized more, as well as what is specifically required within each area. In fact, each model can be analyzed by rating the relative significance of musical, clinical, or personal qualifications, and then examining specific competencies or qualities within each area.

An examination of therapist qualifications often reveals the basic clinical philosophy of a model. Those models that advocate "musician as therapist" are philosophically quite different from those that advocate "therapist as musician."

Those that require advanced piano competencies are quite different from those that call for instrumental flexibility. Models that emphasize forbearance and patience are quite different from those that advocate authenticity.

SESSION FORMAT

Improvisational music therapy is provided in individual, dyadic, family, or group settings. In individual sessions, the therapist works with the client alone, whereas in dyadic sessions, the therapist works with two clients at once. The dyad may be a child and parent, husband and wife, lovers, work partners, or unrelated peers. In family sessions, the therapist works with an entire family as a unit, or focuses on one person as s/he relates to parents and siblings. In group sessions, the therapist works with three or more clients, most often peers.

Each model of therapy sets forth criteria for placing clients in the most appropriate setting. Some models use one setting exclusively (e.g., individual or group) because it is indigenous to the treatment approach itself. Other models use different settings at different stages of treatment, and still others place clients in several settings at once. In any event, one of the most important decisions a therapist makes is determining the best placement or "session format" for a client.

When placing a client in a group, it is important to consider his/her readiness for the kinds of interpersonal experiences that will take place, and the many different demands that group participation will make. Often the prerequisites for group placement depend upon the size and composition of the group. The size of the group varies according to the goal of the model, and according to the needs and characteristics of the clients. The composition of the group is determined according to several variables. Though models may vary somewhat in the ideal composition of a group, all groups are homogeneous with regard to certain variables, and heterogeneous with regard to others.

In addition to specifying criteria for placement, group prerequisites, and the size and composition of groups, a model usually specifies the length and frequency of therapy sessions, and the length of treatment itself. The length and frequency of sessions may depend upon the client, the type of setting, the model, or any number of other factors. The length of treatment is usually a function of the severity of the client's problem and the nature of the therapeutic approach.

MEDIA AND ROLES

As mentioned earlier, improvisational music therapy may employ various expressive modalities and media. The main modalities are music, verbaliza-

tion, movement/dance, drama, poetry, and art. The main media in music are voice, instruments, and body. These modalities and media can be used alone or in various combinations.

Models of improvisational therapy differ in what modalities and media are used most often, and in which musical media are used by client, therapist, and other participants in the session. Hence, the use of modalities and media is closely tied to the expressive or communicative roles of each person in the therapeutic situation.

In some models, the therapist makes all or most of the decisions regarding media and roles. Generally, the rationale for these decisions is based on the expressive or communicative needs of the client, the opportunities for self-expression and communication in the different modalities and media, and the need for support or guidance from the therapist.

In other models of therapy, the client is asked to choose his/her own modalities and/or media. Sometimes, the client is even given control over what modalities and media the therapist will use.

To summarize, important decisions regarding media and roles in improvisational music therapy are: which modalities other than music will be used; which musical media will be used by client and therapist (i.e., voice, instrument, body, or combinations thereof); what instruments are used by the therapist and client(s); who selects the musical media and instruments for whom; and whether the therapist and client will interact through any kinds of musical activity other than improvising (e.g., song-writing).

ASSESSMENT

Assessment is the process whereby a therapist collects and analyzes information about a client deemed necessary for planning and implementing an effective treatment program. An assessment may lead to specific hypotheses about the nature and causes of the client's diagnostic condition, or it may lead to greater insight into the client's personality, problems, needs, resources, and potentials. All of this information helps the therapist to map out a direction for therapy while also determining what will be the most effective treatment strategies.

In improvisational music therapy, the main method of assessment is to engage the client in improvisation, either alone, with the therapist, or within a group. Other musical activities such as listening, performing, and composing may also be used. The focus of the therapist's observations during these musical tasks varies from one approach to the next.

Whether the client improvises alone or musically interacts with another person, it is not enough to simply describe and classify the client's responses. Usually, the improvisational therapist is also interested in discovering what

makes the client respond a certain way, and what can lead the client to respond in a different way. Hence, during an assessment the therapist asks questions such as: When does the client exhibit a particular response, and under what conditions can it be modified or changed? Who elicits a response from the client, and who can influence its change? And, how is the response emitted, and what aspects are usually changed?

The therapist may record data from the musical assessment through audio or visual tape recordings, written narratives, musical notations, or behavior checklists. The data may be analyzed in any number of ways, depending upon the overall purpose of the assessment. The purpose of the assessment is usually determined by the client population and the therapist's theoretical orientation.

In addition to improvisatory or structured musical tasks, the therapist may also collect assessment data through a clinical interview at the beginning of therapy. The clinical interview is used to collect information regarding the client's personal, musical, and clinical history. This information serves to supplement and clarify findings from the improvisational assessment.

Assessment also consists of collecting information on the client from other disciplines. Sources of data may include referral forms, institutional records, diagnoses, test results, assessment reports in other therapeutic modalities, team meetings, consultations with the primary therapist, and so forth.

While much of the assessment work is done at the beginning of therapy, most therapists continue in their efforts to probe, study, and understand the client. Since the client is engaged in music-making throughout the therapy process, there is a continuous and generous supply of data on the client at every moment. For this reason, assessment and evaluation are often one and the same process in improvisational music therapy, even though their purposes are somewhat different.

EVALUATION

Evaluation is the process of determining how much progress a client is making towards achieving the goals of therapy. Progress is usually evaluated by observing any changes that the client is making as a result of treatment, and by comparing the client's current status with his/her status at a previous time (e.g., beginning of therapy). Assessment data may therefore provide baselines or criteria for evaluating client progress.

Evaluation is also concerned with whether a particular treatment strategy has been effective in inducing change or helping the client meet a particular goal. In fact, this is the other half of measuring client progress. If the client is not making any changes or progressing, it may be due to the client, or it may be due to the ineffectiveness of the treatment strategy. Evaluation is therefore a dual process of evaluating client progress and determining the effectiveness of various intervention and treatment strategies.

Evaluation is a means of charting goal achievement at various stages of therapy. Since the goals and stages of improvisational therapy vary from one approach to the next, evaluation can have different focal points. When the goals are musical, evaluation focuses on stages of musical growth; when the goals are interpersonal, evaluation focuses on stages in the development of relationships, both in the therapy setting as well as in other social contexts; when the goals pertain to specific symptoms, evaluation focuses on stages in their elimination, reduction, or substitution. Finally, when the goals are intellectual or emotional, evaluation focuses on corresponding stages of growth in these areas.

Procedures for conducting evaluations may include log reviews, team meetings, periodic narrative reports, systematic observations, a readministration of assessment procedures, and/or direct client feedback. Evaluation records may be in the form of narratives, data reports, or checklists.

PREPARATION OF A SESSION

By their very nature, improvisational therapy sessions need to be spontaneous yet planned, and open-ended yet structured. They also have to involve both the therapist and the client or group in the decision making. From a practical standpoint, the question is: Which aspects of the session should be planned beforehand by the therapist, and which aspects should be left to the moment for the client(s) and/or therapist to determine.

Each model of improvisational music therapy has its own way of dealing with this issue. In some models, the therapist formulates a long-range goal plan or overall therapeutic approach at the beginning of therapy and modifies it at periodic intervals thereafter. In other models, the therapist maps out the direction of therapy in shorter time frames. In some models, the therapist makes detailed plans for each session, whereas in others, the therapist allows each session to emerge according to some natural or organic structure.

Whether the model employs highly structured, planned sessions, or very spontaneous and open-ended ones, all therapists make certain basic preparations. Of utmost importance is to inquire about the emotional and/or physical state of the client immediately before the session. This can be done by reading the client's charts or by consulting other staff members who work with him/her daily. When the client is not institutionalized, this can be done by asking the client or his/her guardians at the beginning of the session. Any significant events or changes that have taken place since the previous session must be taken into consideration.

Another essential thing to do before the session is to prepare the physical environment. Room decor, lighting, acoustics, and the arrangement of furniture, seats, equipment, and musical instruments can have profound effects on the

client and his/her ability to benefit from the session. The chief concern is to provide a physical environment that maximizes the client's ability to interact with objects and persons in a safe, secure, pleasurable, and therapeutic way.

Depending on the particular model of therapy, the therapist may also prepare for a session by: selecting modalities, media, materials, and activities to be used; analyzing previous sessions to identify musical materials and themes produced by the client; preparing improvisations that use the client's musical materials and identifying emotional issues from the previous sessions that need further investigation.

PROCEDURES

As used here, a "procedure" is a strategy or method used by the therapist to engage the client in a specific aspect of the therapeutic process, or to accomplish a specific methodological objective. The method or strategy may consist of a series of operations or interactions, and may be accomplished through the use of various techniques. Because a procedure is used to engage the client therapeutically, it is sometimes referred to as a "work" phase within the session.

A procedure or method is different from a model in that it is not a comprehensive approach to therapy. It does not include goals, theoretical foundations, philosophies of therapy, and/or assessment procedures as a model does. A procedure is also different from a technique in that it is not a single operation aimed at eliciting an immediate response. It is more elaborate, takes more time to implement, and has broader and less immediate methodological objectives. Thus a procedure is part of a model or approach, and a technique is a part of a procedure. Examples of a model are "Analytical Music Therapy" or "Integrative Improvisation Therapy." Examples of procedures are improvisations, discussions of an improvisation, projective story-telling. Examples of techniques are musical reflection, movement synchrony, and verbal confrontation.

Procedures vary from one model to the next, in terminology and in the actual operations and interactions used to engage the client. Procedures also vary within a model according to whether the session is individual, dyadic, family, or group. Notwithstanding these variations, the procedures used in improvisational therapy generally fall into categories according to the methodological objectives given below. Note that each methodological objective deals with engaging the client in a particular aspect of the therapeutic process. The main objectives are to:

. . . establish rapport with the client;
. . . help the client feel safe and secure;
. . . bring pleasure and motivate the client;
. . . facilitate the client's interaction with the physical and social environment.

. . . prepare the client emotionally and intellectually for a therapeutic encounter;
. . . bring awareness and insight;
. . . induce experimentation and change;
. . . support the client during experimentation and change;
. . . bring a sense of closure or conclusion.

Since improvisation is one of the main procedures used in meeting these objectives, a major concern for the therapist is how to engage the client in an improvisation. Improvisations are usually stimulated by presenting the client with any of the following:

. . . a musical option within an existing composition (e.g., call and response);
. . . a rhythmic or melodic theme;
. . . a scale, beat, speed, or meter;
. . . a musical mood (e.g., soft and slow);
. . . a sound quality or timbre (e.g., pizzicato);
. . . a procedural instruction (e.g., rondo);
. . . a relationship between the improvisers (e.g., imitations, synchrony);
. . . a program (e.g., image, story);
. . . an instrument.

The therapist may participate in the improvisation or allow the client to improvise alone, depending upon the objective. When participating in the improvisation, the therapist may use various musical techniques, and if the improvisation is discussed afterward, the therapist may use various verbal techniques. The techniques are designed to elicit immediate reactions from the client which will facilitate achieving the objective.

In most models, the procedures are used according to a certain sequence. The sequence helps to insure that the client is ready to move from one work phase to another, while also giving the session and the client's experiences a meaningful structure.

There are two basic ways to sequence a session. In the first way (i.e., a "structured session"), the procedures are sequenced so that the session moves towards and away from a focal event. The session has a beginning, middle, and end, and elicits feelings of direction and expectation. The beginning is usually aimed at preparing the client in some kind of therapeutic "encounter," and the end of the session is aimed at gaining a sense of closure or reaching some kind of conclusion. In this type of session, the therapist usually works directively and according to a plan.

In the second way (i.e., a "free-flowing session"), the procedures are used in cyclic phases that are repeated from the beginning of the session to the end. The cycles are usually experiential loops that provide a natural structure to the ongoing activity. In this type of session, the therapist observes the client

moment-to-moment and allows the therapeutic process to unfold phenomenologically, without a preconceived structure or plan. To give the session a sense of organic direction, and to make each experience structurally meaningful, the therapist and client may look for recurring themes or for layers of experience. The themes may emerge in musical content or in emotional content.

TECHNIQUES

As used here, a "technique" is an operation or interaction initiated by the therapist to elicit an immediate response from the client, or to shape his/her immediate experience. As mentioned previously, a technique is different from a procedure. First, it is a single action or interaction that takes a relatively brief period, whereas a procedure is a set of operations that may take part of a session, an entire session or even longer to implement. Second, a technique is designed to have an immediate effect, whereas a procedure is geared towards the gradual accomplishment of a methodological objective.

A technique may involve action or interaction in musical, nonmusical, verbal, or nonverbal modalities, as well as in various media. It may also involve the therapist, client, significant other, peer, or group as a whole.

Every model of therapy has its own set of techniques and terms for them. Most often, the techniques are closely tied to a particular procedural phase. The majority of techniques used in improvisational therapy are either musical or verbal.

DYNAMICS

Therapy, regardless of its theoretical orientation, and regardless of whether it is done through music, words, or other expressive modality, always involves the client in some kind of interaction or encounter. For therapy to take place, someone or something must act in some way on someone in order to produce an effect or reaction. A therapist may act upon a client; a client may act upon him/herself or another client; music may act upon a client; or music may be the medium for therapist and clients to act upon each other. These interactions or encounters comprise what is commonly called the "dynamics" of therapy.

In improvisational therapy, the primary dynamic elements are the client, the therapist, the musical instruments, and the improvised music itself. Also included may be other clients, significant others, and any other stimuli or objects which are used as part of the therapy process (e.g., pictures, stories, cue cards, verbal images, etc.). These elements become dynamic forces in therapy when: (1) they impinge on or are acted upon by the client; and (2) when they serve as agents of therapeutic response or change.

The dynamics of therapy can be likened to chemistry. Just as chemical elements combine to form compounds, and then interact to produce reactions, structural changes, or new combinations, so do the elements in therapy combine and interact to achieve therapeutic reactions, personality changes, and new relationships. In improvisational therapy, the most important interactions and relationships to analyze are:

. . .within the client's music (intramusical);
. . .between the client and his/her music (intramusical and intrapersonal);
. . .within the client's self (intrapersonal);
. . .between the client and therapist's or other person's music (intermusical);
. . .between the client and therapist or other person (interpersonal);
. . .within the group's music (intermusical group);
. . .within the group (interpersonal group).

It is important to realize that at any moment in therapy, many of these relationships are taking place simultaneously. It will also become evident that the boundaries between these relationship categories are not always clear because they overlap so frequently.

STAGES OF THERAPY

As the dynamic forces of therapy interact over a period of time, changes begin to take place in the client(s), the therapist, the music, and the many relationships that develop therein. These changes usually take place in predictable stages, depending on the model's goals and methodological sequences. In some models, its underlying treatment theory provides an indication of the stages that will take place. The theory may pertain to: developmental change, various kinds of learning, behavior modification, or group process. In some models, the therapist determines the stages of therapy with specific reference to the client(s), and then formulates goals and methods for each stage.

It is important to examine the stages of a model, because it gives an idea of what the "process" of therapy is. In most cases, the stages that take place within an improvisational model can be described in terms of the musical process of change, and the interpersonal process of change.

REFERENCE

(1) Apel, W., and Daniel, R. T. (1969). *The Harvard Brief Dictionary of Music.* New York: Washington Square Press.