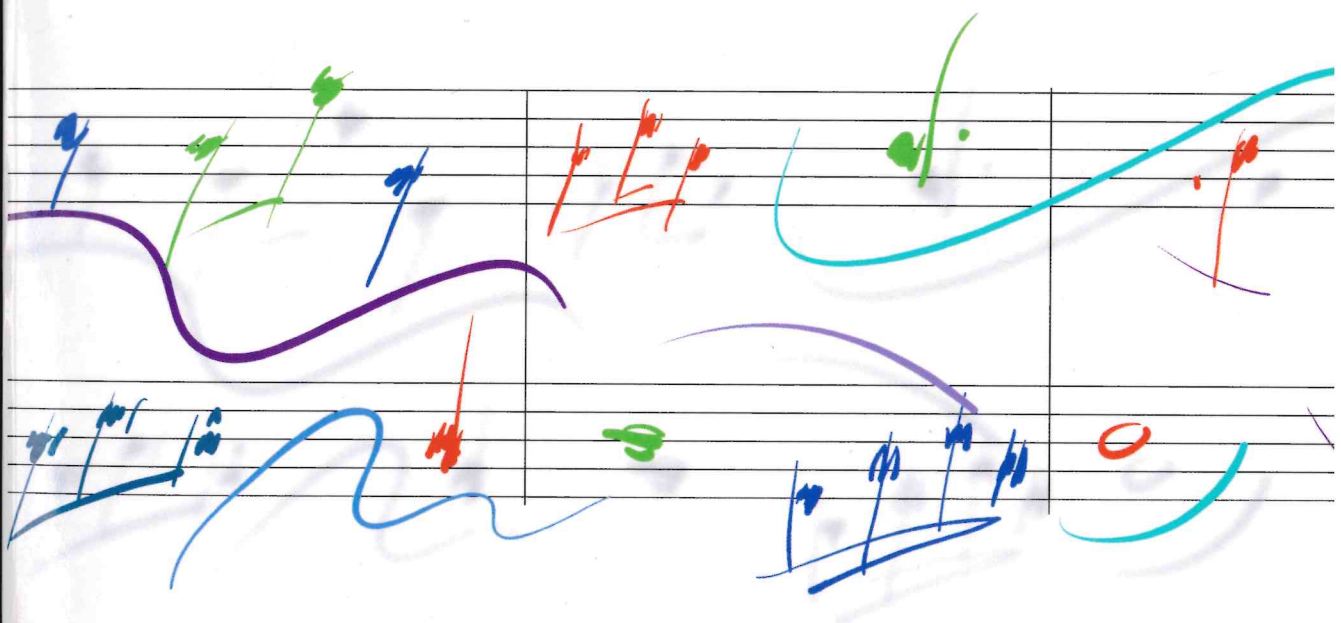
MUSIC THERAPY Handbook



edited by

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CHAPTER 10

Music Therapy Methods

Susan Gardstrom
Suzanne Sorel

From time to time, a music therapist is asked what she *does* with a client in a music therapy session. Does she select a program of recorded music for the client so that he can experience profound relaxation? Does she teach the client to play an adapted musical instrument? Does she help the client to write a song or to express his immediate feelings on a drum? Perhaps you already know that the answer is yes, yes, yes, and yes! Music therapists do all of these things and many more.

Simply put, the therapist arranges for the client to have various types of music experiences that have been selected or designed to meet the client's identified needs. These experiences are called music therapy *methods*. Bruscia (2014) identifies four distinct methods, which he terms receptive (or listening), composition, improvisation, and re-creative (or performance). The methods describe what the client (not the therapist) is doing in relationship to music. In song discussion, for instance, in which the therapist guides the client to listen to and discuss the meaning and relevance of a song, it is the client's role as a listener that defines the experience as *receptive*.

Within each of the four methods are multiple *variations*, or what some call *experiences, interventions*, or even *applications*. Song discussion is one variation of a receptive method. Imaginal listening is another variation. Music anesthesia is yet another. Each of these variations is unique in many regards, and yet all three are bound together in the sense that the client comes to and responds within the music experience as a listener. One clear advantage of using music-oriented nomenclature to describe what music therapists do is that it is neither clientele-specific nor rooted in any one particular approach to clinical practice: Variations of the four methods are used with all types of clientele by music therapists (1) with both entry-level and advanced training, (2) who espouse all types of theoretical and philosophical perspectives, and (3) who practice at supportive, reeducative, or reconstructive levels of therapy (see Wheeler, 1983).

A *method* is different from a procedure and a technique. Briefly, a *procedure* is a set of sequential actions or steps taken by the therapist as she facilitates a particular experience. A *technique*, on the other hand, can be thought of as a single, in-the-moment verbal, gestural, or musical action or interaction of the therapist during a specific procedural step that serves to elicit a desired response or deepen the client's experience or satisfaction within the experience. Let's put the terms all together in one example: Song discussion is one variation of a receptive method. It involves sequential action steps, or procedures, undertaken by the therapist, such as (1) selecting a song based on group needs; (2) describing the purpose and process of song discussion for the clients; (3) playing the song with careful attention to the clients' responses; and (4) facilitating a discussion about the clients' responses to the song. During step 4 in this example, the therapist may use verbal techniques, such as probing or self-disclosure, to elicit a response from a particularly withdrawn client.

Consider that each particular method—that is, each way of being in relationship to music—offers inherent and unique challenges and opportunities for the client. The experience of listening to music is different from the experience of composing music, which is different from the experience of spontaneous music making, and so forth. It is precisely the distinctive challenges and opportunities afforded by each of these experiences that make certain music therapy methods particularly suited to a client's individualized clinical needs and treatment plan.

In this chapter, we introduce you to the essence of each of the four music therapy methods. We also highlight a few of the many unique variations within each method, discuss therapeutic aims that can be addressed with these variations, and provide a few actual clinical examples to illustrate some of the challenges and opportunities afforded by each.[1]

[1]For a comprehensive listing of variations, please see Bruscia's (2014) seminal book, *Defining Music Therapy*.

Receptive Methods

As suggested above, receptive methods are those in which the client assumes the role of a listener in the music experience. Contrary to what you might think, however, this is not a passive role. Although the client is not making music, he is called upon to actively respond to what he hears, in overt and covert ways. His overt responses are external and observable and might include movement to the pulse or verbalizations about what he hears. His covert responses are internal and largely unobservable, and might include his associations and memories or a physiological relaxation response. These types of responses may occur with the other methods, too; the distinction is that receptive experiences are selected or designed intentionally to elicit these various overt and covert responses. Although the inherent challenges placed upon the client are unique to the variation used, all receptive experiences presume that a client can hear and respond to what he hears.

There are more identified receptive variations than any other method. Some frequently employed examples have already been cited above. Others that are commonly used include song (music) communication, eurhythmic listening, and music-assisted relaxation.

Song discussion (Bruscia, 2014), used with verbal clients, essentially involves the client and therapist listening to a song together and finding its meaning and relevance to the client's life. In the case of group therapy, song discussion often functions as supportive therapy—helping clients to experience meaningful connections and a decreased sense of isolation as they communicate with others. As a reeducative tool (see Wheeler, 1983), song discussion can help clients develop insight through the identification, exploration, and communication of thoughts and emotions evoked by their encounter with a selected song, as follows.

CLINICAL EXAMPLE:
Group Song Discussion

At 19, Emily was the youngest resident of the women's unit at the addictions treatment facility where my students and I (Susan Gardstrom) were working. She had attended two prior music therapy sessions but had not uttered a single word (other than her name) or played any instruments, seemingly intimidated by the music-making process or by the presence of the other women, many of whom were twice her age. On this particular day, my cotherapist and I bring in a recording of "Addicted" by Kelly Clarkson and ask the women to take a deep breath and simply allow the words and sounds to enter their consciousness. Emily sits with her head down and her arms folded across her chest, as if for self-protection. The recording begins with the singer's low, breathy voice exposed against a sparse accompaniment of minor harmonies and hollow, percussive sounds. Clarkson's voice increases in intensity but somehow retains its desperate, vulnerable quality as she nears the chorus. Here, she jumps up an octave and delivers an angry message, the potency of which is emphasized by a thick texture of "screaming" guitars and driving drumbeats that can be felt in the chest.

Emily looks up and her eyes are filled with tears. Carla, one of the older and more seasoned members sitting next to Emily, hands her a tissue. As soon as the last sound fades away, Emily speaks about the recent heroin overdose that nearly killed her and that had led to her placement at the facility. As she speaks, it is if the armor melts away, and she gains a new awareness of her own desperate need for help. This disclosure opens the door for verbal sharing from the other women—stories about their own trajectories to and through addiction and all of its attendant emotions. Emily and Carla leave the session arm in arm.

Emily identified closely with the singer and her message. The lyrics of the song—supported by congruous and highly evocative, emotionally rendered music—functioned to bring to the surface critical feelings that could no longer be denied. Tears led to personal storytelling, which led to self-insight and compassionate support from others. (For a detailed account of the mechanisms of song discussion, see Gardstrom & Hiller, 2010.)

A related intervention is called *song (music) communication* or *song sharing*. The essence of this variation is that the client and/or therapist chooses a song to share with others as a way to express or disclose something about self or about the therapeutic relationship or process (Bruscia, 2014). I (Susan Gardstrom) have used song communication in initial sessions with runaway teens as a way "to gently initiate the process of personal sharing in a music therapy group, to learn about the clients and assess their musical proclivities, and to convey interest in the teens' musical offerings as a way to build rapport" (Gardstrom, 2013, p. 632).

Imaginal listening, as the name implies, refers to the use of music with individuals or groups to stimulate imagery. The term *imagery* most often connotes visual images (i.e., mental pictures), but imagery evoked by music may take the form of imagined sounds, smells, bodily sensations, and myriad other incarnations. Imaginal listening has been used to promote increased self-awareness toward "psychological and physical relaxation" (Houghton et al., 2005, p. 206) and well-being (Short, 2007); expand consciousness, support creativity, and assist in the integration of various aspects of the self (Association for Music and Imagery, 2012); deepen spiritual understanding (Maack & Nolan, 1999); manage pain and nausea (Sahler, Hunter, & Liesveld, 2003); and control performance anxiety (Kim, 2008), among other aims.

There are several different types of music-based imagery experiences, such as *music imagery* and the *Bonny Method of Guided Imagery and Music*. These types can be differentiated according to clinical aims, therapist training and role (e.g., level of directiveness), client developmental stage and age, type and length of music selections presented, and level of alertness of the client while listening. *Music imagery* is used within supportive or reeducative levels of clinical practice (see Wheeler, 1983) and can be defined as "directive verbally guided imagery supported by carefully chosen music" (Goldberg & Dimiceli-Mitran, 2012, n. p.). A clinical focus for the experience is predetermined by the therapist and/or the client. The client sits upright (sometimes with eyes closed) and is in a highly relaxed state while listening and imaging. Instrumental recorded music is used most often for music imagery. The selections are brief and contained—that is, they have a simple, repetitive form and minimal variability and tension in all musical elements. The therapist verbally guides the client into the agreed-upon focus by talking over portions of the music; the client then opens his eyes (if closed) and continues imaging—sometimes through drawing or writing—as the music continues to play. Verbal processing typically follows.

The *Bonny Method of Guided Imagery and Music* (BMGIM or GIM; Bonny, 1975) is a reconstructive method (see Wheeler, 1983) used to expand consciousness and bring awareness of inner resources and strengths. In GIM, the adult client (1) reclines and undergoes a brief *induction* by the therapist to promote an altered state of consciousness, (2) *travels* in the imagination while listening to recorded Western classical music and dialogues about the resulting imagery with the therapist, then (3) returns to an alert state to process the imagery and its significance. The music often triggers and supports dynamic imagery. The images revealed are thought to be indicative of unconscious psychological issues that seek resolution (e.g., memories, conflicts, repressed emotions). The client interprets his own imagery with the therapist's guidance. The therapist must have supervised, postgraduate training in order to practice GIM, as this method often elicits complex unconscious material that requires immediate, sensitive, and skillful attention, as in the following example.

CLINICAL EXAMPLE:
Individual GIM Session

Elisha, 54 years old, sought therapy from Marge, a GIM-trained therapist, to gain some clarity about and relief from nagging regret connected to her mother's dementia. After an assessment period, Marge selected three pieces of symphonic music that have been found to be particularly evocative of emotion, including Barber's "Adagio for Strings." She invited Elisha to lie down, close her eyes, and become conscious of her breathing. To help Elisha fully relax and go inward, Marge asked her to imagine the earth's healing energy traveling progressively upward through her body. This induction concluded with the statement, "Now, full of positive energy, let the music take you where you need to go."

As the initial piece began, Elisha immediately began to see the sprawling backyard of her childhood home, with two stately elm trees standing against a perfect summer sky. She was 8 years old. Elisha's two younger brothers appeared in the scene. As the three children played tag in the green grass, Elisha reported, "I can't see anyone else there, but someone is watching over us, protecting us from threat." When the music selection changed, Elisha again saw her younger self, but this time she was sitting alone in a dark and unfamiliar wooded area. Again, she had the sense that someone protective was in her midst. She stated, "I'm alone, but I can be in this scary place and not feel afraid." As the music increased in dynamics and harmonic tension, Elisha imagined herself walking along an emerging path, without knowing where she was headed. She encountered several mythical creatures and, although some were grotesque and seemed to have malevolent intentions, still Elisha felt no fear. As the Barber selection came to a close, Elisha was sitting peacefully on the path, holding a locket that had been given to her by her grandmother. The therapist helped Elisha gradually return to a fully conscious state and

invited her to draw a mandala (circle drawing) to depict any aspect of her journey. Elisha drew the two elm trees from the first scene. When asked to look at her drawing from a distance, Elisha realized that the trees represented her mother and grandmother, both of whom had shielded her as a child from the verbal and physical abuse that her father had perpetrated on her brothers.

In that moment Elisha understood that her recent regret stemmed from the fact that she had not expressed her debt of gratitude and never could: Her grandmother was deceased and her mother had forgotten much of what had occurred during Elisha's childhood. She began to weep, unable to speak for several minutes. Marge sat in attentive, compassionate silence. Elisha requested to hear some comforting music; Marge selected a short piece from Kobialka's *Timeless Motion* CD. The music "held" Elisha until her crying subsided and her breathing steadied. She and Marge then discussed Elisha's newfound awareness and made a tentative plan for a second GIM session to begin exploring her feelings about the abuse in her family of origin.

Music anesthesia is a receptive application that can be conceptualized as the use of music listening to reduce the client's perception of pain and anxiety related to pain, whether chronic or associated with specific medical procedures or surgeries. Music therapy for pain management involves a broad range of music interventions, all of which are individualized in relation to client need (as determined through assessment) and presented within the context of a therapeutic relationship (Kirby, Oliva, & Sahler, 2010). Music therapists have studied and employed music anesthesia with a host of diagnostic groups within both pediatric and adult medical settings (Dileo & Bradt, 2005; Standley & Whipple, 2003).

Procedural support is an important application of music anesthesia. In this application the therapist—espousing the broadly accepted gate control theory of pain (Melzack & Wall, 1965)—uses live or recorded music stimuli to flood the client's neural pathways, thereby competitively blocking pain messages that would otherwise be perceived in the brain (Kirby et al., 2010; Krout, 2007). For instance, a therapist might engage a child undergoing a medically invasive and painful procedure such as an injection through action listening, evoking a specific movement or verbal response with carefully selected song material. In this way the therapist uses music stimuli to redirect the child's attention to lessen his perception of pain.

Eurhythmic listening uses music listening as a way to help clients coordinate some type of motor activity. Various sorts of music can be used, and presentation may be live or recorded, depending on the situation. Examples include pieces with a strong pulse to support rhythmic choreography (e.g., dance or aerobic exercise), free-flowing instrumental selections to elicit creative/expressive movements (e.g., moving freely in response to the character of the music), and music for repetitive or complex movement patterns within a physical rehabilitation protocol (e.g., gait retraining after a stroke). Eurhythmic listening can help individuals or client groups release emotions through an active modality, improve body image, improve physical functioning, and learn movement concepts. Movement can also address clients' needs for increased cardiovascular exercise aimed at weight control. The following example illustrates the use eurhythmic listening in an academic setting.

CLINICAL EXAMPLE: High School Boys' Dance Group

Three 16-year-old boys from a self-contained classroom for students diagnosed with intellectual disabilities were referred to music therapy by the physical education (PE) instructor at their high school. All three boys had Down syndrome but were verbal and ambulatory. Two of the three, Brian and Thomas, exhibited behaviors common during adolescence: rapid mood swings and occasional defiance of authority. The third boy, Jonah, was emotionally stable and cooperative; he had a secondary diagnosis of cerebral palsy, causing weakness on the right side of his body. All three had been having difficulties of one sort or another in their PE course. The PE instructor thought that music therapy might assist the boys in developing the gross motor skills outlined in their individualized educational programs (IEPs).

The music therapist read the students' IEPs, observed all three boys in their PE courses in order to get a sense of the movement expectations and their current capabilities, and talked to the boys about their popular music preferences. The music therapist selected a Linkin Park song that was suitable for rhythmic movement. She choreographed the selected song with modified street dance movement sequences, which the students were able to learn in their music therapy sessions over the course of several weeks. Because the song was preferred and the dance steps perceived as "cool," all three boys were motivated to practice.

In the process of learning the steps, the boys demonstrated achievement of several annual IEP objectives, including (1) maintaining kneeling and standing balance; (2) speeding up, slowing down, or changing direction of movement; (3) jumping with a preparatory movement that includes flexion of both knees with arms extended behind the body; and (4) crossing the midline with upper extremities. The boys also demonstrated social/interpersonal growth as they followed established rules, discovered ways to negotiate differences of opinion, and asked for help from the therapist and each other in a positive manner. In an unprecedented show of compassion, Thomas was able to gently encourage Jonah, who became frustrated with his inability to complete a specific maneuver in the desired tempo.

Music relaxation or *music-assisted relaxation* (MAR) is the use of music to support the client's physiological, physical, or psychological relaxation. Although musical stimuli yield highly individualized responses (Scartelli, 1987), it is believed that certain music experiences, carefully designed and skillfully facilitated, can produce a palpable calming effect. Music listening, in particular, can be used to mask unwanted environmental sounds (e.g., hospital sounds), serve as a diversion from stressful stimuli, or, as noted above, act as "competing stimuli for other peripheral nerve impulses" such as pain (Krout, 2007, p. 135). Additionally, certain cognitive processes that occur as a result of music listening, such as imagery and attention to relaxation narratives, may positively influence brain structures associated with relaxation (Krout).

Robb (2000) notes that music therapists use MAR for both situational (transient) and chronic (persistent) stress conditions. MAR may be indicated "when clients self-report or are observed to have distressing or intrusive levels of anxiety" (Gardstrom, 2013, p. 633), or when they could benefit from learning relaxation techniques toward self-care. MAR also can be used to induce a relaxed state for imagery, promote sleep, and, as noted above, reduce the perception of pain, which is linked to anxiety. MAR is most effective with clients who have strong receptive language skills and the ability to sit still or lie down for extended periods of time without becoming distracted. In this regard, very young children are not good candidates for MAR.

Two basic types of MAR appear in the music therapy literature: *autogenic relaxation* (AR) and *progressive muscle relaxation* (PMR). AR involves "passive concentration of bodily perceptions (e.g., heaviness and warmth of arms, legs, and abdomen; rhythm of breath; and heartbeat) that are facilitated by self-suggestions" (Stetter & Kupper, 2002, p. 45). PMR involves alternately tensing and releasing various muscle groups toward physical relaxation, which may, in turn, lead to increased psychological comfort (Jacobsen, 1938). In both cases, music can be live or recorded, will likely be instrumental, and will have a stable, consistent character, as variability of musical elements may heighten, rather than lower, the physiological and emotional reactivity of

the listener. With PMR, tempo and phrasing of the music are selected for their ability to support periodic tensing and releasing of muscle groups.

Compositional Methods

Compositional methods are different from receptive methods in that they involve a different type of participation on the part of the client. A client who is involved in the process of composition—whether individually or as part of a group experience—is called upon to generate and refine personal opinions, ideas, fantasies, and so forth, and to put them into a workable musical and/or lyrical structure. Clients' abilities to organize, problem-solve, take responsibility, and communicate can be targeted via compositional processes and products (Bruscia, 2014). Therapeutic themes may emerge and be addressed.

Although variations of this method include instrumental composition and music collage (e.g., music audiobiography), *songwriting* is used more frequently than any other type of composition. Because of the centrality of popular song in American culture—it is omnipresent on radio, television, and the Internet—clients of all ages seem to embrace song as an accessible creative form (Baker & Wigram, 2005). Individually and in groups, clients may write a song from scratch or engage in *song transformation* (Bruscia, 2014), in which they personalize a preexisting song structure by rewriting lyrics and/or altering the musical elements accordingly. The therapist's role is to provide varying levels of technical assistance and interpersonal and emotional support during the compositional process. In a group, the therapist serves as a facilitator or mediator, helping the members to recognize and pursue their common aim and reconcile differences that may arise in the creative process.

Improvisational Methods

The word *improvisation* might conjure images of sitting in a dark, smoke-filled jazz club, listening to a trumpeter taking a solo with his trio. This is one way to characterize improvisation—as music that is invented, composed, or created with minimal preparation, often in a performance venue (*Free Dictionary*, 2012). As a music therapy method, improvisation has some of the same characteristics as an improvisational performance, but there are distinct differences in how and why the music is created and played.

Improvisation in music therapy includes any experiences in which the client actively participates in spontaneous music making with the therapist and/or other clients—playing instruments, vocalizing, or sounding their bodies or other objects (Bruscia, 2014). Improvisation that is centered on meeting clinical goals is often referred to as *clinical improvisation*. The creation of extemporaneous music helps clients organize their physical movements in space, initiate new ideas, have an aesthetic experience, develop a relationship with another person, and identify and explore feelings (Bruscia, 2014; Nordoff & Robbins, 2007; Wigram, 2004). The immediacy of improvisation to meet a variety of emotional states and physical needs is a hallmark of this method and the reason that it is used often and successfully across different settings and clientele. Clients in individual therapy can improvise alone or with the therapist; clients in group therapy can also improvise alone or with the therapist, but often improvise with other group members.

The music itself can take a variety of forms, depending upon the media used to produce sound. As noted above, musical instruments and the voice can be used. Clients also can use their bodies to make sounds through stomping, clapping, or can make a combination of sounds with instruments, vocalizations, and the body. The therapist and client have a range of elements with which to work, including rhythmic, tonal, and expressive (e.g., dynamics, articulation, phrasing), to name a few. The client and therapist develop the improvisation by combining these media and elements in unique ways. The character of the improvisation is reflective of the current emotional and physical state of the client and the potential goal areas.

Improvisations can be either nonreferential or referential. A *nonreferential improvisation* is organized solely around, and derives its meaning from, the music and sounds, without representing or referring to something outside of itself (Bruscia, 1987). A *referential improvisation*, on the other hand, is thematic; it is created "in reference to something other than the music itself," such as an "image, title, story, feeling or work of art" (Gardstrom, 2007, p. 16). Following is an example of a referential improvisation in which the music depicts a planetary theme.

CLINICAL EXAMPLE: Individual Vocal and Instrumental Improvisation

Reva is a 4-year-old girl diagnosed with autism spectrum disorder (ASD). She is verbal, articulate, and bright, yet can be demanding and controlling, requiring a certain sameness and ritual often associated with children with ASD. Ten minutes into her first music therapy session, she moves to the cymbal and begins to spin it. "The sun," she says, quietly. "The planets move around the sun," she continues. It sounds as though she is repeating something she has heard on television or in a movie. I (Suzanne Sorel) listen to her verbal idea and sing a melodic line incorporating her words: "The planets circle around the sun, yes they do." I repeat this descending melody, as Reva begins to move the xylophone, hand drums, and a small conga drum in a circle around the "sun"—the cymbal. I sing the phrase again, and Reva sings it back sweetly, matching pitch and looking over at me briefly, with a hint of a smile on her face. She then declares, with more energy, "There's Venus!", and I musically reflect her statement. Reva improvises an ascending melodic line, "There's Earth," while striking the drum one definitive time. I sing back her phrase, reflecting the tonal and timbral quality.

This exchange continues as we sing about most of the planets together, with Reva in a floaty and high-pitched sing–speak manner. The musical event comes to a climax with a rocket ship ride to Venus, complete with my improvised support during a countdown to blast off. My music of the sun and planets is lilting, with a steady rhythmic ground that provides a musical structure for her fantasy and musical play. The "blast off" music is energetic and mysterious, with diminished chords and ascending chromatic lines to reflect the anticipation of the flight. Reva's "script," which in other settings she would likely recite in a robotic, noninteractive way, has been transformed into a dynamic, joint musical relationship in which she begins to explore a more natural way of communicating through verbalizing, singing, and drumming—all expressing her creativity. The client develops trust in me as she realizes that her scripted words are taking on new meaning and are validated and developed through the forms that are created. She is more apt to share stories and work through crises in future sessions because of the groundwork laid during this improvisational exchange.

Sometimes clients and therapists improvise melodies and lyrics that develop into song forms during the course of the sessions. These songs can be reflective of anything that is related to the client. Clients can also create an improvisation by conducting others who are playing or singing, thus engaging in another kind of improvisatory experience.

Nordoff–Robbins Music Therapy (NRMT), also called *Creative Music Therapy*, is an improvisational approach that requires advanced training. Developed in 1959 by Paul Nordoff and Clive Robbins, the approach involves the improvisational use of music to evoke responses; develop relationships; and address emotional, cognitive, social, and musical goal areas (Nordoff & Robbins, 2007; Sorel, 2010). Many NRMT-

trained therapists work in teams: The primary therapist improvises the music related to the immediate needs and goals of the client, and the cotherapist facilitates the client's relationship to the music through vocalizing, physical and vocal prompting, and movement experiences. The training is humanistic and music-centered, including comprehensive experiential components focused on developing a wide array of improvisatory skills on either piano or guitar. In NRMT the music acts as the primary agent of change (Aigen, 2005), as opposed to functioning as a means to an end or solely as a vehicle for reaching nonmusical goals (Sorel, 2013). The following case exemplifies the Nordoff–Robbins approach.

CLINICAL EXAMPLE: Individual Vocal and Instrumental Improvisation

Ari is a tall, lanky, 16-year-old adolescent with autism. He is primarily nonverbal and often has his hand over his ear in a defensive position. He has a history of self-abuse, such as banging his head and pulling out his hair. He also has had some violent outbursts toward his caregivers, particularly when he becomes overstimulated by sound.

Ari enters his first Nordoff–Robbins Music Therapy session escorted by the cotherapist, Jenny. As the primary therapist, I (Suzanne Sorel) immediately notice the pace of Ari's gait, his solemn facial expression, and the way he grabs the drum mallet and begins to beat in a deliberate way. I join Ari's slow and loud playing by creating a theme on the piano based upon closely textured intervals of fourths and fifths. I am thinking that these intervals may create a sense of grounding and openness. A musical theme is not yet established, as we all get to know each other musically, exploring sounds that are not derivative of any particular musical key. The music has both a holding quality, due to the harmonic intervals, and a sense of forward movement, with the use of certain rhythmic patterns and articulations.

Ari continues to cover his right ear with his hand as he beats loudly with the other. Jenny and I sing a melody that is related to the intervals being played. As the theme develops and we sing out more strongly, Ari hums, lifts his head, and begins to play with alternating hands more assertively. I create, and then repeat, a particular melodic rhythm, and Ari immediately incorporates my idea into his playing, exhibiting his innate musicality by punctuating the phrase with a flourish on the cymbal. Although Ari does not repeat this phrase again, he begins to make vocal sounds and stands up straighter, more fully involved and engaged, demonstrating his acute listening. Ari, who tends to be isolated, obsessed with routines, and unable to form meaningful relationships, immerses himself in this musically creative improvisational experience with these two new people. His sustained attention and involvement through and with the music are notable.

Because improvisation is associated with freedom and thought to be formless (and possibly chaotic), you might think that a therapist and a client just start playing whatever comes to mind. On the contrary, clinical improvisation generally has some kind of underlying structure, guided by the therapist's clinical responsibility and sensitivities. Thus, the therapist must develop skills in initiating, shaping, and guiding the music that is being created.

Re-Creative Methods

Re-creative methods involve the client's reproduction of precomposed musical material, much of which therapists may find in the public domain. Clients can re-create music vocally, instrumentally, through participation in musical productions and games involving music, and by conducting music using a musical score (Bruscia, 2014). On the surface, re-creative experiences may look just like a performance, a recreational sing-along, or even a music lesson. However, in re-creative music therapy—even when performance for others is involved—the focus is on specific clinical aims, a few of which Bruscia (2014) lists as "Develop sensorimotor skills; Improve attention and reality orientation; Develop memory skills; Improve interactional and group skills" (p. 132). Clients may also experience feelings of self-worth and achievement through performance of a song or participation in a musical production.

As with the other music therapy methods, music therapists who use re-creative experiences first identify the needs of their clients and then choose or arrange compatible music experiences—experiences that will challenge the client in a particular way or provide a unique opportunity for growth and development. Sometimes these challenges and opportunities are best presented in the *process* of re-creating music, and sometimes they are best presented via the re-created musical *product*; sometimes the focus of a single experience or session shifts between process and product, because both have value for a particular client or client group.

In the selection and arrangement of musical material, music therapists consider the musical elements, formal structure, lyrical content, and emotional tone, among other factors. The therapist's facilitation may involve modeling, teaching (with or without adaptive or traditional notation), and coordinating rehearsals and performances. The therapist can also support clients' musical offerings through listening, providing feedback, accompanying, and joining.

Vocal re-creation involves using the voice to re-create precomposed material, as in the following example.

CLINICAL EXAMPLE: Vocal Re-Creation

Rosalie, an 80-year-old woman with middle-stage Alzheimer's disease, spends most of her time disoriented and anxious, unable to recognize many close friends and family members, and unaware of her immediate surroundings. When the music therapist begins to play and sing the song "I Could Write a Book," from the musical *My Pal Joey*, Rosalie immediately begins to sing most of the lyrics, smiles, and plays the basic beat on a tambourine. The memory of the song is vivid and intact, and she is immediately brought into the present moment emotionally and musically, as demonstrated by her playing, singing, smiling, and relating to the music therapist. Despite her inability to have a conversation, Rosalie's ability to respond meaningfully within this re-creative experience illustrates the benefits of using familiar music from her past. Hours after the music therapy session, nurses in her assisted living center comment that, despite her inability to remember the actual music therapy session, Rosalie is smiling and her emotional state remains placid and content.

Singing songs with live accompaniment is just one example of vocal re-creation; clients can also engage in vocal work, chanting, rapping, and singing along with recordings.

With *instrumental re-creation*, clients rehearse and perform certain parts in a piece of music. Learning and reading notation may be part of this endeavor, as well as playing along with a recording (Bruscia, 2014). Some music therapists use musical games and activities, such as "Name That Tune" or "Musical Chairs." In certain clinical situations, clients conduct peers, guiding a group as "dictated by a score or other notational plan" (Bruscia, p. 133).

With *musical productions*, clients are involved in the planning, rehearsing, and performance of a show, musical, or other kind of performance (Bruscia, 2014). The rehearsals that precede the performance can serve as a time to focus on numerous domains of functioning, including communication, sensorimotor, cognitive, social, and emotional domains. Most cultures, communities, and societies regard music as something to be shared with others. The benefits for the individual involved in the production can relate directly to clinical goals. The following vignette illustrates the re-creative method of musical productions.

CLINICAL EXAMPLE:
Creation and Performance of *Holiday on Wheels* by Adult Group

Eight adults with cerebral palsy and physical, emotional, and cognitive deficits write and perform their own musical as part of the music therapy program at their adult day treatment center. Goals for this project are addressed in multiple ways within the writing, rehearsing, planning, and, finally, performing of the production. I (Suzanne Sorel) initially meet with the group to discuss ideas regarding the production. Ryan, one of the clients, wants the show to relate to the upcoming winter holidays, but he also wants to use the performance to demonstrate his capabilities. All other clients in the group agree: The setting of the musical centers on the holidays, and the characters in the story should overcome some kind of challenge or obstacle to reach a goal. Jill, who likes to write poetry, begins to write lyrics to a song titled "Holiday on Wheels," which relates to the challenges of mobility when living in a wheelchair. Over many weeks, through improvisation and songwriting, the production begins to take shape. Each client explores feelings, both musically and verbally, regarding his or her unique role in the play and how the story regarding the characters should unfold. When the performance day finally arrives, the clients are excited and nervous. They perform the songs and recite their lines to the roar of applause. *Process* and *product* are equally valued in this experience, and the clients are active agents in a distinctive, creative endeavor.

Conclusions

Music is a unique and powerful medium, used throughout the ages to promote health, healing, learning, emotional expression, and community. In music therapy the needs of clients in individual and group sessions are always carefully assessed, and a therapeutic plan is designed to address those needs. The four music therapy methods and their variations highlight the myriad ways that music can target identified aims, within the context of a strong therapeutic relationship.

It is clear that the range of possible experiences is broad, thus requiring extensive clinical and musical skills set on the part of the practitioner. Listening to, composing, improvising, and performing music can be complex endeavors; when choosing how to proceed with her clients, the therapist must carefully consider the inherent challenges and opportunities afforded by these methods. Finally, knowledge of the *how-to*'s of each music experience must be united with a fervent belief in music's potency and a commitment to meeting and treating the individual person.

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