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Music Therapy Improvisation for Groups: Essential Leadership Competencies

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Chapter One

INTRODUCTION

THE EVOLUTION OF THIS BOOK

I have been teaching an introductory course in clinical improvisation to undergraduate music therapy and music education students since 1999 and conducting workshops on the method since 2000. In short, when I began teaching at my university, I inherited an improvisation course that had been proposed by a predecessor but had never been taught. I had not been trained in how to instruct improvisation, so I knew that I would have to rely heavily on published resources and help from other professionals to develop the specifics of the course. Much to my surprise and dismay, I found only two books available on the subject of clinical improvisation at that time, *Improvisational Models of Music Therapy* (Bruscia, 1987) and *Healing Heritage* (Robbins & Robbins, 1998). *Improvisational Models* is a one-of-a-kind, comprehensive reference that systematically and thoroughly describes salient features of over 25 models of clinical improvisation and their accompanying techniques, dynamics, and processes. It seemed to me that Bruscia's book could provide important theoretical foundations for instruction. One chapter in particular, "Sixty-Four Clinical Techniques" (pp. 533–557) supplied helpful clues about specific skills that would be necessary for the facilitation of improvisation. This was a good start; however, Bruscia's book was not designed to serve as a formula for specific skill development in undergraduate training and thus could not serve as a primary text for this introductory course.

I thought that *Healing Heritage* also could be a valuable resource for the music therapist in training, in that it chronicles important historical information about the life and work of pioneers in the field and emphasizes the importance of various musical elements and their unique power in the therapeutic process. Yet, as I reviewed this publication, it became obvious that its value was also as a supplemental rather than primary text. There were two reasons for this. First, the book clearly represents one specific paradigm, *Nordoff & Robbins Music Therapy* (sometimes referred to as *Creative Music Therapy*). This approach,

perhaps the most thoroughly archived of all models of clinical improvisation, originally called for therapists to work in teams of two, with one person improvising at the piano and the other individual assisting the child in his or her responses to the music and the clinical intentions of the pianist (Bruscia, 1987; Robbins & Robbins, 1991). The material in *Healing Heritage* reflects the primacy of piano in this approach; the material revolves around tonal (melodic and harmonic) aspects of music-making. Only in passing do the authors of *Healing Heritage* make mention of rhythmic features or textual/lyrical aspects of improvisation, both of which I believed were essential for students to incorporate into their practice. Second, the training from which the transcriptions originated was not designed for undergraduates, but rather for 15 students who already possessed a degree or diploma in music and who had demonstrated some level of musical competence. (Most were pianists, and four had worked as therapists for up to five years.) Essential aspects of the sequential development of clinical improvisation skills are missing from this book.

Looking for some guidance, I called friends and colleagues in my region who were teaching at the undergraduate level. I found that, with one exception, the individuals I contacted did not teach self-contained undergraduate courses in improvisation, mostly because they did not feel equipped to do so, having received little or no training themselves. (A recent survey by Hiller [2006] has substantiated that board-certified music therapists report a lack of training in the use of clinical music improvisation during undergraduate courses and internships.) In most cases, my colleagues either "touched on" improvisation in the context of other skill-based units or courses or relied on instructors within their departments to initiate students in music improvisation concepts and applications, often with an orientation toward jazz or Orff-Schulwerk. No one with whom I spoke taught a course specifically in group improvisation, which was my intent.

It was at this point that I realized I would have to formulate my own course content and sequence, relying on the knowledge and skills I had acquired through workshop training and self-directed study, as well as assistance from my teaching partner, who was equally enthusiastic about the course and who had had graduate level training in clinical improvisation. At this juncture, he and I pooled and reviewed the various

resources we had acquired from our own training, including course syllabi, handouts from courses and professional workshops, and notes that we had taken on readings and presentations. We also began creating our own handouts to "fill in the gaps" and to concretize meaningful aspects of our own previous clinical experiences in improvisation.

When the course got off the ground, I began evaluating my decisions about what content to include and in what sequence. I relied dually on my own experiences as the facilitator (sensory, affective, reflective, and intuitive experiences) and on student feedback. The latter manifested as both unsolicited and solicited verbal and written evaluations during class and at the end of each semester. I also sought informal, retrospective feedback from alumni who have taken the course and were practicing in the field. Suggestions from individuals who attended workshops that my teaching partner and I offered at state, regional, and national conferences served as further data for evaluation and revision.

As the years passed, I continued to teach the course, making changes here and there. I also kept vigil for a suitable improvisation textbook. In 2004, Wigram published *Improvisation: Methods and Techniques for Music Therapy Clinicians, Educators and Students* (2004). A few sections of this book have particular relevance for the group improvisation skills that were the focus of the introductory course; however, most of Wigram's writing revolves around tonal constructions on piano and the use of relatively advanced techniques in individual music therapy. What I was looking for was a pedagogical resource that could help me (1) determine which knowledge-based and skill-based competencies my students needed to develop in order to lead effective group improvisation, (2) offer a suggested sequence for training in these competencies, and (3) provide practical exercises toward skill development. With encouragement from others, I decided to write the book I had been searching for.

My interest in forming a course (and eventually writing a book) around skills necessary for the facilitation of group improvisation stems from the notion that in this day and age, most music therapists who practice in this country do not have the luxury of conducting individual therapy sessions exclusively. One reason for this is that group treatment is typically considered more cost-effective than individual treatment by

healthcare insurers and treatment agencies. Another reason is that many clients have treatment goals that are accomplished more readily and successfully within a group context. In that the average music therapist will likely be responsible for planning and facilitating group treatment at some point in her or his career, it makes sense that pedagogy and published resources in one of the four fundamental music therapy methods would reflect this expectation.

ESSENTIAL COMPETENCIES

It seems to me that all music therapists, regardless of the clinical populations and ages they serve or the philosophical or theoretical orientations within which they work, require a set of essential competencies in order to effectively lead group improvisation. These competencies are both knowledge-based and skill-based. In other words, therapists must both *know* certain things and *know how to do* certain things. It should be evident that the first set of competencies has to do with the acquisition of information and the latter has to do with the actions that the therapists perform, ideally, as connected to the knowledge that they have acquired.

The American Music Therapy Association (AMTA) and the Certification Board for Music Therapists (CBMT) each designate professional competencies related to improvisation. AMTA includes three broad skills in its document (AMTA, 1999):

> **8. Improvisation Skills**
> 8.1 Improvise on percussion instruments.
> 8.2 Compose and develop original melodies, accompaniments, and short pieces extemporaneously in a variety of moods and styles, vocally, and instrumentally.
> 8.3 Improvise in small ensembles.

Unfortunately, none of these competencies relates to *clinical* music improvisation; there is no mention of clients or therapeutic processes, essential ingredients that define clinical music improvisation and distinguish it from other forms of improvisation, such as jazz. (Detailed

definitions of clinical music improvisation and music improvisation appear in Chapter Two.)

The CBMT *Scope of Practice* (2005) offers two items for our consideration, the first under the heading *Music Theory, Perception, and Skills in Clinical Situations:*

B. Music Skills and Perception
   4. Improvise music (e.g., vocal, instrumental)

Although the heading indicates that this competency applies to clinical circumstances, there is, again, no mention of clients or therapeutic processes. The second has greater relevance but is just as broad as the others:

A. Treatment Implementation
   3. Use methods to achieve therapeutic goals
      h. improvise music to facilitate therapeutic processes

It is my opinion that students and novice therapists need more clear-cut guidance as they prepare to lead clinical improvisation experiences. Among the skill-based competencies, therapists need both nonmusical and musical skills in order to become effective leaders. Simply put, nonmusical competencies include verbal skills and *gestural* actions (movements performed to communicate feeling or intention), while musical skills involve the musical actions that therapists perform. I believe that these two skill sets, nonmusical and musical, function together toward competent facilitation of clinical improvisation.

When I refer to the musical skills that therapists need in order to lead clinical improvisation, I am talking about *clinical music skills*. Implicit here is that the therapists have already developed certain necessary *foundational music skills*—technique, expression, repertoire, etc., on a primary instrument and several additional instruments. The assumption is that therapists can learn to tailor these skills to the therapeutic setting in order to establish and maintain a meaningful relationship with their clients and help these clients progress toward established goals and objectives. Foundational music skills are, for example, what enable therapists to (1) maintain a steady pulse, (2)

generate varied rhythmic patterns, (3) modify dynamics, and (4) play an unmetered tremolo, none of which, at face value, have any particular clinical purpose or require any kind of relationship with another player. Clinical music skills, on the other hand, are employed when those same therapists (1) maintain a steady pulse as a way to provide needed constancy for the other players, (2) generate varied rhythmic patterns to discourage unhealthy rigidity and entice novel musical dialogue, (3) modify dynamics in order to model freedom of expression of various feeling states, and (4) play an unmetered tremolo in order to suspend the improvisation while the players switch instruments, reflect on what they have just played, or decide what to play next. In other words, music therapists who have developed clinical music skills are able to create music in an authentic, communicative, flexible, and intentional manner. In this context, *authentic* means with genuineness of expression, *communicative* means with a desire and ability to make meaningful contact with the other players, *flexible* means in a responsive and adaptable manner, and *intentional* means with a clear clinical purpose in mind. It is, perhaps, a combination of these four dimensions that therapists ultimately ought to strive to achieve in their improvisational work.

Darnley-Smith and Patey (2003) write about discerning some of these clinical music abilities in the potential music therapy candidate:

> In addition to playing prepared music, can the player improvise in response to another player? Do they listen to what another might play and respond in the moment? Can they use their voice to sing expressively, even if they might never have had formal training? Of prime importance, music therapists need to feel 'at home' in playing music. It needs to be an integral part of them, both in terms of what they do in their lives and as a natural means of self-expression. This is a relationship which formal training with a certificate can suggest but never guarantee. (p. 57)

It is obvious from my experiences as an educator that some of the most technically or expressively talented students (those who possess solid foundational skills) have great difficulty moving past printed notes on the page in order to reach this kind of personal connection to their authentic

"inner music" and its outward communicative power with clients. Does this mean that these individuals have nothing to offer the field of music therapy? Certainly not! It means that they need to work extra hard to find and create opportunities for meaningful connections with their own music-making and a chance to share these experiences with others. I have created some of the exercises in this book to assist in this process, but this is only the beginning. There is always more work to be done. And, while I firmly embrace the value of improvisation as a therapeutic method, when all is said and done, I also recognize that improvisation is not a "good fit" for every music therapist.

In preparing this book, it is my assumption that most undergraduate students (some percussion majors excepted) have not had sufficient foundational training on percussion instruments, even though these are used more often by certified music therapists than other instruments in group-based improvisation (Hiller, 2006). In my experience, although students may have taken a course or two in percussion techniques or percussion pedagogy, unless these courses are taught or informed by music therapy faculty, the focus is almost always on the playing, teaching, and maintenance of symphonic instruments. I sense that this is gradually changing, with the increasing popularity of and media attention to ethnic instruments and their use in a wide variety of musical genres. At present, however, most of the students whom I encounter have had little or no prior training on the percussion instruments common to music therapy improvisation—djembes, congas, bongos, bodhrans, hand-held rhythm instruments, etc. For this reason, I have included rhythm-based foundational music skill exercises in this text, interspersed among exercises that focus upon the use of these skills toward specific clinical aims.

Likewise, although most musicians have had adequate training in identifying and playing conventional Western scales and modes (chromatic, major, and minor) and the harmonies based upon them, the modalities and harmonies used in clinical improvisation reach beyond these to include unconventional tonal constructions. Thus, I have included some tonal-based foundational music skill exercises.

The knowledge-based and skill-based competencies in the book have been created primarily from my own work in the classroom and clinic with undergraduate students. As noted above, I have also relied

heavily upon several of the facilitation techniques that appear in Bruscia's "Sixty-Four Clinical Techniques" in *Improvisational Models of Music Therapy* (1987, pp. 533–557). Those that I have chosen to include verbatim from this comprehensive list are music-based techniques that my students and I have found most pertinent to undergraduate pre-clinical and clinical training.

Altogether, the competencies pinpointed in this book fall into three categories: Preparatory Skills, Facilitative Skills, and Verbal Processing Skills. *Preparatory Skills* (PR) refer to those decisions and actions of the therapist that, in some cases, precede the arrival of the players and, in all cases, precede the actual music improvisation. In the "before, during, and after" of improvisation, Preparatory Skills are employed *before the experience.* They revolve around the ability of the therapist to comprehend terms and nomenclature germane to the method (Chapter Two), to manipulate the tools and settings used for improvisation, including musical instruments (Chapter Three) and elements (Chapter Four), and to determine suitable structures for improvisation (Chapter Five).

Facilitative Skills revolve around the ability of the therapist to employ techniques that will elicit a response from the players or shape their immediate experience (Bruscia, 1987). In the "before, during, and after" of improvisation, Facilitation Skills are employed *during the experience.* These skills include the ability to use nonmusical (NM) (Chapter Six) and musical (MU) techniques (Chapter Seven) in order to engage your clients, and being able to listen (LI), comprehend, and describe what is heard (Chapter Eight).

Verbal Processing Skills (VP) refer to those skills required to effectively sort out and verbally process the improvisation experience. In the "before, during, and after" of improvisation, Verbal Processing Skills (Chapter Nine) are employed *after the experience.* These skills help the therapist to recognize and discuss significant aspects of the experience with clients and may assist her or his communication with co-therapists, and/or supervisors.

Specific Preparatory, Facilitative, and Processing competencies are displayed in Appendix A and at the top of certain sections within the chapters that follow, as relevant. (Note: Appendix A can be used as a competency checklist to track ongoing progress.)

SUGGESTIONS FOR USING THIS BOOK

This book contains 80 exercises designed to reinforce competency in the aforementioned areas (see Appendix B). The exercises represent three types of learning that have emerged as invariable aspects of the introductory course that I teach. I term these *Didactic Learning*, *Experiential Learning*, and *Independent Skill Development*. Didactic Learning relates to philosophical, theoretical, and/or practical information that is communicated via lecture, discussion, and modeling. Experiential Learning refers to the students' first-hand experiences in the learning/therapy group process that accompanies didactic instruction. In this form of learning, students have opportunities to observe, participate in, co-lead, lead, and verbally process improvisation experiences. In Independent Skill Development, the third style of learning, students engage in skill-building experiences independently and with partners, outside of the classroom setting.

The exercises for Experiential Learning and Independent Skill Development are meant to serve as a "jumping off point" in the maturity of specific competencies. As such, the reader should feel free to abbreviate, simplify, amplify, or modify the exercises as needed. Repetition of exercises is recommended if time permits.

The book also contains several, diverse clinical vignettes designed to serve as models or challenge the reader to grapple with clinical decisions related to the use of improvisation.

If this book is used as a text for an undergraduate course, it is suggested that students complete reading assignments prior to classroom sessions and that the instructor allow ample time to present the material and answer questions that may arise before proceeding to the practical exercises. It is further recommended that the instructor assume a variety of roles during the group exercises, including observer, facilitator, and participant. The instructor's decision of which part to play, like the therapist's decision in clinical improvisation, will be dependent upon the goal of the exercise and the particular needs, strengths, deficits, and dynamics of the group. Each of these three roles has distinct advantages: Acting as an observer, the instructor is able to perceive "the whole picture" or attend to details that she or he may otherwise miss while

engaged in music-making. This role also affords the group an opportunity to work through certain challenges without relying on the certainty of being "rescued" by the leader. Acting as a facilitator, the instructor can direct, model, and provide immediate feedback. Acting as a participant with no leadership responsibilities, the instructor can share in the experience of authentic expression and relate to the other players with more equanimity and intimacy.

I strongly recommend periodic lengthening of appropriate exercises in order to allow for sustained engagement in improvisation. *Sustained engagement* (defined here as improvising in a continuous fashion for more than five minutes) has several distinct benefits. First, players need to build stamina in preparation for leading lengthy group improvisations. Second, the improvisers usually develop confidence and become more expressive as they become increasingly familiar with and trusting of their instruments and the group process. Third, novel musical challenges undoubtedly emerge as time passes, giving the players a chance to employ coping and problem-solving skills. Finally, authentic relationships among the players in a group usually need ample time to emerge and mature.

At the end of each chapter, I have placed a vocabulary list of terms that are considered to be important for review. The instructor and students may use this list as a way to summarize the chapter, to review at the start of each new class session, or to evaluate comprehension and retention on a periodic basis. I have found that repeating a brief group exercise from the previous session and asking students to demonstrate what they have accomplished in their independent skill practice are effective means of starting each new class session. At times, I have asked individual students to begin the session by leading the group in an original exercise that targets a specific competency.

If there are students in the classroom who have advanced musical skills, they may be able to assume a greater leadership role than their peers. For instance, they may take responsibility for starting or stopping the improvisation experiences, providing individual assistance for the players who are having difficulty with certain manipulative skills, creating or adapting group exercises, and/or observing the improvisation experiences and providing verbal feedback. I also have relied on the

advanced percussionists to help me keep the instruments tuned and in good working condition.

Vocabulary for Chapter One

1. *Nordoff & Robbins Music Therapy (Creative Music Therapy)*
2. *Gestural*
3. *Foundational Music Skills*
4. *Clinical Music Skills*
5. *Authentic*
6. *Communicative*
7. *Flexible*
8. *Intentional*
9. *Preparatory Skills*
10. *Nonmusical Facilitative Skills*
11. *Musical Facilitative Skills*
12. *Verbal Processing Skills*
13. *Didactic Learning*
14. *Experiential Learning*
15. *Independent Skill Development*
16. *Sustained Engagement*